St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28th APRIL 2021
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
09:00	1.	Employee of the Month - April 2021		Verbal	Assurance	Chair
09.15	2.	Apologies for Absence		Verbal	Assurance	
	3.	Declaration of Interests		Verbal	Assurance	
	4.	Minutes of the Board Meeting held on 31st March 2021		Attached	Assurance	
		5.1	Correct Record & Matters Arising	Verbal		
		5.2	Action Log	Attached		
Performance Reports						
09.30	5.	Integrated Performance Report		NHST(21) 016	Assurance	Nik Khashu
		6.1	Quality Indicators			Sue Redfern
		6.2	Operational Indicators			Rob Cooper
		6.3	Financial Indicators			Nik Khashu
		6.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
09.50	6.	Committee Report – Executive		NHST(21) 017	Assurance	Ann Marr OBE
10.00	7.	Committee Report – Quality		NHST(21) 018	Assurance	Gill Brown
10.10	8.	Committee Report – Finance & Performance		NHST(21) 019	Assurance	Jeff Kozer
10.20	9.	Committee Report - Audit		NHST(21) 020	Assurance	Ian Clayton

AGENDA			Paper	Purpose	Presenter
Break					
Other Board Reports					
10.30	10.	Corporate Risk Register 2021/22	NHST(21) 021	Assurance	Nicola Bunce
10.40	11.	Board Assurance Framework Review	NHST(21) 022	Approval	Nicola Bunce
10.50	12.	Learning From Deaths Quarterly Report	NHST(21) 023	Assurance	Rowan Pritchard-Jones
Closing Business					
11.05	13.	Effectiveness of Meeting	Verbal		Chair
	14.	Any Other Business			
	15.	Date of Next Meeting – Wednesday 28th April 2021			

EMPLOYEE OF THE MONTH AWARD

APRIL 2021

Rebecca Whitting
Senior Project Manager, Health Informatics

CITATION

Rebecca Whitting is a valued member of the Trust clinical project team.
Over the last 12 months Rebecca supported several frontline services to implement transformational clinical digital solutions and systems;

- Named "Maternity Star of the Month" in March 2021, having worked closely with midwives and maternity services to implement the Cardiotocography (CTG) monitoring solution, which records changes in foetal heart rate and identifies those babies at risk of lack of oxygen to prevent cases of stillbirth or irreversible brain damage.
- Supported the Maternity Team through several Maternity system upgrades, enabling the Trust to record and report important data for the Clinical Negligence Scheme for Trusts (CNST), which promotes patient safety and good clinical practice.
- Worked with Trust pharmacy and clinical teams to deploy Electronic Prescribing Medicines Administration (ePMA) in radiology, endoscopy, Newton and ICU step down and in outpatient areas in both Whiston and St Helens.
- Supported the Trust clinical coding team to implement a new and improved clinical coding solution which integrates into the Trust's Careflow PAS system, enabling more accurate and efficient coding of Trust activity.

Rebecca builds excellent working relationships to encourage clinical teams to adopt new and improved technical solutions which improve patient safety and care.
Rebecca demonstrates her caring and compassionate nature together with a true determination to deliver real and tangible benefits for the Trust.
Rebecca's invaluable contribution is the strong relationships she has built between the clinical and informatics teams for each of the projects she has worked on. Both EPMA and maternity services have seen smooth upgrades due to her hard work and her careful focus on patient safety. Nothing is ever too much trouble and she is always an absolute pleasure to work with.

by Dr Andrew Hill, Consultant in DMOP & Kathryn Kumeta, Programme Manager

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Public Board meeting held on Wednesday 31st March 2021 in the Boardroom, Whiston Hospital and via Microsoft Teams

BOARD BRIEFING

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 G Brown	(GB)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mr N Khashu	(NK)	Director of Finance
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Prof R Pritchard-Jones	(RPJ)	Medical Director
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services (Minute taker)
In Attendance:	Fazilet Hadi	(FH)	Aspiring Chair Programme (Observer)
	Dr Ragit Varia	(RV)	Clinical Director Acute Medicine (for item 5)
Apologies:	Mrs C Walters	(CW)	Director of Informatics
	Ms S Amesu	(SA)	Insight NED Development Programme Placement

1. Welcome and introductions

1.1. RF welcomed Fazilet Hadi (FH) to the meeting. FH was observing the Board as part of her participation in the aspiring Chair's development programme.

2. Apologies for Absence

2.1. Apologies were noted as above. RF reported that although SA was unable to join the meeting today, she had asked him to pass on her thanks to the Board members for their help and support during her placement with the Trust.

3. Declaration of Interests

There were no new declarations of interest.

4. Employee of the month

4.1. RF reported that there were four 'employee of the month' awards to catch up on:

4.1.1. Employee of the month for December 2020 – Diane Dearden, Macmillan Lead Cancer Nurse
4.1.2. Employee of the month for January 2021 – Paul Stockton, Respiratory Consultant
4.1.3. Employee of the month of February 2021 – Kerri Maguire, AMD Coordinator
4.1.4. Employee of the month for March 2021 – Karen Bailey, Sister Emergency Department

4.2. Due to COVID social distancing restrictions the staff had been filmed receiving their awards and these films would be on the Trust intranet. The Board noted the citations and congratulated all four members of staff.

5. Patient Story

5.1. The patient story illustrated how the implementation of the COVID virtual ward had supported patients. RV gave a short presentation explaining how the virtual ward worked and the type of patients who still needed oxygen but could be discharged home and supported in their ongoing care by the virtual ward team. Patients had training to use the monitoring equipment they needed to take home and there was a daily check-in with the clinical staff, plus an emergency contact number if the readings dipped below an agreed baseline.

5.2. The Trust had cared for 135 patients on the virtual ward, which was estimated to have saved 616 inpatient hospital bed days. None of the patients selected for the virtual ward had needed to be readmitted to hospital and none of the patients had died. There were currently 11 patients on the virtual ward and most of them were being weaned off oxygen. RV felt this approach could effectively be applied to other areas of medicine, for example early supported discharge, and to support personalised care for conditions such as hypertension, cellulitis and heart failure where monitoring could prevent readmissions and work in conjunction with primary care and the specialist community nursing teams.

5.3. SR read the stories of two patients who had benefited from the COVID virtual ward. The first was a gentleman who had been very anxious in hospital and was very grateful to have been able to continue his recovery from COVID at home, where he could be supported by his wife and maintain contact with his grandchildren. The second was a patient with learning disabilities who lacked capacity and had been unable to tolerate treatment in the hospital environment. In this case, the virtual ward team had supported the patient's carers to look after him in his supported living accommodation, and in these more familiar surroundings treatment compliance had improved, and the patient had recovered.

5.4. LK commented that these were both fantastic examples of adapting care to meet the patient needs and freeing up capacity in the hospital. She asked what the challenges had been in setting up the virtual ward. RV explained that because of the COVID situation everything had moved very quickly to set up the virtual ward, and there had been support and advice from other areas of the country that had already established their wards, so Cheshire and Merseyside benefited from the shared learning. Another help had been that a standard approach had been taken across the patch which meant there were no

variances in the different CCG areas. There had also been some challenges with virtual reporting and the technology, but all of these had been overcome.

5.5. RPJ commented that in many areas the Trust had needed to be agile during the pandemic to adapt care to meet the best interests of the patient, and this was a good example. He thanked RV and the team for all their hard work in setting up and running this service so quickly and for its undoubted success.

5.6. VD agreed that this was a great initiative but asked if it made financial sense. RV responded that the bed day savings were beneficial to patient flow, but also clarified that the most senior medical staff had been involved in the MDT case reviews, but the daily monitoring and contact with the patients had been undertaken by the nurse specialists. He accepted that there were different potential models, e.g. using a reporting hub which could reduce costs, which might be suitable for some patient groups.

5.7. RF thanked RV for explaining the service model and asked that the Board's thanks be passed to the patients for agreeing to share their experiences.

6. Minutes of the Board briefing held on 24th February 2021

6.1. Correct Record

6.1.1. The minutes were approved as a correct record once minute 5.13 was amended to read "other parts of the *world* …"

6.2. Action List

RF confirmed he had circulated the slides from the Chairs' meeting, so action 49 was completed.

AM confirmed the Executive had reviewed the strategic implications of the ICS and action 50 was therefore completed.

NK confirmed that a COVID dashboard had been developed and was on the agenda for the Closed Board meeting, so action 51 was completed.

In relation to action 52 it was agreed that RF would discuss the optimal timing to engage with local businesses with PG and the hospital charity team. The action was therefore closed.

7. Integrated Performance Report (IPR) – NHST (21)007

7.1. 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 briefings.

7.2. Quality Indicators

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

7.2.2. There were 0 never events in February, and 3 year to date (YTD).

7.2.3. There had been 1 case of MRSA in February, which the RCA investigation had shown was community acquired, but was attributable to the Trust because of delays in taking blood cultures when the patient was admitted.

7.2.4. There were 5 C.Difficile positive cases reported in February 2021 (4 hospital onset and 1 community onset). YTD there have been 34 cases (26 hospital onset and 13 community onset). SR reported that the backlog of RCAs was now being worked through and 8 of the cases had so far been identified for appeal. At the same time last year there had been 62 reported cases in total, of which 20 were successfully appealed.

7.2.5. The overall registered nurse/midwife safer staffing fill rate (combined day and night) for February 2021 was 87.0%. February had been a very challenging month for nurse staffing due to high levels of sickness, COVID related absence and school holidays. YTD rate was 92.6%. SR explained that there remained some issues with safer staffing reporting, and although the remunerator number problems had now been resolved, some issues remained with unintentional distortion of the denominator. A manual adjustment was currently taking place to overcome this and ensure the reported figures were reliable, and work was on going with the system supplier. Progress continued to be monitored closely by the Executive Committee.

7.2.6. Within community services, there had been 92 reportable incidents in February, for patients seen by the district nursing service.

7.2.7. There were 2 falls resulting in severe harm in January, YTD 27. One of the falls had occurred when a patient had tripped on his pyjama bottoms. A thematic review of the severe harm falls that had happened in 2020/21 was currently being undertaken to ascertain the impact of the COVID protection measures, i.e. the need for donning PPE before entering a patient's room.

7.2.8. VTE reporting remained suspended due to COVID.

7.2.9. Year to date HSMR (April to November) for 2020/21 was 101.9.

7.2.10. The report was noted.

7.3. **Operational Indicators**

7.3.1. RC presented the update on the operational performance.

7.3.2. The 62-day cancer standard was above the target of 85% in January 2021 at 85.1% and YTD 87.1%. GB noted that the 62-day standard was not being achieved for the gynaecological cancer pathway and asked if this had been impacted by COVID. RC explained that this was one of the complex multicentre pathways, where system capacity had been impacted during COVID, and that there had also been issues where patients had chosen to delay their treatment because of the COVID situation.

7.3.3. The 31-day cancer target was achieved in January with 97.9% performance against a target of 96% and YTD 97.4%.

7.3.4. The 2-week cancer rule was not achieved in January, with 92.2% in month performance, against a target of 93%, the YTD performance was 93.3%.

