St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26th MAY 2021
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
09:30	1.	Employee of the Month - May 2021		Verbal	Assurance	Chair
09.35	2.	Patient Story		Presentation	Assurance	Sue Redfern
09.50	3.	Apologies for Absence		Verbal	Assurance	Chair
09.55	4.	Declaration of Interests		Verbal		
10.00	5.	Minutes of the Board Meeting held on 28th April 2021		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.10	6.	Integrated Performance Report		NHST(21) 024	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						
10.40	7.	Committee Report – Executive		NHST(21) 025	Assurance	Ann Marr
10.50	8.	Committee Report – Quality		NHST(21) 026	Assurance	Gill Brown
11.00	9.	Committee Report – Finance & Performance		NHST(21) 027	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Break					
Other Board Reports					
11.30	10.	Aggregated Incidents, Complaints and Claims Report, September 2020 to March 2021	NHST(21) 028	Assurance	Sue Redfern
11.45	11.	Approval of 2020/21 Quality Account	NHST(21) 029	Approval	Sue Redfern
12.00	12.	Board and Committee Effectiveness Review	NHST(21) 030	Assurance	Nicola Bunce
12.15	13.	Appointment and role of the Wellbeing Guardian	NHST(21) 031	Information	Anne-Marie Stretch
Closing Business					
12.30	14.	Effectiveness of Meeting	Verbal	Assurance	Chair
	15.	Any Other Business		Information	
	16.	Date of Next Meeting – Wednesday 30th June 2021		Information	

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 28th April 2021 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
In Attendance:	Dr Elspeth Worthington	(EW)	Assistant Medical Director (item 13)
	Dr Barnabus Bagguley	(BB)	5th year medical student, Imperial College (visitor)
	Mrs C Duffy	(CD)	Executive Office Manager (minute taker)
Apologies:	Fazilet Hadi	(FH)	Aspiring Chair Programme
	Geoffrey Appleton	(GA)	St Helens CCG
	Tony Foy	(TF)	St Helens CCG
	Alan Lowe	(AL)	Halton LA

1. Welcome and introductions

1.1. RPJ introduced BB, whom he had invited to attend as part of his medical management placement shadowing RPJ. RF welcomed BB to the meeting.

2. Apologies for Absence

2.1. Apologies were noted as above.

3. Declaration of Interests

There were no new declarations of interest.

4. Employee of the month

4.1. CW read out the citation for Rebecca Whitting, Senior Project Manager for Health Informatics, who had been nominated for the award by Andrew Hill, DMOP Consultant and Chief Clinical Information Officer. CW stated that Rebecca is a valued member of the Trust clinical project team.

4.2. Due to COVID social distancing restrictions Rebecca had been filmed receiving her award and the film will be on the Trust intranet. The Board noted the citation and congratulated Rebecca.

5. Minutes of the Board briefing held on 31st March 2021

5.1. Correct Record

5.1.1. The minutes were approved as a correct record.

5.2. Action List

NB confirmed that the Trust objectives had been circulated prior to this meeting. VD had enquired about the Trust contribution to the St Helens strategic place-based targets, but NB had clarified that none had yet been set for this year. The process of agreeing each organisation's contribution was due to commence, with the Trust being represented on the relevant delivery groups. NEDs agreed the objectives, therefore action 53 is complete.

NB reported that the St Helens Integrated Care Partnership (ICP) Board had met for the first time on 27th April and is in the process of setting up the delivery groups, as described above. NB confirmed that the ICP Board is not a statutory board, so consequently it is still appropriate for VD to attend the CCG Governing Body meetings; their statutory functions will remain until April 2022. Action 54 is therefore closed.

6. Integrated Performance Report (IPR) – NHST (21)016

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

6.2. Quality Indicators

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

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

6.2.3. There had been 0 cases of MRSA in March, and 2 YTD.

6.2.4. There was 1 C. Difficile 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). There were 8 cases awaiting the outcome of the appeal process, and all outstanding RCA investigations would be completed by the end of May.

6.2.5. There were 0 falls resulting in severe harm in February, YTD 27. SR confirmed that a thematic review of falls was being undertaken to identify any underlying causes for the increase in 2020/21.

6.2.6. There were no hospital acquired grade 3 pressure ulcers, YTD 1. SR noted that focus on pressure ulcers forms part of the Trust objectives going forward.

6.2.7. VTE reporting remains suspended due to COVID.

6.2.8. Year to date HSMR (April to December) for 2020/21 was 96.6.

6.2.9. The report was noted.

6.3. **Operational Indicators**

6.3.1. RC presented the update on operational performance.

6.3.2. 62-day cancer target performance was 81.3% in February against the target of 85% and 86.6% year to date (YTD).

6.3.3. The 31-day target was 98.4% in February against the target of 96% and 97.5% YTD.

6.3.4. The cancer two-week wait rule performance was achieved in month with performance of 94.6% against the standard of 93% and 93.9% YTD.

6.3.5. RC reported on the significant increase in Emergency Department (ED) attendances in March 2021. Accident and Emergency (A&E) 4-hour performance for March was 85.4% (all types mapped). There were 10,075 type 1 attendances and the average daily attendances had increased to 325, with the highest day reaching 444 attendances. These increases had also been reflected in the UTC. The attendances were being audited and there appeared to be increases amongst those who could not get a face to face appointment with their GP. Discussions with primary care about how best to manage this demand were ongoing.

6.3.6. There were 2,899 ambulance conveyances in March and the average ambulance turnaround time was 30 minutes against the standard of 30 minutes.

6.3.7. The average number of super stranded patients in March was 79 because of partners working together to improve discharge processes. This is better than the 2020/21 improvement trajectory of 92. RC noted the requirement to drive this down as much as possible because of the ongoing pressure on medical beds.

