NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28TH OCTOBER 2020
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
09:40	2.	Apologies for Absence		Verbal	
	3.	Declaration of Interests		Verbal	
	4.	Minutes of the Previous Meeting held on 30th September 2020		Attached	
		4.1	Correct Record & Matters Arising	Verbal	
		4.2	Action Log	Attached	
Performance Reports					
09:45	5.	Integrated Performance Report		NHST(20) 61	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational Indicators		Nik Khashu on behalf of Rob Cooper
		5.3	Financial Indicators		Nik Khashu
		5.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10:00	6.	Committee Report – Executive		NHST(20) 62	Ann Marr
10:10	7.	Committee Report – Quality		NHST(20) 63	Gill Brown
10:20	8.	Committee Report – Finance & Performance		NHST(20) 64	Jeff Kozer
10:30	9.	Committee Report – Charitable Funds *(incl Draft Annual Accounts & Report)*		NHST(20) 65	Paul Growney
10:40	10.	Corporate Risk Register		NHST(20) 66	Nicola Bunce
10:50	11.	Board Assurance Framework		NHST(20) 67	Nicola Bunce
BREAK					
AGENDA				**Paper**	**Presenter**

Other Board Reports				
11:10	12.	Complaints, Claims & Incidents Report	NHST(20) 68	Sue Redfern
11:20	13.	Safeguarding Annual Report 2019/20	NHST(20) 69	Sue Redfern
11:30	14.	EPRR Assurance Framework	NHST(20) 70	Sue Redfern
11:35	15.	WRES Report and Action Plan	NHST(20) 71	Anne-Marie Stretch
11:45	16.	WDES Report and Action Plan	NHST(20) 72	Anne-Marie Stretch
11:55	17.	Q1 2020/21 Learning from Deaths Update	NHST(20) 73	Rowan Pritchard-Jones
Closing Business				
12:20	18.	Effectiveness of Meeting	Verbal	Chair
	19.	Any Other Business		
	20.	Date of Next Meeting – Wednesday 25th November 2020		

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 30th September 2020 in the Boardroom, Whiston Hospital and via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs L Knight	(LK)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mr R Pritchard-Jones	(RPJ)	Medical Director
In Attendance:	Mrs N Broderick	(NBr)	Asst Director of Finance, Income & Contracting *(Observer)*
	Dr J Bussin	(JBu)	Consultant & Responsible Officer *(Observer & presenting MD Revalidation item)*
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Ms J Dwerryhouse	(JD)	Asst Director of Employment Services *(Observer)*
	Mrs K Hughes	(KH)	Head of Media, PR & Communications *(Observer)*
	Cllr Alan Lowe	(AL)	Halton Council *(Co-opted member)*
	Mrs C Slocombe	(CS)	Quality Matron *(for Patient Story only)*
Apologies:	Mrs G Brown	(GB)	Non-Executive Director

1. Patient Story

1.1. CS briefed Board members in relation to a 40-year-old female patient diagnosed with skin cancer at the beginning of the coronavirus pandemic and the innovations introduced to improve her patient experience when physical appointments and surgery were suspended.

1.2. During an appointment with the St Helens Skin Cancer team in March, the patient was advised that due to COVID-19, she could not receive a sentinel node biopsy (a procedure where the sentinel lymph node is identified, removed, and examined to determine whether cancer cells are present).

1.3. As a result, the Skin Cancer Specialist Nurse arranged for the patient to have a CT scan the following day. The nurse also arranged for her to have a wide local excision of the surrounding tissue to where the mole had been to determine if the cancer had spread to the tissue. The results came back 3 days later, thankfully all were negative.

1.4. The patient had since had follow-up appointments with the Skin Cancer team via telephone and attended a video health and well-being event. The team had also been contactable by telephone and able to bring the patient into clinic straight away to assess and relieve any concerns.

1.5. RF recognised that the compassion of frontline staff was of utmost importance under these circumstances and acknowledged how worried the patient must have been when her appointments were cancelled. He asked whether there was a feel for how telephone and telehealth appointments compared with face-to-face appointments, or whether it was still too early to say.

1.6. CW explained the telehealth facility was running across multiple specialities and of the patients that had chosen to have a telehealth appointment approximately 90% said they preferred it to a face-to-face appointment. She acknowledged however, that telehealth appointments were not always appropriate for a first visit, or for every patient, but the technology was contributing to the continued delivery of the Trust's services.

1.7. From a clinical point of view, RPJ explained that a sentinel node biopsy was a staging test; therefore, a patient's outcome would not be made significantly worse by not having the procedure. He understood the worry patients experienced through suspension of face-to-face appointments; knowing your status was important. Clinicians also did not get the same sense of feedback, eg from body language, with telephone appointments that was relied upon to understand whether patients understood the information they had received. So, although using Telehealth was a big step forward and was significantly better than just telephone appointments, there were still some limitations. More data on the impact of Telehealth on patient outcomes would follow in the months and years to following as a national study had been set up to explore this.

1.8. AM stressed the importance of ensuring the cohort of patients for which telephone and Telehealth appointments were not suitable, were not disregarded, eg patients with no access to digital technology, patients who had hearing difficulties, etc. CW advised technology funds were being made available to the Cheshire & Merseyside Health Care Partnership for resources to support this cohort of patients.

1.9. IC congratulated the Trust for enabling the online 'Living with and beyond Cancer' event and queried whether it was being offered for other pathways. RC confirmed this was very much representative of other cancer specialities.

1.10. VD noted that the patient in the story shared at the recent Shadow Board development programme she had chaired had experienced mental health issues, and wondered how the learning from patient stories was disseminated throughout the organisation, as they were such powerful messages. CS confirmed patient stories were shared at the Patient Experience Council and care group governance meetings and she was currently working with the Communications team to create a library of patient stories that staff could access. She would welcome other ideas for sharing these experiences.

1.11. RF thanked everyone for their input and asked CS to pass on the Board's thanks to the patient for agreeing to share her story. He believed Telehealth was definitely a tool for the future, however not in isolation.

2. Employee of the Month

2.1. The Employee of the Month Award for August 2020 was presented to Noah Moran, Registrar, Intensive Care Unit.

2.2. The Employee of the Month Award for September 2020 was presented to Chris Yates, Deputy Head of Business Intelligence & Analytical Services.

3. Apologies for Absence

Apologies were noted from GB.

4. Declaration of Interests

There were no new declarations of interest

5. Minutes of the previous meeting held on 29th July 2020

5.1. Correct Record

5.1.1. The minutes were approved as a correct record.

5.2. Action List

5.2.1. No actions were due in the current month.

5.2.2. Action 41 – 7-Day Services – RPJ reported there were challenges around the reporting requirements for 7-Day Services because of the changes that had been made to services during the pandemic but felt that now the Trust was restoring more services, it was important to assess the impact on the 7-Day Services standards. **DUE NOV 20**

5.2.3. Action 42 – mandatory training compliance levels had been distributed to VD and via the Quality Committee. **COMPLETED**

6. Integrated Performance Report (IPR) – NHST(20)054

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

6.2. Quality Indicators

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

6.2.2. There had been 1 never event in August and 3 reported year to date. As there were similarities between 2 of these never events, a series of listening events had been held with the staff involved and the patient safety team had arranged human factors training, which had resulted in changes of process to reduce the risk of a similar incident happening again. RF stressed that the most important aspect was to ensure the Trust was learning lessons from any such incidents. A full report of the RCA investigations for the 3 never events had been made to Quality Committee.

6.2.3. SR reported that although there had been no grade 3 pressure ulcers reported in July and one YTD, there was a concern at the increases in grade 2 pressure ulcers being reported. A programme of work was underway to understand the reasons why and make improvements.

6.2.4. The HSMR reported figure for April was 129.4 which was very high. RPJ had investigated and it appeared to be linked to the spike in COVID in April which had not previously been included in the HSMR modelling, because all hospitals had seen a similar increase. The national HSMR had risen to 130 in the same period.

6.3. **Operational Indicators**

6.3.1. RC presented the update on the operational performance.

6.3.2. The 62-day cancer standard was above the target of 85% in July 2020 at 96.0%.

6.3.3. The 31-day cancer target was achieved in July with 98.6% performance against a target of 96%.

6.3.4. The 2-week cancer standard was achieved in July with 95.7% in month, against a target of 93%.

6.3.5. The A&E access time performance for all types mapped was footprint performance for August was 87.7%. The Trust was seeing attendance levels gradually increase each month back towards pre-COVID levels with 9,524 Type 1 attendances in August 2020, compared with 9,810 in July 2019.

6.3.6. Bevan Court, the new modular wards on the Whiston Hospital site, opened on 25th August 2020 providing additional bed and assessment capacity, to reduce bed occupancy and congestion in A&E.

6.3.7. There were 2,565 ambulance conveyances in August compared to 2,744 in July and the ambulance turnaround time averaged 25 minutes against the standard of 30 minutes.

6.3.8. The average daily number of super stranded patients (length of stay of greater than 21 days) in August 2020 was 61 compared with 132 in August 2019.

6.3.9. The 18-week referral to treatment target (RTT) was not achieved in August 2020 with 60.5% compliance against a target of 92%.

6.3.10. There were 137 52+ week waiters.

6.3.11. The COVID pandemic had had a significant impact on RTT and diagnostic performance as all routine operating, outpatient and diagnostic activity had to be cancelled. Activity had now restarted in all areas, albeit at a reduced capacity compared with pre-COVID, due to social distancing and infection control measures. All patients had been, and continued to be, clinically triaged to ensure urgent and

cancer patients remained a priority for treatment.

6.3.12. Community services experienced continued high levels of district nurse activity. Community matron caseloads were also increasing as they moved away from direct care home support and began taking referrals again from primary care.

6.3.13. VD asked whether the Trust was operating the NHS111 'call before you walk (into A&E)' initiative that had commenced at Warrington and Halton Hospitals NHSFT. RC confirmed it was due to be introduced to the Trust at the end of October. RC reported that there were increasing numbers of patients coming to the A&E department who could have been seen in Primary Care and commented that the success of the NHS111 First initiative would depend on there being sufficient alternative pathways for patients in community settings.

6.3.14. In response to VD's query relating to whether the Trust was seeing many post-COVID patients, RC confirmed that all patients who had been treated in the hospital were being followed up post-discharge.

6.3.15. RF congratulated the Trust in managing the restoration and recovery of elective services and ensuring that as many patients as possible received the treatment they needed.

6.3.16. LK queried whether ward-based assessments undertaken by social care staff had resumed. RC confirmed that face-to-face assessments had not resumed and were unlikely to do so soon, but a virtual process had now been introduced. This was not ideal and was putting additional pressure on the ward nursing staff to support the Social Workers and patients to complete the process. Alternative use of administrative staff plus changing the focus of the hospital discharge team using a 'safari' approach was being implemented to help address these pressures.

6.4. **Financial Indicators**

6.4.1. NK presented the update on the financial performance.

6.4.2. As a result of the COVID-19 pandemic, 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 6 months from April to September 2020. All Payment by Results (PBR) were 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.

6.4.3. The Trust had therefore reported a balanced YTD position at the end of Month 5 in line with the national guidance. This assumed full reimbursement of COVID-related costs and additional expenditure incurred. The financial envelope for the remainder of the financial year for the Trust had not yet been finalised.

6.4.4. The agency ceiling issued by regulators for 2020/21 was £7.8m, which was a £0.2m increase on 2019/20. Year to date spend was £3.4m which was £0.2m below the agency cap and slightly above the previous year's spend.

6.4.5. Although the CIP programme was on hold under the block payment arrangement, forecast risk had been discussed at the Finance & Performance Committee meeting and it was agreed CIP plans for the next financial year would be reviewed in January.

6.4.6. At the end of month 5, the cash balance was £34.0m. The closing balance continued to be high due to the changes in funding arrangements related to COVID-19, where the Trust received block payments one month in advance.

6.4.7. NK reported discussions were currently ongoing, with a decision on the financial envelope expected in the next 2 weeks. The revised financial regime had not factored in a 2nd wave of COVID cases, which would change the planning assumptions again for the remainder of 2020/21.

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on the workforce performance.

6.5.2. Appraisal compliance was 66.7% (target = 85%), which continued with recovery plans to catch up on the appraisals cancelled during COVID.

6.5.3. Mandatory training compliance was 80.3% and also remained below the target of 85%. Plans were in place to continue the recovery.

6.5.4. Sickness (including normal sickness and COVID-19 related sickness) in August was 5.4%, which was a 0.2% increase compared to July. Frontline Nursing, Midwifery and HCAs sickness was 4.5%, which was a 0.7% improvement on July. AMS confirmed these figures did not include COVID absence for reasons other than sickness, eg for staff in self-isolation, pregnant workers, or on special leave due to childcare.

6.5.5. AMS reported that the national pause to the sickness process agreed with the Trade Unions at the start of the pandemic was to be reviewed that day and hopefully as a result, the process could re-start.

6.5.6. LK reported that the Workforce Council had reported a spike in staff turnover, but this was related to the temporary employment of students during the 1st wave of COVID.

6.5.7. VD asked about the welfare of staff who had worked during the pandemic and what the Trust could do to support them. AMS confirmed the Trust's health and wellbeing services had been expanded to offer a wider suite of services, particularly to support staff mental health and wellbeing. Staff were being encouraged and supported to come forward with any issues so they could be addressed.

6.5.8. RPJ added that the paper on the agenda relating to medical revalidation showed that the process this year was very much framed around a reflective conversation with Doctors rather than training or personal development plans. He proposed working with the appraisers to gather the reflections of Medics working during the pandemic.

6.5.9. AMS informed Board members that staff from each ward and clinical service had now met with directors for a pandemic review and reflection meeting to discuss what could be learned and what could be done differently. It had been extremely powerful to hear this from staff first-hand, with some being very emotional. Feedback received from all staff had indicated they appreciated the opportunity to share their experiences and know that the Executive team was listening. The directors had also ensured that every area was personally thanked for their contribution to the Trust's overall response.

6.5.10. Board members noted that applications for NHS careers at universities had increased dramatically this year and PG confirmed that in his organisation applicants for care roles had doubled, as people had been inspired by the NHS and care sector response to the pandemic.

6.5.11. Board members noted the report.

7. Committee Report – Executive – NHST(20)055

7.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held during July and August 2020.

7.2. The committee had approved:

7.2.1. The 'go live' for the new hospital switchboard. RF thanked IT team for introducing the new technology which would help improve communications across the Trust. CW explained that the new switchboard had many enhanced functions such as voice recognition, virtual operator and auto put through to right extension number. The introduction had gone extremely well and already there was a significant reduction in the time for calls to be answered. The implementation plan was continuing, and more functions would be added as staff were trained and each change became embedded.

7.2.2. The business case for NHSE/I Urgent and Emergency Care capital to support additional urgent care capacity for winter 2020/21, which the Trust had since learnt had been successful.

7.2.3. COVID-19 executive lessons learned and a second surge action plan. AM reflected that some of the biggest concerns had related to communications with relatives due to the restrictions on visiting and the directors were exploring ways of improving this, so that relatives were kept informed. There had also been a number of complaints about the visiting restrictions, particularly when the rules were relaxed nationally. It was recognised that this was a delicate balancing act to optimise the safety of everyone in the hospital, but there was an emotional toll for the patients, relatives, and staff.

7.2.4. AM supported the increased use of technology for outpatient appointments and acknowledged the benefits they had created during COVID to allow the review of cancer and urgent patients. She was however concerned not all patients were digitally enabled. PG agreed that especially in elderly and deprived populations the NHS could not assume that all patients would be able to access or use digital healthcare solutions. The technologies were a very important development and offered another option for many patients but were not suitable for all consultations or all patients.

7.2.5. Additional emergency medical team cover to enable the Trust to do more elective activity at St Helens Hospital.

7.3. The committee also considered regular assurance reports, ie the monthly safer staffing report, the Board Assurance Framework (BAF), the Corporate Risk Register and the Integrated Performance Report.

7.4. AM also highlighted the discussions relating to out of hour anaesthetic cover, which the committee had revisited several times, to balance the options that would make the greatest impact verses the additional costs.

7.5. The discussions on the impact of COVID on pressure ulcers, falls and never events were also flagged and the ongoing work to understand the root causes of this increase and the support staff needed.

7.6. IC asked, in relation to item 3.3, for more details of the costs of a critical care bed. NK explained that the Trust already had the infrastructure, which was not currently commissioned, so the critical care bids were in relation to the supplementary equipment, which was circa £200k per bed space.

7.7. In relation to item 5.3, LK asked if there were things that had been put in place during COVID that the Trust would like to continue. AM responded that there were many initiatives that the Trust would like to continue but would not have the ongoing funding for. RC reported that this had been collated into a report for the national Medical Director and it was agreed this should be reported and discussed at the Finance & Performance Committee. **ACTION: NK**

7.8. LK asked about the Trust approach to quality improvement. RC confirmed there was an established service improvement council, which was supported by a dedicated service improvement team who were expects in improvement methodologies and supported services across the Trust. **ACTION: RC to share details with LK**

7.9. VD asked whether the Trust had enough in-house testing capacity given the need, together with forthcoming winter pressures. RC reported that the Trust had sufficient capacity to ensure that non-elective admitted patients, pre - operative and pre-procedure and staff with symptoms (or household contacts) were tested. The in-house testing of staff meant there was a fast turnaround of results and enabled staff to return to work if they were well, which was crucial to sustain services. The Trust supply of reagents had recently been increased from the central distribution mechanism which increased capacity from 3,000 per week to 7,000 per week, and this was enough to meet the predicted demand. The Health Work and Wellbeing department had recently had a business case approved for more staff, so that the process of reviewing staff

referrals and arranging tests remained as quick as possible.

7.10. In relation to item 8.1 relating to nosocomial infection rates, IC believed this demonstrated how contagious the coronavirus was.

7.11. PG enquired about the long-term impact of COVID on patients. RPJ explained that all discharged patients were receiving follow up with the respiratory team, as there was increasing evidence that some people did suffer long-term consequences from the virus, however the Trust did not yet have a full or clear picture of the on-going impacts.

7.12. VD offered her congratulations on the National Cancer Patient Experience Survey results, which had shown a significant improvement and reflected lots of hard work by the services.

7.13. Board members noted the report.

8. Committee Report – Quality – NHST(20)056

8.1. VD presented the report on behalf of GB, which summarised the key issues considered at the Quality Committee in September.

8.2. The committee chair had asked that the report outlining the findings of the pressure ulcer review be presented at Quality Committee to provide assurance that the right actions were being taken.

8.3. The committee had received assurance that the HSMR figure of 129.4 for April had been investigated. The national HSMR position was 130 for the same period and this was linked to the first spike in COVID cases. Other data sets had also been used to triangulate the Trust mortality position.

8.4. The committee had also been assured by the processes that had been put in place to review cancer referrals and waiting lists, to ensure patients with the highest clinical priority were identified and received the treatment they needed.

8.5. The draft 2019/20 Quality Account had been reviewed and approved for circulation to external stakeholders. This would come to the Trust Board for approval in October.

8.6. The Care Quality Commission (CQC) had completed its review of the infection prevention and control board assurance framework and concluded that Trust was meeting all the requirements.

8.7. Members received updates from Patient Experience and Safety Councils, Workforce Council, Clinical Effectiveness Council, the Safeguarding Annual Report, and the combined Adult & Children Safeguarding Report for 2019/20.

8.8. The Committee had noted the that plans were in place to achieve the Trust's target of vaccinating 95% of frontline staff for flu, building on the success of the 2019 Flu campaign and the need to implement different approaches to ensure compliance with restrictions in place due to COVID. The NHSE/I completed healthcare worker flu vaccination best practice management checklist had been completed and the Trust had achieved or was on target to achieve all the

requirements.

8.9. RF thanked all the NEDS for their continued rigour in escalating matters of concern to the Board and the executive team for always responding comprehensively.

8.10. Board members noted the report.

9. Committee Report – Finance & Performance – NHST(20)057

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

9.2. Committee had reviewed the integrated performance report in respect of the finance and performance KPIs and had also discussed in detail the April HSMR figure.

9.3. The committee had reviewed the month 5 financial performance, the phase 3 recovery plan submissions and an update on the 2020/21 capital programme.

9.4. The committee had also been briefed on the latest information regarding the financial control total issued to the Cheshire & Merseyside HCP for the remainder of 2020/21 and how this would be allocated to constituent health care organisations. The lack of a clear financial plan for the remainder of the year was a risk, but the level of risk was not yet certain.

9.5. There had also been a discussion and agreement to re-start planning for next year's CIP.

9.6. The strong cash position had been noted as a result of commissioners paying block contracts one month in advance.

9.7. Improvement had been seen in activity, although there was a slight decrease in August for outpatients due to the number of working days in the month.

9.8. In relation to control totals, VD wondered whether the Trust was at greater risk of incurring less funding. JK confirmed there was a risk and NK had raised this, however he assured Board members that the Finance team was doing everything to optimise the Trust's position.

9.9. Board members noted the report.

10. Committee Report – Audit - NHST(20)058

10.1. IC presented the report, which provided feedback on matters arising from the Audit Committee held on 2nd September 2020.

10.2. The Trust's external auditors, Grant Thornton UK LLP (GT), presented the annual audit letter, which was a 'for publication' public summary of findings, including the Trust's unqualified opinion, and a 'clean' value for money conclusion, which were both significant achievements. The committee had congratulated the Trust finance team.

10.3. Mersey Internal Audit Agency (MIAA) provided detail on progress against the 20/21 internal audit plan. After a pause in the planned activities as a result of COVID-19, work had now restarted, and progress made with the 2020/21 fieldwork.

10.4. Committee was concerned that there were actions not completed from previous MIAA audit reports, that had exceeded the agreed timescales. IC had asked that managers be asked to account for their progress in person at the next Audit Committee meeting in November.

10.5. The Trust's Anti-Fraud Specialist presented an update, which was discussed and accepted. There were no concerns around planned delivery, and face-to-face fraud awareness sessions would be replaced by e-learning.

10.6. Invoiced debt over 90 days overdue remained relatively steady at c£9m.

10.7. The Head of Procurement's paper relating to Tender and Quotation Waivers was noted. The Committee commended the team for maintaining financial controls during a time of significant pressure.

10.8. The losses and special payments report was discussed and accepted.

10.9. Board members noted the report.

11. Medical Revalidation Annual Declaration – NHST(20)059

11.1. RPJ introduced JBu, the Trust's Revalidation Officer. JBu had been in post for a year and RPJ praised her contribution so far. He explained the revalidation process had been formally paused during COVID but had now re-started, but with a different emphasis for this year centred on a conversation about health and wellbeing rather than professional development.

11.2. JBu presented the paper which provided feedback and assurance to the Board that arrangements for medical appraisal and revalidation were operating effectively at the Trust and in accordance with regulations.

11.3. In response to a query from IC regarding the comparison with the previous year's declaration, JBu confirmed this year's declaration was different in that it was more detailed, and systems had all been reviewed. AMS added that the medical revalidation process was still in its infancy and continued to evolve, however, JBu had identified areas for improvement.

11.4. VD queried how many appraisers the Trust had and if this was sufficient. JBu confirmed the Trust was currently just under the optimum number due to staff turnover and there was an ongoing process to recruit and train new appraisers.

11.5. LK stated that the Employee Relations Oversight Steering Group had met, however meetings were currently suspended due to COVID.

11.6. Board members noted the report and approved the statement of compliance confirming that the organisation, as a designated body, was compliant with the regulations.

12. STHK Workforce Strategy and NHS People Plan 2020/2021 – NHST(20)060

12.1. AMS presented the report which provided members with assurance that the Trust was delivering on the workforce strategy priorities which had been aligned with the objectives set out in the recently published NHS People Plan.

12.2. AMS delivered a short presentation summarising the 2020/21 NHS People Plan and identifying the key actions for the Trust.

12.3. The Trust had reviewed and refreshed the workforce strategy action plan, to be able to performance manage the delivery of work needed to deliver the People Plan. This would be monitored by the Workforce Council and reported to the Quality Committee. The plan fostered a culture of inclusion and belonging as well as action to grow and train the Trust's workforce and work together differently to deliver patient care.

12.4. AMS noted that in future the annual staff survey would be realigned to be in line with the 'NHS People Promise' rainbow.

12.5. It was noted that a longer-term NHS People Plan, would be developed following the next government comprehensive spending review.

12.6. In relation to the digitisation and connectivity, VD asked about plans to ensure that all staff could access the technology, as not all staff could currently access a computer. AMS acknowledged the reliance on email due to its speed of delivery and spread, although she accepted its reach was not comprehensive. She explained the Trust had also introduced digital message boards and a new staff 'app' for mobile phones/personal digital devices, which would be great for staff working from home.

12.7. Board approved the Trust approach to delivery of the 2020/21 NHS People Plan.

13. Effectiveness of Meeting

13.1. RF asked Cllr Lowe for feedback. AL thought it had been an excellent meeting and the technology had worked very well. AL thought the 'NHS People Promise' rainbow used in the NHS People Plan was very powerful.

13.2. Cllr Lowe thanked the minute taker for co-ordinating responses to queries he had raised earlier in the week.

13.3. RF also asked one of the observers for feedback. NBr stated she had enjoyed the meeting and found it informative as a participant on the Shadow Board development programme. The content provided joint and consistent messages, not only in Board members' own areas of expertise but also across boundaries. Patients, staff, and carers were always at forefront of the discussions. She had particularly liked the recommendation for including health and wellbeing in staff appraisals.

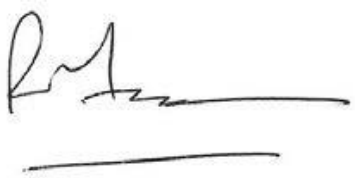
14. Any Other Business

14.1. Although he feared the country was heading towards a second wave of the coronavirus, RF stressed the importance of continuing to meet the highest standards of governance and asked members to contact him with any issues or concerns.

14.2. RF thanked members of the Communications and Media team for the successful virtual AGM and encouraged all Board members to watch the recording on the website which displayed some of the Trust's great work during 2019/20 and through the first wave of the pandemic.

15. Date of Next Meeting

15.1. The next meeting will be held on Wednesday 28th October 2020 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.



Chairman: ……

28th October 2020

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 28TH OCTOBER 2020

No	Date of Meeting (Minute)	Action	Lead	Date Due
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**
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**
41	24.06.20 (10.5)	In relation to 7-DS, RPJ to report back to Board regarding "activity re-set" later in the year. **ON AGENDA**	RPJ	25.11.20
~~43~~	~~30.09.20 (7.7)~~	~~COVID initiatives contained in report for national Medical Director to be reported and discussed further at Finance & Performance Committee~~. **COMPLETED**	~~NK~~	~~For F&P~~
~~44~~	~~30.09.20 (7.8)~~	~~RC to share with LK the improvement methodology (as discussed in Service Improvement Council) including quality.~~ **COMPLETED**	~~RC~~	~~28.10.20~~

Paper No: NHST(20)061
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.

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no Never Events in September 2020. (YTD = 3).

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

There were 4 C.Difficile (CDI) positive case reported in September 2020 (2 hospital onset and 2 community onset). YTD there have been 18 cases (8 hospital onset and 10 community onset). The annual tolerance for CDI for 2020-21 has not yet been published (the 2019-2020 limit is being used in the absence of publication of the 2020-21 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2020 was 93.3%. YTD rate is 94.4%.

