St Helens and Knowsley Teaching Hospitals NHS Trust

STHK Trust Board Papers – May 2020

issued in lieu of meeting

Public Board Papers attached:		
1.	Action Log	Attached
2.	Integrated Performance Report	NHST(20)32
3.	Committee Report – Quality Committee	NHST(20)33
4.	Committee Report – Finance & Performance Committee	NHST(20)34
5.	Aggregated Complaints, Incidents & Claims	NHST(20)35
6.	Information Governance Annual Report	NHST(20)36
7.	Trust Objectives 2019/20 and End of Year Review	NHST(20)37

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 27TH MAY 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. DEFERRED DUE TO COVID-19**	AM	**TBC**
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. DEFERRED DUE TO COVID-19**	RPJ	29.07.2020
30	29.01.2020 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **DEFERRED DUE TO COVID-19**	NB/NK	**TBC**
33	29.01.2020 (15.7)	Include the introduction of a Shadow Board in the Trust's Workforce Leadership Priorities for 2020/21 in the next HR Workforce Strategy/HR Indicators Report.	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. **DEFERRED DUE TO COVID-19**	AM	**TBC**
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	**TBC**

St Helens and Knowsley Teaching Hospitals NHS Trust

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(20)032
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 was 1 Never Event in April 2020 relating to wrong site administration of nerve block. (YTD = 1).

There were no cases of MRSA in April 2020. (YTD = 0).

There were 3 C.Difficile (CDI) positive cases reported in April 2020 (3 hospital onset and 0 community onset). (YTD = 3). The annual tolerance for CDI for 2020-21 has not yet been published (the 2019-2020 trajectory is being used in the absence of publication of the 2020-21 objectives).

There were no grade 3 avoidable pressure ulcers in March 2020. (2019-20 YTD = 1).

During the month of March 2020 there were 3 falls resulting in severe harm. (2019-20 YTD Severe harm fall = 13)

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2020 was 95.3%. 2019-20 YTD rate is 96.3%. March and April 2020 returns have been suspended.

Performance for VTE assessment for February 2020 was 95.70% against a target of 95%. (2019-20 YTD = 95.54%). March and April 2020 returns have been suspended.

YTD HSMR (April -November) for 2019-20 is 104.7

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: 27th May 2020

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (March 2020) at 88.0%. YTD 86.2%. Performance in February 2020 was 83.4%. The 31 day target was achieved with 96.0% performance in month against a target of 96%, YTD 97.1%. Performance in February 2020 was 95.95%.
The 2 week rule target was achieved with 94.5% in month and 91.0% YTD against a target of 93.0%. Performance in February 2020 was 95.7%. Cancer work continues in conjunction with Clatterbridge and Surgical Cancer hub in development.

Accident and Emergency Type 1 performance for April 2020 was 81.8% and YTD 81.8%. Type 1 Performance in March 2020 was 74.0%. The all type mapped STHK Trust footprint performance for April was 88.5% and YTD 88.5%**.** All Types performance in March 2020 was 85.6%. Due to the impact of Covid-19, the Trust received only 5,548 Type 1 attendances in April 2020 (compared with 9,911 in April 2019 and 7,835 in March 2020). 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.

Total ambulance turnaround time was 31 mins in April (actual notification to handover time has not yet been published but was achieved at circa 11 mins on average (target 15 mins). Notification to handover time in March 2020 was 14:37 mins. There were 2168 ambulance conveyances in April and 2,460 in March 2020.
NB: ***STHK had the highest number of ambulance conveyances across Cheshire and Merseyside and Greater Manchester in April .***

The average number of super stranded patients in April was 66 which was significantly below the target of 92 @ end of March 2020. (100 was the average in March).

The 18 week referral to treatment target (RTT) was not achieved in April 2020 with 83.3% compliance and YTD 83.3% (Target 92%). Performance in March 2020 was 90.3%. There were 3 52+ week waiters. The 6 week diagnostic target was achieved in March with 99.7% compliance (Target 99%). Performance in February 2020 was 99.9% **NB Elective programme closed down with only urgent and 2ww patients being managed.**

Financial Performance

At the March 2020 Board the Trust agreed to a plan of £0.3m deficit excluding the Financial Recovery Fund (FRF). This allowed the Trust to access £0.3m of FRF assuming the planned deficit is achieved.

Following the COVID-19 crisis the financial regime for 2020/21 was put on hold and a system introduced to ensure all Trusts remained in financial balance for an initial period of four months from April to July 2020. All PBR payments have been replaced with a block payment on account with any additional expenditure above this value reimbursed in a retrospective top up including costs incurred relating to COVID.

Surplus/Deficit - At the end of month 1 StHK has reported a balanced YTD position in line with guidance. Within this the Trust has assumed full reimbursement of COVID related costs of and additional expenditure incurred.

The agency ceiling issued by regulators for 2020/21 is £7.8m which was a £0.2m increase on 2019/20. In total the current spend is £0.6m which is £0.3m below the agency cap and in line with the previous years spend.

The requirement for CIP is currently on hold under the block payment arrangement.

At the end of month 1, the cash balance was £36.6m. This high closing balance was due to changes in funding arrangements related to COVID-19.

Human Resources

In March sickness was 7.3%, this has increased to 9.4% in April due COVID-19 which is an increase of 2.1%. This includes normal sickness reasons at 6.3% and those sick with COVID19 symptoms. These figures do not include a further c. 6% of staff off work due to isolating, shielding, pregnancy or special leave. Qualified Nursing, Midwifery & HCA sickness was 11.9% .
Mandatory Training compliance is 81.2% (target = 85%) and the appraisal compliance of 74.4% (target = 85%) was significantly affected in month by covid.

The following key applies to the Integrated Performance Report:

▲ = 2020-21 Contract Indicator

▲ £ = 2020-21 Contract Indicator with financial penalty

● = 2020-21 CQUIN indicator

T = Trust internal target

UOR = Use of Resources

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-20	6.6%	6.6%	No Target	2.4%		A recent unexpected rise in HSMR 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	▲	Nov-19	1.09		1.00						
Mortality: HSMR (HED)	Q	▲	Nov-19	97.7		100.0	104.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Nov-19	109.3		100.0	104.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Oct-19	97.7		100.0	98.9		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust continues to work internally and with healthcare partners to minimise unnecessary readmissions.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Nov-19	97.0		100.0	92.1		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	Nov-19	101.2		100.0	99.5					
% Medical Outliers	F&P	T	Apr-20	0.1%	0.1%	1.0%	1.0%		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	Apr-20	93.3%	93.3%	52.5%	39.3%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Mar-20	75.2%		90.0%	72.3%		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. OP attendance letters - As a result of COVID many appointments had to be moved or replaced with telephone appointments. Due to the need to rapidly implement this change our reporting of these data is being reviewed for accuracy. 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. Whilst ED has significantly improved, OP has deteriorated in March. We are investigating what might sit behind this unexpected observation.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Mar-20			95.0%	87.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Mar-20	96.5%		95.0%	94.9%					

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CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

St Helens and Knowsley Teaching Hospitals NHS Trust

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Mar-20	91.2%		83.0%	89.3%		Target is being achieved. 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	▲ £	Apr-20	1	1	0	1		Never event reported in April 2020, relating to wrong site administration of nerve block.	Quality and patient safety	RCA is being undertaken. Immediate actions in place to mitigate chances of recurrence. Safer surgery actions and checks in place to minimise the likelihood of never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20	98.5%		98.9%	98.7%		Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Apr-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	▲ £	Apr-20	0	0	0	1		There were no cases of MRSA in April 2020.	Quality and patient safety	The annual tolerance for CDI for 2020-21 has not yet been published. The 2019-2020 trajectory is being used in the absence of publication of the 2020-21 objectives.	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Apr-20	3	3	48	43		There were 3 positive C Diff samples in April 2020. Internal RCAs on-going with more recent cases of C. Diff.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Apr-20	1	1	No Target	25					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Mar-20	0		No Contract target	1		One category 3 avoidable pressure ulcer reported in November 2019	Quality and patient safety	The incident has undergone RCA process, a missed opportunities or lapse in case identified. Action plan in place for improvement	SR
Number of falls resulting in severe harm or death	Q	▲	Mar-20	3		No Contract target	13		3 falls resulting in severe harm in March 2020	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	▲ £	Feb-20	95.70%		95.0%	95.54%		**March and April 2020 submissions suspended.** 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	Mar-20	3		No Target	26					
To achieve and maintain CQC registration	Q		Apr-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%		No Target	96.3%		**March and April 2020 submissions suspended.** 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	Feb-20	1		No Target	5					

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St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	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	▲ £	Mar-20	94.5%		93.0%	91.0%		Cancer services continue to operate a restricted service due to COVID. Ongoing tracking of patients and development of Cancer Surgical Hub begun	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity 2. Capacity demand review on going at speciality level 3. Trust pilot site for SFIT lower GI which will improve cancer access and pathways. full roll out of pilot commenced early 2020 4. Trust commenced Rapid Diagnostic Service early 2020 5. development of Cancer surgical Hub	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Mar-20	96.0%		96.0%	97.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Mar-20	88.0%		85.0%	86.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Apr-20	83.3%	83.3%	92.0%	90.3%		COVID restrictions to elective programme causing drop in RTT performance. Each patient remains on PTL and tracked. OP process in place to manage referrals and existing PTL	COVID restrictions have stopped elective programme and therefore the ability to achieve RTT is not possible. Many surgical wards converted to Medical wards to support COVID admissions	RTT continues to be monitored and patients tracked.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Mar-20	99.7%		99.0%	99.7%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Apr-20	3	3	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-20	0.4%	0.4%	0.8%	0.7%		Reportable cancellations improved in April due to the reduction in activity levels. The 28 day re-list target was failed in March due to the cessation of all routine elective activity All routine elective work cancelled until COVID restrictions lifted	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Mar-20	91.4%		100.0%	98.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20	0		0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-20	81.8%	81.8%	95.0%	69.8%		Accident and Emergency Type 1 performance for April 2020 was 81.0% and YTD 81.0%. Type 1 Performance in March 2020 was 74.0 % The all type mapped STHK Trust footprint performance for April was 88.5% and YTD 88.5%. All Types performance in March 2020 was 85.6%. Due to the impact of Covid-19, the Trust received only 5,548 Type 1 attendances in April 2020 (compared with 9,911 in April 2019 and 7.835 in March 2020). 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. Total ambulance turnaround time was 31 mins in April (actual notification to handover time has not yet been published but was achieved at circa 11 mins on average. on average (target 15 mins). Notification to handover time in March 2020 was 14:37 mins. There were 2168 ambulance conveyances in April and 2,460 in March 2020. NB: STHK had the highest number of ambulance conveyances across Cheshire and Merseyside and Greater Manchester in April .	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	▲	Apr-20	88.5%	88.5%	95.0%	83.9%					
A&E: 12 hour trolley waits	F&P	▲	Apr-20	0	0	0	0					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Feb-20	0		0	2		**March and April 2020 submissions suspended.** 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	Apr-20	9	9	No Target	319		% new (Stage 1) complaints resolved within agreed timescales continues to remain above the 90% target. Number of new complaints received dropped significantly in April, with 100% responded to in the agreed timescales.	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. Complainants made aware in April of the significant delays that will be experienced in receiving responses going forward due to current operational pressures.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Apr-20	16	16	No Target	310					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Apr-20	100.0%	100.0%	No Target	92.9%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20	24		No Target	21		**March and April 2020 submissions suspended.** In February 2020, the average number of DTOCS (patients delayed over 72 hours) was 24.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Apr-20	202	202		333					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Apr-20	66	66		126					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-20	86.7%		90.0%	86.5%		**March and April 2020 submissions suspended.** 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%		90.0%	95.6%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-20	100.0%		98.1%	98.8%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-20	100.0%		98.1%	97.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-20	100.0%		95.1%	96.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-20	100.0%		98.6%	99.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-20	95.0%		95.0%	94.6%					