6.3.8. The referral to treatment (RTT) performance in February was 70.6% against the target of 92%, and the 6-week diagnostic waiting time performance in March was 72.9% against the target of 99%. There were 1124 over 52-week waiters for elective procedures. 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.

6.3.9. RF commented that considering the circumstances and the pressures of the last 12 months the access performance remained good compared to many other NHS Trusts. Members briefly discussed the need for primary care to return to pre-COVID working practices as soon as possible. RC reported that he had invited primary care network (PCN) lead GPs to visit and spend time in the ED to see exactly why patients are attending, and the impact this is having.

6.3.10. NK confirmed that RC had given assurance on patient safety in the last Finance and Performance meeting. RC outlined measures in place to ensure the safety of all patients in ED wait areas. SR confirmed the continuation of all normal safety measures. She noted the challenges of timely discharges, due to the Social Services (SS) not attending wards in person. Proactive mitigations have been put in place to include SS in virtual ward rounds, but their physical return now needs to be driven forward. Some placements are particularly challenging, especially those for CAMHS patients, who sometimes require 1:4 care, which presents its own challenge to wards and the security team.

6.3.11. PG acknowledged that the discharge target is being met, even without the physical presence of SS, and asked how this is being managed. RC explained that focus has been given to avoid any unnecessary delays; however, there have been different cohorts of patients throughout the pandemic and close working with all the local authorities. A hospital discharge team has been formed, led by Mike Roscoe and Diane Stafford, who give focus and energy to this every single day, to drive it forward. RC expressed concern when the Trust returns to 'normal' levels of activity and 'normal' electives, then it will not be as straightforward.

6.3.12. The success of the Bevan Court initiative was acknowledged. RC described the plans to implement direct admissions to Bevan Court, bypassing ED completely. Work is ongoing with NWAS and the frailty team to drive this forward. The Executive team were commended for their decision to create the Bevan Court beds.

6.3.13. IC requested clarity on the maximum daily capacity for ED in the initial design of the hospital. RC confirmed that originally, it was circa 250. However, the space has been adapted since the hospital opened to increase capacity to manage higher numbers, but only for circa 300 – not the 400+ that have been attending. RC stressed the importance of having the correct streaming pathways in place and working well, therefore.

6.3.14. LK asked what level of involvement local authorities and primary care were having in developing the restoration and recovery plans. RC reported that there had not been much involvement to date and the emphasis had mostly been on acute trust planning. LK acknowledged the difficulty and impact these barriers could cause. RC reported that there is work ongoing through the Cheshire & Merseyside (C&M) Hospital Cell to reframe all urgent and emergency care as a system issue. The ICS will manage ED performance in the future, and for the system to achieve the targets all organisations need to play a part.

6.3.15. GB expressed concern about the worrying figures for ED and the number of ambulances, as the Trust is trying to also ramp up elective activity at the same time. It would seem to be a 'perfect storm'. She enquired whether 'NHS 111 First' was having an impact and RC confirmed that it was. He noted that the difficulty faced is that if 'NHS 111' does not have suitable and responsive alternative services to direct patients to, the default is to send them to ED. It was acknowledged that the system needs to act on this. It was noted that the Trust is almost back to pre-pandemic attendance figures, and GB expressed her concern about the forthcoming winter months and the detrimental impact it could have on the Trust as a provider. RC will continue to drive the message forward.

6.3.16. AM reported that she felt it was important that the ICS became responsible for ED performance and it did not rest with the Hospital Cell/Acute Hospital Provider Collaborative. She had argued that there needs to be a whole system response to get the emergency and urgent care services operating effectively and this was not purely an acute hospital issue.

6.3.17. There was discussion on the future of the C&M ICS, and who are taking ownership of the system, as CCGs have been left disenfranchised by the changes during the pandemic and the proposals in the NHS White Paper. There were concerns that the C&M ICS does not yet have the infrastructure in place – unlike Greater Manchester and South Cumbria who have more developed structures.

6.3.18. The report was noted.

6.4. **Financial Indicators**

6.4.1. NK presented the update on financial performance and noted that the outturn figures were still subject to audit at this point.

6.4.2. At the end of Month 12 the Trust is expecting to report a deficit full year position of £2.6m, which has improved by £5.4m from the forecast reported at month 11. This is due to additional funding for annual leave provision from NHSI. NK noted that the expenditure forecast had been accurate it was the additional income that had changed the position.

6.4.3. NK thanked colleagues for the focus given to maintaining financial control during the pandemic.

6.4.4. At the end of month 12, the cash balance was £51.4m. This high closing balance is because of 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 increased the Trust's cash position. This early payment policy has now ended.

6.4.5. VD asked if the Trust would have performed better under a PbR payment system. NK confirmed that the Trust had not deviated from the expenditure forecast set at the start of the year but the emergency financial regime for the pandemic had recognised that activity patterns were very different

during the pandemic. He noted that the ICS will be reporting on the run rate spend going forward. VD congratulated NK and the finance team.

6.4.6. GB enquired about the CIP going forward and NK stated that it will be brought back by NHSE/I for 2021/22. He reported that the system financial gap is c£80m, therefore the CIP could potentially be c2.5%. This is being monitored through the Finance & Performance (F&P) Committee and NK confirmed that the Trust is in a favourable position, with potential CIP schemes already identified. GB also congratulated NK and the team on the year end position, particularly considering the extreme pressure that everybody has been under.

6.4.7. JK confirmed that the CIP is analysed at F&P and is ready to go when necessary. He acknowledged the challenges that the system allocation will bring.

6.4.8. The report was noted, and RF added his congratulations to NK and the whole Executive team for the management of the finances over the past year.

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on workforce performance and noted the context of the pandemic on the data.