There were no grade 3 avoidable pressure ulcers in August 2020. (YTD = 1). Reducing the number of Trust-acquired avoidable pressure ulcers, including category 2, is a priority for this year.

During the month of August 2020 there were 3 falls resulting in severe harm. (YTD severe harm fall = 16)

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

YTD HSMR (April to June) for 2020-21 is 111.9

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 20/21 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: 28th October 2020

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (August 2020) at 92.7%. YTD 88.0%. Performance in July 2020 was 96.0%. The 31 day target was achieved in August with 98.1% performance in month against a target of 96%, YTD 97.6%. Performance in July 2020 was 98.6%. The 2 week rule target was achieved in August with 94.5% in month and 93.9% YTD against a target of 93.0%. Performance in July 2020 was 95.7%.
The situation with regard to patients not wanting to attend for appointments is beginning to improve and we are now seeing an increase in the numbers of referrals and patients receiving treatment.

Accident and Emergency Type 1 performance for September 2020 was 80.4% and YTD 82.8%. Type 1 Performance in August 2020 was 78.9%. The all type mapped STHK Trust footprint performance for September was 89.2% and YTD 89.4%. The Trust is seeing attendance levels flatten in September, with the average daily attendance being the same as August (307). Total attendance for September was 9,219. For August, it was 9,524 . July attendances were 9,374 compared with 8,764 in June, 7,815 in attendances May 2020 and 5,548 in April.

Total ambulance turnaround time in September was 27 mins. (Standard is 30 minutes). Arrival to notification time was 14 minutes which includes on average 6-7 mins time for crews to notify ED of their arrival on site. There were 2,435 ambulance conveyances in September, compared with 2,565 in August

The average daily number of super stranded patients in September 2020 was 62 compared with 121 in September 2019. This remains significantly below the target of 92 @ end of March 2020. (61 was the average in August, 60 in July 2020 and 70 in June 2020).

The 18 week referral to treatment target (RTT) was not achieved in August 2020 with 60.5% compliance and YTD 60.5% (Target 92%). Performance in July 2020 was 54.9%. There were (137) 52+ week waiters. The 6 week diagnostic target was not achieved in September with 70.8% compliance. (Target 99%). Performance in August 2020 was 71.0%. **NB Elective programme closed down with only urgent and 2ww patients being managed during March, April and May.**

The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. We have now restarted activity in all areas, albeit at reduced capacity compared with pre-covid due to social distancing and infection control measures. All patients have been and continue to be clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Community Nursing activity levels have returned to a typical level of activity pre-COVID. Across specialist nursing, district nurses and community matrons we are actively monitoring to ensure there is no waiting list.

Patient harm incidents are in line with expected reporting levels. There has been one moderate harm incident relating to skin damage; which was identified in our community nursing team following discharge from hospital.

Urgent Treatment Centre activity remains at typical levels , with an average of 140 daily attendances.

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 six months from April to September 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 6 The Trust has reported a balanced YTD position in line with guidance. Within this the Trust has assumed full reimbursement of COVID related costs and additional expenditure incurred year to date by the Trust (£16.3m YTD). The Trust has had confirmation that expenditure for months 1 to 4 have been approved.

The agency ceiling issued by regulators for 2020/21 is £7.8m which was a £0.2m increase on 2019/20. The year to date spend is £3.9m which is £0.2m below the agency cap and slightly above the previous years spend.

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

At the end of month 6, the cash balance was £47.0m. This high closing balance continues to be high due to changes in funding arrangements related to COVID-19 where the Trust receives block payments one month in advance.

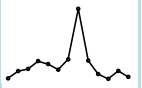
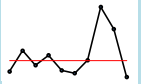
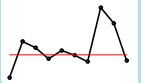
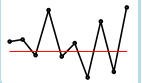
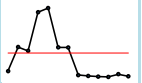
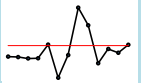
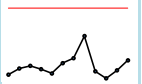
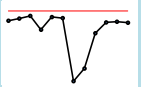
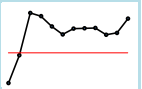
Human Resources

In September overall sickness was 6.1% which is a 0.7% increase from August. Front line Nursing, Midwifery and HCA's is 7.6% which is an increase of 1.3%. Front line Nursing and Midwifery only is 5.5 which is a 1.0% increase from August. These figures do not include covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension, or special leave due to e.g. childcare. Appraisal compliance in September is 64.5% which is below the target of 85% by 20.5%. Mandatory training compliance remains below the target of 85% by 6.3%. These continue to be impacted by covid, sickness and isolation .

The following key applies to the Integrated Performance Report:

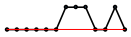
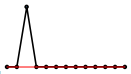
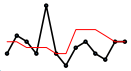
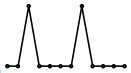
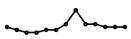
▲ = 2020-21 Contract Indicator
▲£ = 2020-21 Contract Indicator with financial penalty
● = 2020-21 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

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	Sep-20	1.9%	2.7%	No Target	2.4%		The spike in April reflects the initial height of the COVID pandemic. The overal trend up to August show this spike returned to normal in the crude figures.	Patient Safety and Clinical Effectiveness	The high HSMR covers the early period of COVID admissions. Of note, the National HSMR for this period is reported as 130. These data are being interrogated to review. Independent consideration of our COVID mortality is currently showing it to be in line with expected rates. This has returned to expected levels as COVID inpatient numbers dropped in the time frame reported.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	May-20	1.09		1.00						
Mortality: HSMR (HED)	Q	▲	Jun-20	90.9	111.9	100.0	101.6					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jun-20	93.3	126.6	100.0	101.2					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	May-20	104.0	99.8	100.0	97.4		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	Low readmission was likely a reflection of the upswing in COVID cases with low overall numbers of patients.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jun-20	92.9	91.0	100.0	91.9		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. Increased discharges in recent months with improved integrations with system partners. Superstranded patients reduced considerably.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jun-20	117.5	108.7	100.0	100.3					
% Medical Outliers	F&P	T	Sep-20	0.04%	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	Sep-20	53.2%	55.4%	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	▲	Aug-20	74.7%	73.2%	90.0%	72.3%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. Specific wards have been identified and new processes developed to support improvement. OP attendance letters - As a result of COVID many appointments had to be moved or replaced with telephone appointments. Not all appointments were conducted at the expected time and a brief disconnect in generating letters occurred. This has been addressed and we continue to support clinicians with our novel processes.		Specific wards have been identified with poor performance and staff are being supported to complete discharge in a timely manner. All CDs and ward managers receive weekly updates of performance. Specific areas in surgery and medicine have been targeted and performance improved.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Aug-20	88.4%	84.1%	95.0%	84.9%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Aug-20	97.1%	96.5%	95.0%	94.9%					

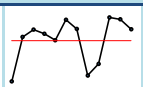
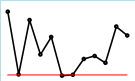
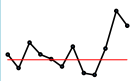
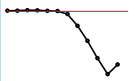
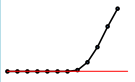
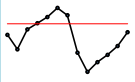
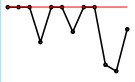
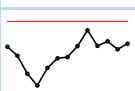
Sep-20

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

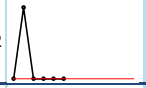
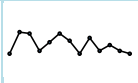
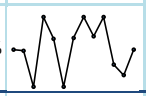
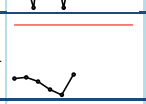
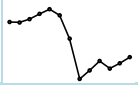
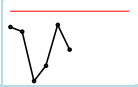
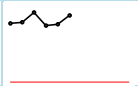
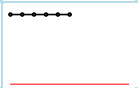
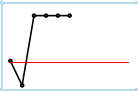
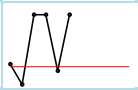
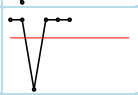
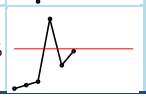
	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Sep-20	95.8%	92.5%	83.0%	89.3%		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	▲£	Sep-20	0	3	0	1			Quality and patient safety	RCA is being undertaken. Immediate actions in place to mitigate chances of recurrence. Local actions and checks in place to minimise the likelihood of re-occurrence .	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	Sep-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	Consistent good performance is supported by the EPMA platform.	RPJ
Number of hospital acquired MRSA	Q F&P	▲£	Sep-20	0	0	0	1		There were no cases of MRSA in September 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	▲£	Sep-20	4	18	48	42		There were 4 positive C Diff sample in September 2020.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-20	4	15	No Target	25		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Aug-20	0	1	No Contract target	1		No category 3 or 4 pressure ulcers in August 2020.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April.	SR
Number of falls resulting in severe harm or death	Q	▲	Aug-20	3	16	No Contract target	13		3 falls resulting in severe harm in Aug 2020. The incidents were reported from Ward 2A, 2C and 3A.	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	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 to September 2020 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA. Performance remained above target.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. A spike of thrombotic events during the height of COVID reflects the nature of the disease and performance has now improved.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Sep-20	3	29	No Target	26					
To achieve and maintain CQC registration	Q		Sep-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	Sep-20	93.3%	94.4%	No Target	95.6%		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	Sep-20	2	20	No Target	8					

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	▲ £	Aug-20	94.5%	93.9%	93.0%	91.0%		Cancer performance improving as services get back on track. 62 day performance and 2 ww access target achieved	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 is secured additional Imaging capacity via temp CT facility and C&M funding for additional USS approved 4. Trust commenced Rapid Diagnostic Service early 2020 5.Cancer surgical Hub at St Helens to recommence 6. ESCH plans reignited	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Aug-20	98.1%	97.6%	96.0%	97.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-20	92.7%	88.0%	85.0%	86.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Aug-20	60.5%	60.5%	92.0%	90.3%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled.	COVID restrictions had stopped elective programme and therefore the ability to achieve RTT is not possible.	RTT continues to be monitored and patients tracked. Long waiters tracked and discussed in depth at weekly PTL meetings. activity recommenced but at reduced rate due to social distancing requirements, PPE, patient willingness to attend and this has begun to be impacted upon as Covid activity increases again. urgents, cancers and long waiters remain the priority patients for surgery at Whiston	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Sep-20	70.8%	63.8%	99.0%	99.7%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Aug-20	137	137	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-20	0.7%	0.4%	0.8%	0.7%		All routine elective work was cancelled until COVID restrictions lifted and this impacted adversely on the 28 day re-list target	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	▲ £	Aug-20	92.3%	87.1%	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	▲	Sep-20	80.4%	82.8%	95.0%	69.8%		Accident and Emergency Type 1 performance for September 2020 was 80.4% and YTD 82.8%. Type 1 Performance in August 2020 was 78.9%. The all type mapped STHK Trust footprint performance for September was 89.2% and YTD 89.4%. The Trust is seeing attendance levels flatten in September, with the average daily attendance being the same as August (307) Total attendance for September was 9219 - for August, it was 9,524 . July attendances were 9374 compared with 8764 in June, 7,815 in attendances May 2020 and 5,548 in April. Total ambulance turnaround time in September was 27 mins. (Standard is 30 minutes). Arrival to notification time was 14 minutes which includes on average 6-7 mins time for crews to notify ED of their arrival on site. There were 2435 ambulance conveyances in September, compared with 2565 in August.	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 COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Sep-20	89.2%	89.4%	95.0%	83.9%					
A&E: 12 hour trolley waits	F&P	▲	Sep-20	0	0	0	0					

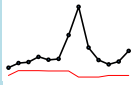
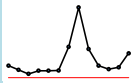
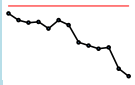
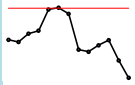
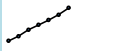
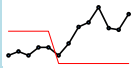
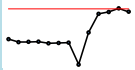
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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 to September 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	Sep-20	19	111	No Target	319		% new (Stage 1) complaints resolved within agreed timescales continues to remain above the 90% target year to date.	Patient experience	The Complaints Team continue to focus on increasing response times with active monitoring of any delays and provision of support as necessary. Complainants made aware in April of the significant delays that will be experienced in receiving responses going forward due to current operational pressures, with continued focus on achieving the target of 90%.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-20	16	117	No Target	310					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-20	93.8%	94.9%	No Target	92.9%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20	24		No Target	21		**March to September 2020 submissions suspended.** In February 2020, the average number of DTOCS (patients delayed over 72 hours) was 24.		COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity/reduce delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Sep-20	248	228		333					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Sep-20	62	63		126					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-20	86.7%		90.0%	86.5%		**March to September 2020 submissions suspended.**	Patient experience & reputation	Despite the suspension of national submissions, the profile of FFT continues to be raised by members of the Patient Experience Team as a valuable mechanism for receiving up-to-date patient feedback. 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. There has been an increase in posters being displayed during August 2020 (lastest month). 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.	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%					

Sep-20

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	▲	Sep-20	6.1%	6.3%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.3%		In September overall sickness was 6.1% which is a 0.7% increase from August. Front line Nursing, Midwifery and HCA's is 7.6% which is an increase of 1.3%. Increases are as a result of sickness due to testing following track and trace N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include, covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension, or special leave due to e.g. childcare.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team review COVID and non COVID absences daily to ensure staff eligible for swabbing are referred to HWWB. Additional health and well being support is provided to help staff with stress, anxiety and depression caused by the impact of COVID19. This includes ongoing support to shielding returners and other staff anxious about working in a covid environment. Daily on site mental health support staff in ICU and additional resilience support has been provided to Matrons in September. Staff have also required support in dealing with childcare issues resulting from being sent home from school to isolate or testing positive.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Sep-20	7.6%	7.7%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-20	64.5%	64.5%	85.0%	79.4%		Appraisal compliance in September is below target by 20.5%. This has been below target since August due to appraisals previously being paused due to COVID19 where service demands have impacted on the capacity to complete appraisals. Mandatory training compliance remains below the target by 6.3%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance continues to be impacted by COVID 19 with both Appraisal and Mandatory training compliance has decreasing in month and below target. The requirement to complete Appraisals and Mandatory training was resumed in July. Appraisals can be completed through the e-forms and remotely to enable improved compliance. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Sep-20	78.7%	78.7%	85.0%	84.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2			No Contract Target			**Further submissions suspended by NHSE/NHSI until further notice.**	Staff engagement, recruitment and retention.	The Q3 survey in the form of the Annual Staff Survey opened on 1st October and will close on the 30th November.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Sep-20	1.1%		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	Sep-20	suspended	suspended	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 six months of 2020/21.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Sep-20	suspended	suspended	-	16,152					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Sep-20	-	-	-	3,900					
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-20	14	14	2	7					
Capital spend £ YTD (000's)	F&P	T	Sep-20	9,000	9,000	26,700	10,293					
Financial forecast outturn & performance against plan	F&P	T	Sep-20	-	-	-	3,900					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-20	94.4%	94.4%	95.0%	87.9%					

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020-21 YTD	2020-21 Target	FOT	2019-20	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	89.7%	100.0%	89.5%	100.0%	100.0%	100.0%	100.0%	94.6%	100.0%	86.7%	76.5%	100.0%	100.0%	92.4%	85.0%		92.7%		
	Total > 62 days		2.0	0.0	2.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	2.0	0.0	0.0	3.0			8.0		
	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	1.0	0.0	1.0			1.0		
Lower GI	% Within 62 days	▲£	60.0%	85.7%	100.0%	78.9%	100.0%	50.0%	100.0%	82.6%	76.0%	85.7%	76.5%	100.0%	75.0%	80.0%	85.0%		83.2%		
	Total > 62 days		2.0	1.0	0.0	2.0	0.0	2.0	0.0	2.0	3.0	1.0	2.0	0.0	1.0	7.0			15.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	1.0	0.0	1.0	3.0			3.0		
Upper GI	% Within 62 days	▲£	100.0%	85.7%	100.0%	87.5%	88.9%	100.0%	100.0%	80.0%	60.0%	80.0%	60.0%	100.0%	100.0%	81.6%	85.0%		90.5%		
	Total > 62 days		0.0	1.0	0.0	1.0	0.5	0.0	0.0	1.0	2.0	0.5	2.0	0.0	0.0	4.5			8.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	2.0			2.5		
Urological	% Within 62 days	▲£	83.3%	92.3%	84.6%	92.0%	86.4%	86.4%	69.2%	79.3%	74.2%	66.7%	100.0%	100.0%	90.0%	85.6%	85.0%		85.5%		
	Total > 62 days		3.0	1.0	2.0	1.0	1.5	1.5	6.0	3.0	4.0	2.0	0.0	0.0	1.0	7.0			25.0		
	Total > 104 days		0.5	0.0	0.0	0.5	0.5	1.0	1.0	0.0	1.0	2.0	0.0	0.0	1.0	4.0			6.5		
Head & Neck	% Within 62 days	▲£	50.0%	28.6%	28.6%	20.0%	66.7%		25.0%	20.0%	100.0%	0.0%	100.0%	100.0%	66.7%	87.5%	85.0%		29.3%		
	Total > 62 days		1.5	2.5	2.5	2.0	1.0		1.5	2.0	0.0	0.0	0.0	0.0	0.5	0.5			13.0		
	Total > 104 days		0.0	1.5	1.0	0.0	0.0		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0			3.5		
Sarcoma	% Within 62 days	▲£	100.0%	50.0%	100.0%	0.0%	100.0%					100.0%				100.0%	85.0%		66.7%		
	Total > 62 days		0.0	1.0	0.0	1.0	0.0					0.0				0.0			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	▲£	40.0%	50.0%	0.0%	75.0%	54.5%	80.0%	66.7%	100.0%	100.0%	40.0%	100.0%	100.0%	100.0%	76.9%	85.0%		69.1%		
	Total > 62 days		3.0	1.0	0.5	1.0	2.5	1.0	2.0	0.0	0.0	3.0	0.0	0.0	0.0	3.0			14.0		
	Total > 104 days		0.0	1.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			1.5		
Lung	% Within 62 days	▲£	100.0%	57.1%	90.0%	100.0%	58.3%	100.0%	71.4%	75.0%	69.2%	86.1%	100.0%	88.9%	60.0%	82.9%	85.0%		85.0%		
	Total > 62 days		0.0	3.0	1.0	0.0	2.5	0.0	1.0	1.0	2.0	5.0	0.0	1.0	2.0	10.0			16.5		
	Total > 104 days		0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	1.0	1.0			1.5		RC
Haematological	% Within 62 days	▲£	85.7%	100.0%	78.9%	100.0%	86.7%	80.0%	100.0%	100.0%	50.0%	66.7%	100.0%	66.7%	80.0%	75.9%	85.0%		86.7%		
	Total > 62 days		1.0	0.0	2.0	0.0	1.0	1.0	0.0	0.0	1.0	0.5	0.0	1.0	1.0	3.5			7.5		
	Total > 104 days		0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0			1.0		
Skin	% Within 62 days	▲£	95.0%	98.2%	80.2%	94.4%	95.8%	78.4%	93.9%	95.2%	91.2%	100.0%	92.5%	97.4%	100.0%	95.8%	85.0%		92.0%		
	Total > 62 days		1.5	0.5	8.0	1.5	1.0	5.5	1.5	1.5	2.5	0.0	1.5	1.0	0.0	5.0			26.0		
	Total > 104 days		0.5	0.0	1.5	0.5	0.5	1.5	1.5	1.0	0.0	0.0	0.5	0.0	0.0	0.5			7.5		
Unknown	% Within 62 days	▲£	100.0%				100.0%	0.0%						100.0%	100.0%	100.0%	85.0%		69.2%		
	Total > 62 days		0.0				0.0	0.5						0.0	0.0	0.0			0.5		
	Total > 104 days		0.0				0.0	0.0						0.0	0.0	0.0			0.0		
All Tumour Sites	% Within 62 days	▲£	85.9%	86.2%	83.1%	88.9%	86.2%	85.2%	83.4%	88.0%	82.0%	81.6%	87.5%	96.0%	92.7%	88.0%	85.0%		86.2%		
	Total > 62 days		14.0	11.0	18.0	9.5	10.0	11.5	12.0	11.5	14.5	13.0	7.5	3.0	5.5	43.5			135.5		
	Total > 104 days		1.0	2.5	5.0	1.0	1.5	2.5	2.5	3.5	2.0	2.0	3.5	1.0	4.0	8.5			28.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£															85.0%		80.0%		
	Total > 31 days																		0.0		
	Total > 104 days																		0.0		
Acute Leukaemia	% Within 31 days	▲£	100.0%		100.0%												85.0%		100.0%		
	Total > 31 days		0.0		0.0														0.0		
	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)062
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during September 2020. There were 4 Executive Committee meetings held during this period. The Executive Committee approved: • Resources to support the delivery of the 2020 flu vaccination programme • Additional SAS Grade Anaesthetic cover • Re-establishment of the COVID incident command and control structure following the increase in patient admissions. The Committee also considered regular assurance reports covering; a monthly safer staffing report, Risk Management Council and Corporate Risk Register and Integrated Performance Report.
Trust objectives met or risks addressed: All 2020/21 Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 28th October 2020

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were 4 Executive Committee meetings in September 2020.

At every meeting bank or agency staff requests that breach the NHSE/I cost thresholds are reviewed and Chief Executive's authorisation recorded.

All meetings included a standard agenda item to consider COVID pandemic or restoration and recovery, COVID specific expenditure requests and issues escalated from the operational gold command meetings.

2. 3rd September 2020

2.1 2019/20 Draft Quality Account

The Director of Nursing, Midwifery and Governance introduced the draft Quality Account for the previous financial year. The national timetable for publication of Quality Accounts had been put back to November as a result of COVID-19. A number of amendments to the text were agreed and the revised draft would be presented to Quality Committee on 22nd September and circulated to stakeholders and commissioners for review and comment.

2.2 Acute Kidney Injury (AKI) Action Plan

The Medical Director reported that a Hydration Steering Group had been formed and is meeting regularly. A number of measures are being trialled on pilot wards, the data monitored and audits undertaken to assess the impact. The most recent data available indicated that for 65% of AKI patients the problems had started before they were admitted. It was agreed that coding of comorbidities was essential and regular monitoring of the impact of the changes that had been put in place.

2.3 Out of Hours Anaesthetic Cover

The Director of Operations and Performance presented an update on the proposals, which clarified a number of points where the committee had requested additional information. The final options to improve cover were expected to be presented before the end of September, and in the meantime the additional anaesthetic cover agreed during COVID was being maintained.

2.4 Trust Board Agendas - September

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

2.5 COVID Issues

The Director of Operations and Performance detailed the issues escalated from Gold Command, including the impact of social workers not coming to the hospitals to

undertake face to face assessment of patients, an update on restoration arrangements for theatres and progress with completing the staff risk assessments.

A funding bid was approved to assist with the risk assessments of all lead employer doctors.

Committee reviewed the progress against the 2nd Wave Executive Action Plan, noting that business continuity and local escalation plans had been reviewed. All other actions remained on track against the agreed timescales.

3. 10th September 2020

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

The Director of Corporate Services presented the chair's assurance report from the RMC meeting held on 8th September reviewing the changes to the Trust risk register during August. 13 high scoring risks remained escalated to the CRR and there had been no new risks escalated during the month.

3.2 Flu Vaccination Programme 2020/21

The Deputy CEO/Director of HR presented the plans for delivering flu vaccinations to staff. The increased importance of the flu vaccination programme this year was recognised and additional temporary staff resources and IT equipment to assist with the delivery of the programme were approved. The launch date is the end of September.

3.3 COVID Issues

The committee agreed to extend the funding for a number of COVID initiatives; additional touch point and rapid cleaning teams, social distancing wardens, elective procedure patient testing capacity and Hospedia TV access for inpatients. It was acknowledged that these services remained essential as COVID cases increased again, but there was concern that the additional costs would not be built into the Trust run rate or financial envelope from October, which presented a risk.

The Director of Integration presented the latest public health monitoring information for each of the Trust's catchment boroughs. This showed that the incidence of COVID positive cases was increasing everywhere, although Liverpool and Knowsley had the highest number of cases per 100,000 of population.

Issues escalated from Gold Command included; the visiting policy, changes to the national advice to staff who are pregnant and the need to re-establish the in-house staff testing capability. It was agreed that the planned relaxation of the visiting restrictions should be paused in response to the increasing incidence of COVID.

3.4 Phase 3 Plans

The Director of Operations and Performance confirmed that the draft Phase 3 plan for restoration and recovery of elective activity had been submitted. Committee acknowledged the complexity of developing these plans and that they would be

increasingly difficult to deliver if there was another spike in COVID patients needing hospital care.

3.4 PLACE 2020

The Director of Corporate Services confirmed that the annual PLACE inspection process had been cancelled for this year due to the impact of COVID-19.

4. 17th September 2020

4.1 Apprenticeship Update

The Deputy CEO/Director of HR introduced the paper which detailed the impact of COVID-19 on the apprenticeship programme and the plans for recovery. Many apprenticeship providers had stopped providing supervision at the beginning of lockdown in March 2020 and recruitment had been suspended. This meant that the Trust, in common with most other organisations had not been able to spend all the levy pot. National representations were being made to extend the time period to 36 months, so that this funding could be used for the benefit of staff, but it was not certain this would be agreed. The process of recovery had now started, against the updated training needs matrix for the Trust, with the aim of utilising the full levy fund going forward. It was noted that the Trust levy contributions had increased as more services had been transferred, but as the majority of these staff were clinical professionals there was not necessarily an increase in the demand for apprenticeships.

4.2 Mandatory Training and Appraisals

The Deputy CEO/Director of HR presented the mandatory training and appraisal figures for August. This showed the impact of the suspension of appraisals and non-clinical mandatory training between March and June as a result of COVID-19. Each Director had developed a recovery plan for their areas of responsibility, but the challenge was acknowledged if COVID cases started to increase again.

An update was provided on the steps being taken to improve the experience of appraisals following the feedback from the 2019 staff survey. Staff had been questioned on what they valued from an appraisal and the process was being re-designed to better meet these expectations and include the requirements set out in the NHS People Plan. A trial of the new system was planned, which would be followed by a Trust wide re-launch later in the autumn.

4.3 Safer Staffing - August

The Director of Nursing, Midwifery and Governance presented the report which demonstrated that registered nurse staffing levels had been above 90%. The deep dive analysis also demonstrated that there were no incidents of patient harm that could be linked to staffing levels on any of the wards.

4.4 Out of Hours Anaesthetic Cover

The Director of Operations and Performance presented the finalised business case to provide enhanced out of hours anaesthetic cover. The case for additional 24 hour cover

at Specialty Doctor/Associate Specialist (SAS) anaesthetist level was approved. Further consideration was needed of the requirement for theatre team support and if this needed to be on site or could be on standby.

4.5 Integrated Performance Report (IPR)

The committee reviewed the draft IPR and agreed the narrative commentary to be added. It was agreed that more detail should be included about grade 2 pressure ulcers which were an area of concern. There was concern about the HSMR figure reported for April and the Medical Director agreed to investigate if this was linked to the impact of COVID.

4.6 COVID Issues

The latest weekly public health information showed a further increase in cases and committee discussed what this could mean for hospital admissions. The in house staff testing service had been re-established very quickly to respond to the increase in demand for staff or family members with symptoms. Concerns had been escalated about the impact of school children being sent home and some of the advice about self-isolation and testing that was being issued to parents. There were significant numbers of staff affected, which was increasing absence levels. It was agreed that the staff redeployment hub needed to be re-established.