7.3.5. The A&E access time performance for all types mapped for February was 85.6%, YTD 86.9%. The Trust saw average daily attendance levels increase during February to 277, compared to 270 in January. Total attendances in February were 7,783. RC reported that the A&E attendances had continued to rise, and in the last week there had been days when attendances had exceeded 400. RF commented that this was putting a lot of pressure on the staff again, so soon after the COVID demands had started to ease.

7.3.6. There were 2,553 ambulance conveyances in February. The ambulance turnaround time averaged 27 minutes against the standard of 30 minutes.

7.3.7. The UTC saw 3,045 patients in January 2021. 99.9% of patients were seen and treated in 4 hours.

7.3.8. The district nurse caseload was 1247 in January and the community matron caseload was 145.

7.3.9. The average daily number of super stranded patients (length of stay of greater than 21 days) in February 2021 was 86, compared with 125 in February 2020.

7.3.10. The 18-week referral to treatment target (RTT) was not achieved in February 2021 with 70.6% compliance against a target of 92%. There were 1124 over 52-week waiters at the end of February, and the ambition was to reduce this back to zero as quickly as possible. VD asked about the ethical issues of selecting patients for surgery. RC explained that clinical need was used to categorise the patients, which meant that it may take longer to clear the backlog of long waiters. The Board was reviewing the proposed recovery trajectories for 2021/22 in the closed Board meeting.

7.3.11. The COVID pandemic had had a significant impact on RTT and diagnostic performance as all routine operating, outpatient and diagnostic activity had been suspended for periods in each wave of COVID. All patients continued to be clinically triaged to ensure urgent and cancer patients remained a priority for treatment.

7.3.12. The 6-week diagnostic target was not achieved in February, with performance of 70.1% against the target of 99%, but this is an improving position compared to 65.3% in January.

7.3.13. The report was noted.

7.4. **Financial Indicators**

7.4.1. NK presented the update on financial performance.

7.4.2. At the end of Month 11 the Trust had reported a deficit YTD position of £0.2m and deficit outturn position £8.1m. However, since the report had been produced, the Trust had received confirmation that it was being allocated a further £4.4m towards the £5.5m accrued for untaken annual leave during the last year. This meant the year end deficit would reduce to £3.7m.

7.4.3. NK commented that despite all the uncertainty, the Trust expenditure forecast had been very accurate and had not changed throughout the year. RF felt that given the turbulence and the emergency financial regime, that this was a significant achievement.

7.4.4. At the end of month 11 that cash balance was £74.3m, due to advance payments from commissioners and from lead employer clients.

7.4.5. NK confirmed the Trust remained on track to fully spend the whole capital allocation for 2020/21.

7.4.6. The report was noted.

7.5. **Workforce Indicators**

7.5.1. AMS presented the update on workforce performance.

7.5.2. Overall sickness absence for February was 7.7%, which was a 0.7% decrease from January. These figures included COVID sickness but no other forms of COVID absence Nursing, midwifery and HCA sickness during February had been 12.2%. These figures reflected the rates of COVID within the local community.

AMS reported that the government had now confirmed that shielding for clinically extremely vulnerable people would end from 1st April, which would enable a return of significant numbers of staff.

7.5.3. Appraisal compliance in February was 55.5% and mandatory training compliance was 75.7%. Recovery plans were being developed for these. In relation to appraisals, managers were continuing to "check-in" with staff on a regular basis even if there was not capacity to undertake a proper appraisal discussion. AMS reported that most of the mandatory training was now available online, which provided more flexibility for when the training could be undertaken, and staff had taken to it really well.

7.5.4. LK asked if the new annual health and wellbeing conversations will be part of appraisals. AMS responded that she and the HR team had debated this and were proposing that it should be incorporated, but that there would also be other avenues available to staff in case they did not wish to discuss the issues with their immediate manager. Part of the role of the wellbeing guardian would be to promote the health and wellbeing conversations. RPJ commented that there was now a lot of

focus on wellbeing in medical appraisals, recognising the likely aftermath of COVID. VD expressed some concern about combining performance and healing conversations. AMS acknowledged there were pros and cons to either approach but felt that the key was to ensure there were multiple routes for staff to feel empowered to discuss their health and wellbeing.

RF commented that it was not solely an HR task to look after staff and support their recovery. He acknowledged this was a huge challenge for the whole NHS and he admired the work that AMS and her team were doing to put things in place to ensure that staff felt valued.

7.5.5. The report was noted.

8. Committee Report – Executive – NHST (21)008

8.1. AM presented the report and highlighted the key issues considered by the Executive Committee at the four meetings held during February 2021.

8.2. Decisions had been taken by the committee to invest in upper gastrointestinal cancer nurses to support this very complex pathway, so that the nurses could track and be a point of contact throughout the treatment journey. A new gastroenterology consultant post had also been approved in response to the increasing referrals and COVID backlog, which would support diagnostic capacity. Investment in a dedicated community Electronic Patient Record (EPR) would enable the Trust to be more sophisticated in collecting and analysing community patient data and allow a move away from the current dependency on legacy systems managed by other Trusts. Finally, additional educational support for the trainee nurse associates, which supported the workforce strategy and would help grow the future workforce.

8.3. AM also drew the Board's attention to another important issue that had been discussed:

8.3.1. Internal medicine training posts – where changes to the national training programme and standards means reduced service contribution from the doctors in training, and the need for more people to be employed to safely cover the rotas. This is a significant additional cost pressure for the Trust, and the Executive Committee is continuing to explore options for bridging the gap.

8.4. The remainder of the report was taken as read and noted by the Board.

9. Quality Committee Chair's Assurance Report – NHST (21)009

9.1. GB presented the report, which summarised the key issues considered at the Quality Committee meeting in March. This had been the first normal meeting for several months as a result of COVID, so there had been an element of catching up on a few issues and reports.

9.2. GB highlighted that RC had provided a verbal update on the skin cancer follow up issue, and that there would be a full report and update on the action plan at the April meeting.

9.3. Committee had noted that as a result of the unprecedented circumstances in 2020/21, the impact on several quality metrics was now being seen. A deep dive into the SUIs that had occurred in 2020/21 had been requested, to identify themes and test if COVID had contributed to the increase.

9.4. Committee had welcomed the assurance provided by the update from the primary care and community services care group, on the performance and quality monitoring systems and processes that had been put into place. The report had also detailed some of the changes made to community services during the pandemic to support care homes.

9.5. There had been a comprehensive suite of reports from maternity services about staffing and perinatal mortality reviews. It had been noted that the number of red flag staffing incidents had increased, although none had resulted in any harm. Committee had previously requested a review of the maternity quality and performance dashboard, and this report was now expected in April. FH asked if maternity services had investigated the impact of ethnicity on outcomes. SR responded that this was not currently a feature of the perinatal mortality review tool and process.

9.6. The committee had also received the standard Chairs' assurance reports from the reporting councils.

9.7. IC noted the comments relating to the review of the Integrated Performance Report (IPR) and asked if all NEDs would be involved. NK confirmed that all NEDs would be engaged as key stakeholders alongside the other "users" of the IPR, and that this was quite a complex project that would take several months to complete. It was noted that many of the KPIs were contractual and there were national standardised reporting requirements, which also needed to be considered.

9.8. The report was noted.

10. Finance & Performance Committee Chair's Assurance Report – NHST (21)010

10.1. JK presented a summary of the key issues discussed at the Finance & Performance Committee meeting in March.

10.2. The Committee had reviewed the finance and operational performance and noted the increase in ED and acute medicine attendances and admissions.

10.3. The improvement in the forecast outturn position had been noted.

10.4. As the operational planning guidance had not been published at the time of the meeting, the Committee had considered the expenditure plans for 2021/22, and were recommending an opening expenditure budget to the Board. NK commented that the planning priorities and operational planning guidance had subsequently been published on 25th March and a briefing had been prepared for Board members. The Trust had not yet received a funding allocation, but it was expected that a paper setting out the income and expenditure position for 2021/22 would be presented at the April meeting.

10.5. Progress on CIP planning for 2021/22 had continued and a significant number of schemes had been identified.

10.6. The committee had received Chairs' assurance reports from the procurement and capital planning councils.

10.7. The report was noted.

11. Trust Objectives 2021/22 – NHST (21)011

11.1. AM presented the paper, explaining that the situation this year was complicated, as it had been proposed to carry forward a number of initiatives which had been stalled in 2020/21 as a result of the pandemic. The first part of the paper was a review of the achievement of the 2020/21 objectives and identification of those that needed to be rolled forward. The second part of the paper detailed the proposed objectives for 2021/22. The objectives had been extensively reviewed by the Executive to ensure they took forward the aspiration of 'Five Star Patient Care', and as in previous years, would make up the core of the individual objectives for the directors. The NEDs had also been consulted and supported the proposal to carry forward some of the objectives.

11.2. IC stated that he was not familiar with the mechanisms that were used by the Finance and Performance Committee to monitor some of the proposed outcomes measures.

11.3. IC noted that for objective 5.3 it was not clear where the delivery of the Digital Aspirant Programme (DAP) would be monitored. NB clarified this had been omitted in error but was via the Executive Committee as part of the agreed DAP accountability arrangements.

11.4. IC was pleased that additional objectives had been added to the communications section for 2021/22 and recognised why the progress planned for 2020/21 had not been made.

11.5. LK noted that 7-day working was not included in the 2021/22 proposed objectives. RPJ explained that although the national monitoring of the specific measures had now ceased, these had to some extent been overtaken by the new ways of working that had been introduced during the pandemic for acute medicine. The medical management team were considering more nuanced internal metrics that could be used to monitor the impact going forward.

11.6. GB commented that she found it remarkable that anything other than responding to the pandemic had been achieved, and she felt it was important not to feel as though the Trust had failed. It was also imperative to recognise that there were significant challenges ahead to restore services and performance.

11.7. VD agreed but wondered if there still needed to be a specific objective related to future ambition for community services.

11.8. VD felt that the Board should consider reviewing its strategy considering all the structural changes that were happening to the NHS but accepted there were still many unknowns.

11.9. AM confirmed that the first section of the paper was a matter of record. She proposed the Executive review section 2, based on the feedback from the

NEDs to see if any changes were needed. This would be circulated for final approval before the next Board meeting.

11.10. The objectives were therefore approved subject to any minor amendments needed based on the NED comments. **ACTION: AM**

12. Care Quality Commission (CQC) compliance and registration – NHST (21)012

12.1. SR presented the paper which provided assurance that the organisation continued to maintain compliance with the CQC fundamental standards and conditions of registration.

12.2. The estimated annual registration fee of £282k for 2021/22 was reported.

12.3. During 2020/21, the CQC had undertaken a review of the Board infection prevention control assurance framework and reviewed the compliance of the Mass Vaccination Site (MVS) at St Helens Saints Rugby Stadium to confirm that all relevant Key Lines of Enquiry (KLOE) were being met. There had been no issues highlighted as a result of these reviews.

12.4. GB commented that the advances in telehealth were important in achieving the standards about personalised care.

12.5. RF reported that he had received lots of positive comments from people about the MVS. He felt it was important to record how proud the Board was of this achievement and acknowledge the hard work of everyone involved in making it work so efficiently.

12.6. The Board was assured that the Trust continued to meet the fundamental standards.

13. Elimination of mixed sex accommodation annual declaration – NHST (21)013

13.1. SR presented the report which confirmed that no mixed sex breaches had been reported by the Trust during 2020/21. The Trust continued to implement the Same Sex Accommodation Policy to prevent breaches. One concern had been raised during the year in relation to the Coronary Care Unit, but this was allowed under the guidance due to the clinical needs of the patients for specialist care.