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NHS St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Apr-20	9.4%	9.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.3%		In overall April sickness was 9.4%. This includes normal sickness reasons at 6.3% and those sick with COVID19 symptoms. Front line Nursing, Midwifery and HCA's is 2.5% higher than the overall Trust rate. In May all sickness is now improving on a daily basis. N.B These figures do not include, staff in isolation, pregnant workers, staff shielding, or on special leave due to carer responsibilities	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Due to COVID-19, there has been a steep increase in sickness. On a daily basis, the HR Advisory Team are reviewing COVID and non COVID absences to ensure staff eligible for swabbing are referred to HWWB, those who are near end of period of self isolation are returning to work and those who are on LTS due to non COVID are managed accordingly inline with policy. Additional health and well being support is provided to help staff with stress, anxiety and depression caused by the impact of COVID19.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Apr-20	11.9%	11.9%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-20	74.4%	74.4%	85.0%	79.4%		Appraisal compliance in April is below target by 10.6% due to appraisals being paused for 3 months due to covid. Mandatory training compliance has reduced by 3.3% since last month and is below the target by 3.8%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The improvements made last months have been impacted by COVID 19 with both Appraisal and Mandatory training compliance seeing a reduction in performance in month to below the target. Managers reported they were struggling to identify sufficient capacity to complete appraisals and release staff for training due to COVID19. The completion of appraisals has been paused for 3 months during COVID19 and the content of Mandatory training has been adjusted to allow focus on IV. ventilation skills, induction and clinical refresher courses.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Apr-20	81.2%	81.2%	85.0%	84.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2			No Contract Target			**Quarter 4 submission suspended.** 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			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Apr-20	0.5%	0.5%	No Target	10.1%		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	Apr-20	3.0	3.0	3.0				Delivery of Control Total	The 2021 financial plan has been put on hold and a system introduced where Trusts will breakeven for the first four months of 2020/21.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Apr-20									
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Apr-20	0	0	0						
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-20	11	11	2						
Capital spend £ YTD (000's)	F&P	T	Apr-20	1,909	1,909	26,700						
Financial forecast outturn & performance against plan	F&P	T	Apr-20			-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-20	83.2%	83.2%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-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	▲ £	100.0%	100.0%	84.6%	73.7%	100.0%	89.7%	100.0%	89.5%	100.0%	100.0%	100.0%	100.0%	94.6%	92.7%	85.0%		96.5%		
	Total > 62 days		0.0	0.0	1.0	5.0	0.0	2.0	0.0	2.0	0.0	0.0	0.0	0.0	1.0	11.0			5.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					
Lower GI	% Within 62 days	▲ £	80.0%	94.4%	100.0%	88.9%	60.0%	60.0%	85.7%	100.0%	78.9%	100.0%	50.0%	100.0%	82.6%	83.2%	85.0%		86.6%		
	Total > 62 days		1.0	0.5	0.0	0.5	3.0	2.0	1.0	0.0	2.0	0.0	2.0	0.0	2.0	13.0			10.5		
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	2.0					
Upper GI	% Within 62 days	▲ £	75.0%	88.9%	85.7%	83.3%	90.9%	100.0%	85.7%	100.0%	87.5%	88.9%	100.0%	100.0%	80.0%	90.5%	85.0%		74.7%		
	Total > 62 days		1.5	0.5	1.0	1.0	0.5	0.0	1.0	0.0	1.0	0.5	0.0	0.0	1.0	6.5			12.0		
	Total > 104 days		0.5	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0					
Urological	% Within 62 days	▲ £	90.9%	87.1%	91.3%	96.9%	87.5%	83.3%	92.3%	84.6%	92.0%	86.4%	86.4%	69.2%	79.3%	85.5%	85.0%		86.0%		
	Total > 62 days		1.5	2.0	1.0	0.5	2.5	3.0	1.0	2.0	1.0	1.5	1.5	6.0	3.0	25.0			29.0		
	Total > 104 days		0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.0	0.5	0.5	1.0	1.0	0.0	5.5					
Head & Neck	% Within 62 days	▲ £	100.0%	0.0%	25.0%	0.0%	16.7%	50.0%	28.6%	28.6%	20.0%	66.7%		25.0%	20.0%	29.3%	85.0%		57.1%		
	Total > 62 days		0.0	1.5	3.0	0.5	2.5	1.5	2.5	2.5	2.0	1.0		1.5	2.0	20.5			12.0		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	1.5	1.0	0.0	0.0		0.0	1.0	4.0					
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	▲ £	77.8%	66.7%	100.0%	40.0%	83.3%	40.0%	50.0%	0.0%	75.0%	54.5%	80.0%	66.7%	100.0%	69.1%	85.0%		77.8%		
	Total > 62 days		1.0	2.0	0.0	3.0	1.0	3.0	1.0	0.5	1.0	2.5	1.0	2.0	0.0	17.0			10.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.0	0.0	0.0	0.0	0.0	1.5					
Lung	% Within 62 days	▲ £	92.9%	71.4%	100.0%	88.2%	100.0%	100.0%	57.1%	90.0%	100.0%	58.3%	100.0%	71.4%	75.0%	85.0%	85.0%		90.4%		
	Total > 62 days		0.5	1.0	0.0	1.0	0.0	0.0	3.0	1.0	0.0	2.5	0.0	1.0	1.0	10.5			8.0		RC
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.5	2.5					
Haematological	% Within 62 days	▲ £	83.3%	100.0%	80.0%	100.0%	50.0%	85.7%	100.0%	78.9%	100.0%	86.7%	80.0%	100.0%	100.0%	86.7%	85.0%		76.7%		
	Total > 62 days		1.0	0.0	1.0	0.0	1.0	1.0	0.0	2.0	0.0	1.0	1.0	0.0	0.0	7.0			9.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0					
Skin	% Within 62 days	▲ £	94.9%	95.0%	97.1%	94.4%	92.8%	95.0%	98.2%	80.2%	94.4%	95.8%	78.4%	93.9%	95.2%	92.0%	85.0%		93.4%		
	Total > 62 days		1.0	1.0	0.5	1.5	2.5	1.5	0.5	8.0	1.5	1.0	5.5	1.5	1.5	26.5			20.5		
	Total > 104 days		0.0	0.0	0.0	1.5	1.0	0.5	0.0	1.5	0.5	0.5	1.5	1.5	1.0	9.5					
Unknown	% Within 62 days	▲ £	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	0.0	1.5	0.0		0.0				0.0	0.5			2.0			1.0		
	Total > 104 days		0.0	0.0	0.5	0.0		0.0				0.0	0.0			0.5					
All Tumour Sites	% Within 62 days	▲ £	90.0%	89.6%	87.6%	85.6%	85.7%	85.9%	86.2%	83.1%	88.9%	86.2%	85.2%	83.4%	88.0%	86.2%	85.0%		88.3%		
	Total > 62 days		8.0	8.5	9.0	13.0	13.0	14.0	11.0	18.0	9.5	10.0	11.5	12.0	11.5	141.0			119.5		
	Total > 104 days		1.0	1.5	2.0	1.5	3.0	1.0	2.5	5.0	1.0	1.5	2.5	2.5	3.5	27.5					
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £				100.0%	66.7%									80.0%	85.0%		90.0%		
	Total > 31 days					0.0	0.5									0.5			1.0		
	Total > 104 days					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)033

Title of paper: Committee Report – Quality Committee

Purpose: To summarise May's Quality Committee papers which were distributed on 15th May 2020. No meeting was held due to the current pandemic.

Agenda Items Discussed

Integrated Performance Report (IPR)
IPR highlighted improving HSMR score and noted the impact of COVID-19 on a number of indicators including 52 week waits and staff sickness and on the suspension of the reporting of some key indicators including safer staffing and friends and family test.

Incidents, Never Events and Serious Incidents Thematic Review
The report summarised the number and type of incidents reported, noting a slight decrease in reported incidents in Q4. The report highlighted the actions being taken to address lessons learned from Q3 and Q4's 16 Strategic Executive Information System (StEIS) reported incidents, including the actions being taken by the falls team. It was noted that the number of StEIS reportable falls per calendar month has fallen in the last four successive years.

Quality Improvement/Clinical Audit Activity Report: Quarter 3 2019-220
The report provided information on the number of audit projects completed and disseminated in Q3, as well as the number of newly registered projects, highlighting the broad range of services audited and action plans submitted.

Mortality Surveillance Update
The report provided an update on the extensions made to the criteria for cases to be reviewed and the strengthened process in place to provide assurance that any areas of concern in specific diagnostic groups are identified as early as possible. A quality improvement tool has been developed that will be used to review all COVID-19 deaths within the Trust.

National Institute for Health and Care Excellence (NICE) Guidance Compliance
The Trust's process for monitoring compliance with newly released NICE guidance was outlined, with a summary of quarterly compliance, the actions taken to address any gaps and a full list of audits taken based on NICE guidance.

Workforce Strategy 2019-20 Action Plan Update
A summary of progress in delivering the action plan to address the priorities outlined in the national interim People Plan and in the NHS Long-term Plan. It was noted that the majority of actions have been completed or are on trajectory to be delivered by the due date and that ongoing work is required to sustain the progress.

Assurance
Committee members were assured in respect of ongoing oversight of StEIS reported incidents, delivery of audit programme, compliance with NICE guidance and delivery of the Workforce Strategy.

Additional Information Requested Committee members have requested further information relating to stroke care, mortality and nutritional support for patients. **Matters for Escalation to the Board** There were no matters for escalation to the Board.
Corporate objectives met or risks addressed: Care, safety, pathways, communication, system
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff, regulators and commissioners
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: Gill Brown, Non-Executive Director and Chair of Committee
Date of meeting: 27th May 2020

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST BOARD

Paper No: NHST(20)034
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 21st May 2020

Summary:

Conference call attended by:

N Khashu – Director of Finance & Information
R Cooper – Director of Operations & Performance
I Clayton – NED
P Growney – NED
J Kozer* - NED (separate call)
G Lawrence – Deputy Director of Finance & Information

Agenda Items

For Assurance

- Integrated Performance Report
    - It was noted that there had been 1 never event in April 2020.
    - It was noted that all statutory targets were below target as a direct result of the current COVID-19 pandemic.
    - It was noted that while A&E attendances were down during April, activity has started to increase during May.
- Finance Report
    - The Trust has delivered a break-even position in line with national planning assumptions. This had been delivered by accruing a further c£5m in relation to "top ups" on agreed block contracts.
    - The strong cash position was noted as a result of commissioners paying block contracts one month in advance.
    - It was noted that the Trust's capital programme had yet to be approved as a result of the C&M HCP exceeding the capital allocation issued by NHSE/I.
- NHSE/I Budget allocations
    - The committee noted the report and understood the rationale for the Trust requiring adjustments to the base income and expenditure assumptions issued by NHSE/I.
    - The committee looked at detail to the drivers of the increases and the costs associated to the COVID-19 response.
    - The committee noted the governance that had been supporting the approval of all COVID costs.

Risks noted/Items to be raised at Board:

- The committee noted the risk on the capital programme because of the Cheshire & Merseyside HCP being over-subscribed on the central capital allocation.
- The committee noted the risks in the delay in treating patients in line with statutory standards with the direct cause being the current pandemic.