5. 24th September 2020

5.1 COVID Issues

The public health data showed that the rate of COVID was doubling every 7 days in the local population and this was now being reflected in the number of patients being admitted. The Medical Director reported that the North West had the highest infection rates in the UK. The decision was taken to re-escalate the internal command and control arrangements with Gold Command to meet 3 times a week. Areas seeing undifferentiated patients would once again be designated as high risk, which meant that the risk assessments for staff working in these areas would need to be reviewed.

The Directors of Nursing across the North West had issued further guidance asking trusts to review their visiting policies and advising not to relax the restrictions in areas where the incidence of COVID was increasing. It was acknowledged that this was stressful for patients and their relatives and had resulted in negative media coverage, but the need to protect patients and staff from unnecessary exposure had to be the paramount consideration.

The committee agreed that arrangements for staff needing to take time off work to look after children who were being sent home from school should be temporarily reviewed to reflect the exceptional circumstances.

The elective programme and recovery plans were continuing to be delivered, but it was agreed that the pre-operative self-isolation periods needed to be increased again to protect vulnerable patients who needed a general anaesthetic.

Expenditure requests for the Health Work and Wellbeing staff self-isolation hub and staff for the additional CPAP beds were approved. It was acknowledged that whilst elective activity continued there would be few staff to redeploy into other critical roles, which would be different to the first wave of COVID. It was agreed that the full winter plan and additional funding requirements would be presented to the committee as soon as possible.

The Trust had now received an additional allocation of reagents from the central push delivery system, which meant testing capacity had increased to over 700 per day.

5.2 Marshalls Cross Health Care Centre (MCHCC)

The Director of Operations and Performance gave an update on MCHCC. Good progress had been made against the 2020/21 Quality Outcomes Framework (QOF) targets. The practice had responded well to the pressures of COVID, ensuring that patients could continue to make an appointment and face to face appointments and health checks had now resumed.

The practice had recruited a clinical pharmacist and currently had two army nurses undertaking clinical placements.

5.3 Acute Medical Model

The Director of Operations and Performance gave an update on the review of medical pathways, with a view to ensuring that more patients were admitted directly to the correct speciality bed. The first phase of the process included the pathways in the Emergency Department, frailty and direct admissions from NWAS and community services.

The observation and assessment units would be included in the next phase of the project.

5.4 NHS People Plan

The Deputy CEO/Director of HR presented a briefing on the NHS People Plan for 2020/21 and the action plan that had been developed to ensure the Trust delivered against all the requirements. The action plan combined the local commitments the Trust had made in its own Workforce Strategy with those in the national People Plan. Monitoring would be undertaken by the Workforce Council with regular reports, and provide assurance to the Quality Committee. The actions covered many areas and an executive lead had been assigned to each.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)063

Title of paper: Committee Report – Quality Committee

Purpose: To summarise October's Quality Committee and escalate any areas of concern

Agenda items discussed

Matters arising and action log
The action log was updated, noting that risk assessments for malnutrition are monitored by the Nutritional Steering Group and the importance of these was reiterated to the ward managers and matrons; end-of-life training is now included as part of core clinical training; work to strengthen the safety culture in theatres; ongoing actions to ensure improved performance in sending e-discharge summaries within 24 hours.

Summary of Pandemic Review Meetings
The Committee was pleased to note that the Executive Team had met with a number of teams from across the Trust to hear first-hand about their experiences of providing care during the pandemic and the actions that will be undertaken going forward.

Review of Pressure Ulcers 2019-20
A thematic review was presented to identify the causes leading to the increased number of pressure ulcers in 2019-20 and the actions being taken to reduce these, which is a priority for the Trust in 2020-21. The Quality Committee sought assurance that the procedures for identifying Trust-acquired pressure ulcers are robust and requested further information on the governance and controls assurance processes.

Safeguarding Quarterly Report
The Committee received the quarterly report, noting the rise in safeguarding activity and the increasingly complex cases being managed by the Safeguarding Team. Assurances were provided that community services were making an increased number of referrals and that staff in the Urgent Treatment Centre apply appropriate professional curiosity to identify any concerns during patient assessments. The number of Deprivation of Liberty Safeguards has continued to increase each quarter. Work is ongoing to ensure mandatory training targets are met. Capacity within the team is regularly reviewed in light of the increased activity.

Infection Prevention Annual Report 2019-20
The Infection Prevention annual report for 2019-20 was presented, which highlighted the arrangements in place for preventing infections across the Trust, the key achievements in reducing infection rates during the year and the plans for the forthcoming year. The Committee sought assurance that staff were completing their mandatory training for infection prevention, noting the actions being taken to achieve full compliance. The Committee approved the annual report for submission to the full Board.

Patient Safety Council Chair's Report – October 2020
A reduction in the number of incidents was reported, which is in line with the reduced activity seen during the pandemic. The Council noted that there had been an increase number of falls resulting in fractured neck of femur and the actions being taken to reduce

this. An update was received by the Council on actions being taken following theatre incidents, with assurance that a recent audit of 'stop before your block' showed 100% compliance.

Integrated Performance Report (IPR)
Committee members reviewed the information contained in the IPR, noting in particular that HSMR figure is subject to wide fluctuations due to the pandemic, however any specific conditions causing concern are identified and reviewed in detail, with actions being taken to improve hydration highlighted. The Committee were pleased to note the achievement of cancer targets and ongoing work to meet emergency access and 18 week referral to treatment targets. Staff absence due to COVID 19 is being closely monitored, with support in place to ensure staff are able to return to work as quickly as possible when well. The number of staff having flu vaccinations is higher than at the same point last year. Committee members sought further detail relating to the number of patients on waiting lists.

Medicines Management Storage Security Audit Report
The Committee were pleased to see considerable improvement in the secure storage of medicines reported following the latest audit undertaken in August/September and noted ongoing actions to sustain this.

Patient Experience Council Chair's Report October 2020
A summary of the meeting was provided, including reports highlighting the actions taken following patient feedback via the patient story and from FFT and the work of the cancer symptoms advice line. The roll out of dedicated family support ward links to additional wards, following a successful pilot on one ward, was highlighted as having a positive impact both in keeping relatives up-to-date and in answering telephone calls.

Quarterly Complaints, PALS, Claims and Friends and Family Test Report
The report highlighted the sustained improvements in the management of complaints and the low conversion rate of PALS contacts to formal complaints. The decrease in claims for both quarters 1 and 2 was highlighted, noting the impact of COVID. A number of actions taken as a result of complaints, claims and FFT were included.

Clinical Effectiveness Council Chair's Report – October 2020
Presentations were received from rheumatology and obstetrics and gynaecology, noting an increase in activity. The actions being taken to increase life support mandatory training were noted. It was noted that resuscitation services benchmark well in terms of recovery rates, indicating that DNACPR orders are being used appropriately.

Clinical Audit Programme and Progress Report biannual report
The Committee was pleased to note the ongoing delivery of the internal and external clinical audit programme, achieving 96% compliance against the plan.

Mandatory Training Compliance Report
There has been a slight improvement in mandatory training compliance in key subjects, with actions detailed to deliver further improvements.

Safer Staffing Monthly Report – August and September
The latest safer staffing report was noted, with overall RN fill rates above 90% and care staff above 100% due to the number of close observations required.

Matters for Escalation to the Board • Ongoing scrutiny of actions being taken to reduce pressure ulcers • Improved performance in safe storage of medicines • Ongoing delivery of the Trust's clinical audit programme
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: 28th October 2020

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)064

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 22nd October 2020.

Summary:

Meeting attended by:

J Kozer – NED & Chair (JK)
I Clayton - NED (IC)
P Growney – NED (PC)
S Amesu – Associate NED (SA)
N Khashu – Director of Finance & Information (NK)
R Cooper – Director of Operations & Performance (RC)
AM Stretch – Deputy CEO / Director of Human Resources (AM)
RP Jones – Medical Director (RPJ)
S Pedder - Deputy Medical Director (SP)
A Bassi – Deputy Medical Director (AB)
G Lawrence – Deputy Director of Finance & Information (GL)
S Clark – Head of Financial Management (SC)

Agenda Items
For Assurance

A) Integrated Performance Report

- It was noted that the number of patients not wanting to attend for appointments is beginning to improve and the level of super stranded patients had decreased to 62 from 121 last year.
- Assurance was sought on diagnostic waits and whether we are preforming at the same levels as local peers if the standard cannot be met currently. AB confirmed that the Trust is on par with the rest of the regional and performing particularly well on endoscopy with the most vulnerable patient being prioritised.
- The NEDS queried COVID performance and which Committee is the correct forum given the breath of information available. It was confirmed that the metrics are in the respective reports but may not be visible all together. AMS suggested a discussion of the letter from Bill McCarthy at Board to ensure that the right committees review the correct information.
- The Committee also discussed the testing of asymptomatic front-line staff and the potential adverse impact on absence on top of current levels being reported.

B) Finance Report Month 6

- The Trust has delivered a break-even position in line with national planning assumptions. This is the last month that the Trust will operate under the current regime.
- This has been achieved by submitting "top ups" for both COVID related expenditure and core operational spend above the allocated monthly block arrangements. A copy of the NHSE/I Budget Allocations paper from this Committee is shared monthly with NHSE/I and accepted.
- Cash position continues to be strong as a result of commissioners paying block contracts one month in advance.

For Information

C) Month 6 2020/21 Financial Performance

- Improvement seen in activity across the points of delivery, although there was a slight decrease in August for A&E as there are fewer days that month. Activity continues to return to previous year levels with only a marginal increase in cost.

D) 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 contents of this paper have been subject to a number of discussions with NHSE/I and is shared monthly. Top up payments are applied for based on this paper and have been paid for months 1-5 with no expected challenge in M6.

E) CIP Planning 21/22

- The Committee noted the progress made on CIP for 21/22 and understood that no national target is in place yet so an assumption of c£15m has been made in line with 20/21.
- The Committee were assured on the number and value of schemes in progress and how this compared to previous years.
- The committee agreed that QIA must be maintained given expected financial framework will be focussed on block payments going forward.

F) Cheshire & Merseyside Health & Care Partnership Resources for (Q3 & Q4)

- The Committee received a presentation on the offer made to the Trust by C&MHCP and the forecast outturn position this would create.
- The Committee discussed the risks within the forecast and the steps needed by the Trust and HCP to reduce the system gap.
- The Committee agreed with the Trusts review and approach on the forecast outturn and recommend a discussion at Board on the forecast position.

G) Review of COVID expenditure

- The committee reviewed a high proportion of the respective COVID schemes that have been approved by the Trust during the year.
- The committee were assured that there is a robust process in place to review these schemes on an on-going basis.

H) Briefing Papers accepted from

- CIP Council – Terms of Reference were ratified.

Risks noted/Items to be raised at Board

- Current forecast outturn which is still being refined and with management actions.
- Assured on the controls for the approval of spend for COVID/Activity related items.
- Review of COVID metrics as a whole for the Trust.

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: 28th October 2020

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)065

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 22nd October 2020

Summary

1. Action Log: FOR INFORMATION
   - Introduction pack for new starters
   - Discussion of progression of departmental/staff fundraising and getting their engagement.
   - Provision of information around the role of the Charity and how it fits within the Trust for current and new staff.
   - Evaluation of items bought from the Charity and how they have benefitted staff/patients both directly and indirectly.
   - All affected by current situation.
2. Financial position: FOR INFORMATION
   - The Committee noted the level of investments and recent income and expenditure.
3. Approval of expenditure: FOR DECISION
   - 2 x Paxman Scalp Cooling Systems for the Lilac Centre funded by the Steve Prescott Foundation donation.
4. Fundraising update: FOR INFORMATION
   - Fundraising strategy update - Day to day working and month by month plans, how this has changed due to Covid-19.
   - NHS Charities Together Grants – Ongoing discussions for spending plans and the fact they will be acknowledged in the 2020-21 Annual Report.
   - Community Services – Administration of donations received for community services, how to manage these donations.
5. Other business: Annual Report and Accounts 2019-20: FOR DECISION
   - The Annual Report and Accounts 2019-20 was approved by the Committee on behalf of the Trust Board, subject to the independent examiner's report completed by Grant Thornton UK LLP, the Trust's external auditor.
6. Other business – Christmas monies - FOR DECISION
   - The Committee agreed £5.00 per patient to be spent on Christmas gifts, plus biscuits/sweets for visitors. Discussions to be had as to how to enhance patients' experience over Christmas if present visiting arrangements are still in place.

Risks noted / items to be raised at Board

- The Board is asked to ratify the approval of the Annual Report and Accounts 2019-20, via a separate paper presented to this meeting of the Trust Board.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Paul Growney, Chair, Charitable Funds Committee

Date of meeting: 28th October 2020

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)065a
Title of paper: Charitable Funds Accounts and Annual Report
Purpose: The Trust Board is asked to ratify the Charitable Funds Committee's approval of the Charitable Funds Draft Annual Accounts and Annual Report 2019-20, which took place at the meeting held on 22nd October 2020.
Summary: The Charitable Funds Draft Annual Accounts and Annual Report 2019-20 were approved by the Charitable Funds Committee on behalf of the Trust Board, subject to the independent examiner's report completed by the Trust's external auditor, Grant Thornton UK LLP. The accounts show that for the year 2019/20, income was £255.2k with expenditure of £250.9k and an unrealised loss on investments of £57.7k, giving an in-year net movement of funds of £53.4k(loss). Brought forward into 2019/20 were fund balances of £595.1k and 2019/20 year end balances are £541.7k. A copy of the draft annual accounts and report can be made available on request.
Corporate objectives met or risks addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.
Financial implications: None as a direct consequence of this paper.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Trust Board is asked to ratify the approval of the Charitable Funds Draft Annual Accounts and Annual Report 2019-20.
Presenting officer: Nikhil Khashu, Director of Finance & Information
Date of meeting: 28th October 2020

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)066

Title of paper: Corporate Risk Register

Purpose: To inform the Board of the risks that have currently been escalated to the Corporate Risk Register (CRR) from the Care Groups via the Trust's risk management systems.

Summary:

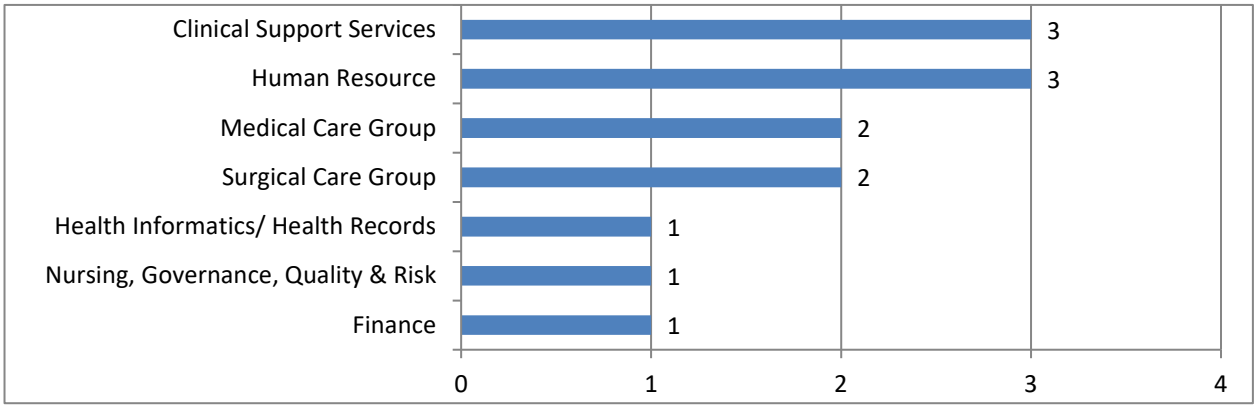
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council (RMC), which reports to the Executive Committee providing assurance , that all risks:

- Have been identified and reported;
- Have been scored in accordance with the Trust risk grading matrix;
- Any risks initially rated as high or extreme have been reviewed by a Director;
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

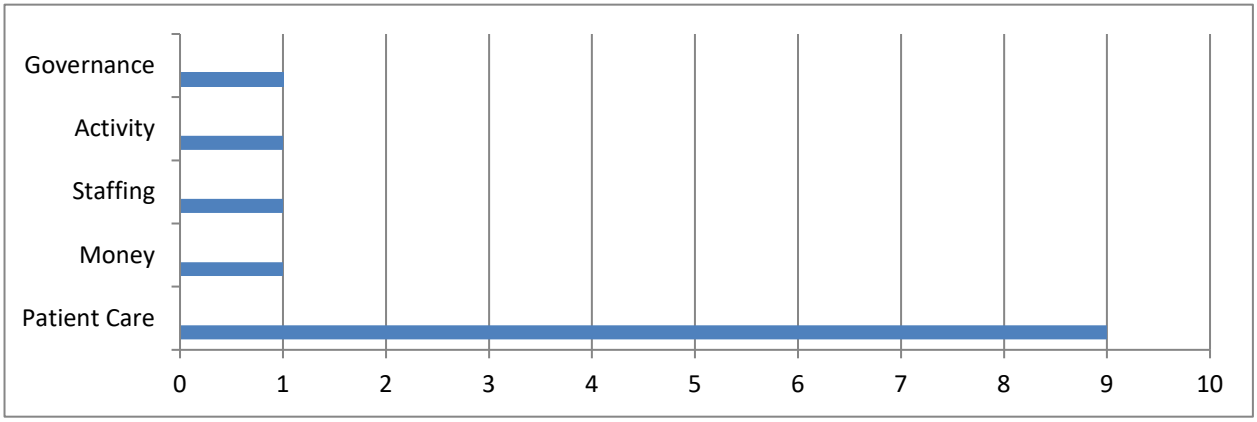
This report covers all the risks reported and reviewed until the end of September 2020 and is a snapshot, rather than a summary of the previous quarter. A comparison with the previous Board report in July 2020 is included to illustrate the movement in risks during the period. The report shows:

- The total number of risks on the risk register is 683 compared to 722 in July. The reduction is due to 2019/20 CIP risks being closed;
- 54% (364) of the Trusts risks are rated as Moderate or High compared to 50% (365) in July;
- 13 risks that scored 15 or above had been escalated to the CRR (there were 15 risks escalated in July). 3 of these escalated risks relate to the impact of COVID-19.

The spread of CRR risks (Appendix 1) across the organisation is:



The risk categories of the CRR risks are:



The report also includes comparisons with the previous quarterly report (July 2020) and against the same period last year – October 2019 (Appendix 2 and 3).

Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high-quality patient care.

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Commissioners, Regulators.

Recommendation(s): The Trust Board notes the risk profile of the Trust and the risks that have been escalated to the CRR

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 28th October 2020

CORPORATE RISK REGISTER – OCTOBER 2020

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/10/2020	Previous Reporting Period 01/09/2020	Previous Reporting Period 03/08/2020
Number of new risks reported	10	14	25
Number of risks closed or removed	29	34	33
Number of increased risk scores	4	3	4
Number of decreased risk scores	8	7	14
Number of risks overdue for review	154	50	44
Total Number of Datix risks	**683***	**697**	**717**

*includes risks that have been reported but not yet scored at Datix is a live system.

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
24	**32**	**23**	**88**	**9**	**134**	**54**	**128**	**31**	**138**	**3**	**7**	**3**	**0**
79 = 11.72%			**231 = 34.27%**			**351 = 52.08%**				**13 = 1.93%**			

The risk profile for each of the Trust's Care Groups and for the collective Corporate Services are:

2.1 Surgical Care Group – 186 risks reported 28% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**7**	**8**	**27**	**3**	**37**	**14**	**41**	**9**	**33**	**2**	**0**	**0**	**0**
20 = 10.75%			**67 = 36.02%**			**97 = 52.15%**				**2 = 1.08%**			

2.2 Medical Care Group – 129 risks reported 19% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**11**	**3**	**15**	**0**	**26**	**3**	**24**	**10**	**25**	**0**	**1**	**1**	**0**
24 = 18.60%			**41 = 31.78%**			**62 = 48.06%**				**2 x 1.55%**			

2.3 Clinical Support Care Group – 91 risks reported 14% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**3**	**1**	**8**	**0**	**13**	**15**	**18**	**6**	**22**	**1**	**1**	**1**	**0**
6 = 6.59%			**21 = 23.08%**			**61 = 67.03%**				**3 = 3.30%**			

2.4 Primary Care and Community Services Care Group – 32 risks reported 4% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**0**	**0**	**5**	**0**	**2**	**3**	**8**	**3**	**11**	**0**	**0**	**0**	**0**
0			**7 = 21.88%**			**25 = 78.13%**				**0**			

2.5 Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR and Medicines Management) – 236 risks reported 35% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
7	**11**	**11**	**33**	**6**	**56**	**19**	**37**	**3**	**47**	**0**	**5**	**1**	**0**
29 = 12.28%			**95 = 40.25%**			**106 = 44.91%**				**6 = 2.54%**			

The highest proportion of the Trust's risks continues to be identified in the Corporate Care Group. The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	1	23	14	3	**41**
Estates and Facilities Management	0	4	14	6	**24**
Nursing, Governance, Quality & Risk	1	18	7	3	**29**
Finance	1	7	10	4	**22**
Medicines Management	0	20	37	7	**64**
Human Resource	3	34	13	6	**56**
Total	**6**	**106**	**95**	**29**	**236**

3. The Trusts Highest Scoring Risks – Corporate Risk Register (CRR)

Risks of 15 or above are added to the CRR (Appendix 1).

Appendix 1

Summary of the Corporate Risk Register – October 2020

KEY	Medicine		Surgery		Clinical Support		Corporate		Community &PC	

New Risk Category	Datix Ref	Risk	Current Risk Score I x L	Lead & date escalated to CRR	Last Review Due	Target Risk Score I x L	Action plan in place	Governance and Assurance
Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies, **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	26/08/2020	4 x 2 = 8	Action plan in place	Quality Committee
Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 5 = 20	17/03/2020 Sue Redfern	29/09/2020	4 x 2 = 8	Action plan in place	Executive Committee
Money	1152	**If** there is an increase in bank and agency, **then** there is a risk to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	01/07/2020	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1353	If activity at St Helens Hospital continues to be increased, **then** there is a risk that the current medical cover will not be sufficient	5 x 3 = 15	26/02/2020 Rob Cooper	07/09/2020	5 x 1 = 5	Action plan in place	Quality Committee
Governance	1772	**If** there is a malicious cyber-attack on the NHS, **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	09/11/2016 Christine Walters	27/08/2020	4 x 3 = 12	Action plan in place	Executive Committee
Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance, **then** it will fail the national access standard	4 x 5 = 20	30/03/2020 Rob Cooper	03/09/2020	4 x 2 = 8	Action plan in place	Finance and Performance Committee
Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	30/03/2020 Rob Cooper	22/06/2020	3 x 2 = 6	Action plan in place	Quality Committee
Patient Care	2502	**If** there is a no deal Brexit, **then** there could be an adverse impact on the supply of medical consumables and devices	4 x 4 = 16	21/09/2018 Nik Khashu	29/09/2020	3 x2 = 6	Action plan in place	Finance and Performance Committee
Patient Care	2708	**If** a large number of senior medical staff are adversely impacted by the NHS pension tax rules, **then** the Trust could experience reduced senior clinical capacity	4 x 4 =16	04/07/2019 Anne-Marie Stretch	26/08/2020	4 x 2 = 8	Action plan in place	Executive Committee
Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient	5 x 3 = 15	04/09/2019 Rob Cooper	03/09/2020	5 x 2 = 10	Action plan in place	Executive Committee
Patient Care	2848	**If** the trust does not have sufficient anaesthetic and obstetric on call cover, **then** there is a risk of delayed medical management if there should be simultaneous medical emergencies.	5 x 3 = 15	21/02/2020 Rowan Pritchard-Jones	30/06/2020	5 x 2 = 10	Action plan in place	Quality Committee

Patient Care	2866	**If** the Lilac Centre cannot maintain the required level of specialist nurse staffing as a result of the additional COVID-19 restrictions, **then** there is a risk to service continuity for cancer patients	4 x 4 = 16	27/07/2020 Rob Cooper	18/09/2020	2 x 2 = 4	Action plan in place	Executive Committee
Patient Care	2932	**If** a patient's fluid balance is not recorded, **then** there is a risk that the patient could become dehydrated or fluid overloaded.	4 x 5 = 20	30/09/2020 Rowan Pritchard Jones	30/09/2020	4 x 2 = 2	Action plan in place	Quality Committee

Blue text = Risks escalated since the July Trust Board report

Risks that have been de-escalated or closed from the CRR since the July 2020 Board report are;

New Risk Category	Datix Ref	Risk
Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels, **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients
Patient Care	2641	**If** the community midwives do not have access to technology to enable contemporaneous patient notes, **then** there is a risk to patient care
Patient Care	2871	**If** there is disruption to the supply of PPE, **then** there could be a risk to patient and staff safety without sufficient supply to respond to COVID-19
Patient Care	2872	**If** routine antenatal appointments cannot be completed during the COVID-19 pandemic, **then** there could be a risk of harm to women and their babies

Appendix 2

Trust Risk Profile – July 2020

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
48	**32**	**22**	**91**	**9**	**154**	**58**	**122**	**32**	**139**	**4**	**9**	**2**	**0**
102 = 14.13%			**254 = 35.18%**			**350 = 48.48%**				**15 = 2.08%**			

Trust Risk Profile – October 2019

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
56	**53**	**20**	**119**	**11**	**157**	**58**	**131**	**35**	**122**	**4**	**10**	**0**	**0**
129 = 16.62%			**287 = 36.98%**			**346 = 44.59%**				**14 = 1.80%**			

Appendix 3

CRR – October 2019

The risks highlighted remain or have been re-escalated to the current CRR

Risk Category	Datix Ref	Risk	Current Risk Score I x L	Target Risk Score I x L	Governance
Patient Care	762	If the Trust cannot recruit sufficient staff to fill approved vacancies, then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 2 = 8	Quality Committee
Money	1152	If there is an increase in bank and agency, then there is a risk to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 3 = 8	Quality Committee
Patient Care	1358	If the Cheshire and Mersey PACs system experiences system issues, then there is a risk to patient safety	4 x 4 = 16	4 x 1 = 4	Executive Committee
Patient Care	1605	If the Trust is unable to fill gaps on the SpR rota then there is a risk to patient safety	4 x 4 = 16	3 X 1 = 3	Quality Committee
Governance	1772	If there is a malicious cyber-attack on the NHS, then there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	4 x 3 = 12	Executive Committee
Patient Care	2083	If inpatient bed occupancy levels are over 95% then this will negatively adversely affect the admission of medical patients from the ED	3 x 5 = 15	2 x 2 = 4	Executive Committee
Patient Care	2334	If the Medway migration issues in PBS are not resolved, then there is a risk to efficient service delivery across the Trust	4 x 4 = 16	4 x 2 = 8	Executive Committee
Patient Care	2428	If the breast imaging service cannot recruit staff to cover the vacancy arising following retirement of the previous post holders, then capacity to deliver this specialist service will be reduced	4 x 3 = 15	3 x 3 = 9	Executive Committee
Patient Care	2502	If there is a no deal Brexit, then there could be an adverse impact on the supply of medical consumables and devices.	4 x 4 = 16	3 x2 = 6	Finance and Performance Committee
Patient Care	2708	If a large number of senior medical staff are adversely impacted by the NHS pension tax rules, then the Trust could experience reduced senior clinical capacity	4 x 4 =16	4 x 2 = 8	Remuneration Committee
Money	2746	If the Trust does not achieve its activity plans, then the planned income may not be achieved	4 x 4 = 16	4 x 3 = 12	Finance and Performance Committee
Patient Care	2750	If there are national PDS spine data mismatch errors following the implementation of Medway, then diagnostic imaging results could be affected.	5 x 3 = 15	5 x 2 = 10	Executive Committee
Patient Care	2759	If there is not sufficient medical cover on ward 4E then patients will not receive the required standard of care	4 x 4 = 16		Quality Committee
Patient Care	2565	If there is not sufficient capacity or capability in the Safeguarding Team the Trust may not be able to fulfil its statutory obligations	5x3=15	2x2=4	Quality Committee

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(20)067
Title of paper: Review of the Board Assurance Framework (BAF) – October 2020
Purpose: For the Executive Committee to review the BAF in advance of its presentation to the Trust Board.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in July 2020. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Recommended changes** No changes to the risk scores recommended at this review
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review the BAF and note the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 28th October 2020

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

Mission: To provide high quality health services and an excellent patient experience

BAF Ref	Long term Strategic Risks	Strategic Aims					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	✓		✓		✓	✓
3	Sustained failure to maintain operational performance/deliver contracts	✓	✓		✓	✓	✓
4	Failure to protect the reputation of the Trust			✓			✓
5	Failure to work in partnership with stakeholders	✓	✓	✓	✓		✓
6	Failure to attract and retain staff with the skills required to deliver high quality services	✓				✓	✓
7	Major and sustained failure of essential assets, infrastructure	✓	✓	✓			✓
8	Major and sustained failure of essential IT systems	✓	✓	✓			✓

Alignment of Trust 2020/21 Objectives and Long Term Strategic Aims

2020/21 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
COVID-19 Recovery Objectives						
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Objective supports this aim		Change from previous year		New for this year	

Risk Scoring Matrix

Impact Score	Likelihood /probability				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible (very low)	1	2	3	4	5

Likelihood – Descriptor and definition
Almost certain - More likely to occur than not, possibly daily (>50%)
Likely - Likely to occur (21-50%)
Possible - Reasonable chance of occurring, perhaps monthly (6-20%)
Unlikely - Unlikely to occur, may occur annually (1-5%)
Rare - Will only occur in exceptional circumstances, perhaps not for years (<1%)
Impact - Descriptor and definition
Catastrophic – Serious trust wide failure possibly resulting in patient deaths / Loss of registration status/ External enquiry/ Reputation of the organisation seriously damaged- National media / Actual disruption to service delivery/ Removal of Board
Major – Significant negative change in Trust performance / Significant deterioration in financial position/ Serious reputation concerns / Potential disruption to service delivery/Conditional changes to registration status/ may be trust wide or restricted to one service
Moderate – Moderate change in Trust performance/ financial standing affected/ reputational damage likely to cause on-going concern/potential change in registration status
Minor – Small or short term performance issue/ no effect of registration status/ no persistent media interest/ transient and or slight reputational concern/little financial impact.
Negligible (very low) – No impact on Trust performance/ No financial impact/ No patient harm/ little or no media interest/ No lasting reputational damage.