13.2. The Board approved the annual declaration, which would be posted on the Trust website.

14. 2020 Staff Survey Report and Action Plan – NHST (21)014

14.1. AMS presented the report detailing the result of the 2020 staff survey which had been undertaken between September and December 2020, whilst the Trust was experiencing the 2nd wave of COVID. The staff survey questions had been adapted this year to reflect the experiences of the pandemic and the responses were grouped into 10 themes. There was a proven link between “happy staff” and “happy patients”, so it was very pleasing that the Trust had scored the highest of all acute Trusts across 4 of the 10 themes, 2nd in a further four and 3rd in the remaining two themes. The Trust had scored the highest of North West Trusts across all 10 themes. AMS noted that the Trust had now

achieved the best scores nationally for 5 years running for the questions relating to the quality of care provided and staff engagement, which was a wonderful reflection of the culture of the organisation.

14.2. The survey had included the opportunity for staff to make free text comments. These were still being analysed nationally and would be shared with individual Trusts soon.

14.3. AMS confirmed that despite the positive results the Trust was not complacent, and although the scores were above the national average, there were areas for further investigation and improvement. A deep dive had been undertaken and areas of the Trust identified where the scores were not as high. This deep dive had informed the initial action plan, which would be taken forward and bespoke plans put in place to respond to any concerns at a care group or service level. These plans would be reported to the Executive Committee and once agreed, monitored via the workforce council, which would provide assurance to the Quality Committee and on to the Board.

14.4. RF commented that when he had attended the Quality Health presentation of the results the previous day, he had been extremely proud and humbled by staff who reported that they still looked forward to coming to work, despite the pandemic and the personal risks they were coping with.

14.5. The NEDs congratulated the Executive on this fantastic set of results which demonstrated the commitment to creating a positive environment for staff.

14.6. LK asked how staff were selected to participate in the survey. AMS confirmed that a cross section of staff were invited to participate who were representative of the total staff population. It was noted that the response rate in 2020 had been slightly lower than usual, but the analysis showed that it did still reflect the staff demographics.

14.7. AM commented that one of the proposed objectives for 2021/22 to have a quality improvement movement, was motivated by the question about the ability of staff to contribute to changes in their department. AM hoped to get everyone feeling fully involved and invested in making care safer. RF felt this would be a wonderful initiative, and GB agreed that it was a very positive thing to do in the wake of the pandemic.

14.8. The Board noted the report

15. St Helens Cares Integrated Care Partnership (ICP) Collaboration Agreement – NHST (21)015

15.1. NB introduced the paper and explained that members were being asked to approve the revised collaboration agreement between the partners involved in St Helens Cares. The changes reflected the development of Primary Care Networks (PCNs) and anticipated the development of ICPs in the new NHS structure if the proposed legislation was passed in 2022.

15.2. IC stated that he was supportive of the agreement but noted that there was still much uncertainty about what the legislation would mean in terms of collective accountability.

15.3. VD felt there should be some consideration of how NEDs would be engaged in the ICP, when CCGs were abolished. She also felt it would be important to clarify the contribution each organisation was expected to make to delivering the ICP strategic ambitions. **ACTION: NB**

15.4. The St Helens Cares collaboration agreement was approved.

16. Effectiveness of Meeting

16.1. RF asked FH for her reflections on the effectiveness of the meeting. FH reflected on the range of issues discussed and felt there were things she could take back to her own Community Trust. She thought that the Board were collegiate and friendly, and showed obvious respect and compassion for the people served by the Trust. She had been impressed by the use of performance data to provide assurance to the Board. Finally, she felt that equality, diversity and inclusion could potentially have been more prominent on the agenda. FH thanked the Board for letting her observe the meeting. RF thanked FH and commented that the feedback was very useful and thought provoking.

17. Any Other Business

17.1. RF commented on the video message and summary of the year, which had been made to commemorate the anniversary of the first national lockdown. He felt it was very poignant and urged all the Board members to watch if they had not already done so. He asked that the Board's thanks be conveyed to the media and communications team.

17.2. NB reminded Board members that the 2021 local elections were taking place in May and that we were now in a pre-election "period of sensitivity", where the NHS needed to avoid involvement in any issues that could be regarded as political.

18. Date of Next Meeting

18.1. The next meeting will be held on Wednesday 28th April 2021 at 09:00 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 28th APRIL 2021

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (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	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **Deferred due to COVID-19**	AM	**TBC**
53	31.03.21 (11.10)	Trust objectives approved subject to any minor amends from NEDs – to be circulated prior to April Board	NB	28.04.21
54	31.03.21 (15.03)	Clarification on the contribution required to deliver strategic ambitions of St Helens Cares ICP, and on required NED engagement	NB	28.04.21

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(21)016
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 March 2021. (YTD = 3).

There were no cases of MRSA in March 2021. (YTD = 2).

There was 1 C.Difficile (CDI) positive case reported in March 2021 (0 hospital onset and 1 community onset). YTD there have been 40 cases (26 hospital onset and 14 community onset). 3 further cases have been successfully appealed (1 hospital onset and 2 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 February 2021 was 87.0%. YTD rate is 92.6%.

Reported incidents across community services have increased from previous month. In total 106 were reported (compared with 92 in January) . 84 of the incidents were skin related . None of the incidents were moderate or above.

During the month of February 2021 there were no falls resulting in severe harm. (YTD severe harm falls = 27)

There were no grade 3 hospital acquired pressure ulcers with lapses in care in January 2021. (YTD = 1). Reducing the number of Trust-acquired pressure ulcers with lapses in care, including category 2, is a priority for this year.

Performance for VTE assessment for February 2020 was 95.70% against a target of 95%. VTE returns for March 2020 to March 2021 have been suspended.

YTD HSMR (April to December) for 2020-21 is 96.6

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 April 2021

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (February 2021) at 81.3%. YTD 86.6%. Performance in January 2021 was 85.1%. The 31 day target was achieved in February 2021 with 98.4% performance in month against a target of 96%, YTD 97.5%. Performance in January 2021 was 97.9%. The 2 week rule target was achieved in February 2021 with 94.6% in month and 93.9% YTD against a target of 93.0%. Performance in January 2021 was 92.2%. The situation with regard to patients not wanting to attend for appointments is continuing to improve and we are seeing further increases in the numbers of referrals and patients receiving treatment.

Accident and Emergency Type 1 performance for March 2021 was 74.3% and YTD 78.0%. The all type mapped STHK Trust footprint performance for March 2021 was 85.4% and YTD 86.8%**.** The Trust saw average daily attendance levels significantly increase in March 21 compared with February 21, with the average daily attendance of 325 up from 277 in February . Total attendances for March 2021 were 10,075, February 2021 were 7783.

Total ambulance turnaround time was achieved in March 2021 with 30 mins on average. There were 2899 ambulances conveyed in March (busiest Trust in C+M/GM) compared with 2553 in February.

The UTC saw 3066 patients in February 2021, which is an increase of 21 patients (0.7%) compared to the previous month. UTC attendances are becoming ever closer to pre-covid activity levels, despite still being in lockdown for the reporting month. Overall 99.9% of patients were seen and treated in 4 hours.

Community nursing referral numbers have shown a further reduction in February from January (527 from previous month rate of 575). This relates to a drop in referrals from GPs (from 141 to 100), although there has been an increase in referrals from acute care (from 168 to 209) which is linked to the gradual increase in hospital activity. Community matron caseloads are continuing at similar levels (146 in February compared with 147 in January).

The average daily number of super stranded patients in March 2021 was 79 compared with 100 in March 2020. This remains below the target of 92 @ end of March 2020. (86 was the average in February 21, 90 in January 2021, 72 in December 2020, 89 in November, 69 in October, 62 in September, 61 in August, 60 in July 2020 and 70 in June 2020). Work is ongoing with all system partners to maintain the current position.

The 18 week referral to treatment target (RTT) was not achieved in February 2021 with 70.6% compliance and YTD 70.6% (Target 92%). Performance in January 2021 was 72.8%. There were (1124) 52+ week waiters. The 6 week diagnostic target was not achieved in March 21 with 72.9% compliance. (Target 99%). Performance in February 2021 was 70.1%.
NB Elective programme closed down in Wave 1 with only urgent and 2ww patients being managed during March, April and May. Due to the impact of Covid in January 2021 and February, only cancer cases, some urgent cases and limited routine cases were undertaken. Additional theatre capacity to facilitate non urgent patients did not come back on stream until mid March, due to ongoing covid pressures. All theatres were fully re-opened from April as shielding staff were able to return.

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.

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 six months from April to September 2020. From October this changed to a system-wide funding envelope with a block payment allocated to the Trust by Cheshire and Merseyside Health Care Partnership. A revised forecast was submitted on 22nd October to NHSI and C&M HCP.

Surplus/Deficit - At the end of month 12 the Trust are expecting to report a deficit position of £2.6m this has improved by £5.4m from the forecast reported at March due to additional funding for the Annual Leave provision from NHSI. The Trusts deficit is being driven by the reduced resources allocated in the second half of the year by the Health & Care Partnership (HCP).
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 will be in the region of £9.4m which is £1.8m above the agency cap and £1.2m above the previous years spend.
The requirement for CIP is currently on hold under the block payment arrangement.
At the end of month 12, the cash balance was £51.4m. 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. The Trust is also receiving lead employer payments in advance of invoices which is increasing the Trust cash position.

Human Resources

In March overall sickness was 5.6% which is a 2.1% decrease from February. Front line Nursing, Midwifery and HCA's was 7.9% which is a decrease of 4.3% since February . Front line Nursing and Midwifery only was 6 % which was an decrease of 4.2% since February. The reductions in these figures demonstrates the impact Covid has had on levels of sickness in the Trust and reflect the reduced levels of Covid nationally and locally since February. These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension or staff on special leave e.g. due to childcare. Appraisal compliance is below target by 33.7%. Mandatory training compliance remains below the target by 9.3%. Compliance for both continues to be impacted as a consequence of the second spike in COVID 19 including high sickness, isolation, special leave absences and other service demands.