6.5.2. 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; nursing and midwifery alone was 6%, which is a decrease of 4.2% since February. AMS noted that the reductions demonstrate the impact COVID has had on levels of sickness in the Trust and reflect the reduced community levels of COVID nationally and locally since February. AMS pointed out that the figures include normal and COVID 19 sickness reasons only; they do not include other 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.

6.5.3. Appraisal compliance was 51.3% and mandatory training compliance was 75.7%. Compliance against the 85% targets for both continues to be impacted because of the spike in COVID 19 including high sickness, self-isolation, special leave absences and operational service demands.

6.5.4. AMS described the recovery plan in development for appraisals and noted that a report is due to be presented to Executive Committee. She highlighted that it had been an extremely difficult year for staff, with a lot of asks and expectations. Going forward, energy and enthusiasm will be applied to ensure improvement in appraisal compliance, however it was acknowledged that it could take several months to hit the 85% target again.

6.5.5. RF acknowledged the difficult year and noted that the appraisals process can offer staff a clear way forward.

6.5.6. GB confirmed that the figures are regularly scrutinised at Quality Committee (QC). She noted that as a year-end figure, given the pandemic, it is an understandable result. As Chair of the QC, she was aware of the

challenges that have been faced, and it is hoped that this is a one-off. GB agreed that focus can now be given to recovery and noted that assurance had been accepted at QC of the actions being taken.

6.5.7. LK echoed GB's comments, and asked about communication to staff. AMS confirmed that with the roll out of the Trust objectives, staff will be thanked and given an outline of the year to come with appraisal for staff being a key focus. She advised that there have been talking and listening events with staff and managers, for input into solutions on the way forward for appraisals prior to a big relaunch.

6.5.8. VD had wanted to ask about the staff and was pleased that AMS had reported on the listening events. She enquired about feedback, and whether staff felt they had missed out. AMS explained that questions on appraisals had been taken out of the staff survey nationally as it was recognised that they had been suspended. She stated that staff have reported really appreciating being told 'thank you' by their manager, which had been reiterated throughout the year. It is now intended to build on this and continue with more frequency going forward.

6.5.9. NB reported that on a practical level, all development courses, university placements etc., had all been suspended too, so there had been limited traditional development opportunities for staff.

6.5.10. RF noted that the HR department looks after the Trust's 7000+ staff but acknowledged that it has a much larger remit as Lead Employer. He acknowledged that the recovery was a considerable task and commended the approach being taken.

6.5.11. The report was noted.

7. Committee Report – Executive – NHST (21)017

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

7.2. Consideration had been given to the reconfiguration potentials of the ED, which could improve patient flows and efficiency. Several options had been identified via the feasibility study, which could be explored further as part of the long-term site development plans. However, the Executive had agreed that the immediate 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 had been commissioned.

7.3. AM reported on concerns that the proposed financial allocations for 2021/22 did not currently reward trusts who were able to undertake more activity to reduce the activity backlog, she had been in discussion with the regional team to see if marginal costs could be adjusted to reflect actual activity levels and therefore support innovation and incentivise increased productivity.

7.4. AM confirmed that the Trust objectives for 2021/22 are now at the 'poster friendly' stage. She reported that the target date for Start of Year Conference is 17th May 2021, which will be the launch of the Trust objectives.

7.5. VD commented on the progress of the work with Acute Kidney Injury (AKI) and was pleased to note that it is now on Care Flow Vitals. She asked if this would alert staff and if it could be removed from the Board Assurance Framework (BAF). RPJ noted that alerts will go to staff; however, he explained that the project is about hydration and is aimed at prevention. He outlined the use of fluid balance charts, which are now electronic and available to all. He confirmed that he expects a reduction in hospital acquired AKI, and GPs will be encouraged to give robust focus to this in the community. He confirmed for VD that he therefore expects that the BAF risk will reduce by the next quarterly review.

7.6. VD asked how the Trust will determine the resources for prevention as community services are on a block contract. AM noted that the model for community services being provided by an acute trust is rare in C&M, whereas it is the norm in both Greater Manchester and Cumbria and Lancashire. She felt that there were opportunities to shape priorities and delivery models in St Helens, where the Trust holds the community nursing services contract. She noted that the Trust will be part of both Provider Collaboratives in C&M, the one for acute and specialist trusts and the one for mental health and community services. AM described the greater challenges of working with Halton and Knowsley on this type of development, because there is no vertical integration of services. She reported that the first meeting of the St Helens ICP Board had been very positive and commitment to the integrated model had been reconfirmed.

7.7. AM highlighted that the Internal Medicine Trainees business case had been approved by the Executive Committee, this would result in a cost pressure for the Trust but was unavoidable to meet the new training standards from August 2021.

7.8. The work being undertaken on the future model of community midwifery provision for Halton was also noted.

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

8. Quality Committee Chair's Assurance Report – NHST (21)018

8.1. GB presented the report, which summarised the key issues considered at the Quality Committee meeting in April.

8.2. GB informed members that Nicola Gilman (NG), Non-Executive Director from Buckinghamshire Healthcare Trust and Aspirant Chair programme participant had observed the meeting. She had given very positive feedback, stating that the meeting was a very interactive experience, which was open and transparent. NG had thought it particularly interesting as consideration had been given to the whole IPR, which was not undertaken in her own trust.

8.3. Committee had noted that the IPR provided a picture of the impact of COVID-19 on performance in many areas during 2020/21 and was now focusing on receiving assurance about the recovery plans.

8.4. Committee had requested more context to be included in the Patient Safety Council (PSC) report, going forward.

8.5. Committee had received a comprehensive report on the work of the patient pathway programme and had been assured by the actions already taken and those planned. The costs of the patient pathway programme work had been noted. The Executive was commended for the quick action taken to resolve this matter.