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Safety thermometer • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSE/I Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery	To Board; • IPR • Patient Stories • Quality Board Rounds • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking • COVID IPC Board Assurance Framework	5 x 3 = 15	CRAB Medical Implementation and reporting for routine outcome monitoring.	Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, inquests and mortality reviews Development of the 2020 – 2023 Nursing Strategy – currently subject to consultation (Revised to November 2020) Development of ward quality accreditation tool and real time quality dashboard (December 2020) Reduce hospital acquired AKI (Revised to January 2021)	Implementation plans for the four key 7-day service standards by 2020 Review of patient information to improve accessibility and understanding (Revised to December 2020 due to impact of COVID-19) Six monthly workforce safeguards reports for all clinical staff groups (Revised to March 2021 due to COVID-19) Maintaining highest quality and IPC standards during COVID 2nd wave (February 2021). Delivery of never event improvement plans and human factors training (December 2020) Enhanced monitoring and support to staff to maintain quality standards whilst caring for COVID patients (December 2020)	5 x 1 = 5	R P-J/ SR

Risk 2 —Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board • COVID-19 exceptional expenditure financial governance process	4 x 4= 16	Continue collaboration across C&M to deliver transformational CIP contribution Monitoring of management plans to deliver GiRFT recommendations ~~Board understanding of emergency NHS financial regime and move to block contracts for 2020/21~~	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances Cash requirements to service capital costs for committed PFI UP charges and other essential capital demands for patients care from 2020/21.	Seek all possible sources of capital funding including national bids to support capacity planning Deliver the financial plans agreed with the C&M HCP as part of the system position for 2020/21 (March 2021) Preparation for changes to supplies and procurement regulations as a result of EU Exit (January 2021)	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool • COVID-19 EPRR operational command and control structure in place	4 x 5=20	Implementation of routine capacity and demand modelling ~~Review business continuity and escalation/COVID-19 mobilisation plans in case of a 2nd wave~~ ~~Incident review and lessons learnt as a result of COVID-19 and how innovations can be incorporated in to BAU~~	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow for winter 2020/21	Implement new contractual arrangements for Widnes UTC (August 2020) ~~Develop COVID -19, restoration and re-escalation plans and recovery trajectories (October 2020)~~ Deliver Phase 3 – restoration and recovery trajectories and maintain essential /priority services, during COVID 2nd wave (March 2021) Deliver the system Winter Plan for 2020/21 in partnership with the Urgent Care Delivery Board (March 2020/21) Clinical triage and prioritisation of patient waiting lists where treatment was delayed due to COVID (November 2020)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSE/I Segmentation Rating	4 x 2 = 8	Regular media activity reports , including social media, to the Executive Committee		Deliver the 2019 staff survey action plan (March 2021) ~~Implement post COVID-19 staff check-ins until QWR can be re-instated (October 2020)~~ Update the Trust website (December 2020) Staff communication and engagement strategy for staff during COVID 2nd wave (November 2020) Improve communications with relatives whilst hospital visiting remains restricted due to COVID (October 2020)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending StHK Board and Trust NED attending Governing Body • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Health and Care Partnership governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN • Annual staff engagement events programme • COVID -19 Command and Control structure and Cheshire and Merseyside Hospital Cell	4 x 3 = 12		C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks	Participation in One Halton Programme Board Membership of the Knowsley Health and Care Executive Group to develop plans for integrated place based care Membership of St Helens Cares Board and chair of the Provider Board Continue participation with the Collaboration at scale board and work streams (Suspended due to COVID-19) Continued engagement with C&M HCP senior leadership as part of the system response to COVID-19.	4 x 2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Workforce KPIs • Recruitment and Retention Strategy action plan • Career and leadership development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES and WDES reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Steering Group Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment process and redeployment hub	5 x 3 = 15		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3 Recovery and restoration plans for activities suspended due to COVID-19	Development of a C&M collaborative staff bank (Delayed due to COVID-19) ~~Develop the local response (Trust and health system) to the NHS People Plan when published (April 2020 – not yet published due to COVID-19)~~ Review of trust appraisal process (March 2021) Staff support during and post COVID-19 (On going) Develop the Trust longer term Agile Working Strategy (December 2020) Delivery of the NHS People Plan local action plans for 2020/21 (March 2021)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning and social distancing (COVID-19)	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.	~~Recovery plan post COVID for all PPM programmes (September 2020)~~	3 year capital programme to deliver the Same Day Ambulatory care capacity, (on going to 2022) ~~Deliver modular ward beds by Q2, 2020/21~~. Estates and accommodation strategy to respond to increasing demand and new ways of working (Revised to March 2021) Operational plans to accommodate 10 year lifecycle works with minimal service disruption (March 2021 as delayed due to COVID-10) Plans to deliver COVID-19 capacity expansion following successful national bids (December 2020)	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M STP Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports (5YFV) • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval Annual Corporate Governance Structure review Technical Development	ISO27001 Service Improvement Plans Communications Strategy Digital Maturity Assessment Programme reviews post COVID-19 to establish recovery plans (amended to March 2021)	ISO27001 (revised to December 2021 due to COVID) Medway/DAP benefits realisation programme delivery (revised to September 2022) Implementation of IPS Intrusion Prevention System) that detects cyber-attacks within the network. 50% complete (revised to September 2021) Migration from end-of-life operating systems – 80% complete. Will purchase extended support to ensure end of life mitigation is in place (Jan 2021) Delivery of the Digital Aspirant Programme (2020 – 2022) ~~Migration to MS365, new email system (March 2021)~~ Continued IT support for effective virtual and agile working and patient consultations in COVID-19 restoration and recovery phases (March 2021)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)068
Title of paper: Complaints, Claims & Incidents
Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during 2020/21 Q1 & Q2
Summary • Total incidents reported in Q2 = 3761, compared with 3177 in Q1 • Total patient incidents in Q2 = 3187, compared with 2733 in Q1 • Total patient incidents graded as moderate/severe/death in Q2 = 37, compared with 39 in Q1 • The highest number of incidents reported relate to falls and pressure ulcers • Number of complaints received in Q2 = 67, compared to 48 in Q1. • Number of PALS contacts in Q2 = 1215, compared to 1204 in Q1 • Number of new claims received in Q2 = 9, compared to 3 in Q1 • The top reasons for patient complaints, PALS contacts and claims were consistent with previous reports and were clinical care, communications, admissions & discharges, appointments, patient care/nursing care and values and behaviours of staff • In addition, PALS have received a lot of contacts complimenting the Trust's staff and services
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: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 28th October 2020

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarters 1 & 2 2020/21, highlighting any trends, areas of concern and the learning that has taken place.

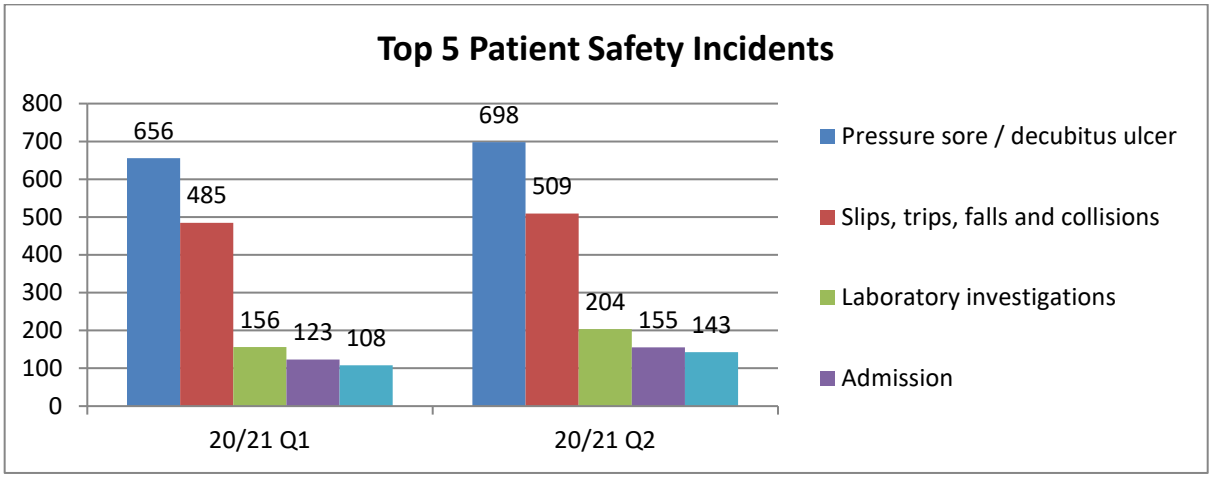
The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

During Q1 there were 3177 incidents reported, of which 2733 were patient safety incidents whilst in Q2 there was a rise in reporting with 3761 incidents reported and 3187 affecting patients. This represents an increase of 18.4% in all incidents and 16.6% increase in patient incidents. The rise between Q1 and Q2 follows a drop in reporting from Q4 2019-20 when 3743 incidents were reported (15.1% decrease) compared to Q1.

Q1 had 21 incidents reported to StEIS and 39 categorised as moderate harm, severe harm or death. Q2 had 21 incidents reported to StEIS and 37 categorised as moderate harm, severe harm or death. In comparison, during Q4 10 incidents were reported to StEIS and 42 categorised as moderate harm, severe harm or death.

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories are community and Trust acquired pressure ulcers and slips, trips and falls. These are consistently the highest reported incidents as in Q4 2019-20 there were 560 pressure ulcers reported and 526 falls. Pressure ulcers have seen a rise of 17.1% from Q4 to Q1. This is largely due to the new Community Services taken on from 1st April 2020. In Q4 there were 17 pressure ulcers under Community Services whereas in Q1 and Q2 2020-21 there were 157 reported pressure ulcers and 177 respectively, including community acquired.



2.1. Review of incidents reported to StEIS in Q1 and Q2 2020-21

In Q1, the Trust reported 21 incidents to StEIS, as well as 21 in Q2, as outlined in the table below.

Incident	Q1	Q2	Total
Inpatient falls sustaining fractured neck of femur	11	7	18
Incidents identified through mortality review	2	3	5
Never events	2	1	3
Delay in cancer treatment	0	3	3
HSIB Baby cooling	0	3	3
HSIB maternal death	0	1	1
HSIB infant death	1	0	1
Alleged abuse on patient by staff	1	0	1
Adverse media coverage	1	0	1
Delay in blood transfusion	1	0	1
Grade 3 pressure ulcer	1	0	1
Delay in diagnosis resulting in bi-lateral amputation	1	0	1
Delay in identification and treatment of cauda equina	0	1	1
Clexane omission	0	1	1
Delay in treatment for chemical eye splash	0	1	1

During Q1 there were 6 StEIS reports submitted to the CCG while in Q2 there were 21 reports submitted, 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.

2.3. Benchmarking

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

	Oct 2019-Mar 2020	
	Trust %	National %
No harm	82.4%	74.2%
Low	17.0%	23.6%
Moderate	0.4%	1.8%
Severe	0.1%	0.2%
Death	0.0%	0.1%

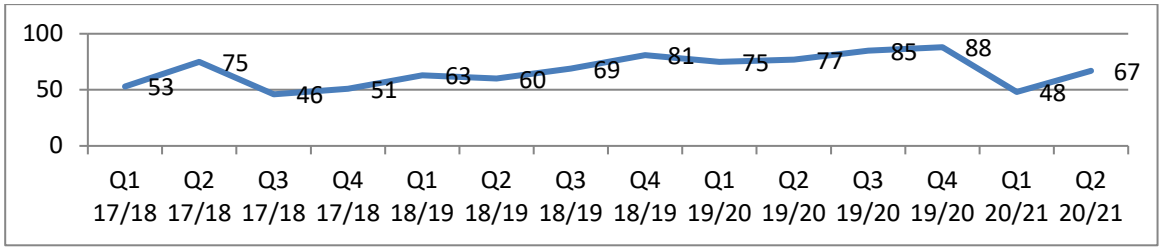
3. Complaints

The table below shows that the Trust received and opened 67 first stage complaints in Q2, which is an increase of 39.5% from Q1 when the Trust received and opened 48 complaints; noting that Q1 had fewer complaints than most quarters. The number of second stage complaints increased to 7 in Q2 from Q1 when 6 were received. The main reasons that complainants lodge second stage complaints are because they want further information or do not agree with the findings.

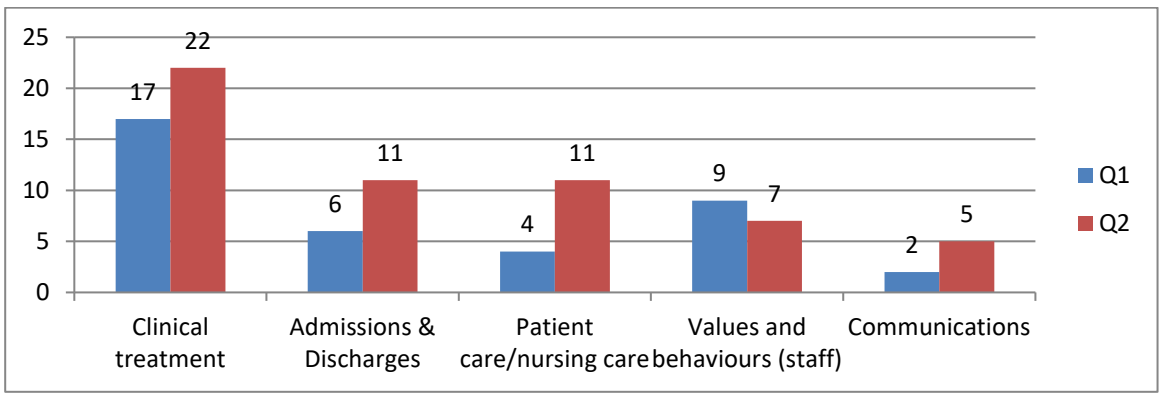
The Trust acknowledged 100% of all complaints received within 3 working days in Q1 and Q2 in line with NHS legislation, maintaining the standard achieved in 2019-20. The Trust's response time to first stage complaints decreased slightly to 92.54% in Q2 from 98.7% in Q1. The number of overdue complaints in Q1 increased from 3 in Q1 to 4 in Q2, however, the Trust continues to sustain the improvements made to complaints handling.

Indicator	2018-19	2019-20	2020-2021	
			Q1	Q2
Total number of new complaints including community services	273	325	48	67
Total number of new complaints received (excluding community services)	267	320	45	65
Acknowledged within 3 days – target 100%	99.3%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	92.1%	93.4%	98.7%	92.5%
Number of overdue complaints	1	1	3	4
Second stage complaints	36	36	6	7

3.1. Complaints activity - first stage complaints received by quarter



3.2. Top five reasons for complaints Q1 & 2 2020-21



The top five reasons have remained consistent in Q1 and Q2 2020-21. Clinical treatment gives rise to the most complaints, followed by admissions and discharges.

3.3. Complaints by top five locations

The Emergency Department received the highest number of complaints in Q1 and Q2 and this can be attributed to the high levels of activity.

Top 10 locations and Care Groups	Q1	Q2	Total
A & E (MCG)	10	13	23
Ward 2E Obstetrics	2	5	7
Ward 1C AMU	0	6	6
Ward 1A Medicine for Older people	2	2	4
Ward 2C Respiratory	1	3	4
Total	15	29	44

3.4. Comparison of complaints received and upheld with neighbouring trusts for Q1 (latest available data)

NHS Digital publishes data on written complaints for each of the NHS trusts in the country on a quarterly basis. Latest figures have not been published due to the Covid-19 situation.

3.5. Closed complaints

67 complaints were closed in Q1 and 58 were closed in Q2.

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.

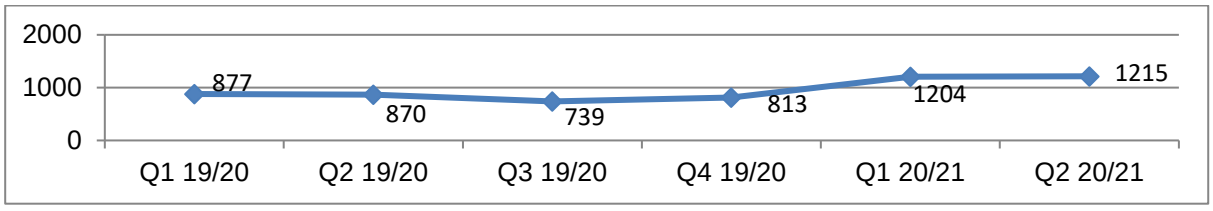
3.7. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

There were no PHSO enquiries or investigations opened in quarters 1 & 2 2020-21.

4. PALS

The number of PALS contacts has increased significantly in quarters 1 & 2 compared to previous years.

4.1. Number of PALS enquiries by quarter



In Q1, 98.5% of PALS queries were resolved and there was a slight decrease in Q2 when 98.3% were resolved. In Q1, 18 PALS enquiries converted to formal

complaints, which is a 1.5% conversion rate and this increased slightly in Q2 when 21 PALS enquiries converted to formal complaints which is a 1.7% conversion rate.

4.2. PALS enquiries by subject

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

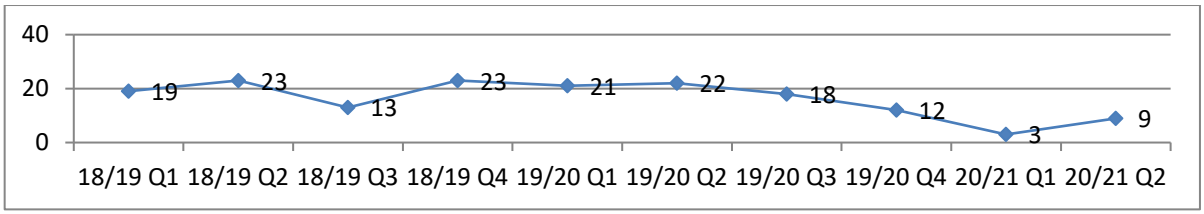
No	Theme	Q1 2020-21	Q2 2020-21
1	Communications	590	372
2	Appointments	109	154
3	Signposting/compliments	118	147
4	Clinical treatment	66	107
5	Patient care/nursing care	63	87

The top 5 themes remain consistent in the financial year. There has been a decrease in PALS enquiries relating to communication in Q2 (372) compared to Q1 when there were 590 enquiries.

5. Clinical Negligence Claims

The table below illustrates that the Trust received 3 new clinical negligence claims in Q1 and an increase in Q2 with 9 new clinical negligence claims received. Of the nine claims received in Q2, one was previously investigated as a complaint, one was previously investigated as an incident and one was previously investigated as an incident under the Early Notification Scheme for maternity.

The major reason for claims in Q1 and Q2 was failure to diagnose or delay in diagnosis.



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

Care Groups	Q1 2020-21	Q2 2020-21
Surgical Care Group	2	5
Medical Care Group	0	3
Clinical Support Services	1	1
Total	3	9

The Surgical Care Group received the highest number of claims in Q1 with 2 new claims and 5 new claims in Q2.

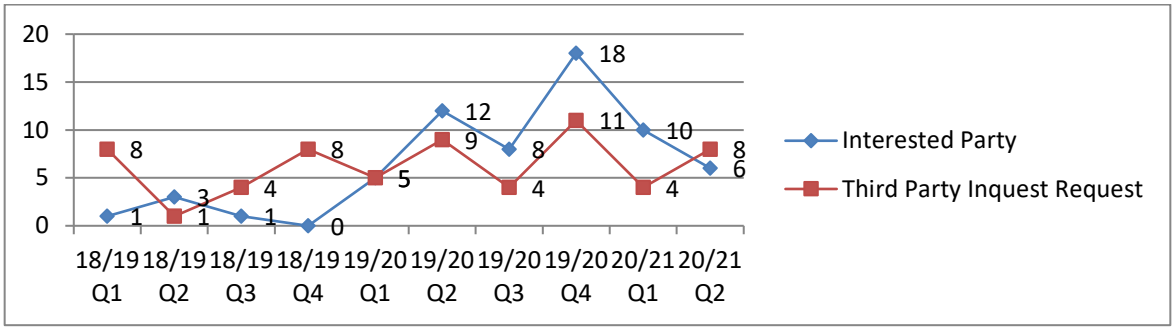
5.2. Actions taken as a result of clinical negligence claims closed in Q1 & Q2

In Q1, 14 claims were settled with damages, 8 defended and 1 closed following file review. In comparison in Q2, 10 claims were settled with damages, 7 defended and 5 closed following file review. 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.

6. Inquests

The table below illustrates that there was an increase in the number of inquest requests received in Q1 and Q2 2020-21. Fourteen inquests were opened in Q1, same as Q2.

Two inquests were closed in Q1, both of which were interested party inquests with a conclusion of natural causes, with no actions for the Trust and another with a conclusion of narrative verdict with no actions for the Trust. In Q2, 33 inquests were closed; the majority of the closed inquests were old inquests which the new coroner reviewed and closed. There were no findings against the Trust.