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 27th May 2020

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(20)035
Title of paper: Incidents, Complaints, Concerns & Claims – Quarter 4 2019-20
Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 4 2019-20 (Q4).
Summary • Total incidents in Q4 = 3729, a 7% decrease from Q3 • Total patient incidents in Q4 = 3091, a 7.7% decrease from Q3 • Total patient incidents graded as moderate/severe/death = 42, 7% decrease from Q3 • The highest number of incidents reported relate to falls (564) and pressure sores (557) • Number of complaints received in Q4 = 88, compared to 85 in Q3 • Number of PALS contacts in Q4 = 810, compared to 739 in Q3 • Number of new claims received in Q4 = 9, compared to 16 in Q3 • The top reasons for patient complaints, PALS contacts and claims have been consistent for the last four quarters. The most common reasons remain; clinical care, communications, waiting times, patient care/nursing care and values and behaviours of staff.
Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Anne Rosbotham-Williams, Deputy Director of Governance on behalf of Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 27th May 2020

1. Introduction

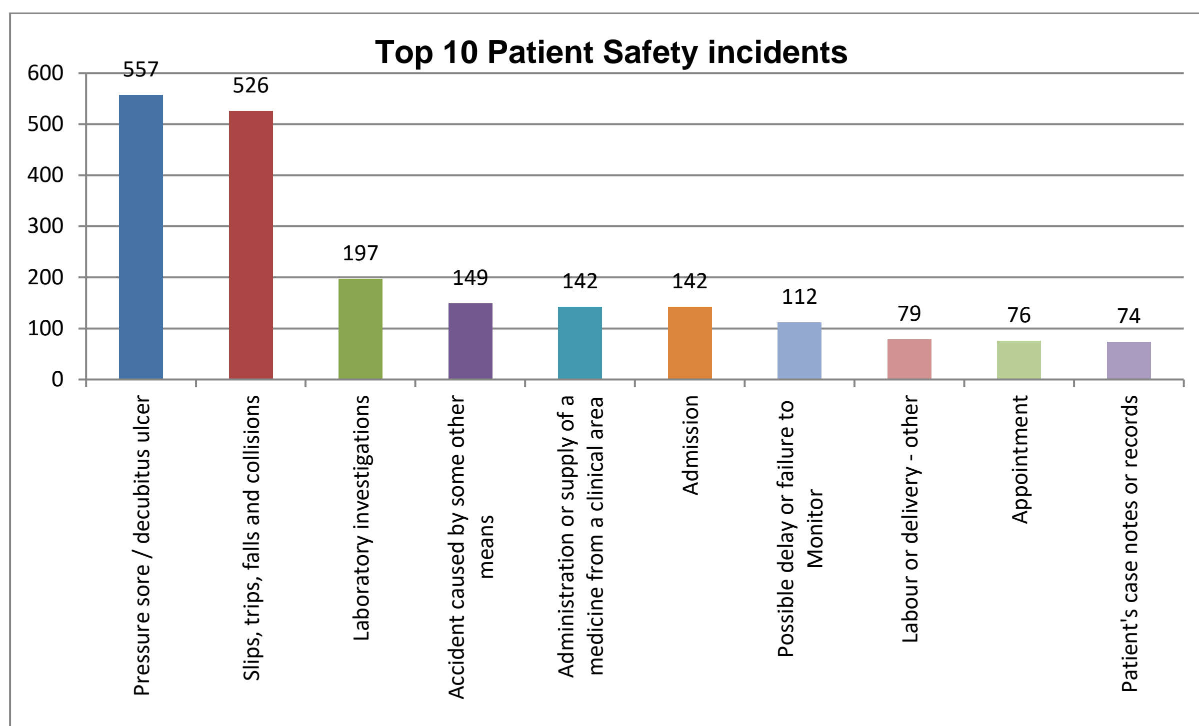
This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarter 4 (January – March 2020), highlighting any trends, areas of concern and the learning that has taken place.

The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

During Q4 there were 3729 incidents reported, of which 3091 were patient safety incidents. 10 incidents were reported to StEIS and 42 categorised as moderate harm, severe harm or death. In comparison, during Q3 there were 4011 incidents reported of which 3348 were patient safety incidents, indicating 7.03% decrease on total incidents and 7.68% decrease on patient safety incidents. 6 incidents were reported to StEIS and 45 categorised as moderate or above, which is a 6.67% decrease from Q3.

All patient safety incidents are categorised by the NRLS dataset. The highest reported categories are pressure ulcers which include community acquired and hospital acquired and slip, trip and falls. These are consistently the highest reported incidents as in Q3 there were 626 pressure sores reported and 519 falls.



2.1. Review of incidents reported to StEIS in Q4 2019-20

In Q4, the Trust reported 10 incidents to StEIS as outlined in the table below.

Incident	Total
Inpatient falls sustaining fractured neck of femur	3
Sepsis pathway not followed	1
Suboptimal care of deteriorating patient	1
Intrapartum death. HSIB Investigation	1
Squamous cell carcinoma (SCC) left ear - delay in diagnosis	1
Occipital Haemorrhage	1
Delayed diagnosis of lung cancer	1
Never event - retained swab	1

During Q4 there were 3 StEIS reports submitted to the CCG, with examples of lessons learned and actions taken in Appendix 1.

2.2. Duty of Candour

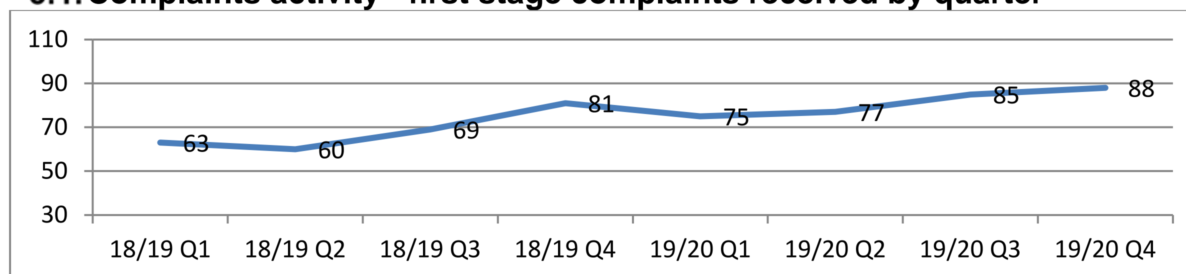
Duty of candour was completed for all cases reported via StEIS in the table above.

3. Complaints

Indicator	2017-18	2018-19	2019-2020				
			Q1	Q2	Q3	Q4	Total
Total number of new complaints including community and primary care services	224	273	75	77	85	88	325
Total number of new complaints received (excluding community and primary care services)	224	267	74	76	84	86	320
Acknowledged within 3 days – target 100%	97.8%	99.3%	100%	100%	100%	100 %	100%
Response to first stage complaints within agreed timescale – target 90%	67%	92.1%	95.6%	91.9%	93.6%	92.8%	93.4%
Number of overdue complaints	1	1	1	1	6	1	1
Second stage complaints	44	36	10	6	14	6	36

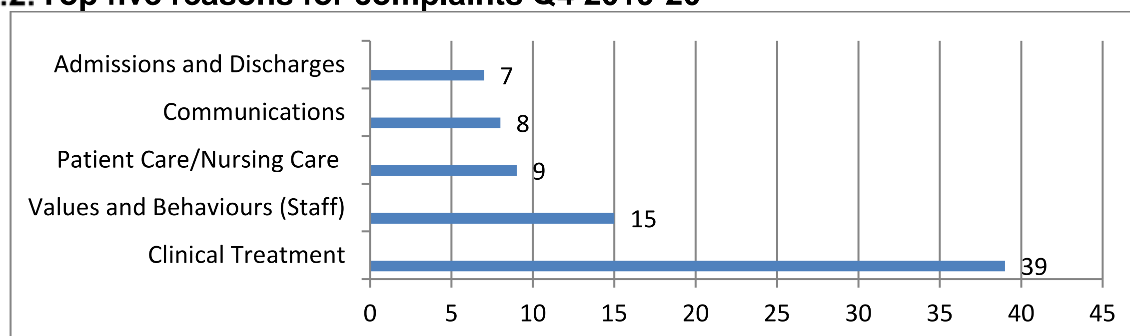
The table above indicates that the Trust received 325 complaints in 2019-20, a 19% increase from 2018-19 when 273 complaints were received in total. The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation in 2019-20 compared to 99.3% in 2018-19. The Trust's response time to first stage complaints increased slightly to 93.4% in 2019-20 from 92.1% in 2018-19. The Trust received 36 second stage complaints in 2019-20, the same as 2018-19. The number of overdue complaints in 2019-20 was 1, the same as 2018-19, which demonstrates that the Trust continues to sustain the improvements made to complaints handling.

3.1. Complaints activity - first stage complaints received by quarter



The number of first stage complaints received during 2019-20 has increased compared to 2018-19.

3.2. Top five reasons for complaints Q4 2019-20



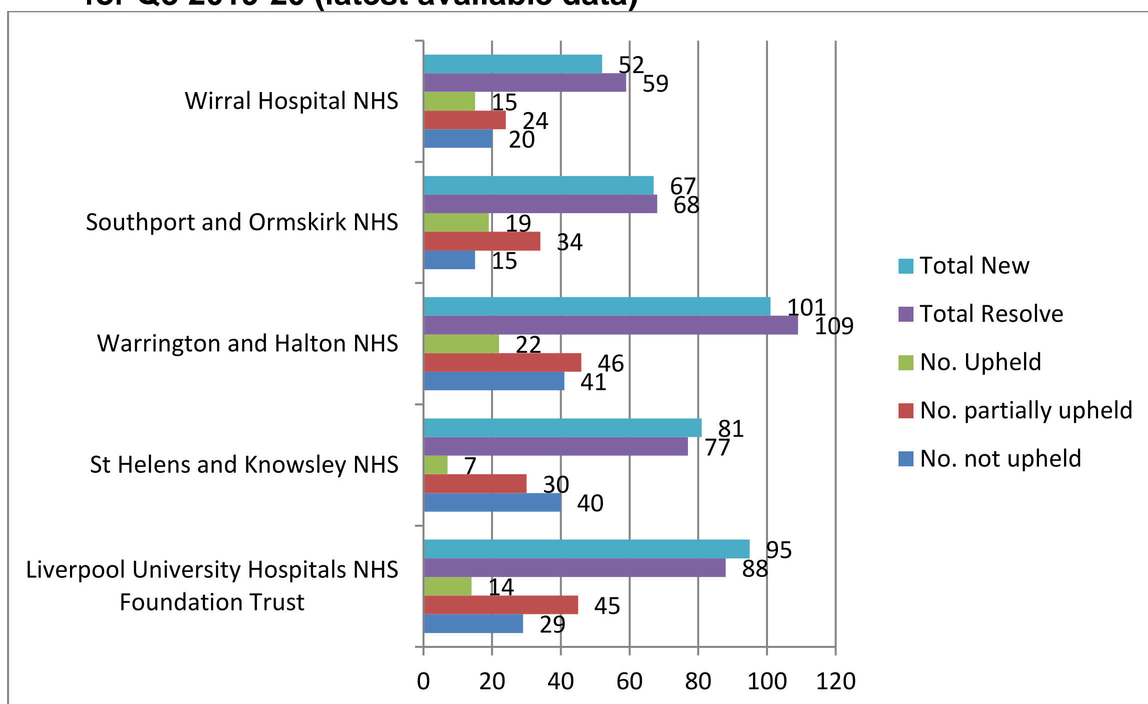
The top five reasons have remained consistent since the beginning of the financial year. Clinical treatment gives rise to the most complaints, followed by values and behaviours (staff), with the majority of these complaints relating to staff interaction with patients/families or carers. Feedback from Friends and Family Test rates staff attitude very positively, however, any negative feedback is taken seriously to ensure a consistently high standard of care is provided. There are plans to review and relaunch the Trust's ACE behavioural standards which will reinforce the Trust's values going forward.

3.3. Complaints by top ten locations

The Emergency Department received the highest number of complaints in each quarter of 2019-20 and this can be attributed to the high levels of activity.

Top 10 locations and Care Groups	Q1	Q2	Q3	Q4	Total
A & E (MCG)	11	17	20	23	71
Ward 1B GPAU/ Short Stay (MCG)	6	4	5	2	17
Ward 4A Urology/General Surgery (SCG)	3	1	3	3	10
Clinic Ophthalmology (SCG)	4	2	2	3	11
Delivery Suite (SCG)	2	2	3	0	7
Ward 4B SAU/General Surgery (SCG)	4	0	0	3	7
Clinic Surgical Whiston (SCG)	0	3	2	2	7
Orthopaedic Surgery, Whiston (SCG)	2	2	1	2	7
Ward 4C Colorectal/General Surgery (SCG)	2	1	2	1	6
A & E Paediatrics (MCG)	0	2	2	2	6
Total	34	34	40	41	149

3.4. Comparison with neighbouring trusts of complaints received and upheld for Q3 2019-20 (latest available data)



NHS Digital publishes data on written complaints for each of the NHS trusts in the country on a quarterly basis. Q4 figures were due in June 2020 but have been postponed due to the Covid-19 situation. The table above demonstrates that this Trust had the lowest number of complaints upheld.

3.5. Closed complaints

During Q4, 79 complaints were closed. It should be noted that majority of the complaints relating to clinical treatment are not upheld. Additional information on complaints is contained in Appendix 2.

3.6. Dissemination of learning

A summary of actions taken from complaints is provided to the Quality Committee. Each complaint response includes any learning that has been identified and the necessary actions for each area. Incidents and complaints are a standing agenda item on the Care Group and ward governance meetings' agenda to ensure that lessons identified from complaints are disseminated and to embed any actions taken to improve the quality of patient care.