8.6. Committee had 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.

8.7. The report was noted, and GB commented that it is good that the Committee is now returning to full attendance.

9. Finance & Performance Committee Chair's Assurance Report – NHST (21)019

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

9.2. The Committee had reviewed the finance and operational performance and noted that the 2-week cancer performance was achieved for February with 94.6% of patients achieving the standard. The committee was pleased with the performance around cancer overall but had asked for future deep dives in non-achieving specialities.

9.3. The draft deficit of £2.6m for the 2020/21 financial year had been noted. It was also noted that the full capital allocation had been spent.

9.4. Committee had reviewed the draft financial and operational plans for April to September. NK highlighted that work is ongoing with the ICS on developing these plans and they are not yet finalised.

9.5. RF commended the comprehensive input from both the Executive and NEDs and praised the achievement of the ambulance turnover times during the unprecedented circumstances.

9.6. The report was noted.

10. Audit Committee Chair's Assurance Report – NHST (21)020

10.1. IC presented a summary of the key issues discussed at the Audit Committee meeting in March.

10.2. IC commented on the excellent reporting of the standing order items to Committee. He noted that the organisation is to be congratulated on the substantial assurance received from MIAA on the delivery of the 2020/21 internal audit plan.

10.3. Committee had approved the internal audit plans for 2021/22 and the anti-fraud plan.

10.4. IC commented on the changes to the accounting standards which could impact on the development of the annual report and accounts.

10.5. NEDs had been made aware of the ISA 540 requirement which had been raised regarding disclosures and judgement. IC was comfortable that this was being dealt with appropriately.

10.6. The report was noted.

11. Corporate Risk Register 2021/22 – NHST (21)021

11.1. NB presented the report to provide assurance that the Trust is operating an effective risk management system.

11.2. There were 18 high risks that had been escalated to the Corporate Risk Register in March, some of which reflected the pressures of COVID-19 on services. NB outlined the spread of the risks across the care groups and categories. She noted that as with the rest of the organisation, the care Group and service risk managers were also resuming business as usual activities in relation to reviewing risks.

11.3. RF commented that risks happened, the report was very reassuring and clearly demonstrated the spread and management of the risks across the organisation.

11.4. VD asked about the three risks which had increased from amber to red. NB clarified that the SPR doctors' risk was linked to junior doctor rota cover and will now reduce going forward. The blood science risk was related to the volume of work due to COVID and would also now reduce going forward. The counselling risk was due to vacancies within a small department and the consequent impact on capacity.

11.5. Members accepted the risk profile and noted the report.

12. Board Assurance Framework Review – NHST (21)022

12.1. NB presented the report for assurance that the Trust has put in place sufficient controls and means of assurance to ensure the delivery of its strategic objectives.

12.2. NB reported that none of the planned actions were overdue, but some deadlines had been adjusted because of the pandemic.

12.3. Then alignment of the strategic risks to the 2021/22 Trust objectives would be undertaken for the next quarterly report.

12.4. The Board agreed with the recommendation that there should be no changes to the BAF risk scores.

12.5. Members approved the report.

13. Learning from Deaths quarterly report – NHST (21)023

13.1. RPJ introduced EW, who joined the meeting to present the Learning from Deaths Quarterly Report 2020/21 Q2 & Q3. RPJ paid tribute to the work of EW and the team noting that there is now improved traction to the reporting process, and a real learning culture being embedded across the organisation.

13.2. EW explained that the table presented within the report did not add up because some of the Structured Judgement Reviews (SJRs) remained outstanding. She

clarified that as with the rest of the organisation, the service is on catch up because of the impact of the pandemic. She highlighted that the process used is a dynamic one, and therefore some of the SJRs will have already been downgraded since the production of the report.

13.3. EW asked members to note the good progress made on recognition and reporting of adverse events. She outlined the successes, particularly the improvement in death certification, noting that the recruitment of a team of Medical Examiners in October 2020 had made a huge difference.

13.4. GB thanked EW for a very concise and interesting report and acknowledged the improvements. She enquired how members could be assured that learning and improvements are being embedded within the organisation.

13.5. EW clarified that all cases are monitored via the mortality surveillance team and confirmed that therefore they remain on the radar.

13.6. RPJ reported on the amount of work being undertaken into ensuring that the process is as sophisticated as possible. The implementation of the CRAB system had helped in this respect.

13.7. RF agreed that the report had provided members with assurance that the review process was robust and confidence that key learning was disseminated Trust wide.

13.8. Members noted the report.

14. Effectiveness of Meeting

14.1. RF asked BB for his reflections on the effectiveness of the meeting. BB reflected the Board meeting was extremely professional and was the best meeting he had observed. He felt that the meeting had given him confidence that challenges could be made appropriately and addressed accordingly by the Board. BB thanked the Board for letting him observe the meeting. RF thanked BB for his positive feedback.

15. Any Other Business

15.1. RF commented on the recent Granada news programme, which had featured the Mass Vaccination Centre at Saints Rugby Ground in St Helens. He thought the feature was excellent, and commended Kim Hughes on her involvement in getting the programme made. AM commented that she had been perturbed whilst watching the programme as a large queue of people could be seen. Upon investigation, it transpired that the queue belonged to the primary care network (PCN) vaccination hub, which has a much smaller waiting area than the Trust. The Trust will now offer to assist the PCNs going forward to avoid people waiting outside for the vaccination.

15.2. RF reminded Board members that the new Trust website is now live and advised those members who had not already done so, to view it. He noted that it is excellent, very clear and user friendly. He congratulated all those involved in its concept and fruition.

16. Date of Next Meeting

16.1. The next meeting will be held on Wednesday 26th May 2021 at 09:00 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……

Date: ……

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(20)024
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 April 2021. (YTD = 0).

There were no cases of MRSA in April 2021. (YTD = 0).