7. Recommendations

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

ENDS

Appendix 1 – Examples of actions taken following StEIS reported incidents

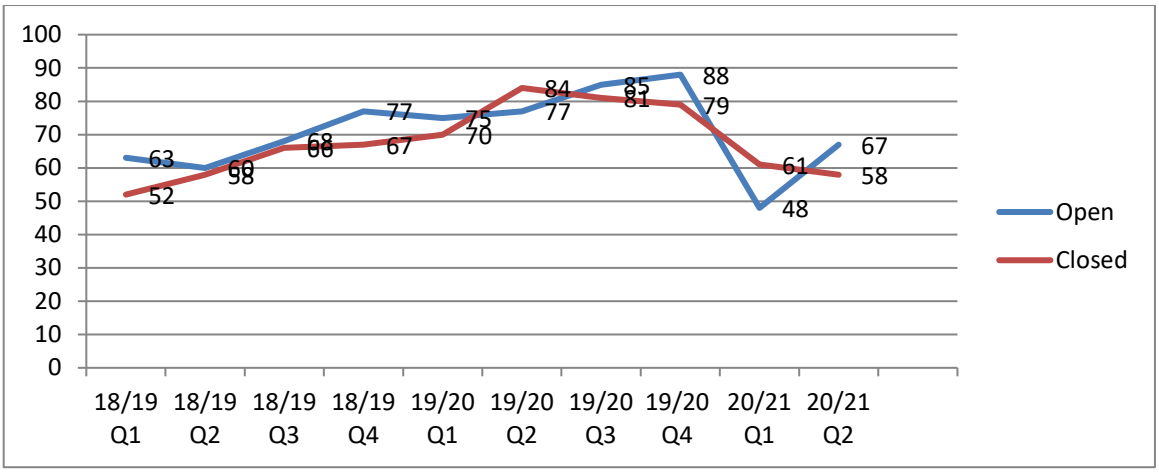
Incident	Actions
Review of care in Emergency Department (ED) – Delay to endoscopy	• Present the investigation report to the MCG Governance meeting, including care and service delivery problems, contributory factors, root causes, lessons learned, recommendations and actions • To consider the addition of the major haemorrhage protocol to the Acute Upper GI Haemorrhage referral form • Review the Acute Upper Haemorrhage referral form giving consideration to adding 'contact the on call Gastroenterologist (hot week Consultant)' • Escalation of NEWS to medical staff in line with Deteriorating Adults Policy • Raise awareness of the requirement to review critically unwell patients in a timely manner • Earlier consideration for administration of FFP once the INR was available as per Protocol • To present this investigation report to Gastroenterology Governance meeting
Delay in liver cancer diagnosis	• Present the investigation report to the MCG Governance meeting, including care and service problems, root causes, lessons learned, recommendations and actions • Service provision review to support a business case for maintenance, action and appropriate follow up for patients on the surveillance programme database • Explore the possibility of an IT database solution for HCC surveillance monitoring • Patients who have additional communication needs must have these met
Investigation into unexpected patient death whilst on immunotherapy for cancer treatment.	• Documentation needs to be completed fully and accurately – training to be undertaken • More robust pathway – to get senior review by consultant (face to face) before go ahead if a concern is raised. • Work with Clatterbridge to review Meditech system. To ensure NEWS is inputted at each treatment, to enable alert if abnormal.
Missed follow up appointment to discuss histology	• Cancer Pathway Tracking Service (CNS) Weekly implemented • Patients who present with a possible lesion will be tracked by cancer services via email from trauma coordinator to cancer information. • On call Consultant to be made aware of any possible cancer patients so can be followed up appropriately • Patients to attend outpatient clinic as per Consultants/Registrar outcome form or patient clinical records. • Urgent review and update Admin SOP • Administrative staff should not be able to unilaterally remove unbooked patients from PTL without senior authorisation. • Histology results to be stamped with date, time, consultant, referred to…Sign for use within Plastic Surgery Department • Secretaries must not document on the top of histology "OPD" and must be clear of their role and follow process. • Reflection in personal portfolio and formal discussion at appraisal • Review discharge leaflets • Add to agenda for departmental, Consultant and Audit meetings • Audit to be submitted to Quality Improvement and Clinical Audit
Delayed diagnosis of sepsis	• Discuss the investigation report in the Governance meetings, including care and service delivery problems, contributory factors, root causes, lessons learned, recommendations and actions • Reflection with the Triage Nurse, discussing the RCA findings and patient journey • Tier 2 training to be undertaken by the Triage RN • Review training compliance for sepsis training on ward 4B/ED and formulate a plan to achieve 85% if currently below this • 2 education sessions to be held on 4B with the Sepsis Nurse discussing the RCA. Signatory lists need completing. • Discuss RCA & patient journey in staff meeting • Undertake an audit of MET calls where sepsis is indicated, auditing if sepsis 6 pathway followed. Results to be discussed in MET staff meeting. • Discuss RCEM standard of consultant sign off for unscheduled returners to ED within 72hrs of discharge with the same condition in safety huddle • Undertake 2 audits of Transfer Forms and feedback results in staff meeting,

	formulating an action plan if necessary • Documentation audit checking actions recorded in notes correspond with recorded NEWS. Formulate an action plan if needed. Feedback findings in staff meeting • Review initial CT results and addendum to identify any learning
Investigation Into Retained Surgical Swab Surgical Never Event	• The use of all swabs should be counted by the theatre team and the count should follow the process as AfPP • Theatre etiquette should be maintained. Surgical teams should not be interrupted during procedures. • A working group should be established to explore the issue of peri-operative communication within theatres. • All staff who work in the operating theatre should be reminded of their responsibility to adhere to all national and local policies and procedures. • Theatre team to call a HALT moment if deemed necessary in the event of noise or interruptions • Mandatory counts to be re-commenced in accordance with the 'Operating Theatres Standard Operating Procedures' Policy (version 3), if processes are interrupted • Audit checks and direct observation of the quality and consistency of mandatory checks to be completed by theatre managers • Theatre team members involved in this incident to undergo a process of professional critical reflection, both individually and collectively.
Wrong route administration of Ketamine	• Pre-written prescription sheet to be developed with the assistance of pharmacy to include a list of possible medication and drugs that could be given through the procedure. The consultant performing the procedure must complete this prescription at the WHO checklist meeting prior to the procedure starting. This will include the route of administration. • Completion of this will be included in the WHO checklist which is audited. Audit results to be included in the nursing report presented at the monthly Radiology Operations and Governance meeting (ROG) • WHO checklist to be altered to include prescribing of drugs and medication that may be given during the procedure • New procedures to be discussed at the 121 monthly meetings held with the matron. • Use of radiology 'request for change' form to identify any change in processes. The form includes the questions 'training required?' and 'follow up audit required?' Request for change presented at the ROG meeting, discussed and included in the minutes. • Present radiology pharmacy link nurse to produce a monthly report which will be included in the nursing report presented at the ROG meeting • Advice to be sought re the size/amount of medicines to be ordered relating to the requirement. • Included in the 'request for change' form • Nursing protocols altered to include separate handling processes for I.V. and oral medications • Matron for IR nursing staff to be involved in the professional leadership of radiology nurses • Quality programme to be built around the radiology nurses. This will include the governance of radiology nursing procedures and protocols. • Nursing sister to implement daily safety huddle with the other radiology nurses. • Nursing sister to attend monthly Matron/Ward manager meetings. • Feedback to be presented at the monthly ROG in nursing report • All staff employed by radiology to undergo competency reassessment to ensure competency in all fields. • Radiology nursing staff to undergo training in oral medicine administration and complete competency • Current processes to be reviewed and expert advice to be sourced from ANTT/ Infection Prevention and Control Nursing Team
Never Event: Wrong Side Block	• 'Stop before You Block' must take place every time regional anaesthesia is carried out. Monitoring in accordance with action 3. • Written communication sent to all anaesthetists and operating department Assistants and Anaesthetic Nurses.

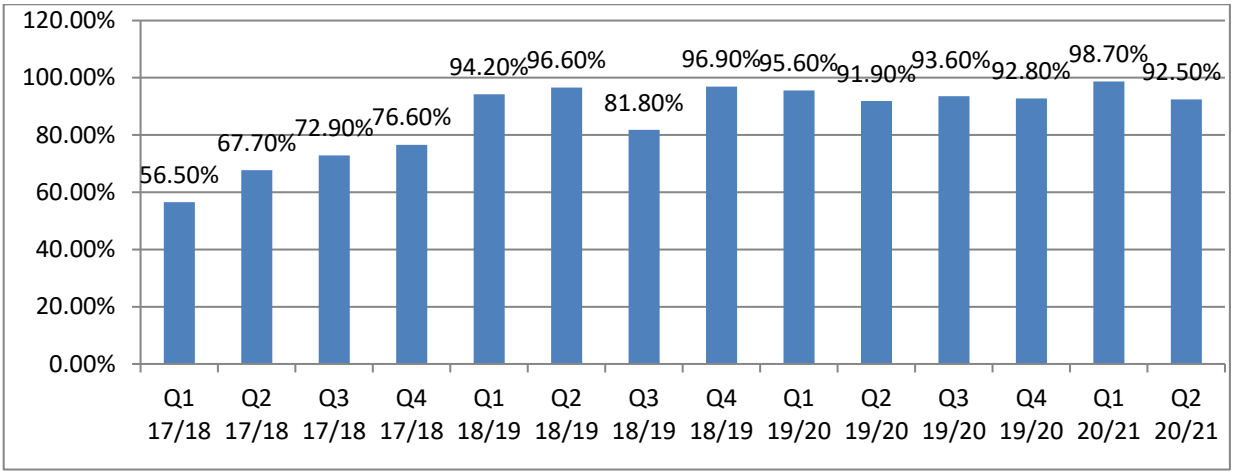
	• Information included in Trust induction. • Stop before you block audits every 2 months until compliance >95% and then 3 monthly thereafter. • Reports and action plan to be agreed at the Anaesthetic departmental meeting. • Clinical Director, Anaesthesia to discuss at Anaesthetic departmental meeting and agree any additional measures to be included in the Trust policy and communicate these with the Operating Theatre Operational managers. • Produce revised anaesthetic chart. • Clinical Director to consult with colleagues and approve • Review policy statement • Issue further directive • Set out different models for conducting a Debrief • The operating theatre escalation plan should be reviewed and shared with the theatre team and users. • Communications to anaesthetists, ODPs and Anaesthetic Nurses • Communications to anaesthetists, ODPs and Anaesthetic Nurses • formal re-launch event for stop before you block to include anaesthetists, ODPs and Anaesthetic Nurses • Communications to anaesthetists, ODPs and Anaesthetic Nurses • Stop before you block posters must be displayed in any area where regional anaesthesia takes place. • The consultant anaesthetist must discuss the case and his learning for this event with one of the senior medical staff at a level above Clinical director. The Anaesthetist has agreed to present the case at the September 2020 Audit meeting.

Appendix 2 – Summary of complaints activity

Received and closed complaints by quarter



1st stage complaints responded to within agreed timescales



Outcome of closed complaints in Q1 & Q2

	Q1	Q2
Not Upheld Locally	26	33
Partially Upheld Locally	23	11
Upheld Locally	12	14
Total	61	58

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

Incident	Learning and actions
The Claimant alleged that incorrect NEWS score was calculated which had an impact on monitoring of the Claimant leading to the Claimant was not subjected to continuous monitoring. Additionally, the Claimant alleged that 2 out of 6 actions in the Sepsis Nurse review were not completed in a timely manner, and there was a failure to repeat blood pressure checks as per recommendations of the Defendant's guidelines.	• Clinical Director, ED circulated trust antibiotic policy to all ED medical team to ensure compliance with first line treatment plans • Antibiotic prescribing audit for urinary tract infections was carried out and audit findings were presented at ED Governance meeting. • Staff were reminded to record vital observations and NEWS electronically from Triage • The NEWS escalation policy, the effect of incorrect NEWS calculations and monitoring had on this patient's journey and outcome were discussed at the team meeting.
The claim involved a development of an infection following a wound puncture in 2014 and the subsequent treatment and management by Vascular Surgery in 2014.	• Investigation identified that there were issues identified in the escalation of deteriorating patient. • When a specialty review is requested the Clinical Lead must complete a full examination of the patient and document in the patient's health record that this examination was performed • Whilst a patient is awaiting expert/specialists review the parent team must maintain responsibility and accountability for the management of the patient until transfer of care is complete. Thus ensuring senior review of the patient is maintained • The Trust sepsis pathway must be adhered to and instigated on admission to the emergency department • Junior doctors must escalate concerns to a senior team member and document the request for review in the health record. • Raise awareness with clinicians with regards to allowing perceptions to influence decision making.
Patient was admitted in 2017 for an elective standard trans-peritoneal laparoscopic left nephrectomy. It is alleged that surgeon perforated the vena cava and small bowel during the first incision.	• The incident leading to the claim identified lessons learned around the attendance at the theatre huddle/safety briefing as there was some confusion surrounding who was to be the key operating surgeon. • All theatre team, key operating surgeon and key operating anaesthetist are to be present at the theatre huddle/safety brief, as per Local Safety Standards for invasive Procedures Policy. • It must be documented on the theatre handover tool of any key operator or member of the multidisciplinary team who has not attended or has been delayed for the huddle/safety brief.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)069
Title of paper: Safeguarding Annual Report 2019/20
Purpose: To provide the Trust Board with information and assurance that it effectively discharged its safeguarding responsibilities during 2019/20
Summary: The report provides information and assurance for all aspects of safeguarding children and adults during the financial year 2019/20 and highlights the increased performance and activity in safeguarding. DoLS referrals are increasing. The Trust received a green / significant assurance rating for all aspects of safeguarding with one exception being the amber rating of PREVENT Level 3 compliance in Quarter 3, prior to the COVID-19 outbreak. NHSE compliance against PREVENT Level 3 was achieved in February 2020. Recruitment against the safeguarding business case agreement was completed in March 2020 with 3.8 staff increase in post by mid-March 2020.
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None from this report.
Stakeholders: The Trust, staff, patients.
Recommendation(s): Trust board members are asked to approve the report and agree the future developments recommended in the report
Presenting officer: Sue Redfern, Executive Director of Nursing, Midwifery and Governance, Executive Lead for Safeguarding
Date of meeting: 28/10 /2020

St Helens and Knowsley Teaching Hospitals NHS Trust

Safeguarding Annual Report

April 2019 – March 2020

Author: Susan Norbury Assistant Director of Safeguarding

Contents

1. Introduction

1.1 St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguard children, young people and adults at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly (with children's parents or carers) with children and young people.

1.2 Safeguarding activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG), as well as the Local Safeguarding Children Partnership Boards and Safeguarding Adults Boards.

1.3 The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2019 – March 2020), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

2. Key Achievements

- The Trust received a green / significant assurance rating for all aspects of safeguarding with one exception being the amber rating of PREVENT Level 3 compliance in Quarter 3, prior to the COVID-19 outbreak.
- The Trust approved the business case submitted by the Assistant Director of Safeguarding and increased the Trust safeguarding team by 3.8 whole time equivalent posts to support the safeguarding agenda. All staff were in post by mid-March 2020, Quarter 4.
- The Safeguarding Children Specialist Nurse won a CCG joint partnership award for work with two external specialist nurses on harmful sexual behaviours.
- The Safeguarding Children Specialist nurse has filmed training podcasts on harmful sexual behaviours for the NSPCC which has had national recognition by NHS England.
- The Trust achieved the NHS England PREVENT Level 3 compliance of 85% by mid-February 2020.
- A standard template for safeguarding responses has been developed for adults.
- Increased Deprivation of Liberty Safeguard referrals made this year.
- Joint assurance processes to ensure a joined up children and adults "think family" approach to safeguarding. Team co-located to further support this agenda.

- Key support to maternity safeguarding staff to develop a clear plan regarding maternity safeguarding supervision in line with KPI requirements to achieve green RAG rating.
- Improved monitoring of attendance by midwives at multi agency safeguarding meetings and non-attendance addressed.
- Positive Section 11 scrutiny visit.
- Expansion of safeguarding expertise within current Trust resources, with Paediatric Liaison service being managed under the safeguarding team from November 2019.
- The Trust has engaged and is represented at the newly formed safeguarding partnership board arrangements following recommendations from the Wood review.
- Signs of Safety training and implementation of same has been rolled out, a strength based model of safeguarding implemented by Knowsley and St Helens Local Authorities.
- The safeguarding children policy has been revised and updated to reflect changes in national and local agenda.
- Allegations against professionals' policy updated.
- Safeguarding Strategy developed and ratified.
- Learning Disability Strategy developed and ratified.

3. Governance Arrangements

3.1 This year has seen an increasing amalgamation of the Trust safeguarding adults and safeguarding children's teams with co-location of the team supporting a joint "think family" safeguarding approach.

3.2 Midwifery safeguarding staff continue to be managed by the maternity department management structure. There has been significant support this year for the maternity safeguarding work streams due to changes in staffing and subsequent difficulties in recruitment, particularly required to improve the KPI assurances under the midwifery supervision elements and meeting attendance by community midwives.

3.3 Quarterly reports are submitted to the Patient Safety Council, Patient Experience Council and Quality Committee which feeds into the Trust Board. The reporting governance structure is demonstrated in appendix 1.The Trust has the following governance arrangements:

- Robust internal governance processes to safeguard children including an Executive lead, a Named Doctor, Named Nurse for Safeguarding Children, Named Nurse Safeguarding Adults and Named Midwife in post.
- Internal Safeguarding Assurance Group with invitations to Healthwatch and local CCGs for external and added scrutiny.

- Safer recruitment processes.
- Training of all staff as appropriate for role.
- Safeguarding policies for safeguarding children and young people, allegations of abuse against a professional, safeguarding adults and policies that support those who may have other vulnerabilities, for example those who lack capacity.
- Effective supervision arrangements.
- Close partnership working with other key agencies.

3.4 The safeguarding declaration has been updated this year.

3.5 There are good links with the Complaints Team and Patient Safety Manager where advice will be requested from safeguarding in relation to cases that may meet the safeguarding threshold, including review of appropriate responses.

3.6 KPI feedback performance rating is detailed in the table below. A submission was not required for Q4 2019/20 due to business continuity during the COVID-19 outbreak, however a position statement was submitted as requested. The progress being made by the safeguarding team is indicated in the table below. It was disappointing that the COVID-19 pandemic affected the training compliance during the latter part of Quarter 4 as the Trust was on course to achieve PREVENT compliance and was likely to have been rated as green for significant assurance for both children and adults for Q4.

3.6.1 CCG rating following KPI submissions

Organisation	**Q4 (2018/19) Assurance rating**			**Q1 (2019/20) Assurance rating**			**Q2 (2019/20) Assurance rating**			**Q3 (2019/20)**		
STH&K	**C**	**A**	**T**	**C**	**A**	**T**	**C**	**A**	**T**	**C**	**A**	**T**
			↔			↑			↑			↑

Key: C-Children. A-Adult. T-Trajectory.

4. Joint Targeted Area Inspection (JTAI)

4.1 Halton Local Authority had a Joint Targeted Area Inspection into Child Exploitation undertaken in July 2019. The safeguarding team supported both the Paediatric and Adult Emergency Departments in preparing for the Trust visit by the inspection team. STHK was positively referenced during feedback regarding the joint working with CAMHS (Children and Adolescents Mental Health Services). There were no actions for the Trust following this inspection.

5. Section 11 Front Line visit

5.1 The Trust received a Section 11 scrutiny visit in February from the Scrutineer for Knowsley Safeguarding Children's Partnership Board and St Helens Designated Nurse representing the St Helens Safeguarding Children's Partnership Board. This comprised of a meeting with the Assistant Director of Safeguarding, Named Nurse for Safeguarding Children and Named Midwife, followed by a focus meeting with paediatric staff from different areas of the

Trust that the Assistant Director of Safeguarding and Named Professionals were requested not to attend. The particular focus of the scrutiny visit was on learning and the effectiveness of training. Very positive feedback was given following the visit regarding the passion for safeguarding that was evident, the knowledge of staff and their understanding of actions required. An audit undertaken regarding punch injuries and Emergency Department attendances and the correlation with child exploitation was particularly acknowledged by the Scrutineer who is planning to share this information and the work undertaken on a wider footprint.

5.2 A further scrutiny visit for St Helens Safeguarding Partnership Board was cancelled on two occasions then subsequently halted due to the scrutineer for Knowsley also being scrutineer for St Helens who had undertaken the visit with the Designated Nurse from St Helens.

5.3 As part of Board arrangements the Assistant Director of Safeguarding completed a front line visit for an external agency to support the gathering of information for the Boards.

6. Safeguarding Training

6.1 There are increasing challenges in ensuring compliance with 90% training targets. This target includes provision for those staff on long term sick and maternity leave. This year there has been a significant focus on PREVENT Level 3 training. At the end of Q4 18/19 the Trust had not met its own set trajectory for PREVENT compliance of 38%, achieving 31.5%. Additional face to face sessions were provided, however uptake for the number of places was poor. The NHSE e-learning module was recommended and consistently pushed throughout the year with weekly ESR updates for much of the year and staff and managers monitored closely by the safeguarding team regarding staff compliance. The Trust has subsequently met its set trajectory target each quarter, although the last month of each quarter involved significant targeting of staff and managers by the safeguarding team to achieve the target. In mid-February the Trust achieved NHSE compliance at 85% and was on course to achieve the CCG 90% compliance target, as agreed, by the end of Q4. However the COVID-19 pandemic and ceasing of all non-pandemic related clinical training has resulted in the Trust achieving 87% compliance, with a likely fall in compliance anticipated by the time the training is restarted. The Medical Care Group has consistently been a challenging group to improve compliance levels and as the biggest care group this has had an impact on overall figures.

6.2 The latter half of March saw a decrease in training compliance across all safeguarding training levels as staff could not undertake the sessions or complete workbooks. This will need to be addressed as soon as the training restrictions are lifted following the pandemic to ensure the Trust can evidence its priority of protecting the most vulnerable people using Trust services.

6.3 Signs of Safety is a strength based model of safeguarding which has been rolled out and implemented by both St Helens and Knowsley Social Care. Additional awareness sessions regarding the Signs of Safety roll out have been delivered in the Trust, having been sourced from Local Authority Leads. Safeguarding staff have undertaken the required training, as well as other key

staff identified depending on their role requirements to complete the 2 day training sessions.

6.4 Additional corporate induction sessions have been delivered this year due to the increased numbers of staff joining the Trust. The increase in the number of staff employed by the Trust has increased the numbers requiring training across all levels of training.

6.5 The Safeguarding Children Specialist Nurse has delivered ad hoc training in the Emergency Department and Sexual Health Departments covering specific issues such as domestic abuse and child exploitation. This was noted to have a positive impact on responses made by staff, leading to an increase in contacts to the Safeguarding Team and referrals to other agencies.

6.6 Table: STHK Overall Training compliance by quarter 19/20 including community contract

	Q1	Q2	Q3	Q4	Target
Safeguarding Children Level 1	95.7	92	94.7	91.6	90%
Safeguarding Children Level 2	90.8	92	91	89.2%	90%
Safeguarding Children Level 3	91.9	91	90	82.7	90%
Safeguarding Children Level 4	100%	100%	100%	100%	90%
Safeguarding Adults Level 1	95.7%	95.7%	94.7%	91.6%	90%
Safeguarding Adults Level 2	90.2%	90.1%	90.1%	88.88%	90%
Safeguarding Adults Level 3	94.7%	91.5%	92%	86.63%	90%
MCA	95.7%	95.7%	94.7%	58.3% [exclude If UTC* data not icluded compliance is= 87.45%]	90%
Prevent Awareness	95.7%	95.7%	95%	91.6%	90%
Prevent Level 3	62.8%	71.8%	81%	88.6%	90%

* UTC transferred to the Trust December 2019.

6.7 The decrease in training compliance in Q4 due to the COVID-19 training requirements indicates how the focused targeting of staff by the safeguarding team affects training compliance. The requirement to actively target and monitor staff is very labour intensive and the resource taken to achieve the Trust set PREVENT Level 3 trajectory each quarter has been significant. As the Trust has taken over additional contracts the monitoring of data and training compliance has also been significant. Plans for increased numbers of staff to attend Safeguarding Adults Level 3 has also affected compliance significantly.

In addition training sessions on MCA required for the Urgent Treatment Centre (UTC) staff who transferred to the Trust in December 2019 without being compliant and who have completed this as a separate training course has also affected compliance. A breakdown of training figures by contract was requested following Q3 Quality Committee report and has been provided as part of Q4 data.

6.8 The mandatory training arrangements has meant those staff requiring Level 2 and Level 3 safeguarding adults training undertake unnecessary Level 1 safeguarding training included for non-trained staff in mandatory training. This will be reviewed for 2020/21 to decrease the number of sessions staff attend.

7. Safeguarding Resources / Development opportunities

7.1 The business case presented to the Executive Committee was agreed in October 2019, with interviews held in November and December 2019. The following additional posts have been successfully recruited to the Safeguarding team and were all in place by mid-March:

- 1 x WTE 8A Named Nurse Safeguarding Adults
- 1 X WTE Band 7 Learning Disability Specialist Nurse
- I x WTE Band 7 Mental Capacity Coordinator
- 0.8 WTE Band 3 Clerical Support

7.2 The team structure is demonstrated in appendix 2.

7.3 The Paediatric liaison management was changed to the safeguarding team from the paediatric department in November. The Lead Nurse for Paediatric Liaison has safeguarding included in their job description and the close working and overlaps in monitoring activity and the required referrals means there is additional flexibility within the teams when capacity requires it without the need at the stage of the business case submission for additional posts to cover the children's agenda.

7.4 The Safeguarding Children's Specialist Nurse has filmed training podcasts with two external colleagues on harmful sexual behaviours for the NSPCC. The podcasts have had national recognition by NHS England who is also looking to use them for training a wider audience. In recognition of this work the Safeguarding Children's Specialist Nurse was awarded the CCG's award for partnership work at a CCG presentation to mark Nurse's Day.

8. Safeguarding Team development

8.1 It is vital that the safeguarding teams maintain up to date knowledge and can transfer relevant requirements into the training provision for staff. Training also supports the specialist role and supports revalidation requirements of regulatory bodies. Development of team members also supports succession planning where staff with the required level of skills, knowledge and relevant experience have proved to be an issue previously when recruiting to senior safeguarding posts.

8.2 Key training and briefings have also been attended ahead of legislative changes to the current Deprivation of Liberty Safeguards to ensure the Trust is prepared and can act within the legal framework.

8.3 This year the team has attended the following courses / development days to maintain their professional development requirements in their roles and ensure the Trust has current knowledge, skills and can cascade training at a minimal cost to the Trust:

Role	Course	Length of course	Cost
ADO Safeguarding / Named Nurse Safeguarding Children	National Safeguarding Conference	1 day	NHSE funded
ADO Safeguarding	Safeguarding Supervision	4 days	NHSE funded
ADO Safeguarding / Director of Nursing and Midwifery	Liberty Protection Safeguards	1 day	NHSE funded
Safeguarding Children Specialist Nurse / Safeguarding Adults Specialist Nurse	Domestic Abuse Masterclass	1 day	£50 pp NHS rate
Named Nurse Safeguarding Children / Named Midwife	Signs of Safety	5 days	LA Funded
Named Nurse Safeguarding Children / Safeguarding Children Specialist Nurse	Signs of Safety	2 days	LA Funded
ADO Safeguarding Safeguarding Adults Specialist Nurse	Liberty Protection Safeguards - Hill Dickinson	½ day	Free event to NHS staff
ADO Safeguarding	Improving Learning Disability care in Acute Trusts – Edge Hill University	1 DAY	LD Network Funded
ADO Safeguarding	North West Counter Terrorism Preparation	4 hours	Home Office funded

9. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

9.1 The number of referrals made by the Trust for Deprivation of Liberty Safeguards (DoLS) authorisation remains an ongoing focus as there are fewer referrals being generated than a Trust of this size should be making. The Trust

is a significant outlier compared to other Acute Trusts in the area, although there have been an additional 141 DoLS referrals made this year in comparison to the 232 referrals in the previous year.

9.2 The safeguarding team has provided easy read crib sheets for staff this year, training on specific wards and have actively enquired about mental capacity and DoLS when receiving safeguarding enquiries. The reminders to staff in meetings regarding DoLS requirements and the legal duty to refer and the highlighting to Matrons and Ward Managers, following the dip in referrals in Q2, may have had an impact as evidenced by the increase in Quarter 3 referrals. This has not been sustained, however the additional staff who commenced in post in March 2020 will have a positive impact on this.

9.3 Appropriate referring for DoLS and documentation in relation to assessing mental capacity and acting in a person's best interests could also be improved and evidenced more robustly. The Mental Capacity Act Specialist Practitioner commenced in post in March 2020 and increasing the number of referrals and ensuring staff evidence acting in best interests and being compliant with the Mental Capacity Act will be a key focus of the role in this coming year. This will be done by ward based training and support and proactive following up of issues raised as the pandemic situation eases.

9.4 Table: 5 Year history of DoLS applications data

Year	DoLS Applications
2015/16	190
2016/17	191
2017/18	162
2018/19	232
2019/20	373

9.5 Table: Overall DoLS referrals 2019/20

	Q1	Q2	Q3	Q4	Total
DoLS referrals	91	77	116	89	373

9.6 Table: Breakdown of DoLS outcomes for 2019/20

	Authorised	Unauthorised	D/C prior to assessment	Not assessed by Local Authority	Total
St Helens	6	20	78	65	168

Knowsley	7	10	39	40	96
Halton	0	7	25	30	62
Liverpool	1	3	9	12	25
Out of Area	1	5	6	9	21
Total	15	45	157	153	373

9.7 Unauthorised DoLS referrals are not a reflection on the Trust and relate to patients regaining capacity, discharges or some deaths whilst awaiting assessment. The Local Authorities predominantly do not undertake assessments of people in hospital, however the safeguarding team will liaise with Local Authority DoLS teams where circumstances are problematic, for example family dynamics or safeguarding concerns, to ensure an assessment is undertaken to support the Trust in the restrictions in place to protect the patient and the Trust.