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

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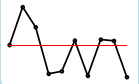
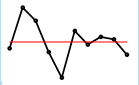
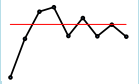
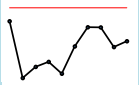
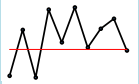
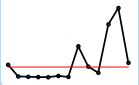
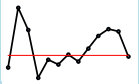
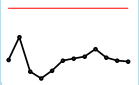
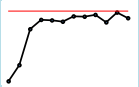
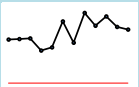
St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Mar-21	2.3%	3.1%	No Target	2.4%		Spike in three waves of covid are reflected in the variation. HSMR continues to be challenging in the pandemic due to disease groups needing three years worth of data.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits despite the second and third waves of COVID. Independent consideration of our COVID mortality is currently showing it to be in line with expected rates. By way of context, HSMR for NW England is 107.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Nov-20	1.09		1.00						
Mortality: HSMR (HED)	Q	▲	Dec-20	82.9	96.6	100.0	101.6					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Dec-20	84.3	101.4	100.0	101.2					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Nov-20	95.3	99.4	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 and has now returned to well within expected limits.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Dec-20	92.9	90.8	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	Dec-20	99.6	106.4	100.0	100.3					
% Medical Outliers	F&P	T	Mar-21	1.4%	1.6%	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	Mar-21	51.6%	58.8%	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	▲	Feb-21	74.9%	75.2%	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. The most challenged area in the Trust has a new SOP in place to track all patients to get discharges completed. The most challenged area in SDECC is the subject of a deep dive to review current process. This has oversight of clinicians from MCG and ED.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Feb-21	91.0%	89.4%	95.0%	84.9%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Feb-21	96.8%	96.8%	95.0%	94.9%					

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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	▲	Q3	85.9%	88.9%	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 of required 80% of patients have spent 90% of their stay in the stroke unit	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲£	Mar-21	0	3	0	1		No never events reported in March 2021	Quality and patient safety	Investigation into previously reported incidents completed and actions in place to mitigate chances of recurrence. Local actions and monitoring procedures in place.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20			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	Mar-21	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	▲£	Mar-21	0	2	0	1		There was no cases of MRSA in March 2021. YTD = 2.	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	▲£	Mar-21	1	40	48	42		There was 1 positive C Diff sample in March 2021. YTD there have been 43 cases, with 3 cases successfully appealed, leaving 40 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Mar-21	2	29	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	▲	Jan-21	0	1	No Contract target	1			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	▲	Feb-21	0	27	No Contract target	13		No falls resulting in severe harm in February 2021 .	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			95.0%	95.54%		**March 20 to March 21 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. Despite second wave, we have understood the risk in patients and minimised events. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Feb-21	12	69	No Target	26					
To achieve and maintain CQC registration	Q		Mar-21	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-21	87.0%	92.6%	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	Feb-21	9	43	No Target	8					

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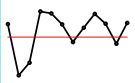
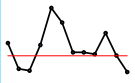
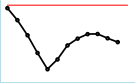
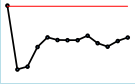
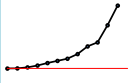
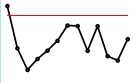
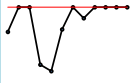
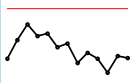
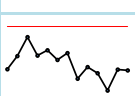
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

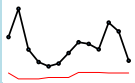
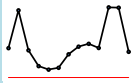
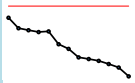
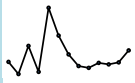
	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Feb-21	94.6%	93.9%	93.0%	91.0%		An increase in complex cases requiring multiple diagnostics resulted in process and capacity issues. There was also an increase in patient cancellations and a delay in CCC pharmacy which is now resolved.	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 continues to utilise Imaging capacity via temp CT facility at St Helens Hospital 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	▲ £	Feb-21	98.4%	97.5%	96.0%	97.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Feb-21	81.3%	86.6%	85.0%	86.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-21	70.6%	70.6%	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	▲	Mar-21	72.9%	67.6%	99.0%	99.7%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-21	1,124	1,124	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Mar-21	0.5%	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	▲ £	Feb-21	100.0%	96.2%	100.0%	98.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Mar-21	74.3%	78.0%	95.0%	69.8%		Accident and Emergency Type 1 performance for March 2021 was 74.3% and YTD 78.0%. The all type mapped STHK Trust footprint performance for March 2021 was 85.4% and YTD 86.8%. The Trust saw average daily attendance levels significantly increase in March 21 compared with February 21, with the average daily attendance of 325 up from 277 in February . Total attendances for March 2021 were 10,075, February 2021 were 7783. Total ambulance turnaround time was achieved in March 2021 with 30 mins on average. There were 2899 ambulances conveyed in March (busiest Trust in C+M/GM) compared with 2553 in February.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital 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	▲	Mar-21	85.4%	86.8%	95.0%	83.9%					
A&E: 12 hour trolley waits	F&P	▲	Mar-21	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	2		**March 20 to March 21 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	Mar-21	28	242	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 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%. The impact of the second/third waves of the pandemic in being able to meet the 90% target was evident in December/January, with performance improving in February and March.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Mar-21	12	207	No Target	310					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Mar-21	100.0%	93.7%	No Target	92.9%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target	21		**March 20 to March 21 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	Mar-21	280	258		333					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Mar-21	79	72		126					
Friends and Family Test: % recommended - A&E	Q	▲	Mar-21	84.7%	88.4%	90.0%	86.5%		FFT submissions recommenced from January 2021, with recommendation rates above target for inpatients and maternity delivery suite and postnatal community year-to-date. ED, antenatal, postnatal and outpatients are slightly below target.	Patient experience & reputation	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 . 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	▲	Mar-21	95.8%	95.8%	90.0%	95.6%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Mar-21	100.0%	90.6%	98.1%	98.8%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-21	97.8%	99.0%	98.1%	97.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Mar-21	95.8%	94.6%	95.1%	96.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Mar-21	100.0%	100.0%	98.6%	99.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-21	94.0%	94.2%	95.0%	94.6%					

Mar-21

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	▲	Mar-21	5.6%	6.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.3%		In March overall sickness was 5.6 % which is a 2.1% decrease from February . Front line Nursing, Midwifery and HCA's was 7.9% which was a decrease of 4.3% from February. 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.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team have been reviewing COVID daily and as the numbers decline the focus of the team is now on non COVID absences in particular long terms absence and getting people back in to work working closely with HWWB. Additional health and well being support is provided to help staff with stress, anxiety and depression caused by the impact of COVID19.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Mar-21	7.9%	8.6%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Mar-21	51.3%	51.3%	85.0%	79.4%		Appraisal compliance in March is below target by 33.7%. Mandatory training compliance remains unchanged and is below the target by 9.3%. Both continue to be impacted as a consequence of the second spike in COVID 19 including high sickness, isolation, special leave absences and other service demands.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance continues to be impacted by COVID 19 with both decreasing in month and remaining below target. The requirement to complete Appraisals and Mandatory training was resumed in July with flexible electronic options available for both to support remote completion and to enable improved compliance. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area and is monitored monthly through Quality Committee.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Mar-21	75.7%	75.7%	85.0%	84.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			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 closed on the 30th November, with results published in March.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Mar-21	1.2%	12.9%	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							Finance indicators within the IPR are greyed out subject to final accounts being completed.	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										
Reported surplus/(deficit) to plan (000's)	F&P UOR	T										
Cash balances - Number of days to cover operating expenses	F&P	T										
Capital spend £ YTD (000's)	F&P	T										
Financial forecast outturn & performance against plan	F&P	T										
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T										

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	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	▲£	100.0%	94.6%	100.0%	86.7%	76.5%	100.0%	100.0%	45.5%	77.8%	100.0%	100.0%	96.3%	100.0%	90.7%	85.0%		92.7%		RC
	Total > 62 days		0.0	1.0	0.0	1.0	2.0	0.0	0.0	3.0	3.0	0.0	0.0	0.5	0.0	9.5			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Lower GI	% Within 62 days	▲£	100.0%	82.6%	76.0%	85.7%	76.5%	100.0%	75.0%	83.3%	90.0%	80.0%	89.5%	78.9%	58.6%	78.8%	85.0%		83.2%		
	Total > 62 days		0.0	2.0	3.0	1.0	2.0	0.0	1.0	1.0	1.0	2.0	1.0	2.0	6.0	20.0			13.0		
	Total > 104 days		0.0	1.0	1.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	5.0			2.0		
Upper GI	% Within 62 days	▲£	100.0%	80.0%	60.0%	80.0%	60.0%	100.0%	100.0%	100.0%	66.7%	100.0%	83.3%	100.0%	100.0%	85.6%	85.0%		90.5%		
	Total > 62 days		0.0	1.0	2.0	0.5	2.0	0.0	0.0	0.0	1.5	0.0	1.0	0.0	0.0	7.0			6.5		
	Total > 104 days		0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	2.5			1.0		
Urological	% Within 62 days	▲£	69.2%	79.3%	74.2%	66.7%	100.0%	100.0%	90.0%	95.7%	87.0%	77.1%	86.7%	80.0%	92.3%	85.3%	85.0%		85.5%		
	Total > 62 days		6.0	3.0	4.0	2.0	0.0	0.0	1.0	0.5	1.5	4.0	2.0	2.5	1.0	18.5			25.0		
	Total > 104 days		1.0	0.0	1.0	2.0	0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	5.5			5.5		
Head & Neck	% Within 62 days	▲£	25.0%	20.0%	100.0%	0.0%	100.0%	100.0%	66.7%	0.0%	20.0%	100.0%	0.0%	33.3%	57.1%	50.0%	85.0%		29.3%		
	Total > 62 days		1.5	2.0	0.0	0.0	0.0	0.0	0.5	1.5	2.0	0.0	1.0	1.0	1.5	7.5			20.5		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			4.0		
Sarcoma	% Within 62 days	▲£				100.0%				100.0%	100.0%	0.0%		100.0%	100.0%	80.0%	85.0%		66.7%		
	Total > 62 days					0.0				0.0	0.0	1.0		0.0	0.0	1.0			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	▲£	66.7%	100.0%	100.0%	40.0%	100.0%	100.0%	100.0%	66.7%	69.2%	69.2%	0.0%	55.0%	60.0%	65.9%	85.0%		69.1%		
	Total > 62 days		2.0	0.0	0.0	3.0	0.0	0.0	0.0	1.0	2.0	2.0	1.0	4.5	1.0	14.5			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	2.0			1.5		
Lung	% Within 62 days	▲£	71.4%	75.0%	69.2%	86.1%	100.0%	88.9%	60.0%	100.0%	100.0%	81.8%	71.4%	100.0%	75.0%	84.6%	85.0%		85.0%		
	Total > 62 days		1.0	1.0	2.0	5.0	0.0	1.0	2.0	0.0	0.0	1.0	2.0	0.0	1.0	14.0			10.5		
	Total > 104 days		0.0	0.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0			2.5		
Haematological	% Within 62 days	▲£	100.0%	100.0%	50.0%	66.7%	100.0%	66.7%	80.0%	100.0%	100.0%		100.0%	50.0%		78.3%	85.0%		86.7%		
	Total > 62 days		0.0	0.0	1.0	0.5	0.0	1.0	1.0	0.0	0.0		0.0	3.0		6.5			7.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0		0.0	0.0		1.0			1.0		
Skin	% Within 62 days	▲£	93.9%	95.2%	91.2%	100.0%	92.5%	97.4%	100.0%	89.5%	92.2%	93.8%	100.0%	96.8%	85.5%	93.9%	85.0%		92.0%		
	Total > 62 days		1.5	1.5	2.5	0.0	1.5	1.0	0.0	4.0	3.0	2.0	0.0	1.0	4.0	19.0			26.5		
	Total > 104 days		1.5	1.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	2.5			9.5		
Unknown	% Within 62 days	▲£						100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	94.7%	85.0%		69.2%		
	Total > 62 days							0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5			2.0		
	Total > 104 days							0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.5		
All Tumour Sites	% Within 62 days	▲£	83.4%	88.0%	82.0%	81.6%	87.5%	96.0%	92.7%	85.8%	85.8%	85.4%	90.2%	85.1%	81.3%	86.6%	85.0%		86.2%		
	Total > 62 days		12.0	11.5	14.5	13.0	7.5	3.0	5.5	11.0	14.0	12.5	8.0	14.5	14.5	118.0			141.0		
	Total > 104 days		2.5	3.5	2.0	2.0	3.5	0.0	4.0	0.5	1.5	2.0	0.0	1.0	3.0	19.5			27.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£							100.0%		100.0%		100.0%	100.0%		100.0%	85.0%		80.0%		
	Total > 31 days								0.0		0.0		0.0	0.0		0.0			0.0		
	Total > 104 days								0.0		0.0		0.0	0.0		0.0			0.0		
Acute Leukaemia	% Within 31 days	▲£															85.0%		100.0%		
	Total > 31 days																		0.0		
	Total > 104 days																		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 (21)017
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 March 2021. There were four Executive Committee meetings held during this period. The Executive Committee approved: • Transfer Lounge Revenue Costs • Internal Medicine Training Scheme Business Case At every meeting the Executive Committee received updates from Gold Command on the COVID-19 pandemic and its impact on the Trust. The Committee also considered regular assurance reports covering; Risk Management Council and Corporate Risk Register, safer staffing and the integrated performance report.
Trust objectives met or risks addressed: All 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 April 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in March 2021.