3.7. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

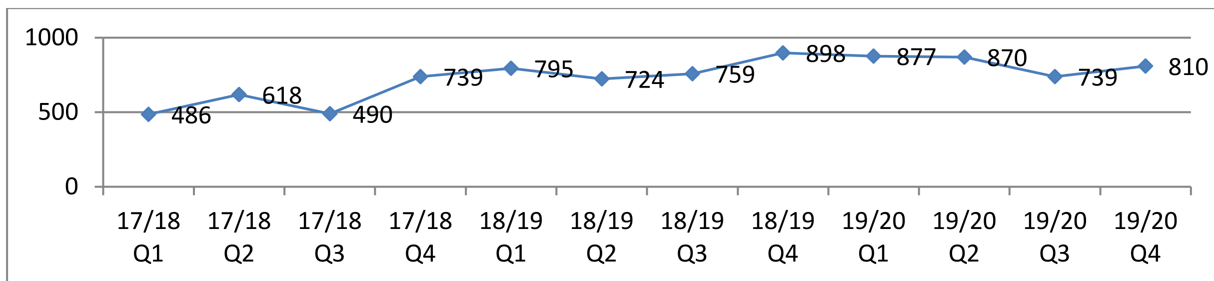
In Q4, the PHSO proposed to formally investigate one complaint and confirmed that they had commenced investigation into one other complaint. Details of both complaints are below:

Description	Main Subject (KO41A)	PHSO – Proposing to formally investigate
Care and treatment afforded to the deceased patient; issues include end of life care, waiting times, faulty equipment which delayed assessment, no involvement of specialist service.	End of life care	Documentation supplied awaiting decision
Description	**Main Subject (KO41A)**	**PHSO–Final Decision**
Complainant alleges that the Trust has not delivered on its pledges and standards prior to the birth of their child, during and afterwards. Lack of openness, care and professionalism in the sharing of information to help them find comfort and closure.	Communication	Awaiting decision

4. PALS

The number of PALS contacts has remained steady following an increase in previous years.

PALS enquiries by quarter



In Q4 2019-20, 96.1% of PALS queries were resolved, with 31 PALS enquiries converted to formal complaints, which is a 3.8% conversion rate and is consistent with previous quarters.

5. PALS enquiries by subject

The top five themes remain consistent with previous reports in this financial year.

PALS enquiries themes	19-20 Q4
Communications	152
Appointments	139
Clinical treatment	90
Patient Care/ Nursing Care	87
Admissions and Discharges (excl. delayed discharge re care package)	53

6. Clinical Negligence Claims

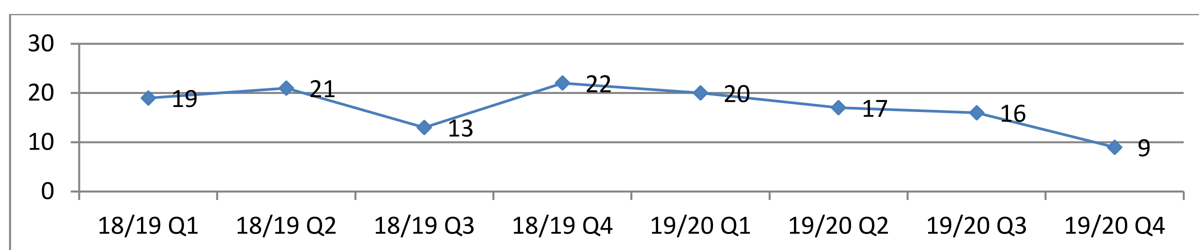
One of the Trust's objectives for 2019-20 was to improve learning as a result of claims, to reduce the likelihood that the same errors are repeated. An action plan was developed to deliver this, which was approved by the Executive Committee in

December. A copy of the action plan was reviewed by the Quality Committee in January and updates will be reported six monthly to the Committee.

Claims are discussed at the Claims Governance Group and lessons learned are submitted to the group, with members charged with cascading the information through their governance meetings. In addition, actions taken following claims are presented to the Quality Committee. Training sessions have been delivered to clinical staff on themes that have been identified from claims and more training sessions are due to be arranged later in the year.

The table below illustrates that the Trust received 62 new clinical negligence claims in 2019-20, a decrease compared to the previous financial year when 75 new clinical negligence claims were received.

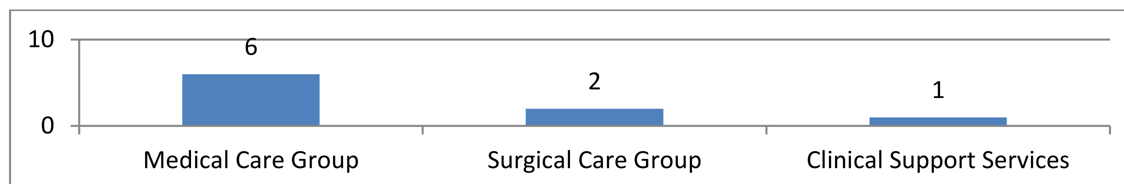
The number of new clinical negligence claims in Q4 was 9. Two of the 9 claims received in Q4 2019-20 had previously been investigated as complaints



The top three main reasons for claims have remained consistent since the beginning of the financial year, as shown in the table below.

Subject	NHSR Instructed Claim
Failure to diagnose or delay in diagnosis	3
Fail/delay in treatment	1
Failure to warn (informed consent)	1

6.1. New clinical negligence claims opened in Q4 2019-20 by specialty



The Emergency Department received the highest number of claims in Q4 2019-20 with 5 new claims and there was 1 new claim received each in obstetric, orthopaedic, medicine for older people (5A) and endoscopy unit.

6.2. Actions taken as a result of clinical negligence claims closed in Q4

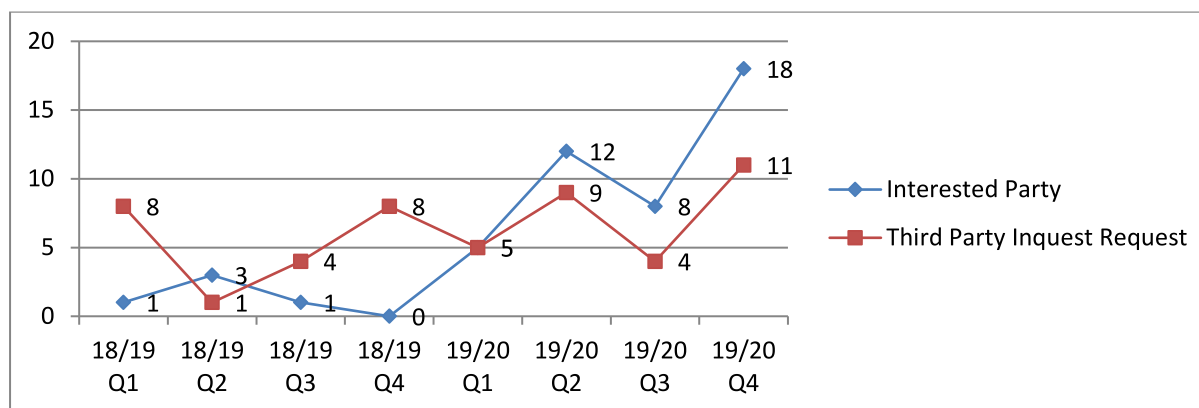
Nine claims were settled with damages, six defended and five closed following file review. Below are the actions taken from some of the learning and actions from the claims settled with damages. Lessons learned are submitted to the Claims

Governance Group and members are asked to cascade through their governance groups. In addition, lessons learned are shared with the Quality Committee. Examples of lessons learned are provided in Appendix 3.

7. Inquests

The table below illustrates that there was an increase in the number of inquest requests received in 2019-20 compared to the previous financial year.

Similarly, there has been an increase in the number of inquests received in Q4 2019-20 in comparison to Q3 2019-20. Ten inquests were closed in Q4, 9 of which were third party inquests and one interested party inquest with a conclusion of natural causes, with no actions for the Trust.



9. Early Notification Scheme

NHS Resolution requires trusts to report all maternity incidents for every baby born at more than 37 weeks gestation who is diagnosed with a brain injury in the first 7 days of life and there is a suspicion that the brain injury may have occurred during labour. These are any babies that fall into the categories below:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone AND was comatose AND had seizures of any kind

In 2019-20 seven maternity incidents fitting the above criteria have been reported. These incidents might result in future clinical negligence claims.

10. Recommendations

It is recommended that the Board note the report and the actions taken as a result of incidents, complaints and claims.

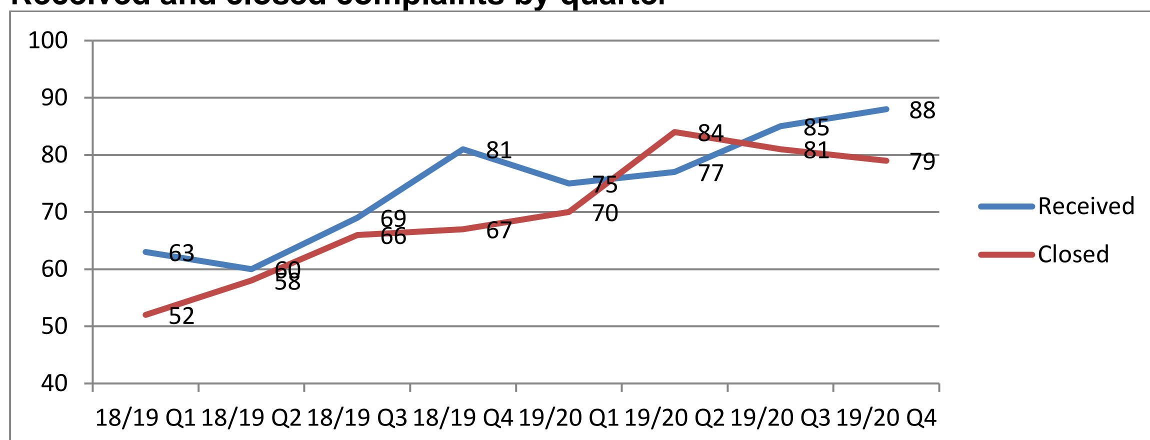
ENDS

Appendix 1 – Lessons learned following StEIS reported incidents

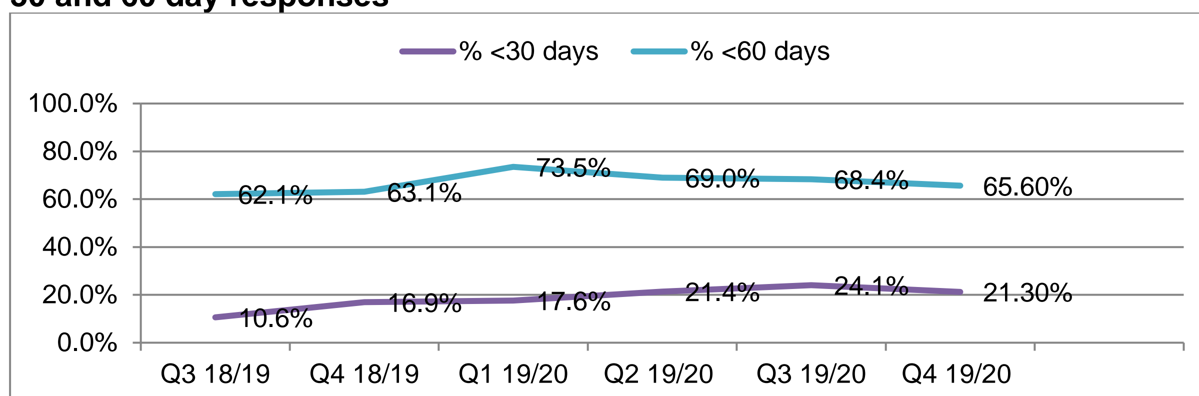
Incident	Lessons learned and actions
Failure to appropriately manage patient in septic shock	• 90% of patients to be catheterised within 1 hour as per Urinary Retention Pathway • Urinary Catheter Policy needs to be followed, including a check of recent urine results and prescription of prophylactic antibiotics for patients with a history of urinary tract infection or difficult catheterisation • Blood tests as part of an ambulatory emergency care (AEC) pathway must be taken in a timely manner • All blood results need a documented review in healthcare records with a plan of action as required • A change in patient condition or results needs to ensure clinical suspicion remains high with a reconsideration of differential diagnosis • Vital observations must be recorded on Patient Track, which can identify trends in observations and eNEWS (The Trust has now moved from MEWS to electronic National Early Warning Score) • Transfer of Care Policy needs to be followed ensuring Transfer Forms contain relevant, up to date and accurate information to ensure continuity of care • Timely referral to, and review by the speciality doctor is critical to the patient journey • Antibiotic policy to be followed when prescribing antimicrobials • Adult Sepsis Policy needs to be followed focusing on the completion of the sepsis screening tool, sepsis 6 pathway and administration of appropriate antibiotics within 1 hour of diagnosis
Failure to manage wound dressing appropriately	• Plastics Dressing Clinic did not document according to St Helens and Knowsley Teaching Hospitals NHS Trust policy • There is a requirement is to improve communication between Plastics Dressing Clinic to community services in relation to joint care of patients • It is a requirement that Plastics Dressing Clinic clearly document in health records the name and designation of person speaking with in order for a clear audit trail. • The community did not share any care plans or wound assessment details with Plastics Dressing Clinic following the commencement of negative pressure wound therapy • The community team did not advise packing of the wound when wound undermining • When a wound has such undermining it is vital that the wound is regularly assessed according to the care plan and measured as this was not evident within the community team records • Poor record keeping in both Plastics Dressing Clinic and Community Services records.
Patient sustained a fractured neck of femur as the result of a fall on Ward 1B	• Falls risk assessment to be completed as per policy • 4AT score should be documented on falls care plan • All doctors will complete post falls review using pro forma • Therapies team to hand over any information gained on assessment • All patients identified at risk of falls should be referred to the falls team if they meet the criteria • Falls care plans should be reviewed post fall • Intentional rounding tool should be completed 2 hourly • Mental capacity assessment and Deprivation of Liberty Safeguards (DoLS) to be considered when patients have fluctuating cognition