10. Liberty Protection Safeguards

10.1 The Assistant Director of Safeguarding has attended training and briefings in preparation of the implementation of the Liberty Protection Safeguards which were anticipated in October 2020. Whilst these sessions have been useful it is difficult for presenters to categorically inform attendees what is likely to happen when there has been no code of practice published to date. The Director of Nursing also attended a full day's training funded by NHS England. Briefings have been provided as part of safeguarding updates to the Patient Safety Council, Patient Experience Council and Quality Committee.

10.2 The Trust as the Responsible Body will need to ensure the following:

- That Schedule AA1 applies to the arrangements
- Determination has been made that the authorisation conditions are met
- Consultations have been carried out with all relevant parties
- Cared-for person has an appropriate person/IMCA appointed where necessary
- A pre-authorisation review has been completed determining that the authorisation conditions are met
- A draft authorisation record has been prepared
- Authorisation record
- Publish information about the authorisation arrangements which are accessible and understandable to the cared for person and the appropriate person

10.3 There is no anticipated additional funding to implement the changes, however it is likely given the need to ensure the independence of the initial assessments, that there will need to be assessors appointed to the role as this could not be undertaken as part of current clinical roles and without training on the legal requirements.

11. Learning Disability

11.1 The safeguarding team continue to refer the details of patients who have died in the Trust who were known to have a learning disability as part of the learning from deaths (LeDeR) requirements. Since June this year all deaths of those with a Learning Disability have been reviewed by medical staff using the Structured Judgement Review process which complements the Learning Disability Screening tool completed by the safeguarding team for those who have died in the Trust. The Assistant Director of Safeguarding attends the monthly Mortality Surveillance Group where all amber/red rated deaths are reviewed.

11.2 The Assistant Director of Safeguarding attends the St Helens LeDeR panel. The membership group and the links from the group is supporting improved communication across primary care, Learning Disability Community Teams and the Trust. Halton's LeDeR panel reviews the completed LeDeR reviews in a similar way to the Child Death Overview Panels.

11.3 There has been no specific learning for the Trust from any of the completed LeDeR reviews to date. One general theme is a lack of identification of the type of learning disability, however the Trust would not have this detail unless previously notified of the same and the CCG are working closely with Primary Care and community teams to improve this communication.

11.4 The St Helens Autism Development Group is attended by the Safeguarding team. The group is chaired by a Local Authority Lead and membership has been very inconsistent and has delayed progress in developing a strategy or work plan. The membership is being reviewed and the meetings will be supported by the Safeguarding team to ensure key learning and resources are made available to the Trust to ensure those with autism are identified and supported in the best way possible.

11.5 The NHSI benchmarking tool was submitted in January and the patient and staff surveys were also circulated as required. The Trust is awaiting feedback from NHSE&I. The newly appointed Learning Disability Specialist Nurse started mid-March and has already started to identify areas for improvement and links to gain community information to support the Trust.

12. Mental Health

12.1 The number of patients detained to the Trust under a Mental Health section has increased again this year.

MHA Detentions	
April – March 2017/18	50
April – March 2018/19	66
April – March 2019/20	109

12.2 The safeguarding team scrutinise the documentation required to ensure the detention is legal and follow up with wards and departments to ensure the

appropriate documentation has been completed. This ensures the Trust has formally accepted the section and that the Trust transfers those on a section appropriately. This takes significant resource by the safeguarding team to ensure the Trust is acting within the law and its own policy. Periodic communication has been cascaded via the Safety Huddle, or Trust meetings with operational staff, to remind them of their obligations to inform safeguarding of any patients sectioned under the Mental Health Act.

12.3 There have been two requests this year for a tribunal for sectioned patients. The coordination of gathering a panel to hear the cases was initiated by the safeguarding team, whilst closely engaging with Core 24 who supported the Trust in discharging the patient to a more appropriate setting, given the Trust is not experienced in the tribunal process and has no regular panel members or experience in this field.

13. Partnership work

13.1 The extent of the strategic external engagement is evidenced in appendices 3 and 4 which demonstrate the meetings the safeguarding team are invited to and attend and the input it has in representing the voice of the Trust as a provider.

13.2 The new Safeguarding Children Board arrangements came into being in June 2019. This required three key partners, Children's Social Care, Police and CCG, to work locally together to keep children safe. Due to these arrangements the Trust is no longer invited to attend the Board meetings. Information from the partnership has been poorly cascaded to date and appropriate inclusion in key sub groups has been poorly managed. The Trust has raised concerns about a lack of inclusion, however following six months of new arrangements there appears to be an improvement in having the right people and providers at appropriate meetings.

13.3 There is representation from both safeguarding children and adults team members for the St Helens and Merseyside Health sub group. Although the health sub groups are no longer part of the Board sub groups they are vital links for gaining information from the Designated Nurses and information sharing from peers. The St Helens Chief Nurse is the chair of the St Helens health group which is useful in sharing the issues in relation to Social Care given the integrated ways of working being undertaken in St Helens. This appears to have improved some of the issues that were being identified by providers in relation to Social Care concerns.13.4 The safeguarding team also attend the Halton and Warrington Health sub group chaired by the Deputy Chief Nurse for Halton.

13.5 A new chair was appointed to the St Helens Safeguarding Adults Board in January 2020. The Trust is represented at the Board by the Assistant Director of Safeguarding. Sub groups of the Board are also supported by the safeguarding adults team. Close working with the Boards ensures the Trust has

a voice in decision making and decisions or themes that will affect the Trust can be highlighted and addressed.

13.6 Following the COVID-19 outbreak the St Helens Board have had virtual meetings between key partners, namely CCG and Local Authority**.** During the March meeting there was a virtual sign off of the Department of Health and Social Care Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry which will have an impact during the pandemic on the Community Tissue Viability team workload. It was negotiated with St Helens CCG Designated Nurse that during the pandemic there would not be any implementation of the tool in the acute setting.

13.7 Knowsley is part of the Merseyside Safeguarding Adults Board and the Trust is not invited to this Board. Information from the Board has not been shared and this has been raised during discussions with Designated Nurses for Knowsley and during the peer review of the Pan Mersey Board in January. A more recent invitation to a joint Merseyside Health forum is starting to plug some of the gaps in gaining information.

13.8 The Trust is also not invited to the Knowsley Safeguarding Children's Partnership Board. Feedback from the children's safeguarding partnership Board is also an issue, with no conduit to provider's from CCG representatives in which to share information. This was raised regularly throughout the year and also at the Section 11 scrutiny visit. This generated the invite to the wider Merseyside Health forum from January 2020 and a more recent meeting with the Designated Nurse for Safeguarding Children being arranged in Knowsley in 2020.

14. External Reviews

14.1 Child Safeguarding Partnership Review

14.1.1 St Helens Safeguarding Partnership Board commissioned a Child Safeguarding Partnership Review for Child C. The initial learning summary completed by the safeguarding team was able to evidence referrals being made in respect of the children following mother's attendances although the extent to the mother's evolving opiate addiction and increased mental health problems was not considered as a think family approach. There were areas of good practice in relation to information sharing for both parties. The final report and recommendations by the independent author have not yet been published.

14.2 Serious Incident Review

14.2.1 A review has been undertaken into the incorrect process following identification of a possible non-accidental injury to a 6 month old baby seen at Halton UTC. This resulted in the baby being referred to Whiston Paediatrics out of hours service for a child protection medical without the correct referral processes. The mental health needs of the father were prioritised over the child

which may not have occurred had the appropriate and timely referrals been instigated. 14.2.2 This case was StEIS reported by Bridgewater Foundation Trust and a joint root cause analysis was completed with STHK. The key points of learning for STHK were as follows:

- Decision in respect of non-accidental injury should not be reliant on any evidence of previous social care involvement i.e. each case should be assessed on the basis of presentation and evidence available at the point of clinical assessment
- Child protection medicals within the hospital should be afforded protected time to ensure completion and minimise anxiety and distress to the child, carers and staff
- Where a child attends hospital with any indication that they have suffered abuse (an unexplained or concerning injury) they must remain in hospital until completion of all investigations and referrals made; home leave for these children must not be sanctioned
- Where a parent does not comply with requests for their child to remain in hospital the situation must be escalated immediately to social care and police

14.2.3 The action plan from this learning has now been completed.

14.3 Learning Review – Maternity Baby A

14.3.1 The learning review followed the non-accidental head injury of a baby who had been born at the Trust although most of the care was provided by an external agency. Overall learning in this case was about the way that agencies worked together in Baby A's case, specifically in regard to lower level parental mental health, the involvement of fathers, coping with crying babies and triggers for shaken babies. Learning for the Trust related to requiring an increased focus on crying babies. The Trust's maternity department has implemented the ICON tool "Babies cry you can cope." ICON information is displayed on the delivery suite. The midwife talks through the leaflet and asks the male to take a photo on his phone. There is now an increased focus prior to discharge and by community matrons in training new parents on crying babies. The community midwife re-visits the poster on the first and fifth day visit and at discharge. In addition, there is opportunity for women to discuss concerns with a manager during the daily 'how are you doing' round for in-patients. If concerns are raised by parents or if practitioners feel the birth was traumatic, there is opportunity to refer the parents to the 'De-Brief' service supported by the Perinatal Mental Health Midwife.

14.3.2 A lead outreach midwife has been identified to lead this work and an audit of records for compliance against the implementation and effectiveness of this work will be undertaken in August 2020.

14.4 Safeguarding Adult Reviews (SARs)

14.4.1 Safeguarding Adult Reviews consider whether there is learning regarding multi agency working which could have been improved, that may have affected the outcome for an individual.

14.4.2 Information has been provided by the safeguarding team for 3 cases this year.

14.4.3 There has been a significant drop this year from Knowsley requests for information due to new joint arrangements in the Merseyside Safeguarding Adults Board, reviewing SARs across Cheshire and Merseyside under one process and there is a subsequent backlog of cases.

14.4.4 Learning from one St Helens case was a lack of information provided by Core 24 staff who had reviewed the StHK patient prior to discharge, however there was no documented evidence of this in Trust records. A subsequent audit is referred to in 21.7 and 21.8.

14.4.5 There have been no cases in the Trust known to the safeguarding team that have warranted referral under a SAR this year.

14.5 Domestic Homicide Reviews (DHRs)

14.5.1 There have been three cases inputted by the safeguarding team in relation to Domestic Homicide reviews this year. A Knowsley case was submitted in April, reviewing four family members over a seven year period. St Helens requested a chronology in May which involved one person over a twelve month period. Warrington recently requested chronologies on three family members submitted in February. There has been no additional learning for the Trust following panel review from the information requested and provided for the Domestic Homicide reviews.

15 PREVENT

15.1 The Trust is invited to and attends the Knowsley Channel panel. Information has been requested and shared under this agenda for three males which included seven additional family members as part of the information gathering and three review cases. There have been no requests from other Local Authorities even though Knowsley's referral rates are lower than other areas in Merseyside. St Helens Designated Nurse for Safeguarding Adults has raised this on several occasions to St Helens Local Authority regarding relevant inclusion of information and meeting attendance. The reviews have been for older males in the late twenties age group, however two cases have been for young teenage children in school.

15.2 The Trust has made no referrals this year in comparison to one referral last year, although one patient who was transferred to the Trust from another Trust had already been referred under Prevent. Nationally referrals are predominantly

from mental health trusts and a high proportion of referrals come from education settings.

15.3 Local area referrals and activity predominantly relate to right wing ideology.

16 Management of allegations

16.1 The Trust Safeguarding Team supports the Human Resources Department and Lead Employer in the management of allegations against staff. This has proved to be increasingly challenging with the increase in the remit of Lead Employer in their management of doctors in training across the country. Given the wide footprint the Lead Employer covers, concerns and allegations involve host placement providers, local authorities, and police forces. Processes are underpinned by Trust policy and, in the event of an allegation involving a child the Local Authority Designated Officer (LADO) will have oversight of cases. The criteria for referrals to LADO as set out in the Working Together to Safeguarding Children (2018) is as follows:

16.1.1 The LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

16.2 There may be up to three strands in the consideration of an allegation:

- a police investigation of a possible criminal offence;
- enquiries and assessment by children's social care about whether a child is in need of protection or in need of services;
- consideration by an employer of disciplinary action in respect of the individual.

16.3 There have been a total of ten allegations / concerns reported to the safeguarding children team in relation to Lead Employer trainees, six of which resulted in referrals to LADO.

16.4 There have been a further five received in respect of Trust Staff, resulting in one LADO referral.

16.5 All cases were risk assessed and relevant safeguarding measure put in place when required. To date no formal disciplinary action /dismissals have been required in the identified cases.

16.6 The safeguarding team has also made three LADO referrals in relation to staff working for other organisations, concerns identified following the attendance of paediatric patients.

17 Domestic Abuse cases / Multi Agency Risk Assessment Conference (MARAC) 2019/20

17.1 Risk assessments for domestic abuse Merseyside Risk Identification Tool (MeRIT) have been consistent over the last two years, however there has been an increase in the level of risk requiring referral to MARAC (highest risk “gold” cases).

17.2 The Safeguarding Team support three MARAC meetings, attending twelve meetings per quarter and supplying information for Halton and Warrington MARAC twice a month.

	18/19 Total	Q1	Q2	Q3	Q4	19/20 Total
Number of MARAC referrals	**76**	22	21	18	28	**89**
Number of MeRiT risk assessments completed	**168**	41	46	40	46	**173**

18 Urgent Treatment Centre (UTC)

18.1 The UTC staff joined the Trust in December 2019. Training information has been separated to CCGs as requested due to issues with previous data provided. From 2020/21 the information will be gathered as part of the Community Contract arrangements.

18.2 StHK safeguarding team met with the UTC team prior to the transfer, supported with pathways and contact details and requested access to System 1 to enable information to be gathered. In February the Named Nurse for Safeguarding Adults agreed a monthly month end safeguarding meeting with the UTC lead, however following the changing working practices during the current COVID-19 pandemic this has not gone ahead to date. The co-ordinator has no concerns regarding missed referrals.

18.3 Attendances by children to UTC have been low during March due to a lack of children attending since the COVID-19 outbreak.

18.4 A retrospective audit is planned when circumstances allow that will review attendances to the Urgent Treatment Centre to ensure the appropriate professional challenge is considered, pathways are being adhered to and quality referrals being made as required.

19 Community Contract

19.1 Safeguarding KPIs have been scrutinised by the Trust’s Assistant Director of Safeguarding given the contract is managed by the Trust. The safeguarding information and evidence is subsequently shared with St Helens CCG. The overall rating has been amber (reasonable assurance), predominantly due to a lack of safeguarding strategy by NWBH and the StHK PREVENT Level 3 compliance. There has been an improvement during the 2019/20 year with two areas of monitoring rated as significant assurance – safeguarding activity and policies. It is anticipated that if training is fully compliant there should be further improvement in the rating for this contract when the whole contract sits with the StHK Trust.

20 Maternity Safeguarding

20.1 The Maternity safeguarding team are managed under the Maternity Department. The current resource is a 0.5 Named Midwife and a full time Specialist Midwife for Safeguarding who started in post in November 2019. Significant support from the Safeguarding Children's team was given to the maternity department due to the shortage of safeguarding staff from June to November. There has been significant input to improve the reporting against the KPI standards, particularly in relation to meeting attendance and safeguarding supervision.

21 Audits

21.1 Audits are a way of reviewing and evidencing care being provided and assessing the following of processes and policies. It ensures continuous improvement. The safeguarding teams have undertaken audits throughout the year.

21.2 An audit was completed by the Emergency Department in conjunction with the Safeguarding Children Team who reviewed a cohort of children discussed at a local Multi Agency Child Exploitation (MACE) meeting. Out of the 53 children identified, 34 children had attended the Emergency Department with a total of 94 attendances between them, all prior to them being highlighted as possible Child Exploitation victims. The attendances led to 8 referrals to Children's Social Care and 31 notifications to allocated social workers. The majority of attendances were secondary to self-harm/overdose.

21.3 The audit highlighted that further exploration may assist in the identification of Child Exploitation in the Emergency Department, therefore a short child exploitation screening tool is being implemented to assist practitioners in gathering the right information and encouraging professional curiosity.

21.4 An audit to review staff understanding in relation to Deprivation of Liberty Safeguards was undertaken to determine the reasons for low number of referrals made by the Trust. This indicated staff predominantly referring when a patient actively requested or tried to leave the ward areas or when there are difficult relationships within families or concern about the care being provided at home. This has been addressed by sharing information and crib sheets with Ward Managers and Matron's and bespoke training as required. In addition the need for a post to support the improvement in training, staff knowledge and documentation under the Mental Capacity Act was agreed.

21.5 An audit reviewing the capture of information regarding dependents, adults and children identified this information was not always documented. This is a requirement under the commissioning standards. The roll out of the carer's passport was the action to support the gathering of this information and the

plan is to re-audit six months following the roll out to ensure there is improvement.

21.6 A multi-agency audit by the Practice and Performance group of St Helens Safeguarding Adults Board has been supported by the Safeguarding Adults Specialist Nurse in reviewing the capture of making safeguarding personal as required under the Care Act 2014. The safeguarding team has been capturing those referrals not made due to the patient's request where they have capacity, however there will be a review to see how this information is captured in an improved format, including evidencing what patients have been asked and what their wishes are and improving staff documentation across the Trust in relation to this.

21.7 An audit has been undertaken by the safeguarding team during March 2020, reviewing the records of 20 patients who have required a mental health assessment during February 2020 within the Emergency Department, to include reviewing the documentation provided to the Trust by staff from another organisation. This follows findings in a Serious Adult Review case where the Trust did not hold the information regarding safe discharge arrangements as there was a lack of evidence of a mental health assessment prior to discharge.

21.8 There are significant gaps in following the process and this has been escalated to key Emergency Department staff for cascade and to leads in the external agency that provide the mental health input under a service level agreement, to address with staff and take interim action. This has also been added to the risk register. When the current COVID-19 crisis allows, the requirements in the policy will be reviewed to ensure the processes are as easy as possible for staff to complete, whilst ensuring the appropriate information is passed to Mental Health practitioners and the Trust has an auditable trail of clinical decision making regarding admissions to, or discharges from hospital. The audit will need to be repeated when the action plan has been completed.

22 Transition

22.1 Links with the Alder Hey Children's NHS Foundation Trust Transition Lead continue. The Trust has highlighted concerns regarding community resources to support the identified patients who are adults still attending Alder Hey Hospital. The 3 – 4 identified patients who may require attendance or admission to the Trust will require a community infrastructure that current resources only provide to those under the care of Alder Hey. The majority of the interventions required will be in the community, therefore this resource is required before the Trust can move forward with transfer of care. Without this in place this vulnerable cohort of patients will not have the required infrastructure needed for their ongoing care needs.

22.2 The Trust has agreed to host the transition conference this year at the end of June. This has saved the Trust from contributing to the cost of the event.

23 Additional Events

23.1 The safeguarding team manned a stall on Nurses Day this year to promote the safeguarding message and promote the training requirements of staff.

23.2 The safeguarding team supported National Safeguarding Adults Week with daily messages regarding the adult agenda throughout the week shared on global email. In addition the two slots available in the Trust for public area stands were requested by two Safeguarding Boards and the team supported this. On the day allocated to the Merseyside Safeguarding Board the representative could not attend which was too short notice for the team to arrange and man a stand. The St Helens Local Authority manned the St Helens Safeguarding Adults Board stand with support from the Trust team. It is anticipated with a bigger team that more safeguarding messages can be promoted this year that supports staff and patients and shares key messages.

23.3 A safeguarding newsletter was developed to cover key messages for safeguarding children and adults and circulated to staff. There have been two editions this year.

24 Case Studies

24.1 A ward contacted the safeguarding team after a patient with a long term condition disclosed her son had previously tried to strangle her. The safeguarding team met the patient to assess the concerns and during the discussions it became apparent that the patient had suffered previous physical assaults, she was being financially abused by a third person and had no access to her own finances, her home had been cuckooed (drug dealers take over the home of a vulnerable person in order to use it as a base for county lines drug trafficking) which had also brought her into contact with the Police. Following this intervention although the assaults had been historic and not recent, which meant the risk tool did not warrant a referral to MARAC under very high risk, the patient agreed for referrals to be made for domestic abuse support services and for additional support to remove her son from the property. The Local Authority involved has subsequently fed back that the patient continues to get support and her circumstances have significantly improved following this intervention and the referrals made.

24.2 A Local Authority contacted the safeguarding team at short notice to support a contact with a patient who was due to attend the Trust and was deemed very high risk of domestic abuse. They were unable to access the patient safely any other way and felt the individual was highly at risk. In discussion with medical, nursing and reception staff the patient was reviewed without the family being

aware, which would have increased the risk, and support was being considered regarding removal from the family home.

24.3 A young person had sustained a significant injury following gang related activity. The individual was refusing to further engage with hospital staff and was at very high risk of having a life changing injury as a result of the non - engagement. Family members and Social Care were unable to persuade the young person to attend, be reviewed or X-rayed. Over a 2 week period the safeguarding children specialist nurse (SCSN) contacted the young person, attending the child's home on two occasions with other colleagues, following which the individual agreed to attend the Trust, contacting the SCSN when they were going to be later than planned to ensure the visit could still take place and the appointments were facilitated by the SCSN. This has resulted in a safe discharge for the individual with no further complications.

24.4 A patient with autism, receiving 3:1 care interventions required anaesthetic to undertake an investigation. The safeguarding team was contacted by the supported living manager as they had difficulties providing care to this individual. As a result of the other concerns, following significant input between all colleagues involved and the safeguarding team a co-ordinated visit was arranged where under anaesthetic the patient had the investigation required, podiatry interventions, a dental check-up and blood for annual screening was also taken. The Trust received thanks and praise for the support offered and the coordination of care that protected the patient and staff involved in his care.

25 Next Steps 2020/21

- Improvement in data capture systems and live databases to give an easy daily overview and support staff with referral processes via Datix.
- Improve knowledge of Trust staff in mental capacity.
- Improve referral rates for DoLS.
- Training requirements review.
- When training compliance achieved consider investment opportunities by delivering training to private hospitals, care homes, hospices etc
- To ensure robust evidence against actions from any reviews is gathered and evidence of learning achieved.
- Improve knowledge of Trust staff in learning disability and autism spectrum disorder to support patients with reasonable adjustments.
- Improve the safeguarding web pages to ensure staff can access information more readily.
- Improve the capture of making safeguarding personal under the Care Act requirements.
- Pressure ulcer changes to safeguarding processes following implementation of Department of Health and Social Care toolkit.
- Strengthen links and working arrangements with new cohorts to Trust – Designated Doctor /UTC/community district nurses.
- Review links and arrangements with maternity safeguarding staff.
- Learn from changes made during COVID-19 outbreak and adopt any best practice/best result working arrangements.

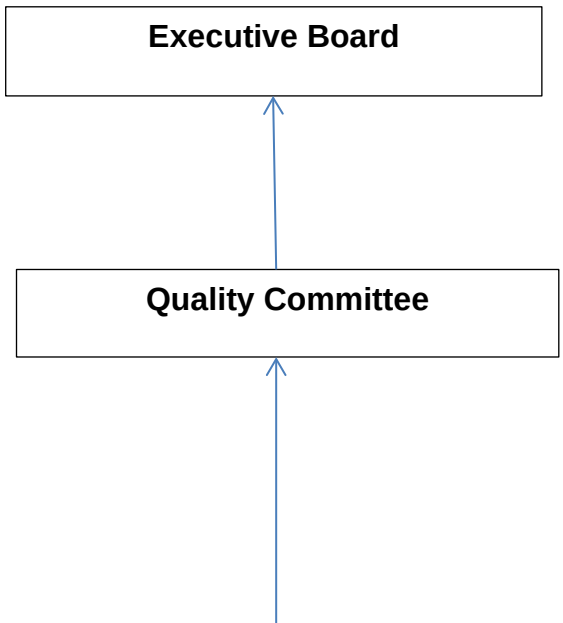
- Regain training compliance of 90% following COVID-19 outbreak.
- Review of Mental Health arrangements.