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 the COVID-19 pandemic or restoration and recovery, COVID-19 specific expenditure requests and issues escalated from the operational gold command meetings.

2. 4th March 2021

2.1 Tele-clinic Audit

The Medical Director introduced a presentation on the work that had been undertaken by the Skin Cancer service to review the effectiveness of tele-clinics. The review had considered the efficacy, productivity and the experience for patients of attending a tele-clinic, rather than a face to face appointment, before surgery. The patients who had responded to the survey had overwhelmingly been satisfied with the experience and had stated they would be happy to have future appointments in this way. The review had also surveyed the clinicians about their experiences of tele-clinics and the majority had felt that the option of tele-clinics should remain after COVID, for selected patients. Less than 5% of tele-clinic consultations had needed a follow up face to face appointment and the patient DNA rates had reduced significantly. The Executive Committee discussed the findings of the review and the next steps in supporting the development of tele and other virtual clinics, recognising the need to maintain training and learning opportunities for clinicians and ensuring standard processes were adopted to safeguard and track patients.

2.2 Emergency Department (ED) – Reconfiguration Potential

The Director of Operations and Performance and Director of Corporate Services provided an update on the work that had been commissioned to explore if structural changes to the ED could improve patient flows and efficiency. A number of options had been identified via the feasibility study, which could be explored further as part of the long-term site development plans. However, at this stage the Executive agreed that the priority was to complete the Paediatric ED and Children's Observation Ward (CHOBS) scheme planned for 2021/22, complete the Urgent and Emergency Care schemes that had been supported during the pandemic and focus on developments that would support the Trust restoration and recovery plans, e.g. additional theatre capacity for which a feasibility study was being undertaken.

2.3 Acute Kidney Injury (AKI)

The Medical Director provided an update on the work to reduce the rate of hospital acquired AKI. The pandemic had impacted on the progress of some of the work streams

as capacity had been directed to the emergency response. However, following approval of the business case in March 2020 the Trust had now appointed a Consultant Nephrologist and additional Renal Specialist Nurses, who had established renal hot clinics and an inpatient renal referrals review system. A Hydration Steering Group had also been established which had reviewed current clinical guidance and risk assessments for AKI. Fluid balance recording was also moving to Care Vitals, so records would be electronic and linked to the patient record. Educational materials are also in development for use internally and with care homes to help prevent community acquired AKI. Research was showing that infection with COVID-19 increased the risk of AKI, so it was likely the Trust would see an increased incidence in the short term. It was agreed that there should now be a renewed focus on AKI and reduction should remain a Trust objective in 2021/22.

2.4 Haemato-oncology

The Director of Operations and Performance provided an update on the discussions with Southport and Ormskirk Hospitals, Liverpool University Hospitals and the Clatterbridge Cancer Centre about the development of the haemato-oncology care pathway.

2.5 Census 2021

The Director of Corporate Services briefed the committee on the arrangements for the Trust to comply with the legal obligation to complete the census for “residents” and “visitors” at the Trust overnight on 21st March 2021.

2.6 COVID-19 Issues

COVID expenditure requests were approved to extend the Patient Information Project Manager post for a further 12 months (recognising the postholder had been re-deployed during the pandemic) and to purchase additional life support training equipment to support the training compliance recovery programme.

The COVID community infection rates had continued to fall and were reported as 103 per 100,000 population in Cheshire and Merseyside, falling from 140 per 100,000 population the previous week. Hospital admission and bed occupancy rates were also steadily reducing.

There had been no definitive or probable nosocomial infections in the previous week and the overall nosocomial infection rate since September 2020 was now 9.2%. 10 of the outbreaks would be closed in the following 7 days (i.e. no new positive cases in 28 days).

The CQC had undertaken an assurance assessment of the Mass Vaccination Centre, and no concerns had been identified.

3. 11th March 2021

3.1 Advancing Quality Alliance (AQuA) Membership

The Director of Finance and Information had undertaken a review and established that the Trust had not been fully utilising the benefits of AQuA membership. It was proposed that going forward the membership resource be aligned to the Service Improvement Team to optimise value for money and a further review be undertaken in 12 months.

3.2 Trust Board Agendas

The Director of Corporate Services presented the draft Board agenda for review. It was agreed that in light of the reducing operational pressures the Board meetings should return to a normal, albeit virtual format.

3.3 Risk Management Council (RMC) Chair's Assurance Report

The Director of Corporate Services presented the Chair's assurance report from the RMC covering the risks reported in February 2021. A total of 636 risks were reported on the Trust risk register, of which 21 had been escalated to the CRR. Updates from the Claims Governance Group and the Information Governance Steering Group were also reported.

The RMC had undertaken its annual effectiveness review and presented the updated terms of reference and annual work plan for approval.

3.4 COVID-19 Issues

The Director of Nursing, Midwifery and Governance reported that the cumulative Nosocomial Infection Rate (NCI) was now 9.1% and there had been no new infections since 25th February.

National guidance had been received to re-introduce patients being accompanied for maternity services appointments and during labour, which was to be implemented by 12th April. Committee discussed options to relax the wider visiting restrictions so that patients, particularly those with a longer length of stay, could have some visits. It was agreed that the Director of Nursing, Midwifery and Governance should develop some proposals to allow these opportunities whilst adhering to infection prevention guidance and minimising risk of COVID transmission.

The Director of Finance and Information presented the latest expenditure reports for the vaccination programme, where costs that had been submitted to NHSE/I for recharge.

3.5 St Helens People's Board

The Director of Corporate Services reported back from the St Helens People's Board meeting. It was noted the Sue Forster the Director of Public Health for St Helens was retiring and had thanked the Trust for its work and support for the public health team during the pandemic.

4. 18th March 2021

4.1 Surgical Robot

The Director of Operations and Performance provided an update on the exploratory talks that were taking place with surgical robot manufacturers, the funding options that were available and the expectation that a business case would be finalised for consideration by the committee in the next few months.

4.2 Trust Objectives 2021/22

The Director of Corporate Services presented the proposals for the Trust objectives for the coming financial year, recognising that a number of objectives from 2020/21 had been postponed or delayed due to the COVID-19 pandemic and would need to be carried forward into 2021/22. The Executive reviewed the progress made against the 2020/21 objectives, agreed which should be carried forward and discussed the new objectives that were needed for 2021/22 to further the development of "Five Star Patient Care". The review of 2020/21 and the proposed objectives for 2021/22 would be presented to the Trust Board meeting on 31st March.

4.3 Integrated Performance Report (IPR)

The Director of Operations and Performance presented the IPR for the performance information reported in February 2021 and agreed the narrative commentary to be included before the final report was issued.

4.4 COVID Issues

The latest nosocomial infection (NCI) data showed that there had been no new NCIs since 25th February. The overall NCI rate remained at 9.1% (from 1st September 2020). Three outbreaks had closed in the previous week and the remaining outbreaks would all close in the coming 10 days (if there were no further new cases reported).

A COVID expenditure request to extend the funding of temporary additional resource in the Hospital Discharge Team was approved, as the national guidance in relation to the hospital discharge process during the pandemic remained in place.

Infection rates in Cheshire and Merseyside were reported as being 57 cases per 100,000 of population which was a further significant reduction.

The Deputy CEO/Director of HR reported that shielding was due to end on 31st March and staff who had been instructed to stay at home could return to work on site (if their role required it) from 1st April. Some of these staff would have been away from the Trust for many months, and it was important that their COVID risk assessments were revisited and they were supported with any anxieties about returning to the workplace.

It was reported that some groups of staff had requested to remain in scrubs/uniform going forward and Gold Command had asked for a review of the Trust uniform policy and assessment of costs. However, a national consultation on standard NHS uniforms was also being launched by the Chief Nursing Officer.

5. 25th March 2021

5.1 Transfer Lounge Revenue Costs

The Director of Operations and Performance introduced a paper which set out the staffing and facilities management costs for operating the new transfer lounge when the building scheme was completed in April, which would increase capacity from 8 to 20 spaces. These costs were approved, and committee discussed the plans to optimise the use of the additional spaces and how this performance would be monitored and reported.

5.2 Staff Survey Results

The Deputy CEO/Director of HR presented the results of the 2020 national staff survey. This was once again a very positive set of results that would be presented to the Trust Board at the March meeting. A deep dive analysis had been undertaken of the results to identify hot spots for each theme, which were being used to develop the Care Group/Service action plans, which would be monitored via the regular team to team meetings.

5.3 Service Developments

The Director of Finance and Information presented a paper detailing the known service development proposals currently being planned within the Care Groups and Services. Directors agreed to work with service leads to review the case for change of any future business cases and the priority needs, as this current list would exceed expected resources. It was also important to support managers to understand the implications of the block contract financial regime, which meant that additional activity would not automatically result in additional income through tariff.

5.4 Internal Medicine Trainees (IMT3) Business Case

The Director of Operations and Performance introduced the case which addressed the queries and concerns raised when the issue was previously discussed in February. The IMT programme was due to commence in August 2021 and the Trust needed to meet the educational standards to retain the training programme. Committee considered again the distribution of trainees across the Trusts in Cheshire and Merseyside, but it was acknowledged that this was unlikely to be addressed in the short term. Comparisons to other Trusts were also reviewed, which had built up additional capacity to meet the IMT requirements over a number of years. It was accepted that the Trust had reached a tipping point but that the increased capacity and cover needed could be achieved with a range of solutions, including physician associates and consultant nurses. This would enhance ward cover on both days and nights, whilst also meeting the IMT programme criteria for the trainees. The total cost of additional staffing to achieve compliant rotas was £1.5m of which £1.0m had been planned for in budget setting, and the remaining £0.5m was a cost pressure. The business case was approved on the understanding that explicit benefits for patient safety, outcomes and quality of care would need to be delivered and reported on a regular basis.

5.5 Safer Staffing Report

The Director of Nursing, Midwifery and Governance introduced the paper which reported the safer staffing figures for February and reported on the progress of the project to improve the accuracy of reporting. With the manual adjustment process in place, the Registered Nurse (RN) fill rate for February was 85.57% and the Health Care Assistant (HCA) fill rate was 101.41%. This was a slightly improved position compared to January but reflected the ongoing staffing challenges and high absence rates as a result of COVID-19.