Appendix 2 – Summary of complaints activity

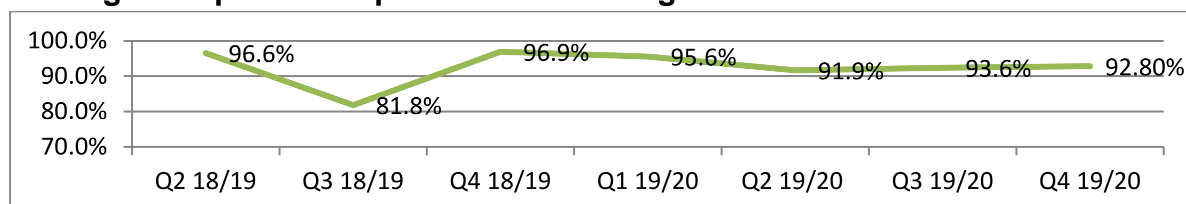
Received and closed complaints by quarter



30 and 60 day responses



1st stage complaints responded to within agreed timescales



Outcome of closed complaints in Q4

	Not Upheld Locally	Partially Upheld Locally	Upheld Locally	Total
Admissions and Discharges (excl. delayed discharge re care package)	4	2	1	7
Appointments	1	1	0	2
Clinical Treatment	19	12	3	34
Communications	2	5	0	7
End of Life Care	1	1	0	2
Other (e.g. abuse/behaviour/theft/benefits)	0	0	1	1
Privacy and dignity	0	0	1	1
Patient Care/Nursing Care	1	4	1	5
Trust Admin/ Policies/ Procedures (Inc. Patient	0	1		1

Record Management)				
Values and Behaviours (Staff)	6	5	1	12
Waiting Times	3	2	1	6
Total	37	33	9	79

Appendix 3 – Examples of actions and learning taken from closed claims

Incident	Learning and actions
Patient was admitted with infection in knee and there was a delay in starting her on antibiotics which led to her developing sepsis in her knee	Emergency department (ED) reviewed sepsis screening tool. Previous sticker used on ED card has now been embedded into the documentation and now encompasses a broader set of flags to include blood pressure
The patient was under the care of the Rheumatology Department for rheumatoid arthritis. He had an x-ray in May 2012 due to bilateral anterior thigh pain. The imaging was reported as showing no abnormality, however, bilateral femur fractures were subsequently diagnosed by another trust after viewing the same images	The department introduced a 'radiologist of the day' rota to take responsibility for all queries of the day which will reduce interruption of the radiologists during reporting sessions. Discrepancy reviews/audits now take place to discuss and learn from any discrepancy in reporting. Random audit of cases by double reporting by external radiologists is undertaken.
The patient was admitted with suspected stroke whilst on admission he fell and sustained a fracture on the ward.	Nurses on the ward received retraining session with falls nurse specialist; Ward nursing staff were re-educated on available equipment to implement to promote patient safety; Falls Nurse Specialist continues to ensure all ward areas are educated and knowledgeable with regard to alternative options for falls prevention methods and equipment.
There was a missed opportunity in November 2015 to diagnose nasopharyngeal carcinoma at an early stage as his presenting symptoms were not linked to create a unified diagnosis when he was seen by Oral and Maxillofacial Surgery department at St Helens Hospital	The case was shared across both ENT and Maxillo-Facial specialities and discussed at their audit meeting for learning.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)036
Title of paper: Information Governance Annual Report (including Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Teaching Hospitals Trust operates within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.
Summary: This Report summarises the Trust's Data Security and Protection Toolkit (DSPT) submission for 2019-20. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. When considering data security as part of the 'Well Led Key Line of Enquiry' as part of the Care Quality Commission (CQC) inspections, they will consider how organisations are assuring themselves against these standards. The Trust has submitted the DSPT assessment at the end of March 2020 for the 2019/20 submission and was able to submit evidenced items for all the assertions as required as part of the submission, the Trust achieved a "standards met" rating for the submission. A number of the assertions and evidenced items were audited by Mersey Internal Audit Agency (MIAA) who provided a report with a rating of Substantial Assurance which is the same rating as the previous year.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board and Commissioners
Recommendation(s): • The Board to note and approve the content of this paper. • Be assured that robust arrangements are in place to effectively manage the Information Governance Agenda within the Trust.
Presenting officer Christine Walters, Director of Informatics
Date of meeting: 27th May 2020

Introduction

The NHS Information Governance Framework is how the NHS handles information about patients and employees, in particular personal identifiable information. The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy.

The DSPT encompasses The National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) the General Data Protection Regulation 2016 and the Data Protection Act 2018.

All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

Larger organisations, such as Acute Trusts, are also required to have their DSP Toolkit submission externally audited to ensure the accuracy of their submission.

Failure to complete the Data Security and Protection Toolkit can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact the Trust's ability to bid for new services in the future. The Information Commissioner has also indicated that satisfactory completion of the Data Security and Protection Toolkit can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2019/20 Submission

Evidence has been provided for the self-assessment against the 10 standards and the associated assertions that sit under each standard. These items are recorded under assertions and represent an indicator of maturity in that area. There are in total 44 assertions and 116 mandatory assertion items that require evidence.

For example, to comply with part of Section 1 for 'Personal Confidential Information', the Trust must provide evidence for the assertions as detailed below:

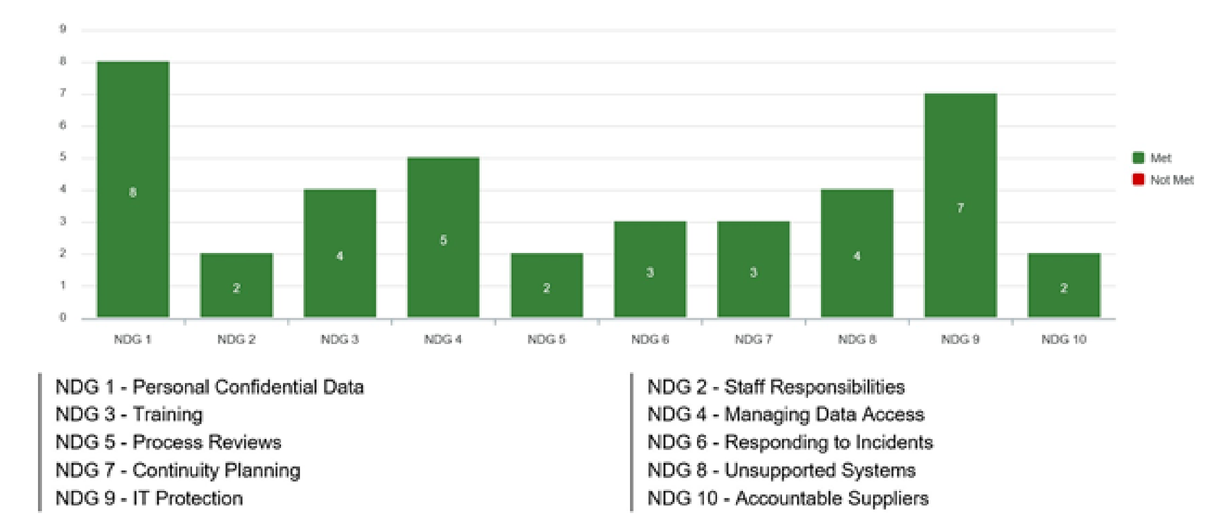
1.1	**There is senior ownership of data security and protection within the organisation.**		
1.1.1	Has SIRO Responsibility for data security been assigned?	Mandatory	**COMPLETED**
1.1.2	List the names and job titles of your key staff with responsibility for data protection and/or security.	Mandatory	**COMPLETED**
1.1.3	Are there clear lines of responsibility and accountability to named individuals for data security?	Mandatory	**COMPLETED**
1.1.4	Is data security direction set at board level and translated into effective organisational practices?	Mandatory	**COMPLETED**

1.2	**There are clear data security and protection policies in place and these are understood by staff and available to the public.**		
1.2.1	Are there Board approved data security and protection policies in place that follow relevant guidance?	Mandatory	**COMPLETED**
1.2.2	When were each of the data security and protection policies last updated?	Mandatory	**COMPLETED**
1.2.3	How are Data Security and Protection Policies available to the public?		**COMPLETED**

1.8	**There is a clear understanding and management of the identified and significant risks to sensitive information and services**		
1.8.1	Does your organisation operate and maintain a risk register that follows an acceptable Information Security risk framework which links to the corporate risk framework?	Mandatory	**COMPLETED**
1.8.2	Senior management have visibility of key risk decisions made throughout the organisation.	Mandatory	**COMPLETED**
1.8.3	What are your top three data security and protection risks?	Mandatory	**COMPLETED**

For the Trust to achieve “standards met”, the Trust must have completed all the items in the DSPT. Our baseline assessment was submitted to NHS Digital in October 2019 with an action plan developed through to March 2020 to address any gaps in compliance.

A summary of the 2019/20 submission is shown below:



Mersey Internal Audit Agency (MIAA) carried out an audit of the Trust's Toolkit submission (as required of larger NHS organisations) during two visits in November 2019 and January 2020 to assess the Trust's compliance against these standards. MIAA audited assertions which covered elements of Information Governance Training, Business Continuity Planning and Unsupported Systems.

The Trust has subsequently received the audit report from MIAA and has maintained its rating of 'Substantial Assurance, this has been reported to the Trust's Audit Committee.

Substantial Assurance

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2019-20.

This section will provide assurance, from the SIRO, that the Trust:

- Have a sufficient framework in place to ensure compliance with all elements of the Information Governance Agenda
- Have an active and effective Information Governance Steering Group forum, meeting regularly
- Manage and investigate any Information Governance / Confidentiality incidents and issues

The Role of the SIRO

Christine Walters, Director of Informatics, is the Trust's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

The SIRO is required to be an Executive Director, Chief Information Officer, or a Senior Manager with access to the Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment, and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the Trust's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust**.**

The SIRO has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The focus of DSPT is on setting standards and providing tools to achieve them. The standards provide assurance across ten areas.

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

The Role of the Caldicott Guardian

Dr Alex Benson is the Trust's registered Caldicott Guardian. Dr Benson is tasked with ensuring that the personal information about those who use its services is used legally, ethically, and appropriately, and that confidentiality is maintained. Dr Benson provides leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader information governance agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance, to the Trust Board, that the Caldicott Guardian function within the Trust is operating at a satisfactory level and that it is appropriately supported within the existing Information Governance structure.

The Trust Caldicott Guardian is supported by the Director of Informatics in her role as Senior Information Risk Owner (SIRO) and the Head of Information Governance & Data Protection Officer and her team.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee accountable to the Trust Risk Management Council and ultimately the Trust Board. The Group, which has been operational since January 2008, oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader Information Governance Agenda and provide the Trust Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust.