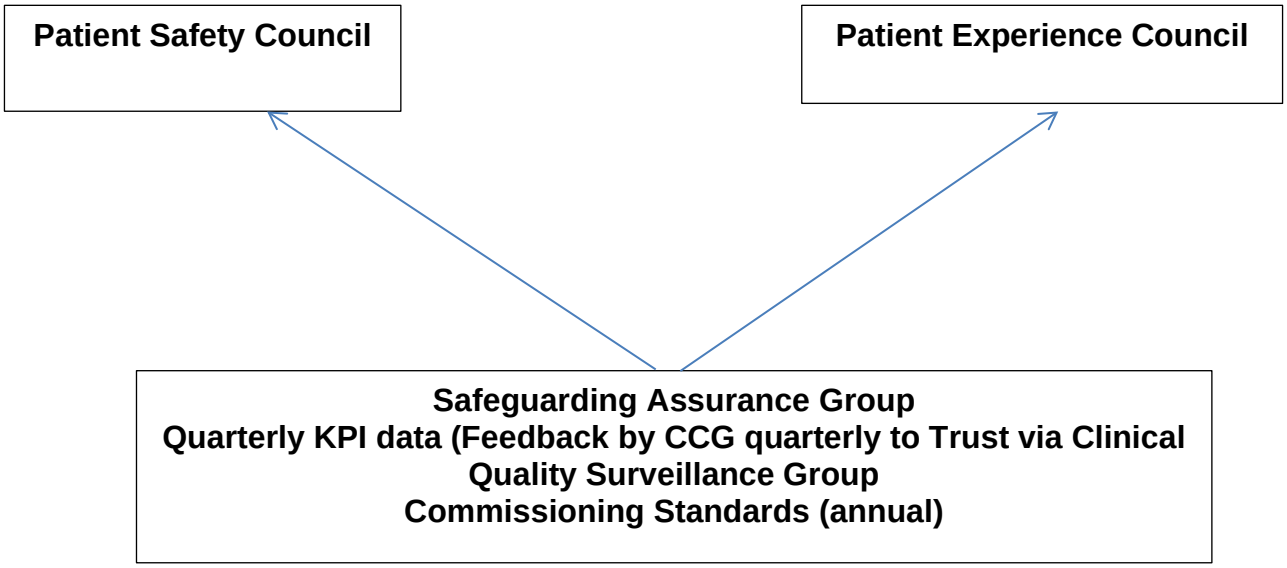
26 Glossary

Acronym	Meaning
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
KPI	Key Performance Indicators
LADO	Local Authority Designated Officer
MACE	Multi agency Child Exploitation meeting
MARAC	Multi Agency Risk Assessment Conference – for high risk / gold domestic abuse cases.
MeRIT	Merseyside Risk Identification Tool – for domestic abuse cases, indicates whether support services are required or referral to MARAC, although professional judgement can overrule scoring to make a referral to MARAC .
NHSE	National Health Service England
NSPCC	National Society for the Prevention of Cruelty to Children
RAG	Red / Amber /Green rating
Section 11	Section 11 audit - places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children
StHK	St Helens and Knowsley Teaching Hospital NHS Trust
UTC	Urgent Treatment Centre

Appendix 1

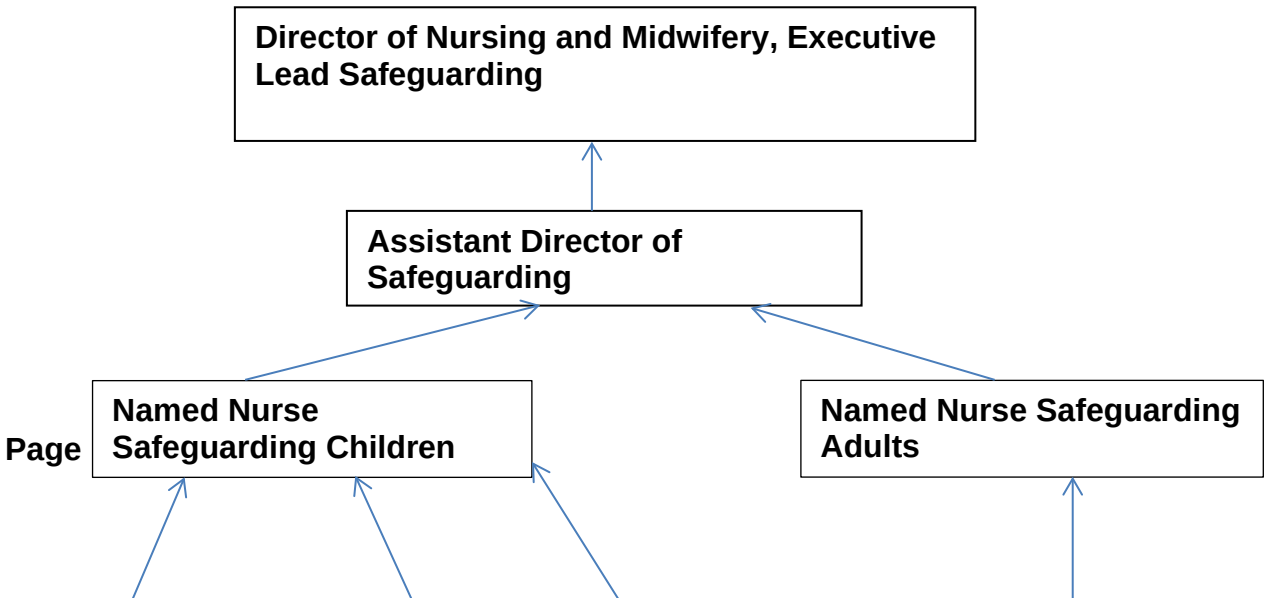
Safeguarding Governance Structure





Appendix 2

Safeguarding Roles and Structure at the end of March 2020

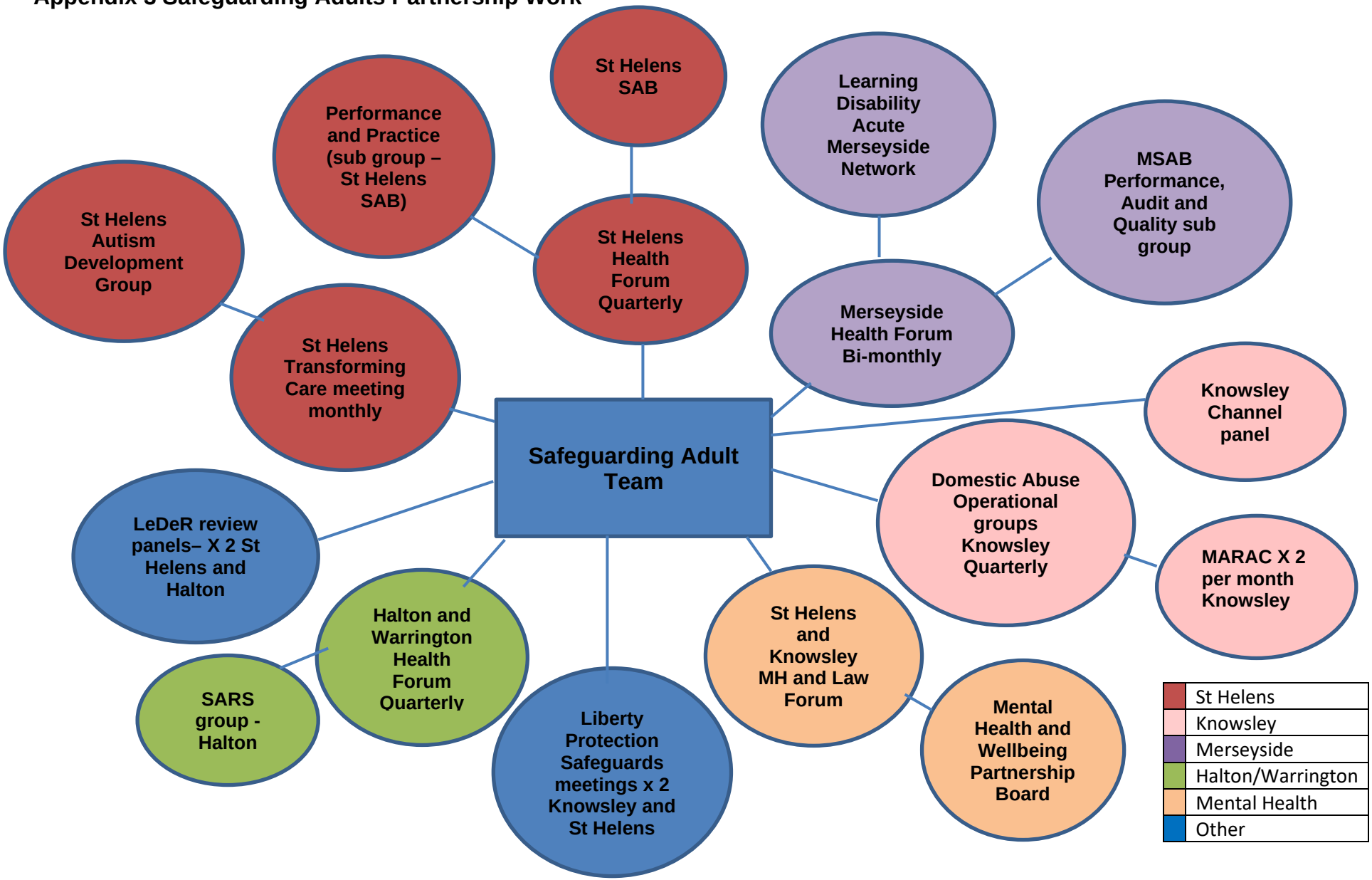


Paediatric Liaison Manager

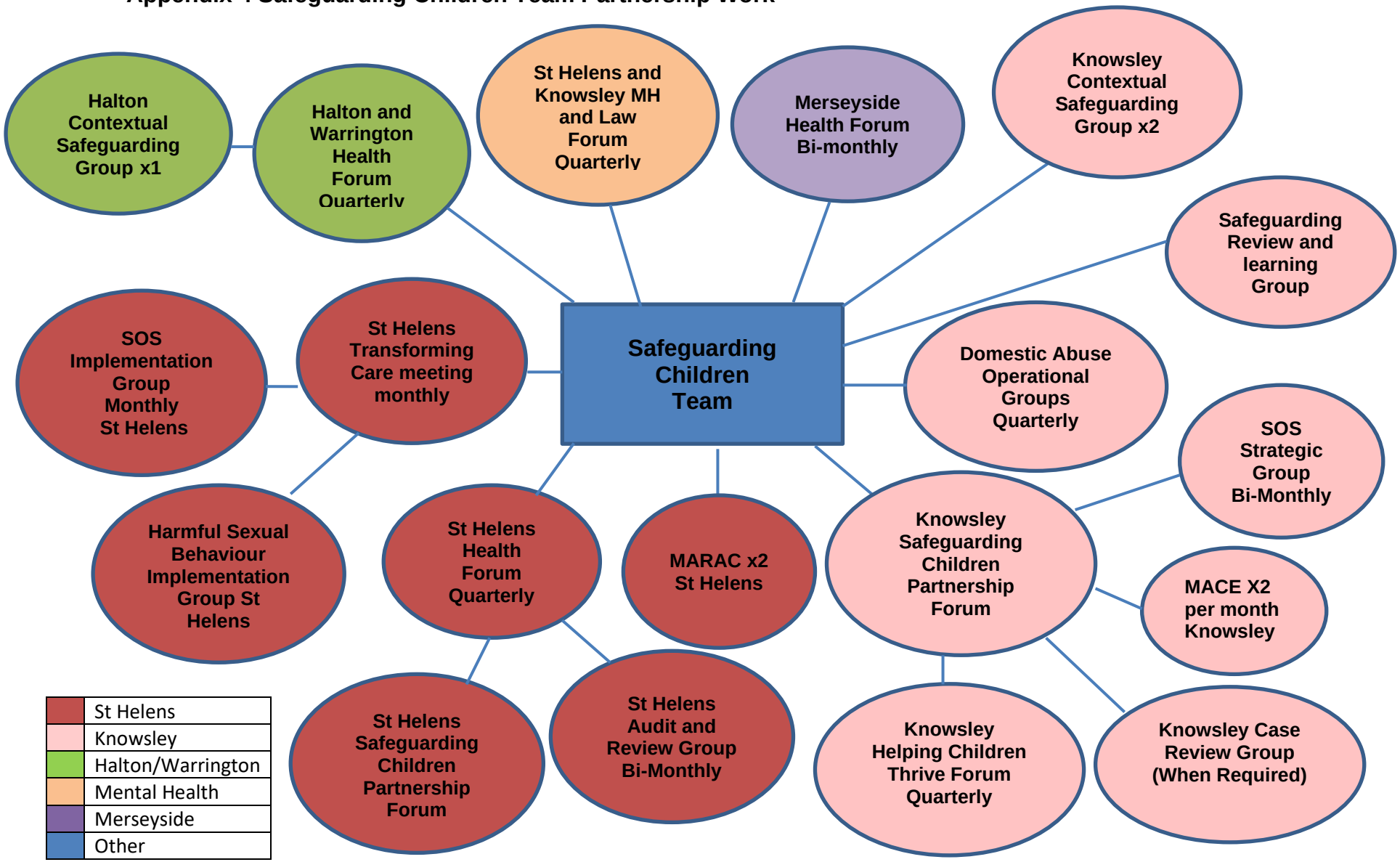
Paediatric Liaison Nurse

Paediatric Liaison Adminisrative Support

Appendix 3 Safeguarding Adults Partnership Work



Appendix 4 Safeguarding Children Team Partnership Work



St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)070

Title of paper: Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2020/21

Purpose: The Trust's annual statement of compliance with EPRR national core standards to be discussed and approved by Trust board, prior to submission to Public Health England and NHSE.

Summary:

The purpose of the EPRR Annual Assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards.

As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. NHS England has set out NHS Core Standards for EPRR, which are the minimum requirements expected. In addition, Core Standard 60 requires acute hospitals to assure themselves against the Decontamination Checklist.

It is a requirement that the Statement of Compliance with the national core standards for Emergency Planning Response & Resilience for 2020/21 is presented to Trust Board before 31st October 2020.

Previously the Trust has been required to self-assess against 64 questions (applicable to the Trust) on Major Incident preparedness and business continuity, including questions on HAZMAT/ CBRN preparedness.

Last year, the Trust was 'fully compliant' with 60 of the 64 question and was 'partially compliant' with 4 questions. The Trust achieved substantially compliance with 93.75%. The 4 questions all relate to chemical, biological, radiological and nuclear defence (CRBN) training:

1. CBRN decontamination capability 24/7 – additional staff need to be recruited in ED;
2. CBRN Training programme – refresher training is required for previously trained staff;
3. HAZMAT/CBRN training trainers – previously trained staff require the National Ambulance Resilience Unit (NARU) 'train the trainer' training. This training is provided by NWAS and has limited places. The Trust has requested places on the next available course and has secured support from the Cheshire and Merseyside EPRR lead to be able to deliver this training in-house;
4. CBRN staff training in decontamination - refresher training is required for previously trained staff.

For 2020 EPRR assurance submission, the process is light touch and the Trust is required to provide progress and assurance on the four actions that were not fully compliant last year, to provide an overview or lessons learnt from the 1st wave of COVID-19 and brief summary of the Trust winter plan.

The Trust is now 'fully compliant' with 3 of the 4 actions and 'partially compliant' with the remaining action. This relates to ED staff decontamination training. The Emergency Department CRBN lead has a training programme in place to achieve 'full compliance', however, there are a number of risks that may delay achievement:

- Capacity to release staff as this training needs to be a face-to-face practical session, ie wearing PRP suits and establishing decontamination tents;

- limited numbers attending session due to social distancing requirements;
- 2nd wave of COVID -19 pandemic.

As a result, the Emergency Department has issued every staff member with guidance on how to identify patients presenting with incidents related to bio hazards and what they should do.

The Statement of Compliance is attached at Appendix A. This was agreed and discussed at Executive Committee on 15th October and will require Trust Board approval before submission on 31st October.

Corporate objectives met or risks addressed: Compliance with EPRR National Core Standards required by regulators and commissioners and ensuring the continued and effective safety and care of patients, staff, partner agencies, visitors and others in the event of a Major Incident or business continuity disruption.

Financial implications: None

Stakeholders: Staff, patients, commissioners, regulators, partner agencies, Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) partners.

Recommendation(s): The Trust's statement of compliance with EPRR national core standards is attached for approval by Trust Board.

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

Date of meeting: 28th October 2020

EPRR CORE ASSURANCE 2020 CHESHIRE & MERSEY

Name of Trust: St Helens & Knowsley Teaching Hospitals NHS Trust

Compliance 2019 Progress made 2020 on partially compliant areas identified last year. (Return N/A if fully compliant)	The Trust was 'fully compliant' with 60 of the 64 question and 'partially compliant' with 4 questions. The 4 areas related to Chemical, biological, radiological and nuclear defence (CRBN) training: 1. **Reference 58: CBRN decontamination capability 24/7**. The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four patients per hours). 24 hours per day 7 days a week. Action is now fully compliant. The staffing rota's have been reviewed which provides 5 trained CRBN trained per shift. **2. Reference 66: CBRN Training programme.** Requirement: Establish system for refresher training for CBRN Action fully compliant Senior Nurse ED Lead for EPRR has revised the training programme. 3 additional staff from ED attended the National Ambulance Resilience Unit train the trainer's course and they are now delivering the training to the ED staff. Covid has had an impact on the availability staff to attend some the training dates planned **3. Reference 67: HAZMAT(hazardous materials) and CBRN Trained trainers** Requirement: The organisation is required to have a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. Action now fully compliant: 3 additional ED staff NARU trainers HAZMAT/CBRN trained trainers (December 2019 and January 2020) **4. Reference 68 CBRN staff training in decontamination** Requirement: Staff who is most likely to come into contact with a patient requiring decontamination understands the requirement to isolate the patient to stop the spread of the contaminant. Action partially completed New decontamination training programme in 2020 delayed due to COVID response. Revised training programme developed and dates in place. **Risks:** • Capacity to release staff as this training is needed to be face to face .practical session i.e. wearing PRP suits and establishing decontamination tents • limited numbers attending session due to social distancing requirements • 2nd wave of COVID -19 pandemic The Trust is now compliant with 63 out of 64 actions
Mid Term Covid Review Date of debrief / Review Key Lessons	• Interim whole Trust review conducted electronically 12th June 2020 as updated August 2020 The aim of the debrief was to capture good practice, identify issues and focus on actions required to maintain essential services and manage the

pandemic response effectively both currently and longer term. This was presented to Executive committee on 9th July. In addition the Trust has conducted pandemic reflection briefings between August and September 2020 with 40 departments including wards, specialists teams and core services to discuss and obtain the views of staff on 4 key questions :

- What was your experience of providing services during the pandemic?
- What went well?
- What could have gone better?
- What could the trust do differently going forward?

Key lessons:

Essential aspects of Trust management of the pandemic response.

- EPRR Infrastructure and the command and control, including decision making and the cascade and escalation of relevant information/actions worked well once established – but possibly should have been put in place earlier?
- Trust wide coordination via a flexible command & control structure with good communication between gold and silver command and between silver and the managers of all areas including non-clinical departments.
- Keeping of a continuous action log at Command meetings to ensure that decisions are swiftly actioned and monitored continuously.
- Trust EPRR email address to provide a central and immediate point of access for senior managers, submissions department and key staff to messages from NHS NW EPRR with instructions, government guidance, and demands for data.
- A responsive and appropriate approach to the management of COVID+ patients and non COVID patients, e.g., cohorting, use of cubicles, use of St Helens as a clean area.
- Mutual aid from other NHS bodies, voluntary agencies and private partners (e.g., Fairfield for staff for endoscopy, Transfer to LHCH for renal replacement therapy and use of British Red Cross re: enhanced wrap around discharge).
- Training and redeployment of staff to support ICU, ED and cohort wards and ongoing training following first wave
- Importance of robust and inventive IT solutions i.e. telehealth to manage and maintain out patients clinics, solutions for patients and relatives contact (especially end of life) and facilitate home working wherever possible for non-patient facing staff self-isolating or shielding.
- Daily communications to all teams via extranet, daily news letters and managers communications. COVID news page on intranet for staff education and information.
- Representation by senior managers and medical staff on regional and national forums.
- Support for urgent Cancer services by provision of a temporary regional centre while Clatterbridge was establishing its new centre.
- Telephone help line for patients with cancer
- Lessons learned from previous emergency planning exercises,

	Exercise Solar Wind in 2018 (aim: sourcing, increasing and management of ventilators, syringe drivers and other equipment prior to a Major Incident) and the week-long national Exercise Novus Coronet in March 2020 proved invaluable.
Process for embedding the learning from the review Include changes to procedures and communications	Trust Learning Good Practice identified to be continued Management • Visibility of the Executive and senior medical management teams as part of the Trust response • The right people operating at the right levels in the command and control structure • Adopted a STOP, THINK, PLAN and DO approach through formal command structure. This might mean pushing back to silver/gold for more time to get things right first time when we had to interpret complex and frequently changing guidance. • Staff from different backgrounds and disciplines working together to achieve common goals, including PFI partners • Mobilised the Trust to refine meetings & decide upon key data needs. • Successful management of supplies of PPE, support to staff to ensure awareness how to" Don and Doff PPE" video to support training and senior management. • Clear communication with key messages to staff re any immediate changes to guidance or practice • Established process for recording national returns to ensure consistency in providing responses to timeframes • Communicated well and in different ways, but recognising that changing guidance from the centre could have been confusing for staff • Management and governance of decisions making (financial, workforce, quality and performance) • Started testing symptomatic staff and risk assessing vulnerable and at risk staff early in the process • Good processes for linking into and feeding back from national forums/calls e.g. MD network, Keith Willets calls, DoNs network, DoFs network • All essential core services (not suspended nationally) both corporate and clinical were maintained • Ability to "suspend" normal processes allowed decisions to be taken faster e.g. minor works variations, but there is a legacy of work to "catch up" on these going forward Staffing • The Redeployment Centre plan was established to manage movement of staff where needed during the pandemic, winter surge and EU EXIT. • Rapidly implemented working from home for large groups of staff • Services that were paused (Learning & OD, Workforce Development) were flexible in delivering to the COVID-19

response requirements, particularly redeployment activity

- Teams were responsive and flexible to deliver at pace, there was a willingness to take ownership outside of usual role
- Staff providing support to each other, when signs of stress were visible.
- Risk assessment and test and trace were paper based due the lack of automation of new data collection forms, e.g. isolation forms, risks assessments resulting in manual processes and difficulty in reporting and providing management information.
- To agree in advance staged escalation plans for each of the care groups based on levels of COVID activity with rolling training for staff as they became COVID Cohort Wards
- The creation of the support team worked really well so would look to replicate this in the future.

IT

- The response to the pandemic has unlocked a wealth of developments and investment in IT solutions enabling remote meetings, training and events, off site working and better communications that will continue to benefit the Trust.
- Telemedicine has been established and is being used to facilitate Out-Patients clinics. Uptake by some services, particularly where they are nurse led e.g. hand therapy, sexual health, stroke follow up, skin team and paediatric respiratory.
- Deployment team commitment, e.g. lead by Digital nurses interfacing with the services
- VPN expansion overnight from approx. 300 users to 2,350 working from home.
- Configured all PCs and Laptops to use the Always On VPN to remove the need for VPN tokens
- Skype for Business for video conferencing with colleagues
- Not all IT solutions equitable across teams or staff – some remain without cameras or audio capability to maintain the same level of effective communications
- Database of equipment and where it is stored so it can be easily located /redeployed
- Development of a staff micro internet site that can be accessed from personal mobile devices and stores all the staff communications, advice, and guidance in one place
- Effective media and reputation management to maintain public confidence, including video content for Facebook to answer common questions and concerns e.g. Maternity

Training

- A rolling training programme developed to support ICU, ED, cohort wards and CPAP wards to provide trained and experienced staff
- Established training for Infection control, PPE donning and doffing, face fit testing
- Procurement and medicines
- Procurement and medicines management have robust plans for

	maintenance and distribution of stocks of PPE and medicines. Communications • The EPPR.STHK@sthk.nhs.uk email address will remain in place as a Trust mailbox for receipt of urgent messages, instructions, guidance and demands for data from NHSNW.EPRR. It is monitored by senior managers, key staff and the submissions team and is a robust conduit for information sharing going forward. • The Silver action log is shared with all management teams and key staff and provides an ongoing picture of the situation and the response. Actions escalated to gold daily and executive meeting 3 x weekly. • The COVID webpage on the trust intranet is a valuable repository of information and FAQs for staff that they have become accustomed to consulting. This style of communication can now be used for any crisis to relay information. Business Continuity • Business continuity plans for shortages and loss of staffing, equipment, PPE and other supplies, medicines and access to areas of the buildings have been used to manage the situation and are being continuously monitored and updated as a result. ICU expansion plans • ICU now has an isolation pod with clear barriers. As COVID surges ICU can now flip its isolation area and clean areas flexibly.
Winter Plans Areas from review that have influenced Winter planning	**a) Trust Winter and COVID 19 Emergency Response Plan:** Learning from COVID has been incorporated into the Trust Winter and COVID 19 Emergency Response Plan and contains the following goals and key deliverables: • The trust have submitted the winter plan which dove tails into the Mid-Mersey winter plan • Bevan Court opened on 25.8.20 with additional beds and a new older peoples priority assessment unit to support SDEC and step down facility for medically optimised patients • Stretcher Triage capacity has recently increased from 5 to 8 spaces to support timely handover of ambulance patients • Additional temporary waiting area in ED (already in situ) to provide additional capacity for winter in the event of second surge • Plan to open an additional winter ward with 32 medical beds between October 20 and March 2021 (Ward 1A) • New discharge lounge with flexibility to take patients on beds - January 2021 • A capital bid has been submitted to increase ICU capacity by 7 beds (14 to 21). • Elective waiting list recovery plan is underway to restore to pre-covid levels and maintain activity during winter (plan to keep St Helens as a 'green site' throughout winter and maintain Fairfield activity) • Fourth endoscopy room in St Helens Hospital expected to open in

	November 2020. • The Trust has commenced its flu campaign in September 2020 • The high intensity user meetings have been re-established with partners • 24/7 Crisis Response Resolution and Home Treatment in addition to psychiatry liaison service
	Goals: - Provide safe care - Keep staff safe - Maintain patient care standards and safety - Maintain staff safety and welfare **Key deliverables:** - Effective testing and tracing service for our staff and patients - Adequate forward supply of PPE - Increase capacity, staffing levels and support to emergency and critical care services - Wellbeing and psychological support to staff - Flu Vaccination - Reduce transmission through 'Hands – Face – Space' supported with strong infection prevention **b) Changes to the Trust Escalation Plan:** There are various escalation triggers as follows: • Escalation Plan Triggers • EMS/OPEL Levels • Critical Care Surge Levels • Rising staff absence COVID/Non COVID related • COVID positive patient results • Trigger for opening of surgery These are being incorporated into revised triggers for inclusion in the Trust Winter and COVID Emergency Response Plan and Trust Escalation plan. **c) Use of Side Rooms and cubicles:** Whiston has a large number of cubicles and side rooms being a new style of hospital so is in a good position to be able to isolate patients. The importance of monitoring activity figures for Flu, RSV etc. are being taken forward as part of the winter plan. The elective plan is developed around these figures and the bed meetings and Silver meetings will continue throughout winter to respond to any changes/escalation issues. **d) Flu Vaccine:** The impact of COVID-19 will continue and planning this year is more challenging than ever in light of staff absence uncertainties and how long COVID-19 policies, will remain in place. Key points of the campaign this year:

	• Ambition to vaccinate up to 100% of staff and also include other members of the workforce, for example students and staff within our partner organisations. • Increased numbers of peer vaccinators across the trust • Regular mass vaccination sessions at sites across the trust service areas with well-advertised slots.

Signed: ……
AEO: Sue Redfern, Director of Nursing, Midwifery & Governance

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)071
Title of paper: Workforce Equality, Diversity & Inclusion Update – Workforce Race Equality Standard (WRES).
Purpose: To inform and provide the Trust Board with an update relating to the Workforce Race Equality Standard (WRES) results and actions.
Summary: Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The Trust is monitored against the 9 indicators of the WRES and this report provides an update on action taken to date.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce.
Financial implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to note and approve the updated WRES report and actions.
Presenting officer: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Date of meeting: 29th October 2020

1. Introduction

Workforce Race Equality Standard Annual Update 2020 (WRES)

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda.

The WRES is made up of nine indicators; the first four measure staff experience over a 12 month period for harassment, bullying, or abuse from patients, relatives or the public. Another four measure workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator nine considers BME representation on executive boards, in relation to the workforce.

The main purpose of the WRES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- ✓ to improve BME representation at the Board level of the organisation.

The data presented refers to the following periods

Indicator 1	1st April 2019 – 31st March 2020
Indicator 2	1st April 2019 – 31st March 2020
Indicator 3	1 April 2018 – 31 March 2020 two year rolling average
Indicator 4	1st April 2019 – 31st March 2020
Indicator 5,6,7 & 8	Staff Survey Results 2019
Indicator 9	31st March 2020

2. Progress to date:

Working in partnership with BAME colleagues across the Trust, the following key developments so far include:

- Establishment of fully operational BAME staff network and appointment of two co-chairs
- BAME network representation at the Trust wide Equality, Diversity and Inclusion Steering Group, driving and shaping the Trust response to inequalities across all protected groups
- 'Everyone Matters' campaign launched to promote staff networks
- Incorporation of diversity statement on all roles above Band 8a in line with the Model Employer (Increasing the BME representation at Senior Levels)
- Established relationships with external VCSE organisations (SHAP and Black Leaders Network)
- Listening events held with International Nurses to understand challenges and how to improve their experience at STHK.
- Developed case study of BAME staff that have successfully progressed their career at STHK
- Implementation of Just Culture process that incorporates a 72 hour pause on cases
- Raised awareness of key religious holidays and dates such as Black History Month, Eid, Rosh Hashana etc. to raise cultural awareness
- Promotion of the Stepping Up Programme across the Trust to our BAME colleagues
- Strong support for BAME colleagues during Covid-19, responding to the disproportionate impact on BAME communities and NHS staff
- Successfully gained place on NHS Employers Partners Programme to commence in 2021.