The Nursing, Finance and HR teams continued to work closely together, and with the Allocate system provider, to understand why the figures had previously been distorted and how the system needed to be reconfigured to overcome this issue. In the meantime there was a high level of confidence in the additional manual processes that had been put in place. A programme of retraining staff in the use of the system was also underway, as well as the development of guidance and regular audit tools for data quality checking in the future.

The Executive was assured by the work that had been undertaken to date and was planned to be completed by the end of April.

5.6 Halton CCG – Community Midwifery Service Review

The Director of Nursing, Midwifery and Governance reported that Halton CCG had engaged with the Trust about the future provision of community midwifery services for Halton, having given formal notice to the current service provider. The Trust was working with the CCG and the other maternity services providers locally, to explore how the service could be delivered differently to better meet the needs of women in Halton and comply with the better births standards.

5.6 COVID Issues

The nosocomial infection (NCI) rate from 1st September 2020 was now 9%, and there had been no new NCI cases reported. Seven outbreaks had been closed in the previous week and the final three outbreaks would close in the next few days (assuming there were no new reported cases).

A COVID temporary expenditure request to support the lateral flow testing of patients and partners attending maternity scans and appointments was approved.

The Director of Finance and Information presented a maternity dashboard for review and comment before being shared with Non-Executive Directors, as an action from the February Trust Board meeting.

5.7 Car Parking

The Director of Corporate Services reported that a letter had been received from Julian Kelly, Chief Financial Officer of NHSE/I on 23rd March, stating that free staff car parking would be extended for the duration of the pandemic (until at least 30th September) and

that the government proposals for free hospital car parking for specific groups of patients and visitors was to be implemented during April 2021. The Estates and Facilities Management Team were developing plans for how these concessions could be implemented and monitored and would bring proposals to the committee for consideration as soon as possible.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)018

Report: Quality Committee Chair's Assurance Report – April 2021

Date of Committee Meeting: 20th April 2021

Reporting to: Trust Board

1. Matters Discussed:

1.1 Nicola Gilman, Non- Executive Director from Buckinghamshire Healthcare Trust and Aspirant Chair programme participant who was observing the meeting was welcomed by the Chair.

1.2 Actions: Patient Safety Council

Committee approved the updated terms of reference for the patient safety council.

1.3 Quality Performance - Integrated Performance Report

Review of the quality and workforce performance indicators. Committee discussed falls, the increased rate of C-section births, ED attendance levels and e-discharge letter performance. It was noted that the IPR reflected the impact of COVID across a range of performance indicators and that recovery plans needed to be much broader than activity alone. Deep dives into serious incidents and maternity services KPI would be reported to committee in May.

1.4 Patient Safety Council (PSC) Assurance Report

The PSC chair responded to queries relating to the most recent tissue viability and falls reports, and noted the increase in VTE was as a result of COVID (a recognised complication of the disease) and investigations had shown the correct supportive management had been in place, although through learning about how best to treat COVID prescribing protocols had recently been changed. In relation to mislabelled lab requests committee was assured that an action plan was in place to reduce incidents.

1.5 Patient Pathway Project – update report

An update report was presented on the work being undertaken to review the skin cancer pathways to ensure that patient follow up protocols and systems are robust. This included the implementation of automated cancer flags and enhanced patient tracking. Following the patient incident that had prompted the initial investigation, 6 incidents have been reported to StIES and are currently being investigated. In response to this, a retrospective audit of skin cancer patients has commenced, in order to provide further assurance and highlight any areas for improvement. The committee was assured by the actions that had been taken in relation to the very small number of patient where a delay in the pathway had been detected. Substantial investment had been agreed by the Executive to complete the required work and ensure that, where appropriate, improvements are applied across all tumor groups.

1.6 Safeguarding Activity – Quarter 4
The quarter 4 report for 2020/21 highlighted the increase in safeguarding activity and complexity during the pandemic. The increase in DOLs referrals was noted and the efforts to maintain compliance with safeguarding mandatory training. CCG assurance that Trust staff had a good understanding of safeguarding as evidenced by the increase in referrals, and recent audits of activity at the St Helens Urgent Treatment Centre and Community Nursing, was noted. The report also detailed the post COVID training recovery plan. The delay in implementing of Liberty Protection Safeguards until April 2022 was noted. The safeguarding team were congratulated and thanked for all their work to keep patients safe during the pandemic.

1.7 Infection Prevention Report Quarter 2 – 4
The report detailed the infections detected and manged during this period and brought IPC reporting up to date. The report included details of coronavirus nosocomial infection rates and the Root Cause Analysis (RCA) findings for the 2 cases of MRSA (1 community acquired but attributable to the Trust due to delays in taking blood cultures) detected during the period. There was also an update on the actions being taken to "catch up" on outstanding RCA panels.

1.8 Patient Experience Council (PEC) Chair's Assurance Report
The PEC had received reports on complaints response compliance, and from the end of life and nutritional steering groups. There had also been a detailed patient experience report from the Medical Care Group. Progress reports had also been received against a number of action plans that are currently being implemented.

1.9 Complaints, Concerns, Claims and Friends and Family Test (FFT) Report – Quarter 4
The number of complaints received in Q4 (71) was increased compared to Q3, but still lower than Q4 in 2019/20. There were 7 new claims received in Q4 and 1252 PALs contacts. FFT recommendation rates remained consistently high for inpatients, but had decreased slightly for ED and maternity services which were linked to the COVID visiting restrictions and increased waiting times. It was noted that the increased PALs activity had not converted into an increase in formal complaints, and committee congratulated the PALs teams for resolving so many of the patient concerns in an informal way.

Committee also received and noted the 2020/21 Complaints and PALs Annual Report.

1.10 Clinical Effectiveness Council (CEC) Chair's Assurance Report
CEC had received speciality reports relating from Radiology and Resuscitation Services; including the ILS/BLS mandatory training recovery programme. Committee discussed the review that was being undertaken on DNACPR and the lessons learnt during the pandemic.

1.11 Workforce Council Chair's Assurance Report – January and March 2021
Committee discussed the process for COVID recovery and the need for prioritisation and some pragmatism. There was also an update on the staff COVID vaccination programme and it was reported that over 90% of staff have now taken up the offer of the vaccine and 69% had now received both doses.

1.12 Guardian of Safe Working Practices Report – Quarter 3
The report detailed the concerns that had been raised about working hours by Doctors in training and the actions that had been taken to resolve any issues. No fines had

been issued by the Guardian of Safe Working Practices during the period, providing assurance that all issues had been resolved.

1.13 Safer Staffing
The report detailed the safer staffing figures for March; RN fill rate of 88.87% and HCA fill rate of 104.91% which were both improvements compared to February and reflected the reduction in sickness and absence rates and the increased availability of nursing staff. The report also included an in depth analysis of staffing in February.

Matters for escalation:

Committee was assured by the actions being taken to address the patient pathway and follow up monitoring risk and also by the action across many services and department to support the recovery of mandatory training performance.

Recommendation(s): To note the report

Presenting Director: Gill Brown, Non-Executive Director and Chair of the Quality Committee

Date of Meeting: 28th April 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21) 019

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 22nd April 2021

Summary:

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
P Growney – NED
AM Stretch – Deputy Chief Exec & Director of HR
N Khashu – Director of Finance & Information
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
A Bassi – Divisional Medical Director
G Lawrence – Deputy Director of Finance & Information

Agenda Items

For Assurance

A) Integrated Performance Report

- 2-week cancer performance was achieved for February with 94.6% of patients achieving the standard.
- The committee was again pleased with the performance around cancer but asked for future deep dives to be done in non-achieving specialities.
- Ambulance turnover time was achieved in March.
- The Trust continues to see increases in NEL activity with a 14% increase in ambulance attendances in March compared to February.
- Sickness continues to improve within the Trust with a 2.1% reduction from February at Trust level and a 4.2% reduction in front line Nursing sickness.
- The committee discussed appraisal compliance and this is now being supported across the Trust as we look to improve this position in the first half of the coming financial year.

B) Finance Report Month 12

- The Trust is reporting a draft deficit of £2.6m for the 2020/21 financial year. This is a £5.5m improvement from M11 as a result of the full annual leave accrual being paid.
- The final financial position is in line with the mitigated options presented to the committee in M7.
- The Trust has spent its full capital allocation of £37.5m.
- The Trust finished the year with a closing cash balance of £51.4m.
- A full set of accounts will be presented to the Audit Committee for approval to Trust Board.
- The committee thanked the Executives for having always having a clear and understandable position. Having no surprises in such a turbulent year was to be commended.

For Approval

A. Draft H1 (April to September) financial and operational plans.
   - The committee discussed the proposed financial and operational guidance that has been issued for the first half of the financial year.
   - The committee reviewed the offer the Trust has received from the Health & Care Partnership (HCP) and the elements that had been excluded.
   - A proposed deficit of between 4.2 – 4.8m was discussed depending on the HCP asking for national cost improvement to be included or excluded.
   - The committee agreed with the current proposal for the draft plan with a further detailed plan to be presented at the May 2021 committee.

For Information

Risks noted/Items to be raised at Board

N/A

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: 22nd April 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)020

Committee Report – Audit

Purpose: To feed back to members matters arising from the Audit Committee – 15 April 2021.

Summary

1. For Assurance

External Audit

- **Audit Progress Report and Sector Update –** Grant Thornton UK LLP (GT) presented a report focussing on changes to the 2020/21 regime, including greater scrutiny of accounting estimates, and changes to audit procedures and reports.

Internal Audit

- **Progress Report** – MIAA provided detail on the delivery of the 2020-21 internal audit plan including four finalised reports [1 *moderate*, 1 *substantial*, and 2 *high assurance*].
- **Head of Internal Audit Opinion 2020/21** – the overall opinion provides substantial assurance. This will be incorporated into the Trust's Annual Governance Statement (AGS) within its Annual Report, which will outline how the Trust achieved high governance standards during COVID.

Anti-fraud

- **Anti-fraud Services Annual Report 20/21** – the Report was discussed and accepted.

Standing Items

- **Audit Log** – the Trust's internal summary of progress in implementing MIAA recommendations was discussed and accepted.
- **Aged Debt –** the Trust's 'over 90 day' debt total has fallen from £11.1m (M9) to £5.6m (M12), whilst improved turnover of the individually largest invoices was noted.
- **Tender and Quotation Waivers –** the Head of Procurement's assurance paper was noted.

2. For Information

Standing Items

- **Losses and Special Payments –** report was discussed and accepted.
- **Year-end update –** a verbal update covering changes to the *going concern* regime and progress against the extended timetable was received.

3. For Decision

- **Draft Internal Audit Plan 2021/22** – the Committee approved the Plan, whilst acknowledging the importance of flexibility, to be able to address emerging new-year risks. In the future, the Committee intends to consider the audit of systems which involve new ways of working.
- **Anti-fraud Plan 2021/22 –** the Committee approved the Plan.

Risks noted / items to be raised at Board The Committee asks the Board to note the achievement of everyone involved in contributing to the overall substantial assurance opinion during a particularly difficult year.
Corporate objectives met or risks addressed: Contributes to the Trust's governance arrangements.
Financial implications: None as a direct consequence of this paper.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): For the Board to note.
Presenting officer: Ian Clayton, NED and Chair of the Audit Committee.
Date of meeting: 28th April 2021.