There were 8 C.Difficile (CDI) positive cases reported in April 2021 (5 hospital onset and 3 community onset). YTD there have been 8 cases (5 hospital onset and 3 community onset). The annual tolerance for CDI for 2021-22 has not yet been published (the 2019-20 limit is being used in the absence of publication of the 2021-22 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for March 2021 was 88.9%. 2020-21 YTD rate is 92.2%.

There has been a slight decrease in incidents reported within community services in Month (98 in March compared with 106 in February). The number of incidents which have resulted in patient harms has also reduced (March 32 from February 41). 83 reported incidents related to skin damage (similar to February level of 84).

During the month of March 2021 there were no falls resulting in severe harm. (YTD severe harm falls = 31)

There were no grade 3 hospital acquired pressure ulcers with lapses in care in February 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 April 2021 have been suspended.

YTD HSMR (April to December) for 2020-21 is 101.6

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 21/22 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: 26th May 2021

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (March 2021) at 85.9%. YTD 86.5%. Performance in February 2021 was 81.3%. The 31 day target was achieved in March 2021 with 97.1% performance in month against a target of 96%, YTD 97.5%. Performance in February 2021 was 98.4%. The 2 week rule target was achieved in March 2021 with 96.9% in month and 94.3% YTD against a target of 93.0%. Performance in February 2021 was 94.6%. 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 April 2021 was 69.1% and YTD 69.1%. The all type mapped STHK Trust footprint performance for April 2021 was 82.9% and YTD 82.9%. The Trust saw average daily attendance levels significantly increase in April 21 compared with March 21, with the average daily attendance of 352 up from 325 in March and 277 in February . Total attendances for April 21 were 10,586, March 2021 were 10,075, February 2021 were 7783.

Total ambulance turnaround time was achieved in April 2021 with 29 mins on average. There were 2729 ambulances conveyed in April (busiest Trust in C+M/GM) compared with 2899 in March.

The UTC saw 4,346 patents in March 2021, which is an increase of 1,280 patients (30%) compared to the previous month. Compared to attendances (3,184) in March 2020, this is the first month activity has exceed pre pandemic levels. This equates to a 36% increase. Overall 99.9% of patients were seen and treated in 4 hours.

Community nursing referral numbers have shown an increase in March from February (590 from previous month of 527). Referrals from acute services are now back to pre-Covid levels with a significant increase in face to face visits undertaken. Community matron caseloads are continuing at similar levels (150 in March compared with 146 in February).

The average daily number of super stranded patients in April 2021 was 102 compared with 66 in April 2020 (79 was the average in March 21, 86 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 March 2021 with 70.6% compliance and YTD 70.6% (Target 92%). Performance in February 2021 was 70.6%. There were (1469) 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

Planning and funding arrangements have been confirmed for the first six months of the 2021/22 financial year. The Trust financial plan, triangulated across activity, workforce and budget, has therefore been finalised for Months 1 to 6 only (referred to as 'H1'). The Trust plan is for £246m of income and expenditure giving a breakeven position overall.
A full financial settlement for October to March (M7-12) will be agreed once there is greater certainty around the circumstances facing the NHS in the second half of the year.
Surplus/Deficit - At the end of Month 1 the Trust has reported a YTD breakeven position in line with the Cheshire & Merseyside system plan for H1 as outlined above.

Agency - The year to date spend is £0.6m which is in line with the previous year's spend at Month 1. The above figures include agency costs incurred for COVID and Mass Vaccination of £0.04 and £0.2m respectively.

Cash - At the end of M1, the cash balance was £67.4m. The cash balance continues to be high due to the impact of projects and expenditure related to COVID-19.

Human Resources

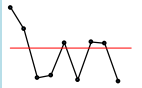
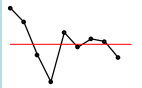
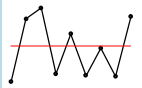
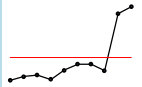
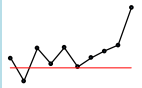
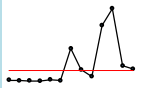
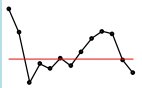
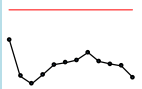
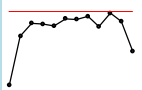
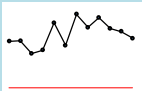
In April overall sickness was 5.5% which is a 0.1% decrease from March. Front line Nursing, Midwifery and HCA's was 7.8% which is a decrease of 0.1% since March . Front line Nursing and Midwifery was 6.1 % which was an increase of 0.1% since March. Now that levels of absence due to Covid have reduced the HR Advisory team are focussing on reducing normal sickness levels in particular long term sickness absence. 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 at 53.8%. Mandatory training compliance remains below the target as 76.4%. Compliance for both has improved but 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:

▲ = 2021-22 Contract Indicator
▲£ = 2021-22 Contract Indicator with financial penalty
● = 2021-22 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Apr-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-21	2.1%	2.1%	No Target	3.1%		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. We continue to independently benchmark the COVID performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Nov-20	1.09		1.00						
Mortality: HSMR (HED)	Q	▲	Dec-20	82.9		100.0	101.6					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Dec-20	84.3		100.0	101.2					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Dec-20	104.9		100.0	99.4		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	A spike in readmissions reflects COVID third wave but remains within expected range	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jan-21	133.9		100.0	96.7		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,	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jan-21	149.6		100.0	112.4					
% Medical Outliers	F&P	T	Apr-21	1.1%	1.1%	1.0%	1.6%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Apr-21	41.4%	41.4%	52.5%	58.8%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Mar-21	71.6%		90.0%	74.8%		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 - a recent deterioration is under review.		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 daily 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	▲	Mar-21	78.5%		95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Mar-21	96.6%		95.0%	96.8%					