The IGSG is chaired by the Trust Caldicott Guardian Mr Alex Benson, with the Trust SIRO as Deputy Chair. Core membership includes Trust Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG has also seen the Group address the following topics in addition to achieving DSP Toolkit compliance -

- Data Protection Impact Assessments ensuring the process is understood and embedded across the Trust.
- National Data Opt Programme – ensuring the Trust is compliant with the requirements.
- Supplier Due Diligence – ensuring current and prospective suppliers meet the relevant Information Governance standards.
- Axe the Fax- monitoring compliance with the national initiative to remove all fax machines from the NHS.

- Investigating unauthorised system access, ensuring the Trust has a robust procedure to support HR and the Trusts Caldicott Guardian.
- Information Asset Management, highlighting the need for ownership of the Trusts key information assets.
- Compliance with Subject Access Requests monitoring compliance with the timescales.

Reportable Incidents

The Trust has a duty to report any incident regarding breaches of the Data Protection Act to the Information Commissioner's Office (ICO) and for the financial year 2019-20 there were two such incidents. One of these incidents has been closed by the Information Commissioners Office with no actions taken against the Trust. The second incident is awaiting the completion and submission to the ICO of the Trust's internal investigation report.

A breakdown of those incidents that have been reported to the ICO is below:

September 2019	Third party information was disclosed in error to a member of staff who made a Subject Access Request (SAR).
February 2020	An employee of the Trust was found to have viewed several colleagues HR records when they were not authorised to do so.

Reporting & Monitoring

Progress against the DSPT and compliance with relevant legislation is monitored by the Head of Information Governance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports are presented by the Head of Information Governance & Data Protection Officer (DPO) to the IG Steering Group and subsequently to the Risk Management Council, then ultimately to the Trust Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met required action plans were prepared and were monitored to ensure improvement and compliance.

Conclusion

It is important that the Trust continues to build and improve on the Information Governance foundations which are already embedded within the Trust. The Information Governance agenda is constantly evolving and will continue to expand with the introduction of new technologies, which are increasing in their complexities and more collaborative working across the Cheshire and Mersey Health Care Partnership and the wider North West region. It is therefore vital that the IG Steering Group continues to monitor the progress and implementation of the Information Governance Agenda within the Trust and that the IG Team are supported in being able to achieve this compliance.

TRUST BOARD

Paper No: NHST(20)036a
Title of paper: Freedom of Information Act Annual Report 2019/20
Purpose: To provide the Trust Board assurance that St Helens and Knowsley Teaching Hospitals NHS Trust strives to comply with the Freedom of Information Act.
Summary: This report is designed to give the Trust Board assurances that the Trust is compliant with the Freedom of Information Act. Statistical analysis of the requests and responses will be shown, comparing the year of the report (2019/20) to previous years, where relevant. Overall, there has been a slight reduction in the number of requests received by the Trust. The overall compliance figure shows a slight improvement on the previous year. We should be mindful of this reduction and expect a spike in requests relating to our COVID-19 response in the coming year.
Corporate objectives met or risks addressed: Systems, Communications
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): The Group to note and approve the content of this report
Presenting officer: Christine Walters, Director of Informatics
Date of meeting: 27th May 2020

Introduction

This report is designed to provide the Trust Board with assurance that the Trust is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for 2019-20 will be shown here, with comparisons to previous years where relevant.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

Table 1 – Annual Comparison of Requests by Applicant Type as a comparison

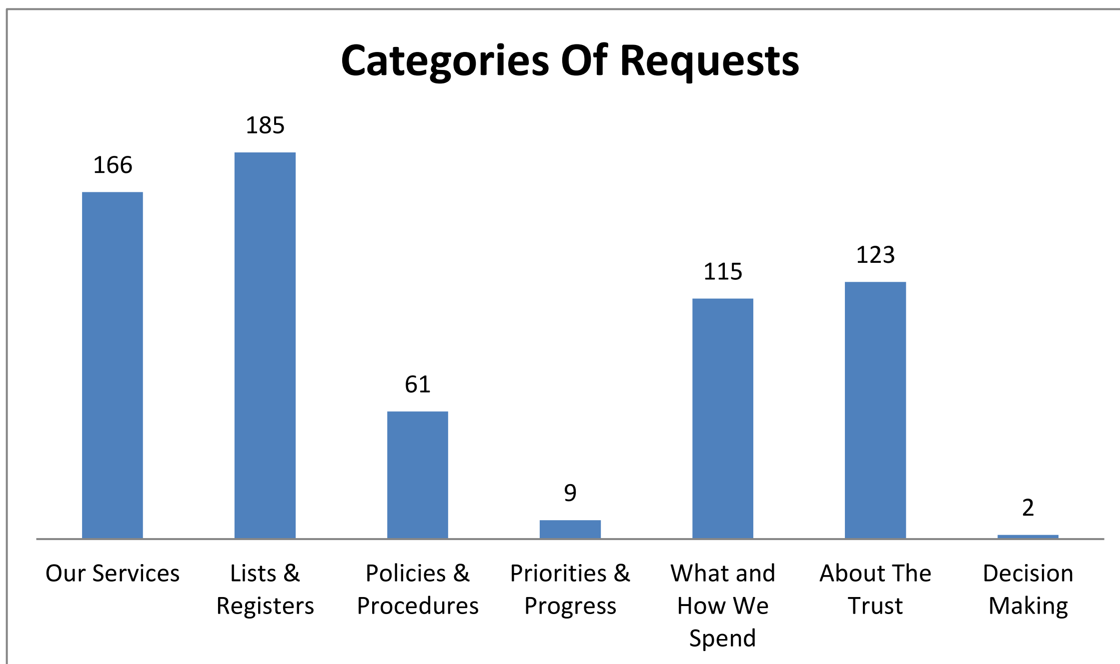
	Total	Press	Public	Staff	Commercial	Student/ Research	MPs	Not Given	Other
Annual Total 2018- 19	717	95	197	0	316	74	5	0	30
Annual Total 2019-20	661	69	191	0	299	61	7	0	34

In total, we have seen a decrease in requests of 56 in 2019-20. This is a decrease of just under 8.5% on the previous year.

Some of this decrease may be attributable to the current situation surrounding the national COVID-19 response and shifting priorities. March saw a significant reduction in requests to the Trust when compared with the previous year (reduction of 15).

As you will see later in the report, requests from commercial applicants account for nearly half of all the Trusts FOI requests, so we should not expect this reduction to be a long-term trend.

Chart 1 - Categories of Request for 2019/20



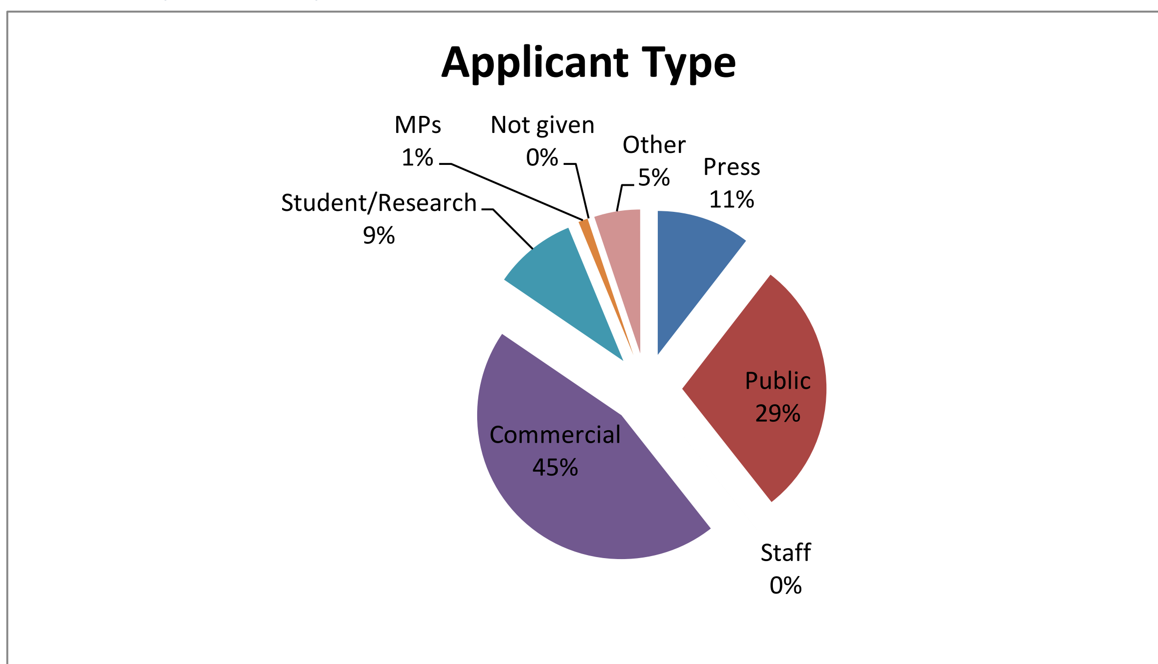
The vast majority of the requests received by the Trust relate to a few key areas. 2019-20 requests remained consistent with previous years in respect of categories. Requesters are primarily interested in how the Trust spends money and the services it provides.

Table 3 - Examples of Category Request

Category	Example of Request
About the Trust	1. Overseas Visitors 2. New Systems Implemented
Decision Making	1. Maternity Closures 2. A&E Diversions
Lists & Registers	1. Software Systems 2. Medications Administered
Our Services	1. Accident and Emergency 2. Human Resources
Policies & Procedures	1. Cyber Security Risk Management 2. Compromise Agreement
What & How we spend	1. Monies owed for treatments 2. Value and Duration of Contracts

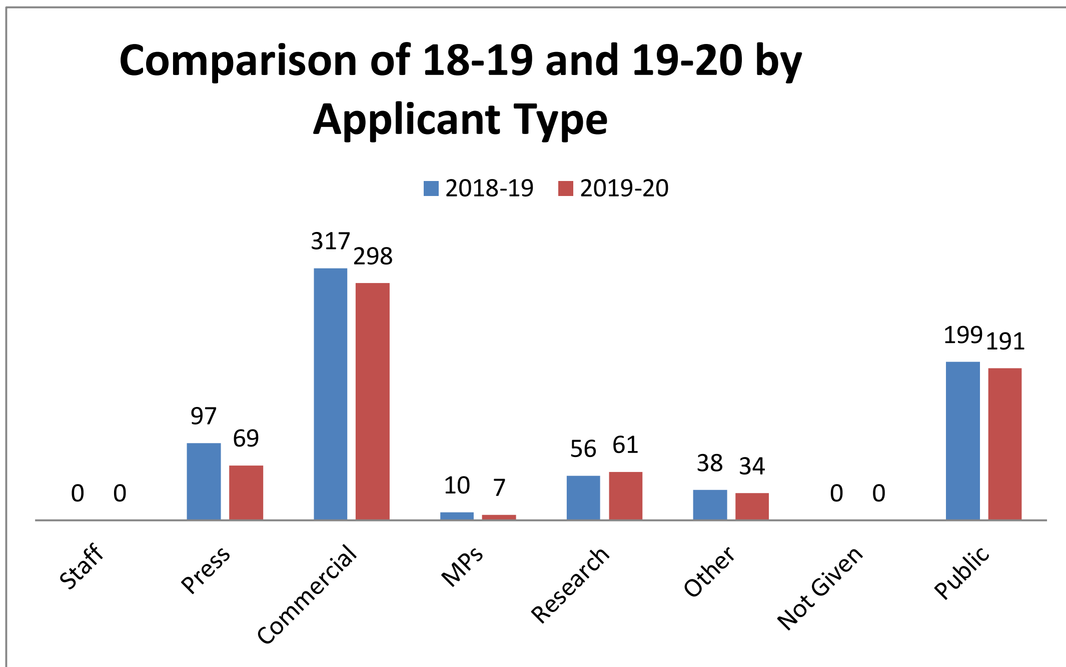
Categories are defined by the FOI Team once a request is received at the Trust. Examples of each type of request are shown in Table 2 above and more information is available from the FOI Team.