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)021

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:

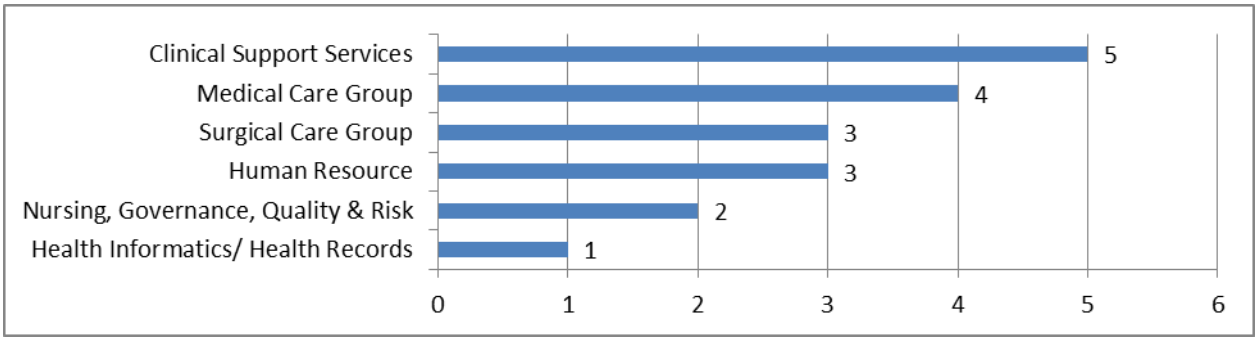
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

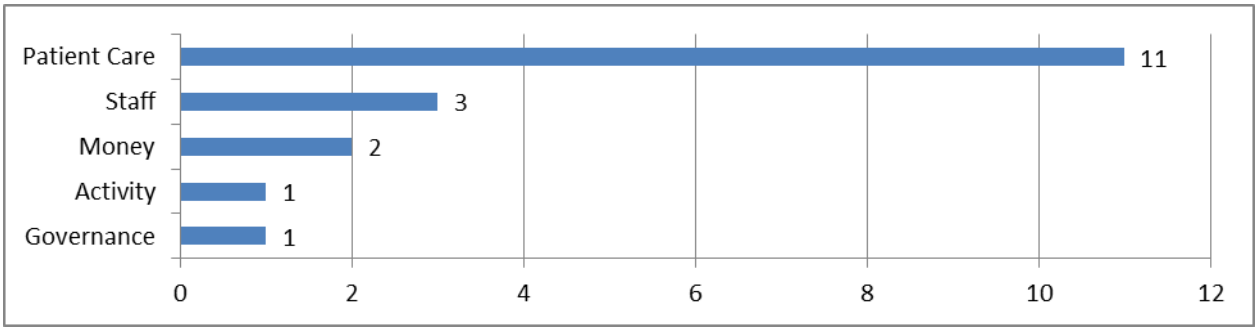
This report covers all the risks reported and reviewed until the end of March 2021 and is a snap shot, rather than a summary of the previous quarter. A comparison with the previous Board report in January 2021 is included to illustrate the movement in risks during the period. The report shows;

- The total number of risks on the risk register is 627 compared to 646 in January. 59% (369) of the Trusts risks are rated as Moderate or High compared to the same percentage 59% but 378 risks in January
- 18 risks that scored 15 or above had been escalated to the CRR (Appendix 1) compared to 24 risks escalated in January.

The spread of CRR risks across the organisation is;



The risk categories of the CRR risks are;



The report also includes comparisons of the Trust risk profile with the previous quarterly report (January 2021) and against the same period last year – April 2020 (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 April 2021

CORPORATE RISK REGISTER – APRIL 2021

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 06/04/2021	Previous Reporting Period 01/01/2021
Number of new risks reported	7	13
Number of risks closed or removed	20	10
Number of increased risk scores	3	3
Number of decreased risk scores	4	5
Number of risks overdue for review	114	109
Total Number of Datix risks	**627***	**646***

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

The number of risks overdue for review had reduced to 87 by the time of the Risk Management Council meeting on 13th April, which followed the Easter Bank holiday weekend and it is part of the Care Group and Service recovery plans to ensure that all overdue risks are reviewed.

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
14	**23**	**18**	**70**	**9**	**116**	**57**	**138**	**32**	**124**	**8**	**5**	**5**	**0**
55 = 8.89%			**195 = 31.50%**			**351 = 56.70%**				**18 = 2.91%**			

**Based on 619 scored and approved risks*

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

2.1 Surgical Care Group – 133 risks reported 21.49% 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	**4**	**2**	**10**	**3**	**27**	**13**	**35**	**9**	**27**	**2**	**0**	**1**	**0**
6 = 4.51%			**40 = 30.08%**			**84 = 63.16%**				**3 = 2.26%**			

2.2 Medical Care Group – 110 risks reported 17.77% 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	**8**	**3**	**9**	**0**	**18**	**4**	**27**	**10**	**22**	**1**	**0**	**3**	**0**
16 = 14.55%			**27 = 24.55%**			**63 = 57.27%**				**4 = 3.64%**			

2.3 Clinical Support Care Group – 103 risks reported 16.64% 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**	**11**	**0**	**16**	**17**	**22**	**6**	**20**	**4**	**0**	**1**	**0**
6 = 5.83%			**27 = 26.21%**			**65 = 63.11%**				**5 = 4.85%**			

2.4 Primary Care and Community Services Care Group – 38 risks reported 6.14% 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
0	**0**	**0**	**4**	**0**	**2**	**5**	**15**	**3**	**9**	**0**	**0**	**0**	**0**
0			**6 = 15.79%**			**32 = 84.21%**				**0**			

2.5 Corporate Departments –235 risks reported 37.96% 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	**8**	**12**	**36**	**6**	**53**	**18**	**39**	**4**	**46**	**1**	**5**	**0**	**0**
27 = 11.49%			**95 = 40.43%**			**107 = 45.53%**				**6 = 2.55%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	1	15	15	4	**35**
Estates and Facilities Management	0	5	13	4	**22**
Nursing, Governance, Quality & Risk	2	16	8	3	**29**
Finance	0	9	10	4	**23**
Medicines Management	0	25	36	6	**67**
Human Resource	3	37	13	6	**59**
Total	**6**	**107**	**95**	**27**	**235**

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

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

ENDS

Appendix 1

Corporate Risk Register – APRIL 2021

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Last Review Due	Target Risk Score I x L	Action plan in place with target completion date	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 levels of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	23/02/2021	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 4 = 16	3 x 5 = 15	17/03/2020 Sue Redfern	05/03/2021	4 x 2 = 8	Action plan in place	Executive Committee
Money	1152	**If** there is an increase in bank and agency staff usage **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	09/03/2021	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1605	**If** there are insufficient medical SPR doctors to cover the rota, **then** there is a risk to patient care.	3 x 4 = 12	3 x 5 = 15	28/10/2020 Rob Cooper	09/03/2021	3 x 1 = 3	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	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	31/03/2021	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 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	29/01/2021	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	4 x 5 = 20	30/03/2020 Rob Cooper	13/01/2021	3 x 2 = 6	Action plan in place	Quality 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 4 =16	04/07/2019 Anne-Marie Stretch	25/02/2021	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	5 x 3 = 15	04/09/2019 Rob Cooper	29/01/2021	5 x 2 = 10	Action plan in place	Executive Committee
Patient Care	2755	**If** the counselling service cannot operate at full establishment due to staff absence **then** capacity to meet the demand will be diminished	3 x 4 = 12	3 x 5 = 15	13/11/2020 Sue Redfern	09/12/2020	1 x 1 = 1	Action plan in place	Executive Committee
Money	2830	If the Maternity service does not achieve the maternity incentive scheme, then a 10% reduction on the annual CNST premium will not be delivered.	3 x 5 = 15	3 x 5 = 15	24/11/2020 Sue Redfern	26/02/2021	3 x 2 = 6	Action plan in place	Quality 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	5 x 3 = 15	5 x 3 = 15	21/02/2020 Rowan	31/12/2020	5 x 2 = 10	Action plan in place	Quality Committee

		management if there should be simultaneous medical emergencies.			Pritchard-Jones				
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	4 x 5 = 20	30/09/2020 Rowan Pritchard Jones	29/01/2021	4 x 2 = 8	Action plan in place	Quality Committee
Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.	5 x 4 = 20	5 x 4 = 20	21/10/2020 Rob Cooper	25/01/2021	5 x1= 5	Action plan in place	Executive Committee
Patient Care	2964	**If** there are not sufficient dieticians to meet the increased incidence of gastro-intestinal cancers **then** this could impact on their treatment outcomes	3 x 5 = 15	3 x 5 = 15	13/10/2020 Sue Redfern	26/02/2021	3 x 1 = 3	Action plan in place	Executive Committee
Staff	2980	**If** there is not sufficient staff to provide 24/7 cover in the blood sciences labs **then** there may not be sufficient capacity to meet demand	3 x 4 = 12	3 x 5 = 15	09/02/2021 Rob Cooper	31/03/2021	3 x 1 = 3	Action plan in place	Executive Committee
Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	29/10/2020 Sue Redfern	08/03/2021	3 x 2 = 6	Action plan in place	Executive Committee
Patient Care	3042	**If** GPs do not receive patient discharge letters in a timely manner **then** there is a risk to patient safety and continuity of care	4 x 4 = 16	4 x 4 = 16	17/03/2021 Rowan Pritchard-Jones	17/03/2021	4 x 2 = 8	Action plan in place	Executive Committee

Blue text = New risks escalated to the CRR since the January Trust Board report

Risks that have been de-escalated or closed from the CRR since January 2021 are;

Risk Category	Risk ID	Subject
Patient Care	1280	Medical patients outlying in surgical beds
Patient Care	2083	Inpatient medical beds occupancy levels
Patient Care	2866	Risk to business continuity on the Lilac Centre if additional staff are sick or in self isolation due to COVID Containment
Patient Care	2998	Insufficient staffing levels on 1A
Patient Care	2502	Brexit adverse impact on the supply of medical consumables and devices
Patient Care	2946	Vital patient observations recorded on the NEWS2 system from triage
Patient Care	2960	IABP for cardiac emergencies
Patient Care	2995	ICU capacity to meet demand created by COVID

Appendix 2

Trust Risk Profile – January 2021

Comparison of the Trust risk profile in the last Board Report

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
20	**23**	**17**	**70**	**9**	**121**	**53**	**135**	**31**	**135**	**11**	**7**	**6**	**0**
60 = 9.40%			**200 = 31.35%**			**354 = 55.49%**				**24 = 3.76%**			

Trust Risk Profile – April 2020

Comparison of the Trust risk profile at the same point in the previous year

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
64	**48**	**21**	**116**	**9**	**155**	**60**	**128**	**31**	**126**	**6**	**12**	**3**	**0**
133 = 17.07%			**280 = 35.94%**			**345 = 44.29%**				**21 = 2.70%**			

Appendix 3

CRR – April 2020

Comparison of the CRR risks reported 12 months previously with the risks highlighted that remain or have been re-escalated to the current CRR