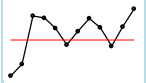
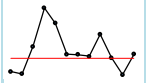
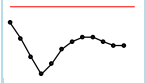
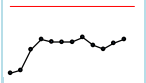
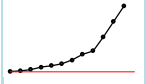
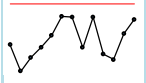
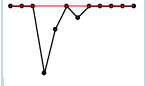
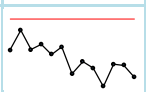
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	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	▲	Q4	93.7%		83.0%	90.4%		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	▲£	Apr-21	0	0	0	3		No never events reported in April 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%			Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Apr-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	▲£	Apr-21	0	0	0	2		There were no cases of MRSA in April 2021. YTD = 0.	Quality and patient safety	The annual tolerance for CDI for 2020-21 has not yet been published. The 2019-2020 trajectory is being used in the absence of publication of the 2020-21 objectives.	SR
Number of hospital onset and community onset C Diff	Q F&P	▲£	Apr-21	8	8	48	40		There were 8 positive C Diff sample in April 2021. YTD there have been 8 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Apr-21	2	2	No Target	29		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Feb-21	0		No Contract target	1		No hospital acquired category 3 or 4 pressure ulcers with lapses in care in February 2021.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April 20.	SR
Number of falls resulting in severe harm or death	Q	▲	Mar-21	0		No Contract target	31		No falls resulting in severe harm in March 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%			**March 20 to April 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 and third wave, we have understood the risk in patients and minimised events. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway. A new spike reflects third COVID wave. All guidance is in place.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Feb-21	12		No Target	69					
To achieve and maintain CQC registration	Q		Apr-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	Mar-21	88.9%		No Target	92.2%		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	Mar-21	6		No Target	49					

Apr-21

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Mar-21	96.9%		93.0%	94.3%		There has been a significant increase in 2WW referrals that are currently being managed within capacity. It is too soon to determine if this trend is the new normal or a result of catch up in the system.	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	▲ £	Mar-21	97.1%		96.0%	97.5%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Mar-21	85.9%		85.0%	86.5%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Mar-21	70.6%		92.0%	70.6%		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. Recovery plans are in place.	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%		99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Mar-21	1,469		0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-21	0.6%	0.6%	0.8%	0.4%		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	▲ £	Mar-21	100.0%		100.0%	97.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0						
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-21	69.1%	69.1%	95.0%	78.0%		Accident and Emergency Type 1 performance for April 2021 was 69.1% and YTD 69.1%. The all type mapped STHK Trust footprint performance for April 2021 was 82.9% and YTD 82.9%. The Trust saw average daily attendance levels significantly increase in April 21 compared with March 21, with the average daily attendance of 352 up from 325 in March and 277 in February . Total attendances for April 21 were 10,586, March 2021 were 10,075, February 2021 were 7783. Total ambulance turnaround time was achieved in April 2021 with 29 mins on average. There were 2729 ambulances conveyed in April (busiest Trust in C+M/GM) compared with 2899 in March.	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	▲	Apr-21	82.9%	82.9%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Apr-21	0	0	0	0					

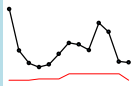
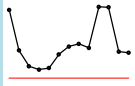
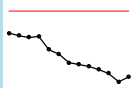
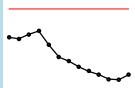
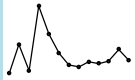
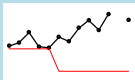
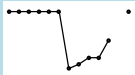
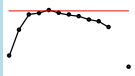
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Feb-20			0			**March 20 to April 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	Apr-21	17	17	No Target	242		% new (Stage 1) complaints resolved within agreed timescales dipped below the 90% target in April. There were a further 5 complaints in April 2021 for Community, therefore the total number of complaints in April 2021 was 22.	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, but dipping in April. This is being closely monitored to bring it back above target.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Apr-21	17	17	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Apr-21	82.4%	82.4%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to April 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	Apr-21	308	308		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Apr-21	102	102		72					
Friends and Family Test: % recommended - A&E	Q	▲	Mar-21	84.7%		90.0%	88.4%		FFT submissions recommenced from January 2021, with recommendation rates above target in month for inpatients, antenatal, postnatal and postnatal community, but below target for ED, Delivery Suite and Outpatients.	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%		90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Mar-21	100.0%		98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-21	97.8%		98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Mar-21	95.8%		95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Mar-21	100.0%		98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-21	94.0%		95.0%	94.2%					