3. WRES Results and Actions

Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Results:

Results:

- BME Staff in Workforce: 9.6%
- White Staff in Workforce: 89.6%
- Not disclosed Ethnicity Data: 0.8%

9.6% of staff identify themselves as being BME at STHK which is an increase on last year which was 8.7%. This trend could be as a result of the recent international recruitment campaign.

The most recent Census (2011) regarding the local BME population (Census Data 2011, next census is 2021):

- St Helens (2.4%) & Knowsley (2.9%)
- Liverpool (12.3%)
- North West (11%)
- England (14%)

This means that the Trust's BME workforce is significantly higher than the local population.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Any changes relating to HR processes to be Equality Impact Assessed and reviewed by Workforce E, D & I Lead.		Workforce E, D & I Lead	Oct 2020	
Incorporate E, D & I element into HWWB discussions with staff (People Plan).		Deputy Director of HR	Dec 2020	
*Ensure BAME staff network co-chairs have nominated person within Silver command to raise any concerns relating to BAME staff.		Workforce E, D & I Lead	Oct 2020	

A focussed quarterly review of BAME leavers across all staff groups		Workforce E,D & I Lead	March 2021	
Indicator 2: Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.				
Results: Relevant likelihood of White staff being appointed from shortlisting is 1.32 times greater than BME Staff in comparison with 1.15 times higher in 2019. The National Guidance states that a figure below "1" would indicate that White candidates are less likely than BME candidates to be appointed from shortlisting. In 2019, the National NHS figure in England is 1.46, the North West was 1.56 and for Acute Trusts 1.44 (Source: NHS Workforce Race Equality Standard – 2019 Data Analysis report for NHS Trusts, first published February 2020).				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
**Develop a video showing the diversity of our staff for use in attracting BAME applicants (BAME Engagement Plan – business case for funding required).		Head of Media, PR & Communications / Workforce E, D & I Lead	March 2021	
**Deliver session on Unconscious Bias for Executive team and senior managers and make an accessible online module available for Line Managers - https://lms.leadershipnhs.uk/login?redirect=/profile		E, D & I Lead	Nov 2020	
Develop positive employee case studies of BAME staff to profile career progression success stories as well as attracting potential staff to apply for vacancies.		Workforce E, D & I Lead	Jan 2021	
Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.				
Results: BME staff: 0.96 in 2019 compared with 1.11 in 2018				

A figure below "1" would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process.

In 2019, the National NHS figure in England was 1.22, for the North West it was 1.06 and Acute Trusts was 1.17 (Source: NHS Workforce Race Equality Standard – 2019 Data Analysis report for NHS Trusts, first published February 2020).

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Ensuring staff are fully trained and competent to carry out their role as case managers, case investigators or panel members.		Head of HR	March 2021	

Indicator 4: Relative likelihood of staff accessing non-mandatory training and Continuing Personal Development.

Results:

- 2018 results = 0.86
- 2019 results = 0.97

A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

The National NHS figure in England in the 2019 survey results is 1.15 for England, 1.26 for the North West and 1.20 for Acute. (Source: NHS Workforce Race Equality Standard – 2019 Data Analysis report for NHS Trusts, first published February 2020).

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Increased promotion of professional development opportunities through the staff engagement app, team brief, BAME staff network and global emails.		Head of Learning & Organisational Development	March 2021	
Develop and deliver courses for staff to enhance skillset when applying for training programmes and/or jobs. To be promoted via the BAME staff network.		Head of Learning & Organisational Development	March 2021	
Greater clarity in the selection process for learning opportunities.		Head of Learning & Organisational Development.	March 2021	

Use the BAME staff network to understand the barriers to professional development.		Head of Learning & Organisational Development	March 2021	
Increased communication of Freedom to Speak up via staff network, team brief, global email and staff app.		Freedom to Speak up Guardian	Nov 2020	
Indicator 5: relates to Staff Survey findings. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months				
Results: • White Staff: 22.5% (of 515 White Staff) in 2019 compared with 23.7% (of 562 White Staff) in 2018 • BME Staff: 30.2% (of 43 BME Staff) in 2019 compared with 30% (of 40 BME Staff) in 2018 The figure has decreased for White staff experiencing harassment, bullying and abuse from patients, relatives or the public in comparison with 2018 and increased slightly by 0.2% for BME staff since 2018. The 2019 staff survey data was released February 2020 and was not available at the time of publication of the national WRES report.				
Increase awareness campaign for patients, service users and the public (in relation to a zero tolerance of abuse).		Patient Inclusion and Experience Lead	Dec 2020	
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
Indicator 6: relates to Staff Survey findings Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months				
Results: • White Staff: 15.5% (of 510 White Staff) in 2019 compared with 17.1% (of 563 White Staff) in 2018 • BME Staff: 30.2% (of 43 BME Staff) in 2019 compared with 12.82% (of 39 BME Staff) in 2018 There has been a decrease in White Staff experiencing harassment, bullying or abuse from staff and a significant increase of BME staff experiencing harassment, bullying or abuse from other staff.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**

**Digital promotional (i.e. screensavers) material around tackling workplace bullying, racism and discrimination.		Workforce E,D & I Lead	Dec 2020	
**Empower BAME staff to raise concerns via the staff network and Freedom to Speak up Guardian via IT Global, Team Brief, 121 virtual drop in session with Freedom to Speak up Guardian		Freedom to Speak up Guardian	Dec 2020	

Indicator 7: relates to Staff Survey findings
Percentage believing that the Trust provides equal opportunities for career progression or promotion

Results:

- White: 94.5% (of 380 White Staff) in 2019 compared with 94.29% (of 403 White Staff) in 2018
- BME: 70% (of 30 BME Staff) in 2019 compared with 85.20% (of 27 BME Staff) in 2018

There has been a slight increase in White staff believing that the Trust provides equal opportunities for career progression or promotion compared with a substantial decrease in BME staff believing that the Trust provides equal opportunities in career progression.

The 2019 staff survey data was released February 2020 and was not available at the time of publication of the national WRES report.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
***Establish a pool of VSMs and Board members to mentor/reverse mentor and sponsor at least one talented BAME member of staff at AfC band 8d or below.		Deputy CEO / Director of HR	March 2021	

Indicator 8: relates to Staff Survey findings
In the last 12 months have you personally experienced discrimination at work from any of the following?

- Manager/team leader or other colleagues

Results:

- White: 4.3% (of 513 White Staff) in 2019 compared with 3.2% (of 567 White Staff) in 2018.
- BME: 16.7% (of 42 BME Staff) in 2019 compared with 14.63% (of 41 BME Staff) in 2018.

Both the BME and White responses show an increase in employees experiencing discrimination at work from managers/team leaders or other colleagues since the 2018 Staff Survey.

The 2019 staff survey data was released February 2020 and was not available at the time of publication of the national WRES report.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
** Specific training around different cultures and religions to reduce stigma, racism and discrimination (BAME Engagement Plan)		E,D & I Lead	March 2021	

Indicator 9: Percentage difference between the organisations' Board voting membership and its overall workforce.

Results:

Trust Board BME is 6.3%. The overall workforce by ethnicity is 9.6%. The difference between Board voting membership and overall workforce for BME is -3.3%.

The Trust Board figure as at 31st March 2020 was made up of 16 board members, inclusive of Non-Executive Directors.
When comparing the Board to the local BME population of St Helens & Knowsley, Liverpool, North West and England in total, these are as follows:

- St Helens (2.4%)
- Knowsley (2.9%)
- Liverpool (12.3%)
- North West (11%)
- England (14%)

(Census Data 2011, next census is 2021)
This means that the Trust's BME Board membership is higher than the BME local population.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
*Establish a diversity advisory group to provide strategic and operational input into key decisions & act quickly and reassure staff when evidence of potential inequalities is identified.		Deputy CEO / HR Director	Oct 2020	

***Senior leaders and board members to have performance objectives on workforce race equality built into their appraisal process – senior leaders should be held accountable for the level of progress on this agenda.		Deputy CEO / HR Director Assistant Director of Organisational Development	Dec 2020	
By March 2021, NHS England and NHS Improvement will have published competency frameworks for every board-level position in NHS providers and commissioners. These frameworks reinforce that it is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion, and of all senior leaders to hold each other to account for the progress they are making.		CEO	March 2021	
In line with the Model Employer (Increasing the BME representation at Senior Levels – section 5.1) identify NED to play an active role in mentoring and sponsoring a BAME member of staff that has the potential to get to an executive role within three years.		Deputy CEO / HR Director	Dec 2020	

*****This incorporates the recommendations from the WRES briefing for boards and COVID-19 EPRR membership in the NHS.

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**Actions that feature as part of the BAME engagement Plan.

*** Actions taken from a 'Model Employer: Increasing black and minority ethnic representation at senior levels across St Helens and Knowsley Teaching Hospitals NHS Trust'.

Ends.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(20)072
Title of paper: Workforce Equality, Diversity & Inclusion Update – Workforce Disability Equality Standard (WDES).
Purpose: To inform and provide the Trust Board with an update relating to the Workforce Disability Equality Standard (WDES) results and actions.
Summary: Implementing the Workforce Disability Equality Standard (WDES) is a requirement for NHS commissioners and NHS provider organisations. The Trust is monitored against the 10 indicators of the WDES and this report provides an update on the proposed actions.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce.
Financial implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to note and approve the updated WDES report and actions.
Presenting officer: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Date of meeting: 29th October 2020

1. Introduction

Workforce Disability Equality Standard Annual Update 2020.

The NHS Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. It has been designed to improve workplace experience and career opportunities for disabled people working, or seeking employment in the NHS.

The WDES is made up of ten indicators; which cover such areas as the Board, recruitment, bullying and harassment, engagement and the voices of disabled staff.
The main purpose of the WDES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,
- ✓ to improve representation at the Board level of the organisation.

Please note that at the time of this report the WDES National Report has not been produced so there is nothing to benchmark the Trust results against.

The data presented refers to the following periods

Indicator 1	Snapshot as at 31st March 2020
Indicator 2	1st April 2019 – 31st March 2020
Indicator 3	This Metric will be based on data from a two year rolling average of the current and previous year.
Indicator 4,5,6,7,8 & 9a	Staff Survey Results 2019
Indicator 9b	Time of completing report
Indicator 10	Snapshot as at 31st March 2020

2. Progress to date:

Working in partnership with colleagues across the Trust, the following key developments so far include:

- Establishment of fully operational Disability & Wellbeing staff network and the appointment of a Chair. In addition to this the Trust has also established a Carer's staff network and a Menopause Staff Network.
- Staff Network Chair representation at the Trust wide Equality, Diversity and Inclusion Steering Group, driving and shaping the Trust response to inequalities across all protected groups
- 'Everyone Matters' campaign launched to promote staff networks
- Established relationship with DWP to develop the Disability agenda
- Developed case studies of staff that have successfully progressed their career at STHK
- Implementation of Just Culture process that incorporates a 72 hour pause on cases
- Raised awareness of key dates such as Dyslexia Awareness Week, Autism Awareness and International Day of Disabilities
- Immediate and effective support for colleagues with long term health conditions during Covid-19
- Successfully gained a place on NHS Employers Partners Programme to commence in 2021.
- Accredited with the Disability Confident Leader status.

3. WDES Results and Actions

Indicator 1: Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff in the overall workforce.

Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes. Links to EDS2 3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

Results:

- Non-Disabled Staff in Workforce: 82.4%
- Disabled Staff in Workforce: 2.8%
- Not Disclosed Disability Status:14.8%

2.8% of staff identify themselves as being disabled at STHK which is a decrease on last year which was 3%. In 2019 17% of staff did not declare a disability compared with 14.8% in 2020.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Further improve the quality of the data held on ESR, including self-service communication to remind employees they can update their data and raise awareness of disability and long term health conditions and of the benefits of declaration via global email and team brief.		ESR Team	Jan 2021	
Ensure Disabled staff network Chair has a nominated person within Silver command to raise any concerns relating to Disabled staff.		Workforce E, D & I Lead	Oct 2020	

Indicator 2: Relative Likelihood of Disabled Staff compared to Non-Disabled Staff being appointed from shortlisting across all posts.

Results:

Relevant likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff: 1.17

A figure above 1:00 indicates that Non-Disabled staff are more likely than Disabled staff to be appointed from shortlisting. This

has increased since 2019 figure of 1.04. As a Trust we offer a guaranteed interview for all disabled staff that meet the essential criteria.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
A focussed quarterly review of Disabled leavers across all staff groups.		Workforce E,D & I Lead	March 2021	
Develop a short guide for recruiting managers on reasonable adjustments that can be offered to applicants in advance of their interview.		Workforce E,D & I Lead	Jan 2021	
Develop positive employee case studies of disabled staff to profile career progression success stories as well as attracting potential staff to apply for vacancies.		Workforce E, D & I Lead	Jan 2021	
Indicator 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: i) This Metric will be based on data from a two-year rolling average of the current year and the previous year. ii) This Metric was voluntary in 2019 and so was not completed.				
Results: Relevant likelihood of Disabled staff entering the formal capability process compared with Non-Disabled staff: 0.00 A figure above 1.00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
Interim monitoring of these statistics on a 6 monthly basis to identify any changes/trends		Workforce E,D & I Lead	Feb 2021	

Indicator 4a): Relate to Staff Survey findings
Percentage of Disabled Staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

I. Patients/Services users, their relatives or other members of the public
II. Managers
III. Other colleagues

Results:
Patients/service users, their relatives or other members of the public:

- Disabled Staff: 34% (of 106 disabled staff) in 2019 and 28.2% (of 110 disabled staff) in 2018
- Non-Disabled Staff: 20.6% (of 452 non-disabled staff) in 2019 and 23.4% (of 492 non-disabled staff) in 2018

Disabled staff are more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public than non-disabled staff. This has increased by 5.8% since 2018.

Managers:

- Disabled Staff: 10.8% (of 102 disabled staff) in 2019 and 10.9% (of 110 disabled staff) in 2018
- Non-Disabled Staff: 6.5% (of 449 non-disabled staff) in 2019 and 7.8% (of 485 non-disabled staff) in 2018

Whilst disabled staff are more likely to experience harassment, bullying or abuse from managers than non-disabled staff, this figure has slightly decreased by 0.1% since 2018.

Other colleagues:

- Disabled Staff: 20.4% (of 103 disabled staff) in 2019 and 18.9% (of 111 disabled staff) in 2018
- Non-Disabled Staff: 11% (of 447 non-disabled staff) in 2019 and 10.6% (of 489 non-disabled staff) in 2018

Disabled staff are more likely to experience harassment, bullying or abuse from other colleagues than non-disabled staff. This figure has increased by 1.5%.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Patients/service users, their relatives or other members of the public: • Increase awareness campaign for patients, service users and the public (in relation to a zero tolerance of		Patient Inclusion and Experience Lead	Dec 2020	

abuse).				
Managers and other colleagues: • Review and approve of Respect and Dignity Policy at work and further communication to remind staff of Trust Values and Behaviours via the global and Team Brief.		HR Business Partners and Workforce E,D & I Lead	March 2021	
Digital promotional (i.e. screensavers) material around tackling workplace bullying and discrimination.		Workforce E,D & I Lead	Dec 2020	

Indicator 4b): Relate to Staff Survey findings
Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Results:

- Disabled Staff: 66.7% (of 42 disabled staff) in 2019 and 47.6% (of 42 disabled staff) in 2018
- Non-Disabled Staff: 42.9% (of 105 non-disabled staff) in 2019 and 52.3% (of 130 non-disabled staff) in 2018

A positive increase of 19.1% more disabled staff in 2019 compared with 2018 said that the last time they experienced harassment, bullying or abuse at work they or a colleague reported it. However there has been a 9.4% decrease in the number of non-disabled staff reporting harassment, bullying or abuse at work since 2018.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Raise awareness of how to report harassment, bullying or abuse at work via staff network, Freedom to Speak up Guardian and Team Brief		Workforce E,D & I Lead	Oct 2020	

Indicator 5: Percentage of Disabled Staff compared to Non-Disabled Staff believing that the Trust provides equal opportunities for career progression or promotion.

Results:

- Disabled Staff: 93.2% (of 74 disabled staff) in 2019 compared with 89.9% (of 69 disabled staff) in 2018
- Non-Disabled Staff: 92.6% (of 337 non-disabled staff) in 2019 compared with 94.2% (of 361 non-disabled staff) in 2018

0.6% more disabled staff believed that the Trust provides equal opportunities for career progression or promotion than disabled staff.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Develop and deliver courses for staff to enhance skillset when applying for training programmes and/or jobs. To be promoted via the Disability staff network, team brief, staff app and global email.		Head of Learning and Development	March 2021	
Increased promotion of professional development opportunities through the staff engagement app, team brief, Disability & Wellbeing staff network and global emails.		Head of Learning & Organisational Development	March 2021	
Develop and deliver courses for staff to enhance skillset when applying for training programmes and/or jobs.		Head of Learning & Organisational Development	March 2021	
Indicator 6: Percentage of Disabled Staff compared to Non-Disabled Staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.				
Results: • Disabled Staff: 20.3% (of 69 disabled staff) in 2019 compared with 30.3% (of 76 disabled staff) in 2018 • Non-Disabled Staff: 14.1% (of 206 non-disabled staff) in 2019 compared with 19.3% (of 238 non-disabled staff) in 2018 Disabled staff are more likely to feel pressured by their manager to return to work despite not feeling well enough to perform their duties in comparison to non-disabled staff. However these percentage have seen a positive decrease since 2018.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
Produce Access to Work guidance for managers to signpost additional support for staff when considering returning to work.		Workforce E,D & I Lead	March 2021	
Indicator 7: Percentage of Disabled Staff compared to Non-Disabled Staff saying that they are satisfied with the extent to which their organisations value their work.				
Results: • Disabled Staff: 54.3% (of 105 disabled staff) in 2019 compared with 43.4% (of 113 disabled staff) in 2018 • Non-Disabled Staff: 59.1% (of 450 non-disabled staff) in 2019 compared with 60.1% (of 494 non-disabled staff) in 2018 There has been a 10.9% increase in disabled staff saying that they are satisfied with the extent to which their organisations value				

their work and a slight decrease of 1% for non-disabled staff.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Awareness of ACE Behavioural standards through relaunch of the values		Head of Learning & Development	March 2021	

Indicator 8: Percentage of Disabled Staff saying their employer has made adequate adjustments to enable them to carry out their work.

Results:

- Disabled Staff: 81.8% (of 66 disabled staff) in 2019 compared with 81.5% (of 65 disabled staff) in 2018

There has been a 0.3% increase in disabled staff saying the Trust has made adequate adjustments to enable staff to carry out their work.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Refresh and develop Reasonable Adjustments guidance for staff and managers.		Head of HR	Jan 2020	

Indicator 9a: The staff engagement score for Disabled Staff compared to Non-Disabled Staff and the overall engagement score for the organisation.

Results:

- Disabled Staff: 7.2 (for 106 disabled staff) in 2019 & 7.2 (for 113 disabled staff) in 2018
- Non-Disabled Staff: 7.6 (for 450 non-disabled staff) in 2019 compared with 7.7 (for 494 non-disabled staff) in 2018

This figure has remained the same for disabled staff and decreased by 0.1 for non-disabled staff since 2018.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Invest and promote relevant awareness days across the Trust to show support for staff members with disabilities – such as International Day for People with Disabilities (3rd December).		Workforce E,D & I Lead	March 2021	

Indicator 9b: Has your Trust taken action to facilitate the voices of Disabled Staff in your organisation to be heard?

Results:
Yes - The Disability Staff Network has been expanded to also incorporate a wellbeing element and has been rebranded the Disability & Wellbeing Staff Network.

Indicator 10: Percentage difference between the organisation's Board voting membership and it's organisation's overall workforce disaggregated

Results:

- By voting membership of the Board.
  Disabled Staff: 0% in 2019 & 2018
  Non-Disabled Staff: 60% in 2019 compared with 80% in 2018
  Not Disclosed disability status 40% in 2019 compared with 20% in 2018

- By Executive membership of the Board.
  Disabled Staff: 0% in 2019 & 2018
  Non-Disabled Staff: 60% in 2019 compared with 80% in 2018
  Not Disclosed disability status 40% in 2019 compared with 20% in 2018

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
Ensure the Trust advertises for Board appointments that the Trust is Disability Confident Leader. Deliver disability awareness training for Board interview panel members.		Workforce E,D & I Lead	March 2021	

Ends.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)073

Title of paper: Learning from Deaths Quarterly Report 2020/21 Quarter 1

Purpose: To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths and key learning has been disseminated throughout the Trust.

Summary:

Month	Total	Green – GWL	Amber	Red
April 2020	71 *(32)	60	2	0
May 2020	42 *(8)	37	0	1
June 2020	30 *(2)	22	2	1

**COVID deaths*

Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, Communication

Financial implications: None

Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners

Recommendation(s): To approve the report, policy and good practice guide

Presenting officer: Dr Elspeth Worthington, Assistant Medical Director

Date of meeting: 28th October 2020

1 EXECUTIVE SUMMARY

Learning from deaths of people in our care can help us improve the quality of the care we provide to patients and their families, and identify where we could do more. *NHSI 2017.*

In Quarter 1 2020/21 a total of 143 SJR's were carried out 32 of which were COVID (29%). 83.21% (119n) of the reviews had an outcome of no concerns (Green or Green with learning). 2.7% (4n) had an AMBER outcome, 1.39% (2n) had a RED outcome. 2 have been StEIS reported, 2 are receiving internal investigation pending escalation and 2 are to be discussed at October MSG. 12.58% (18n) are awaiting review.

See Appendix 1 for the case selection contributing to Mortality Surveillance Group MDT / Learning from Deaths Quarterly Report.

1.1. Shared learning for Q1 2020/21

Q1	1 DNACPR - COVID-19 has highlighted a different concern for patients and families. Forms, completed on admission, with the COVID diagnosis in mind, were part of an MDT approach to define plans to escalate or palliate patients on deterioration. However for patients surviving to discharge further discussion by the clinical team is ESSENTIAL as to whether such a form is required and exactly what it means regards their future healthcare.	2 Acknowledging the difficulty of recognising a patient who is approaching the final stage of their life and requires support in a comfortable death rather than ongoing resuscitation and treatment continues to be a challenge in many areas of the trust. In response to this we have put together a questionnaire to be sent to all staff in the next month – please respond and help direct the teaching and support required in order to improve the patient and bereaved family experience.
Previous learning can be found on the intranet Learning into action		

1.2. Sharing and embedding learning

This learning is shared & evidenced in meeting minutes as per matrix in appendix 2.

1.3. Medical Examiner

7 doctors have been offered the Medical Examiner (ME) posts following interview on 22 July 20 with Dr Sam Pedder, appointed as lead ME. Development of the team is in progress with an aim to be on target to review 50% of Trust deaths by 31st October 2020 and 100% by 1st April 2021. It is anticipated that the appointment of Medical Examiners will reduce the numbers of Amber and Red reviews that are highlighted during an SJR as most of these concerns should be identified by MEs in their initial case note review, thus enabling more prompt duty of candour and appropriate investigations. A governance plan has been established to manage this.

2 ANALYSIS

2.1 Total number of reviews completed for Q1 2020/21

Month	Total	Green – GWL	Amber	Red	Outstanding reviews to be completed
April 2020	71 *(32)	60	2	0	9
May 2020	42 *(8)	37	0	1	4
June 2020	30 *(2)	22	2	1	5

2.2 Specified Groups breakdown for Q4 2019/20 (See Appendix 1)

	Deaths in Scope *	Learning Difficulties Death	Severe Mental Illness Death 2	Child Death	Neonatal Death or Stillbirth	Maternal Death	CQC Alert Death	Previous Alerting Group Death 3	Post-Op Death	Random Selection	Concern Death 4	Cardiac Arrest	COVID 19
April 2020	71	3	0	0	0	0	6	0	7	7	10	6	32
May 2020	42	2	0	0	0	0	**7**	0	8	8	6	3	8
June 2020	30	0	0	0	0	0	6	0	12	7	0	3	2

**25% of all deaths or 30n (whichever is greater) are reviewed each month*

6 CONCLUSION AND RECOMMENDATIONS

The Board is asked to note the contents of this report and receive assurance that:

- SJR process is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised.
- Where concerns have been identified these have received further peer review and escalated as appropriate.

Appendix 1

Total Deaths in Scope[1]

Check against NWB downloaded LD List **'Learning Difficulties Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[5]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
Random Sample, include all low risk deaths[4] **'Sample Deaths'**	SJR
Cardiac Arrests that result in death **'Cardiac Arrest Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths; include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.
6. Random sample to ensure monthly we cover at n30 or 25% whichever is the greater
7. Cardiac Arrests that result in death

Appendix 2

Forum/Communication Channel	Chair	Support
Quality Committee	Val Davies	Joanne Newton
Finance & Performance	Jeff Kozer	Laura Hart
Clinical Effectiveness Council	Dr Sam Pedder	Helen Burton
Patient Safety Council	Rajesh Karimbath	Kim Jeffrey
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Elspeth Worthington	Jane Bennett
MCG Integrated Governance & Quality Meetings	Ash Bassi/Sue Talbot-Crosby	Michaela Eason
MCG Directorate Meetings	Ash Bassi/Sue Talbot-Crosby	Michaela Eason
SCG Governance Meetings	Sam Pedder/Wendy Harris	Gina Friar
SCG Directorate Meetings	Phil Nee	Julie Rigby
CSS Directorate Meetings	Patricia Keeley	Sam Barr
ED Teaching	Ragit Varia/Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Cynthia Foster	
Grand Rounds	Cynthia Foster	

Appendix 3

Lessons Learned June 2019 until April 2020	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	Total
Delay in assessment from Doctor	3	3	2	4	2	2	3	4	2	1	3	29
Delay/Failure in referral to SPCT (Specialist Palliative Care Team) / EOL concerns	1	2	4	2	2	1	1	4	2	3	0	22
Suboptimal documentation	2	2	1	1	1	5	1	0	3	0	1	17
Failure to act on or correctly interpret results	1	3	1	1	2	1	2	1	1	0	1	14
Failure to escalate	2	1	1	0	1	1	0	1	1	0	1	9
Suboptimal communication	0	0	1	1	1	1	1	1	1	2	0	9
Issue with death certificate	1	3	0	0	0	0	1	1	1	1	1	9
Delay in requesting or obtaining investigation	0	1	0	0	2	0	0	0	0	0	1	4
Policy procedure guideline pathway concern	0	1	0	1	1	0	0	0	0	0	0	3
Failure of advanced care planning	0	0	2	1	0	0	0	0	0	0	0	3
Delay in fast track discharge	0	0	0	0	0	1	0	0	1	0	0	2
Delay/ failure to procedure	0	0	0	0	0	1	0	0	0	0	1	2
Unsatisfactory Discharge	0	1	0	0	0	0	0	0	0	1	0	2
Equipment/ IT/Environment	0	0	0	1	0	0	1	0	0	0	0	2
Patient care affected by lack of staff/service availability on weekends/ bank holidays/out of core hours	0	0	2	0	0	0	0	0	0	0	0	2
Management plan	1	0	1	0	0	0	0	0	0	0	0	2
Privacy & Dignity	0	0	0	1	0	0	0	0	0	0	0	1
Total	11	17	15	13	12	13	10	12	12	8	9	132