Chart 2 – Requests by Applicant Type



As mentioned in the introduction of this report, most requests are received from commercial organisations, with members of the public also accounting for a significant portion of total requests. While requests from members of the public are varied, a persistent trend in requests from commercial applicants leans towards information regarding the value and term of contracts with our suppliers. These can be challenging, as we must ensure we balance the need for transparency and accountability alongside ensuring the commercial interests of the Trust are protected.

Chart 3 – Comparison of 2018-19 and 2019-2020 Applicant Type



Trends in applicant types have remained largely consistent with the previous year; the slight drop in numbers from commercial applicants may be congruent with shifting priorities as has previously been mentioned.

Press requests have also seen a significant drop. It is worth noting that we received a high volume of press requests regarding Brexit in the previous financial year. As such, we should expect this number to spike again later in year due to the current COVID-19 pandemic.

While we have seen a significant drop in requests from the press, the FOI Act remains an avenue that both local and national journalists use to extract information from the Trust, and the team always works closely with the Media PR and Communications Team around these types of requests.

Other areas have remained largely steady when factoring in the overall decrease in the total volume of requests.

Performance

As of the 31st March 2020, The Trust has received 661 FOIA requests for the financial year 2019-2020. The Trust strives to respond to all requests in accordance with the 20 working days timeframe that the legislation dictates. Out of the 661 requests received, the Trust has responded to 236 within 20 working days, with 352 of those responses released after the deadline. This means a total of 588 or 88.9% of this financial year's requests have been responded to.

At the time of writing (06/05/2020); there are 73 requests still open which were received between the 1st April 2019 and the 31st March 2020. 73 of these are overdue. This figure has been impacted by the Trust's COVID-19 response. The organisation's priorities have shifted, and some members of the IG team have temporarily been redeployed into other areas to support the current emergency situation.

At the end of the previous financial year we reported a compliance rate of 32% of responses responded to within 20 Working Days. We aim to make significant improvements in this area but can only achieve this with the support of the Departments and Teams that provide the information. At present our compliance rate stands at 35.7% of total requests responded to on time. The improvement is welcomed but there is work to do within the Team as well as from within Departments across the Trust to improve this compliance figure. Software solutions and training are being explored for the team and Department Leads to ensure the Trust makes the improvements required to comply with the Freedom of Information Act 2000 moving forward.

Appeals

The Freedom of Information Act allows requester to challenge decisions to not disclose information. This is also known as a request for an internal review. Where we decide to apply an exemption under the Act, we must be able to justify this and communicate this to the requester. The Trust received 1 appeal for 2019-20. The table summarises this below.

Applicant Category	Overview	Reason for appeal	Outcome
Commercial	The request is for the Trust's contract register including among other things the value, type and duration of these contracts.	Requester does not feel that the time/ cost exemption has been applied appropriately.	TBC – initial calculations from procurement evidence that the exemption is justified. This will be communicated to the applicant as soon as we are able to.

Conclusion

The number of Freedom of Information requests received by the Trust has decreased this year. Despite the slight decrease, the number of requests received continues to have a real impact on resources. This is due to the increased complexity of the requests received often requiring input from several different Departments and Teams across the Trust. This has undoubtedly affected the Trust's compliance with the statutory timescales for this year. Only through training and an adequate software solution will the Trust compliance figures improve utilising automation for reminders and storing requests in an easily accessible central repository.

Finally, with the current situation in mind, we should expect an increase in requests in the coming year. Last year we reported that the increase we had seen in that year could largely be attributed to Brexit planning and knife crime statistics, both prominent news items. It is likely that the current pandemic may result in the same, and this will be monitored closely.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)037
Title of paper: 2019/20 End of Year Review of Trust Objectives
Purpose: To present the final progress review against the 2019- 20 Trust Objectives

Summary:

1. The Trust Board agreed thirty-one objectives for 2019/20 at the Board meeting in March 2019.
2. The objectives were split into 9 categories: 5 representing the Trust's Five Star Patient Care criteria of care, safety, pathways, communication, and systems. There were also 4 other categories covering organisational culture and support for the workforce, operational performance, financial performance, efficiency and productivity and strategic plans.
3. This paper summarises the progress achieved by the end of the financial year.

Colour	Rating
Green	Achieved
Amber	Progressing but not fully achieved by 31st March 2020
Red	Not achieved by 31st March 2020

4. The ratings show that:
   a. 22 objectives are rated green (71%);
   b. 9 objectives are rated graded amber (29%);
   c. No objectives are rated as red (0%).
5. Setting and monitoring the delivery of the annual plan and Trust objectives is a key role for the Board and part of the CQC Well Led assessment.

Trust objective met or risk addressed: provides assurance to the Board that the Trust is making sufficient progress in delivering its annual plan
Financial implications: None directly from this report
Stakeholders: Staff, patients, regulators and all stakeholders
Recommendation(s): The Board is asked to note the progress being made to deliver the 2019/20 Trust Objectives
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 27th May 2020

Trust Objectives 2019/20 – End of Year Review

Objective	Lead Director	Measurement	Governance Route	Progress and RAG Rating March 2020
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 Further improve discharge planning by replicating the success of the "home for lunch" initiatives at weekends	DoOps	33% of patients to leave hospital by noon on the day of discharge consistently across all wards. 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards.	Finance and Performance Committee	33% or above maintained across Medical Care and Surgical care Groups. Although 85% not consistently achieved, NHSE/I review concluded that the trust is within the upper quartile nationally for weekend discharges. Continued focus on processes over the weekend to improve further.
1.2 Implement a new system (NEWS2) for identifying deteriorating patients and improve the timeliness of treatment	DoN & DoI	Implement and embed the use of NEWS2 across all adult services, including Accident and Emergency Department Monitor the impact of NEWS2 on the MET team Maintain NEWS2 compliance of at least 98% for all adult inpatient areas (daily e-Vitals report)	Quality Committee	All inpatient areas (except ICU/SCBU) and adult ED are live with electronic observation recording and associated track and trigger. A Paediatric model for ED is currently being designed. The MET team impact is being monitored by the eVitals. Compliance for NEWS2 achieved 97% in Q4, but this includes some of the exceptional ward moves and closures during March 2020, due to COVID-19
1.3 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 and Board assurance reports	The Trust continues to make progress against the two improvement targets, as demonstrated in the 6 monthly Board Assurance reports.
1.4 Reduce the number of new legal claims against the Trust	DoN	Reduce the number of new claims by 10% compared to 2018/19	Quality Committee	76 NHS reported claims in 2018-19 and 64 in 2019-20, a 16% reduction.

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		Implement improved systems for learning lessons from claims and monitoring the changes put in place to improve patient outcomes and reduce future claims		Actions to reduce claims were presented to QC in January 2020. These actions will be monitored and reviewed at QC every six months with the next review due in July 2020. A review of radiology claims is presently been undertaken by Hill Dickinson to identify themes and to identify whether lesson learning from those claims are embedded in practice. Reports for maternity, ED and orthopaedics have been presented to the Claims Governance Group confirming that the majority of actions identified via lessons learned have been maintained or superseded by further improvements. There has been an increase in clinicians who attend the Claims Governance Group to discuss claims and lessons/actions, which are then cascaded through each specialty. “Getting to grips with investigation incidents, complaints and claims investigation in healthcare” seminars took place on 15th January and 26th February 2020

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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 improve the timely and effective assessment and delivery of care within the emergency department (QA Priority)	DoOPs	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours • Application of NEWS2, and escalation of patients who trigger • 100% compliance with sepsis screening and treatment guidance	Quality Committee	Improvement demonstrated within time to triage and first clinical assessment, but further improvement required to achieve target consistently at all times of day. NEWS2 compliant (see 1.2) 90% target for Sepsis screening achieved in Q2
2.2 Reduce the number of patient falls by 10% compared to 2018/19	DoN	Delivery of the Falls Strategy objectives and continue to undertake RCA's and share lessons learnt from all falls. Regular audits of lying and standing BP, prescribing of hypnotics and undertaking mobility assessments within 24 hours of admission Implement the national CQUIN high impact changes across all inpatient areas	Quality Committee	Falls Strategy objectives achieved. 14% Reduction in total falls/1000 bed days and total harms (moderate category and above)/1000 bed days in 2019/20, compared with 2018/19. Achievement of falls CQUIN with overall compliance of over 80% for the year 2019/20 (Q2-Q4). This includes compliance with lying and standing BP, prescribing of hypnotics, undertaking mobility assessments within 24 hours of admission and implementation of THE high impact changes across all inpatient areas
2.3 Implement a new electronic monitoring system in the maternity unit (CTG monitoring) to ensure patients receive appropriate interventions at the right time	DoN	Complete the business case and procurement of the new system Install and implement the new monitoring system and train staff in its use Monitor outcomes and changes in practice	Executive Committee	The system is now in place on Delivery Suite, with go live due mid-July for 2E and FMAU. All Delivery suite staff are trained in the centralised monitoring system and all staff have been trained in the use of the new monitors, however full implementation has been delayed due to COVID-19 impact. Benefits realisation evaluation planned for 2020/21.

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2.4 Continue to learn lessons and improve practice as a result of reviewing and investigating hospital deaths	MD	Publication of quarterly learning from deaths reports Audit of themes, lessons learnt and changes in practice	Trust Board	Quarterly reports are now an established part of the Board annual work plan and these include learning themes and evidence of dissemination. Embedding change will be evidenced through ongoing audit.
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. Achieve the target of sending 85% of e-discharge summaries to GPs within 24 hours, to allow appropriate care to be continued outside of hospital	DoI	Achieve 85% of discharge summaries sent to Primary Care within 24 hours by Q3 2019/20	Quality Committee	The Medical Director and CCIO are leading on work supporting Clinicians to complete discharge summaries. A longer-term IT solution is in development which will include information on TTO drugs and will be pre-populated with relevant information to help speed up the time required to complete a discharge summary. Discharge summaries performance: Mar ‘ 20 – 88.6% Apr ’20 – 92.2 %
3.2. Maximise the benefits of providing primary and community health services to support integrated care in our local health systems	DoOps	Reduce duplication and amount of handoffs between teams across new end to end pathways Improved patient experience Reduced rate of A&E attendances and hospital admissions	Quality Committee	Cardiology, Frailty, Tissue Viability and Adult Continence end to end pathways are in place. There is a weekly cardiology MDT for community patients. St Helens UTC transferred to the Trust as planned on 1st December. Standardisation and expansion of the priority urgent and emergency care pathways completed, with further developments planned in 2020/21. Marshalls Cross Medical Centre has many more positive reviews on the NHS website and only 2 formal complaints during the year compared to 4 in 2018/19.

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				The Trusts community services consistently achieve a 100% FFT recommendation rate. Overall A&E attendances and hospital admissions continued to rise until March 2020 (start of COVID-19 emergency incident). Plans to work with the Widnes UTC have been progressed
3.3. Increase capacity and improve clinical adjacencies at Whiston Hospital, to create more assessment space and support the expansion of Same Day Emergency Care (SDEC)	DoOps & DoCS	Develop the Full Business Case for approval of the capital schemes by NHS Improvement and commence work on site by the end of Q3	Trust Board	SDEC/Ambulatory Care business case was approved by NHSE/I in September and work on the schemes in ED have commenced with others being progressed in line with the agreed timetable. Some delays have been experienced due to COVID-19 in Q4 of 2019-20 The modular wards (Bevan Court) are progressing in line with the planned schedule and due for completion in June/July 2020. There have also been some delays due to workplace social distancing requirements for the construction workers and issues with supply due to COVID-19 but these are not expected to have a substantial impact on the overall programme and construction has continued throughout March and April.

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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 Improve information for patients, so it is available at the right time and in the right format to meet individual needs (QA Priority)	DoN	Undertake a review of patient information and communication methods across the Trust Develop an improvement plan to enhance the quality, consistency and accessibility of information given to patients Improve scores for responses to questions relating to patient information in patient questionnaires and national surveys	Quality Committee	Project Manager to lead on improving communication and information across the Trust has been appointed. A master database of all leaflets has been developed. An improvement plan was developed in early 2020, which was approved by the Executive Committee and has been partially delivered and will continue into 2020/21.
4.2 Increase the use of Patient feedback, to identify themes which help shape service developments and improvement plans – identifying themes from all sources of feedback e.g. F&FT, Healthwatch, patient surveys, ask Ann e mails, complaints, PLACE	DoN	Develop and comprehensive Patient Engagement Strategy Produce a thematic annual report from all patient feedback Agree and deliver 2 -3 priority initiatives that will have the greatest impact on improving patient experience Publicise the changes made and the difference it has made to patients in the Quality Account	Quality Committee	Patient Engagement Strategy in place. A thematic review of patient feedback completed for January to December 2019. This included feedback received through FFT, NHS website, national surveys, 5 a day surveys, concerns and complaints, feedback from local Healthwatch, PLACE, ask Ann enquires and open and honest questionnaires. In addition, the review details evidence of sharing good practice and actions taken to improve patient and family experience when required. Improvement in the Patient survey questions relating to receiving appropriate information following surgery and receiving understandable answers to questions from doctors. Best NHS trust for Patient Led Assessments of the Care Environment (PLACE) results for the third consecutive year, scoring 100% for cleanliness and condition, appearance and maintenance of the hospital buildings.