Apr-21

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Apr-21	5.5%	5.5%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In April overall sickness was 5.5 % which is a 0.1% decrease from March . Front line Nursing, Midwifery and HCA's was 7.8% which was a decrease of 01.% from March. 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 undertake a review of sickness absence daily and the focus of the team currently is to manage long term sickness absence to get people back in to work. The team work closely with HWWB on all cases. Additional health and well being support is provided to help staff with stress, anxiety and depression caused by the impact of COVID19.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Apr-21	7.8%	7.8%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-21	53.8%	53.8%	85.0%	51.3%		Appraisal compliance in April has improved but is below target at 53.8%. Mandatory training compliance has also improved but still below the target at 76.4%. 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	Apr-21	76.4%	76.4%	85.0%	75.7%					
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	Apr-21	0.9%	0.9%	No Target	12.9%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. The Trust is undertaking a project with NHSE regarding retention of Nurses and this is part of our wider retention strategy and action plan for 2018/19 for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Apr-21	Discontinued	Discontinued	N/A			Planning and funding arrangements have been confirmed for the first six months of the 2021/22 financial year only (H1)	Delivery of Control Total	A full financial settlement for October to March (M7-12) will be agreed once there is greater certainty around the circumstances facing the NHS in the second half of the year.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Apr-21	-	-	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Apr-21	-	-	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-21	21	21	10						
Capital spend £ YTD (000's)	F&P	T	Apr-21	800	800	17,600						
Financial forecast outturn & performance against plan	F&P	T	Apr-21	-	-	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-21	80.3%	80.3%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-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	▲£	94.6%	100.0%	86.7%	76.5%	100.0%	100.0%	45.5%	77.8%	100.0%	100.0%	96.3%	100.0%	97.4%	91.8%	85.0%		92.7%		RC
	Total > 62 days		1.0	0.0	1.0	2.0	0.0	0.0	3.0	3.0	0.0	0.0	0.5	0.0	0.5	10.0			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	▲£	82.6%	76.0%	85.7%	76.5%	100.0%	75.0%	83.3%	90.0%	80.0%	89.5%	78.9%	58.6%	87.5%	79.5%	85.0%		83.2%		
	Total > 62 days		2.0	3.0	1.0	2.0	0.0	1.0	1.0	1.0	2.0	1.0	2.0	6.0	1.0	21.0			13.0		
	Total > 104 days		1.0	1.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	1.0	6.0			2.0		
Upper GI	% Within 62 days	▲£	80.0%	60.0%	80.0%	60.0%	100.0%	100.0%	100.0%	66.7%	100.0%	83.3%	100.0%	100.0%	63.2%	81.9%	85.0%		90.5%		
	Total > 62 days		1.0	2.0	0.5	2.0	0.0	0.0	0.0	1.5	0.0	1.0	0.0	0.0	3.5	10.5			6.5		
	Total > 104 days		0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	3.0			1.0		
Urological	% Within 62 days	▲£	79.3%	74.2%	66.7%	100.0%	100.0%	90.0%	95.7%	87.0%	77.1%	86.7%	80.0%	92.3%	79.2%	84.6%	85.0%		85.5%		
	Total > 62 days		3.0	4.0	2.0	0.0	0.0	1.0	0.5	1.5	4.0	2.0	2.5	1.0	2.5	21.0			25.0		
	Total > 104 days		0.0	1.0	2.0	0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	6.0			5.5		
Head & Neck	% Within 62 days	▲£	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%	50.0%	85.0%		29.3%		
	Total > 62 days		2.0	0.0	0.0	0.0	0.0	0.5	1.5	2.0	0.0	1.0	1.0	1.5	1.0	8.5			20.5		
	Total > 104 days		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	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	▲£	100.0%	100.0%	40.0%	100.0%	100.0%	100.0%	66.7%	69.2%	69.2%	0.0%	55.0%	60.0%	53.8%	64.3%	85.0%		69.1%		
	Total > 62 days		0.0	0.0	3.0	0.0	0.0	0.0	1.0	2.0	2.0	1.0	4.5	1.0	3.0	17.5			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	2.0			1.5		
Lung	% Within 62 days	▲£	75.0%	69.2%	86.1%	100.0%	88.9%	60.0%	100.0%	100.0%	81.8%	71.4%	100.0%	75.0%	100.0%	85.1%	85.0%		85.0%		
	Total > 62 days		1.0	2.0	5.0	0.0	1.0	2.0	0.0	0.0	1.0	2.0	0.0	1.0	0.0	14.0			10.5		
	Total > 104 days		0.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0			2.5		
Haematological	% Within 62 days	▲£	100.0%	50.0%	66.7%	100.0%	66.7%	80.0%	100.0%	100.0%		100.0%	50.0%		75.0%	77.9%	85.0%		86.7%		
	Total > 62 days		0.0	1.0	0.5	0.0	1.0	1.0	0.0	0.0		0.0	3.0		1.0	7.5			7.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0		0.0	0.0		0.0	1.0			1.0		
Skin	% Within 62 days	▲£	95.2%	91.2%	100.0%	92.5%	97.4%	100.0%	89.5%	92.2%	93.8%	100.0%	96.8%	85.5%	94.3%	93.9%	85.0%		92.0%		
	Total > 62 days		1.5	2.5	0.0	1.5	1.0	0.0	4.0	3.0	2.0	0.0	1.0	4.0	2.5	21.5			26.5		
	Total > 104 days		1.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.5	3.0			9.5		
Unknown	% Within 62 days	▲£					100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	80.0%	91.7%	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	1.0			2.0		
	Total > 104 days						0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5			0.5		
All Tumour Sites	% Within 62 days	▲£	88.0%	82.0%	81.6%	87.5%	96.0%	92.7%	85.8%	85.8%	85.4%	90.2%	85.1%	81.3%	85.9%	86.5%	85.0%		86.2%		
	Total > 62 days		11.5	14.5	13.0	7.5	3.0	5.5	11.0	14.0	12.5	8.0	14.5	14.5	15.5	133.5			141.0		
	Total > 104 days		3.5	2.0	2.0	3.5	0.0	4.0	0.5	1.5	2.0	0.0	1.0	3.0	3.0	22.5			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%	100.0%	100.0%	85.0%		80.0%		
	Total > 31 days							0.0		0.0		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	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)025
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during April 2021. There were five Executive Committee meetings held during this period. The Executive Committee approved: • Temporary over establishment of district nurses • Medical Care Group – respiratory consultant business case • Temporary additional upper gastrointestinal surgeon At every meeting the Executive Committee discussed 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: 27th May 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were five Executive Committee meetings in April 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, and COVID-19 specific expenditure requests. The operational Gold Command meetings were reduced to weekly in April, as the number of COVID-19 patients admitted to the Trust continued to reduce.

2. 1st April 2021

2.1 Temporary over establishment of district nurses

The Director of Operations sought approval to over recruit to permanent positions to mitigate current staffing pressures caused by a combination of sickness absence, maternity leave and turnover. It had proved difficult to obtain cover via temporary appointments, the staff bank or agencies, so the proposal was to undertake permanent recruitment. With normal staff turnover rates this represented a limited risk to the pay budget. The Executive Committee approved the permanent recruitment to 4 FTE additional band 5 positions.