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

New 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
Patient Care	1043	If there is a global pandemic e.g. Coronavirus then the trust will need to put in place business continuity and service escalation plans	4 x 5 = 20	4 x 2 = 8	Executive Committee
Money	1152	If there is an increase in bank and agency then there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 3 = 8	Quality Committee
Patient Care	1280	If there is an increased demand for medical beds then some medical patients may need to outlie in surgical beds	3 x 5 = 15	1 x 3 = 3	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	5 x 1 = 5	Quality 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
Activity	1874	If the Trust cannot maintain 92% RTT incomplete pathway compliance as a result of cancelling non urgent operations in response to the COVID-19 pandemic then it will fail the national access standard	4 x 5 = 20	4 x 2 = 8	Finance and Performance Committee
Patient Care	2082	If there is not an established process for the medical review of patients who remain in ED/EAU then the decision to admit could be delayed	4 x 4 = 16	3 x 2 = 6	Finance and Performance 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	Finance and Performance Committee
Patient Care	2223	If ED attendances and admissions increase beyond planned levels then the Trust may not have sufficient bed capacity or staffing levels to provide safe levels of care	4 x 4 = 16	2 x 4 = 8	Executive Committee

Patient Care	2258	If the flexible endoscopy Reverse Osmosis (RO) units cannot be maintained then the endoscopy service could be disrupted	4 x 4 = 16	2 x 3 = 6	Quality 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	3 x 2 = 6	Quality Committee
Patient Care	2502	If there the Brexit negotiations do not proceed 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	Executive Committee
Patient Care	2714	If an interim solution cannot be developed then the Trust may be unable to demonstrate compliance with the FAIR assessment CQUIN contract indicator	3 x 5 = 15	3 x 1 = 3	Finance and Performance 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	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	5 x 2 = 10	Quality Committee
Patient Care	2868	If the Trust is unable to increase critical care capacity during COVID-19 pandemic then it would not be able to meet the expected demand	4 x 5 = 20	4 x 1 = 4	Quality Committee
Patient Care	2871	If there is disruption to the national supply of key goods such as PPE and other medical equipment and services during the COVID-19 pandemic then the Trust will not be able to ensure staff have the recommended equipment	4 x 4 = 16	3 x 3 = 9	Executive Committee

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)022
Title of paper: Review of the Board Assurance Framework (BAF) – April 2021
Purpose: For the Executive Committee to review and agree any changes to the BAF to be presented 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 January 2021. 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 BAF risk scores are proposed.
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: NHSE/I, CQC, Commissioners.
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 28th April 2021

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	

*to be reviewed once the 2021/22 Trust Objectives are finalised

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.

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

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 • 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 • Ockenden Report action plan	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • 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 & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20	CRAB Medical Implementation and reporting for routine outcome monitoring ~~Implement the recommendations of the Okenden Review of Maternity Services (February 2021)~~ Implementation of the improvement plan longer term solutions to ensure all patients whose treatment has been suspended are monitored and receive timely follow up (September 2021) ~~C&M escalation and surge plans to respond to COVID 3rd Wave (February 2021)~~	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 June 2021 due to impact of COVID-19) Development of ward quality accreditation tool and real time quality dashboard (Carried forward to 2020/22 due to impact of COVID-19) Reduce hospital acquired AKI (Carried forward to 2021/22 due to impact of COVID-19)	~~Implementation plans for the four key 7-day service standards by 2020 – reporting suspended due to COVID-19~~ Review of patient information to improve accessibility and understanding (Revised to March 2022due 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 (Revised to May 2022 due to impact of COVID-19) Deliver the Ockenden 1st stage report action plan (September 2021)	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; • NHSE/I monthly reporting • Contract Monitoring Board • NHSE/I 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 Reporting of management plans to deliver GiRFT recommendations to the F&P Committee ~~Understanding of the new NHS financial regime and implications of block contracts and system financial performance~~. ~~Update internal procedures to reflect the changes to procurement and other regulations as a result of the EU Exit trade deal.~~	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~~. Deloitte audit of COVID expenditure – to be reported to Audit Committee when finalised	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)~~ Deliver the financial and activity plan agreed with C&M ICS for the first 6 months of 2021/22 (October 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	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow for winter 2020/21 and beyond ~~Respond to the consultation and model the impact of the proposed new ED waiting time standards for 2021/22.~~ COVID-19 escalation plans to release capacity and trigger mutual aid in place and operational.	Implement new contractual arrangements for Widnes UTC (Revised to May 2021) ~~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 elective waiting lists where treatment was delayed due to COVID (ongoing) Achievement of the elective activity recovery trajectories agreed with C&M ICS (March 2022)	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 & action plan • Workforce/ People Plan and action plan • 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 • IPR • Staff Survey • COVID pandemic reflections staff feedback • 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)~~ Finalise and implement the 2020 staff survey action plan (March 2022) Update the Trust website (Revised to May 2021) Maintain COVID staff communications bulletin and pandemic staff engagement, support and recovery initiatives (June 2021)	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 • JNCG/LNG • 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 Integrated Care System ~~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 Hospital Cell • Equality, Diversity & Inclusion Delivery Group	4 x 3 = 12	Work with the local Boroughs to develop plans for Integrated Care Partnerships (ICPs) from April 2022	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 to develop plans for place based care~~ ~~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 ICS senior leadership as part of the system response to COVID-19. ~~Ratification of the C&M HCP Memorandum of Understanding and Integrated Care System application (April 2021)~~ Continue as a full partner of St Helens cares, contributing to the delivery of the improvement objectives	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 • JNCG/LNG • Education and Development Plan • People 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 • 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 • Medical Workforce OD plan	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • 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 & Midwifery staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment process and redeployment hub	5 x 4 = 20	Implementation of emergency staffing plans and ratios in line with national guidance. Equality Delivery System 2 – action plan	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 Capacity to deliver the recovery and restoration plans for activities suspended due to COVID-19 Attendance management COVID-19 recovery plan ~~COVID-19 absence monitoring, escalation and staff redeployment plans in place and operational~~	~~DIT and other staff C&M collaborative bank (launched in November and continues to develop)~~ ~~Review of trust appraisal process (March 2021)~~ Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going) Develop the Trust longer term Agile Working Strategy (Revised to June 2021 due to COVID) Delivery of the NHS People Plan local action plans for 2021/2 (Revised to March 2022) C&M Lead Provider role for the COVID vaccination programme (On going) Review of Trust flexible and agile working policy (July 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.		3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2022) Estates and accommodation strategy to respond to increasing demand and new ways of working (Revised to June 2021) ~~Operational plans to accommodate 10 year lifecycle works with minimal service disruption (March 2021 as delayed due to COVID-10)~~ ~~Estates and FM support to enable the COVID vaccination programme (April 2021)~~ Develop theatre expansion options to support COVID recovery and restoration (May 2021)	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 • 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 IT Communications Strategy Digital Maturity Assessment ~~Programme reviews post COVID-19 to establish recovery plans (amended to March 2021)~~	ISO27001 (revised to March 2022 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. Extended support in place for the remaining 20%, which will be migrated (December 2021). Delivery of the Digital Aspirant Programme (2020 - 2022) ~~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)023

Title of paper: Learning from Deaths Quarterly Report 2020/21 Q2 & Q3

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
July 2020	28	26	1	0
August 2020	40	39	1	0
September 2020	25	24	0	0
October 2020	29	23	3	0
November 2020	34	27	2	1
December 2020	36	25	3	0

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 April 2021

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 2 2020/21 a total of 93 Structured Judgement Review's (SJR's) were requested 95.69% (89n) of the reviews had an outcome of no concerns (Green or Green with learning). 2.15% (2n) had an AMBER outcome, one is being managed within the Patient Safety Team investigation processes and the other has been StEIS reported. There at two SJR's awaiting review.

In Quarter 3 2020/21 a total of 99 SJR's were requested 75% (75n) of the reviews had an outcome of no concerns (Green or Green with learning). 8.08% (8n) had an AMBER outcome all of which are receiving further input or investigation.
Finally 1.01% (1n) had a RED outcome, this incident had previously been StEIS reported. There are 15 SJR's 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 Q2/3 2020/21

Q2	Know your pathways Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them accordingly. They are there to protect our patients and you.	Palliation - involve primary care When a patient is on a palliative pathway, ensure that advance care plans (DNACPR, preferred place of death) can be met as often as possible. In addition, communication of a missed opportunity for ACP / DNACPR in the community should be shared with the primary care team.
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 Successes

Following case reviews in which significant delays were identified the following have been addressed and improved with the relevant teams.

- Peri-prosthetic fractures – the surgery required following these fractures is undertaken only by a few specifically trained orthopaedic surgeons within the trust. The mortality associated with delayed surgery was significant in these vulnerable frail

patients. To ensure that there is never a gap in caring for these patients, they are now share a rota maximising their availability to operate at all times.

- Surgical reviews on Duffy ward – when patients are transferred for rehabilitation to Duffy Ward, St Helens Hospital, this may follow from admission under a variety of specialist teams. If urgent opinion / review is required from their original admitting team then availability on St Helens site limited the days that it could be provided. Sharing the ownership of this review amongst any member of the speciality present at St Helens on any specific day minimised these potential delays.

- Death certification – since Learning from Deaths commenced within the organisation in its current format in 2018, there have been issues identified with Medical Certificate of Cause of Death (MCCD). Issues have included the wrong cause of death, incorrect terminology, missing significant co-morbidities or recent surgeries. The recruitment of the team of Medical Examiners (commencing October 2020) within the Trust has now led to increased support of the juniors and scrutiny of these certificates leading to improvements in completion of MCCD's.

Quarter	No. of death certificate issues	Quarter	No. of death certificate issues
1 2018/19	9	2 2018/19	10
1 2019/20	4	2 2019/20	2
1 2020/21	4	2 2020/21	0

2 ANALYSIS

2.1 Total number of reviews completed for Q2 & Q3 2020/21

Month	Total	Green – GWL	Amber	Red
July 2020	28	25	1	0
August 2020	40	39	1	0
September 2020	25	24	0	0
October 2020	29	23	3	0
November 2020	34	27	2	1
December 2020	36	25	3	0

2.2 Specified Groups breakdown for Q2 & Q3 2020/21 (See Appendix 1)

	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Cardiac Arrest Death	5	6	4	3	0	6
Concern Death	2	4	2	6	6	9
Diagnosis Group Death	6	11	3	9	7	2
Learning Disability Death	1	3	0	0	6	2
Medical Examiner Referral	0	0	4	2	5	1
Post operative death	10	10	12	3	6	8
Random Selection Death	7	6	6	29	26	16
Severe Mental Illness Death	0	1	1	1	0	1

**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. (Appendix 2)
- 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 Disability 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	Gill Brown	Joanne Newton
Finance & Performance	Jeff Kozer	Laura Hart
Clinical Effectiveness Council	Rowan Pritchard-Jones	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/Debbie Stanway	Joy Woosey
MCG Directorate Meetings	Debbie Stanway	Joy Woosey
SCG Governance Meetings	Tracy Greenwood/Wendy Harris	Gina Friar
SCG Directorate Meetings	Phil Nee	Julie Rigby
CSS Directorate Meetings	Caroline Dawn (Interim)	Sam Barr
ED Teaching	Ragit Varia/Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Cynthia Foster	
Grand Rounds	Cynthia Foster	