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4.3 Increase the range and effectiveness of communication methods with the Trust to improve access and responsiveness for patients, relatives and others	DoN & DoI	Implement a new telephony system to Improve call answering times by switchboard and on the wards and reduce the % of abandoned calls	Quality Committee	Service improvements implemented by the Switchboard team have resulted in the call answer rate improving by 15% over the course of the year. The Trust has also procured a new switchboard solution which was due to be implemented at the end of March. However, the project has been put on hold due to COVID. The new system will enable an answer rate of at least 95% to be achieved during 2020.
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 Maximise the functionality of the new Medway system to support staff to deliver high quality care, including Electronic Prescribing, NEWS2, Medway PAS functionality, E-Handover and a Bed Management module (QA Priority).	DoI	• Reduction in medication errors • Improved discharge processes • More timely communications with GPs and community services • Introduction of a bed management module to improve capacity and demand modelling • Early detection of deteriorating patients • Reduce complaints related to outpatient appointments	Quality Committee	A tactical BI solution has been deployed as an interim solution whilst the Trust awaits readiness of the Medway module. Electronic prescribing and eHandover are fully implemented in the Surgical and Medicine Care Groups. Electronic prescribing has been deployed to Newton Hospital, Endoscopy and Radiology, the deployment to ITU step down has been put on hold due to Covid-19. eHandover in Paediatrics is complete. NEWS2 rollout is complete. The Trust had intended to undertake a pilot of Medway Flow to support bed management/patient flow before the end of March. However, the pilot was put on hold due to Covid-19, as ward staff are needed to test the solution. This will be restarted in due course.

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5.2 Improve the systems for booking outpatient appointments and reduce the number of appointments that must be rearranged	DoI & DoOps	Reduce DNA rates Reduce appointments being re-arranged less than 6 weeks in advance (figures being obtained) Reduce complaints relating to outpatient appointments	Executive Committee	2-way appointment reminders have been implemented for all specialities. The DNA rate for February 2020 was 8.6%, compared to 10.0% in February 2019. The downward trend stalled in March due to the impact of COVID-19 when many patients DNA their appointments.
5.3 Increase the use of the e-Rostering (SafeCare) system to improve the deployment of staff resources	DoN	Auto roster consistently used by all wards for nursing staff roster production by September 2019 Produce routine reports to demonstrate the optimal allocation of staffing resources in line with patient acuity	Quality Committee	e-Rostering and auto roster implemented. SafeCare producing routine patient acuity reports which support the Trust Workforce Safeguards processes.
5.4 Work with partners in St Helens to maximise the use of the Shared Care Record to share information relevant to decisions about patient care.	DoI	Shared care record used for joint care planning for St Helens patients by March 2020	Executive Committee	The St Helens Shared Care record is actively used across the borough and is a key tool in helping to deliver safe patient care. Work is underway with Diabetes, End of Life, COPD and Frailty teams to develop joint care plans. Diabetes and Early Supported Discharge pilots have been agreed. Contact Cares are currently piloting the use of community-wide care plans for patients.

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6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE ***We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development.*** ***We will maintain a committed workforce that feel valued and supported to care for our patients.***				
6.1 Continue to implement innovative approaches to recruitment and retention, to provide high quality care	DoHR	HR Strategy and key Indicators Reports to demonstrate. • 80 additional permanent new nurses recruited to the Trust • 50 further nurses recruited via international recruitment programmes • 20 medical and dental posts recruited via international recruitment programmes • Create more opportunities for staff to retire and return, or adopt flexible working • Increase development opportunities for new staff including rotational programmes • Expansion of apprenticeships, preceptorship and whole career development initiatives	Trust Board	• Social media advertising has been enhanced to publicise open days and recruitment drives with good numbers of attendance at events leading to increased applications to work at the Trust. • Overachieved on target by recruiting 128.62 permanent Band 5 Nurses recruited (excluding international) since April 2019 • Exceed International recruitment target with 54 Nurses recruited since April 2019 • Exceeded International Medical & Dental staff recruitment target with 34 recruited since April 2019 • Internal transfer scheme has been created and is in consultation with staff side for roll out later in 2020/21. • Retire and return policy reviewed to improve opportunities for flexible working requests to optimise returners and aid retention. • Flexible working requests centralisation to improve the process to enable staff to rotate to other wards rather than seek opportunities externally. • A new Registered Nurse Development Programme comprising Preceptorship (up to 12 months) Leadership & Management Qualification (up to 18 months) and senior nurse competencies commenced. • Access to and uptake of Masters

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				level Leadership development (Level 7) apprenticeships by a range of staff groups at local and national universities. 18 staff being supported. • 16 Trainee Nursing Associate Apprentices on programme.
6.2 Continue to respond to feedback from staff to improve the working environment, so that the Trust continues to be recognised as an employer of choice.	DoHR	Reduction in staff turnover rates NHS Staff Survey Action Plan monitoring WRES Action Plan monitoring Local impact assessment surveys Implement new talent management and appraisal tools	Quality Committee	• Overall staff turnover rates continue to benchmark positively, however deep dive required into areas where turnover increased. • 2018 Staff Survey Action Plan completed delivering an improvement in conflict resolution training. • WRES and WDES action plans have been delivered with regular monitoring and review via ED&I Steering Group. 5 new Staff Networks have been set up to support engagement with staff from all protected characteristics also extending to include a Carers Network • Workforce Development Steering Group has introduced Quality Impact Assessments and Equality Impact Assessments for the introduction of new roles. • 'MyWorkpal' e-Appraisal and Talent Management tool launched in September 2019. Implementation and enhancement plan developed to ensure full adoption by March 2021.
6.3 Offer more training and development opportunities, to support staff in realising their potential.	DoHR	Reduction in staff turnover rates Increase the number and range of apprenticeship opportunities open to staff	Trust Board	• A number of initiatives re on-boarding and retaining our staff, e.g. welcome to packs issued to all new starters to enhance the STHK brand • Use of apprenticeships to deliver

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		Increase the % of the apprenticeship levy that is allocated Recruitment to 12 nurse associates and 20 apprenticeship nurse degree places Develop new posts and appropriate specialist training routes for Advanced Care Practitioners and Physician Associates		leadership development at all levels • A new Intranet tool to support staff and managers to easily identify suitable apprenticeships launched. • Continued focus on utilising full value of Levy • 16 trainee nurse associates,16 degree nurse apprentices & 4 ODPs now on apprenticeship programme.
6.4 Implement a workforce capacity and demand modelling system (Activity Manager) to help plan the right number and skill mix of staff	DoHR	Activity Manager theatre management system to be implemented by Q2 and all surgical specialities by 2020 e-Rostering embedded for Medical Staff and Specialist Nurses by 31st March 2020 Produce reports from the Activity Manager and Safe Care systems to demonstrate safe levels of staffing based on the acuity of patients	Executive Committee	• The Activity Management system has been successfully implemented in Theatres, Obstetrics & Gynaecology and Anaesthetics in 2019/20. The Trust continues to lead the way nationally in this productivity initiative. The remaining SCG specialties to follow in 2020/21 and plans for MCG developed. • The e-job planning for Specialist Nurses project e rostering is on-going and will extend into 2020/21. • Safe Staffing reports have been enhanced and now directly from the system and report to Executive Committee and Quality Committee.

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7 OPERATIONAL PERFORMANCE ***We will meet and sustain national and local performance standards***				
7.1 Achieve national performance and access standards	DoOps	IPR to monitor delivery of; • Improvement trajectory for emergency access standards • 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	All access standards achieved with the exception of emergency access standard and some months in relation to ambulance handover.
7.2 Maximise the productivity and effectiveness of clinical services through the use of benchmarking and comparative data e.g. GIRFT and Model Hospital to ensure all services meet best practice standards	DoOps	Participation in national programme of GiRFT reviews and delivery of the resulting action plans Model Hospital reports detailing any issues where the trust is an outlier	Finance and Performance Committee	Participation in the GiRFT programme continues with some very favourable reviews e.g. diabetes and cardiology Improvement plans completed, actioned and monitored following each visit. Model hospital data utilised by all care groups to monitor performance.
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 NHSI Annual Benchmarking review and action plans if the Trust is an outlier on any metrics Annual procurement performance score maintained or improved	Finance and Performance Committee	Reference costs below 100 at 94. Model Hospital WAU was in the best quartile nationally. CIPs of £16m were achieved Financial Plan was achieved The latest Procurement league ranking is 17th nationally, 3rd in the North West Region and 1st in Cheshire and Merseyside.

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8.2 Work with health care organisations across Cheshire and Merseyside to explore further 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	StHK lead on finance, Governance, Payroll and influential in areas of IT. Continued growth in shared services or winning bids that impact across a system (IT).
8.3 Improve demand and capacity prediction and modelling to better align resource utilisation	DoF	Continue to develop and embed the use of modelling tools for A&E, Bed capacity and LoS.	Finance and Performance Committee	Developed a staff capacity model for A&E, demand model for surgical care and on track to expand this for Medical Care.
9 STRATEGIC PLANS ***We will work closely with NHS Improvement, and commissioning, local authority and provider partners to develop proposals to improve the clinical and financial sustainability of services***				
9.1 Working with health care system partners to develop plans to implement the ambitions of the NHS Long Term Plan for our local population	DoInt	IPR & Corporate Activity Reports Develop common pathway metrics and reporting to demonstrate the impact of integrated care Support the introduction of Primary Care Networks	Executive Committee	Five-year place plans developed and submitted to C&M HCP. For St Helens Cares; • Additional community services contracts moving to STHK, including UTC. • Provider Board, Finance and Stakeholder groups established. • Joint executive leadership teams have agreed principles to develop a system financial plan. • A&E attendances higher than previous year, but admissions have been contained. • Primary Care Networks (PCNs) established and developing relationships with the Trust.
9.2 Collaborate with partners to develop plans for integrated care systems (ICS)	DoT	Development paths for ICS or ICP's to be in place by 2021 for St Helens, Knowsley and Halton	Executive Committee	St Helens Cares' continues to evolve with progress on StHK as Lead Provider (see 9.1). Knowsley 'Better Together' is developing further partnership working in health and social care, with priorities agreed for the five-year place plan.

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				Children and Young People is the pilot area to work more closely together in Knowsley over the next year. 'One Halton' providers and commissioners have agreed a set of priorities for the borough across health and social care, with workforce and IM&T being key enablers. The COVID-19 pandemic has paused some of the development paths for the ICS and local ICPs
9.3 Work with the Cheshire and Merseyside Health and Care Partnership to develop sustainable plans for service delivery across the wider health economy	DoOps	Contribute to the C&M 5-year plan to be agreed by Q3 Develop internal plans based on the impact of the C&M 5-year plan for services delivered by the Trust	Trust Board	The Trust continues to be closely involved in all the C&M HCP clinical work streams, with the CEO leading on acute sustainability. C&M HCP programmes disrupted due to COVID-19 and Hospital and Out of Hospital Cells created to manage the system. With Trust CEO designated as the Hospital Cell Commander
9.4 Meet all the statutory and regulatory standards expected of NHS organisations and maintain the highest standards of governance and use of public money	DoCS	Maintain or improve Single Oversight Framework segmentation Maintain or improve Use of Resources (UoR) score	Trust Board	Trust continues to comply with all oversight and regulatory requirements. New system oversight performance monitoring regime came into effect in October 2019. Emergency assurance protocols were introduced in March 2020 in response to the COVID-19 pandemic emergency response and the trust has continued to meet all governance requirements. The NHS introduced a system oversight framework during 2019/20. The UoR score was maintained.

ENDS