2.2 Staff Grade, Associate Specialist and Speciality Doctors (SAS) Contractual Reform

The Deputy CEO/ Director of HR briefed the committee on the new SAS contract that came into effect on 1st April and the transitional arrangements for existing SAS Doctors working for the Trust. In future there would be a single specialist grade pay scale. Transitional arrangements must be completed by 30th September 2021 and central funding has been allocated to support this process. All future SAS appointments will be on the new contractual terms.

2.3 COVID Issues

There had been no new nosocomial infections reported since 28th February 2021 and all previously reported outbreaks were closed.

3. 8th April 2021

3.1 Trust Board Agendas

The Director of Corporate Services presented the draft Board agendas for the April meetings. Proposals to include a review of the NHS White Paper and its implications for the local health system were agreed for the Strategy Board discussion.

3.2 Car Parking Concessions

The Director of Corporate Services presented the plans to implement car parking concessions for specific groups of patients and visitors, in line with the recent NHSE/I directive. The new schemes would become operational on 26th April and reviewed after 6 months to evaluate the administrative costs and impact on car parking income and management.

3.3 Re-introduction of patient visiting

The Director of Nursing, Midwifery and Governance outlined the options for a phased re-introduction of hospital visiting as the COVID-19 infection risk was reducing. The Chief Nursing Officer had mandated pregnant women being accompanied to all appointments and during labour, from 12th April. Arrangements had been put in place to test partners to facilitate this. The North West NHSE/I team were also re-visiting their guidance on a risk based approach to visiting for other inpatients and this would inform a Trust task and finish group. It was agreed that patients with a longer length of stay should be the first priority for allowing visitors back to the wards, but a risk based approach would need to be taken to regulate the number of visitors on the ward at a time, so that social distancing and all infection prevention and control safeguards could be maintained. Members also discussed how to improve the communications between patients and families, which despite the introduction of family liaison officers on high throughput wards, remained very challenging.

3.4 Mid Mersey Digital Alliance (MMDA)

The Director of Informatics reported on discussions with Bridgewater Community Services NHSFT on the services provided by MMDA.

3.4 COVID Issues

There had been no new nosocomial infections and it was agreed that reporting should now be by exception. Expenditure requests to extend existing funding for; staff car parking, additional waste management porters, and ward based medical cover were approved.

Proposals were also agreed to increase sonographer capacity for a limited period to support the increased referrals and recovery of the two week waiting times for patients on the breast cancer pathway.

Committee discussed the negative publicity about the Astra Zeneca COVID-19 vaccine and the impact this could have on some staff groups in taking up their second dose appointments. It was agreed that this should be closely monitored and the Health Work and Wellbeing team should continue to contact staff who had not yet been vaccinated to discuss any worries about the vaccine.

4. 15th April 2021

4.1 Safer Staffing

The Director of Nursing, Midwifery and Governance presented the safer staffing report for March. This showed an improving position reflecting the reductions in sickness and absence related to COVID-19, but there were still a number of areas of concern. In particular members discussed the actions being taken to support the maternity service and ward 2E.

4.2 Medical Care Group – Consultant Business Case

The Director of Operations and Performance introduced the business case which sought approval to create 2 new consultant posts for Medical Care. The care group had identified a number of unallocated consultant sessions across all medical specialties and was seeking to combine these to recruit 2 FTE respiratory consultants. Therefore the posts could be funded from existing resources. Committee sought assurances that the proposals were supported by all Clinical Directors in the Medical Care Group and this was confirmed. The increased respiratory capacity was needed to enhance ward cover, respond to the increase in referrals to the Trust and support a rapid access model from ED. The business case was approved.

4.3 Patient Pathways Project

The Director of Operations and Performance reported on the progress that had been made to review the waiting list management processes for skin cancer pathways. The work to date had also included a review of all patients over the last three years. It was noted that the proposed improvements included both process and system changes and were multifactorial. The improvements would however also be applied across a range of other cancer specialties. To complete the proposed work streams required investment over a 2 year period, to provide additional resilience to the current process until the long term solutions could be developed and implemented. Monthly progress reports would be brought to the Executive Committee and a briefing was also being presented at the Quality Committee in April.

4.4 Risk Management Council (RMC) and Corporate Risk Register (CRR)

The Director of Corporate Services presented the Chair's assurance report from the RMC meeting held on 13th April. The number of high risks escalated to the CRR had now reduced from 24 to 18 as the pressures from COVID eased. The RMC had received reports from the Claims Governance Group and the Information Governance Steering Group.

4.5 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly review of the BAF for discussion prior to presentation at Trust Board. It was agreed that no changes to the strategic risk scores should be recommended at this time.

4.6 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for March and members agreed changes to the commentary.

4.7 Changes at NHSE/I

The Chief Executive reported that Bill McCarthy the Director of NHSE/I North West had announced his retirement.

4.8 COVID Issues

There were no issues escalated from Gold Command. Committee discussed the progress in developing plans to re-introduce visiting for inpatients.

5. 22nd April 2021

5.1 NHS Charities Grants

The Deputy CEO/ Director of HR presented a summary of the £129k of grants that had been received from NHS Charities Together, which included the Captain Sir Tom Moore Foundation and how they had been allocated. The two major projects were the Thank You week for staff, which included the purchase of the Trust hoodies, and plans for the COVID memorial rainbow garden. It was agreed that if further funding became available the priority would be to create a similar rainbow garden at St Helens Hospital. Members thanked NHS Charities Together and the public who had made donations for NHS staff.

5.2 Annual Leave Payments

The Deputy CEO/Director of HR briefed the committee on the recent employment law case; the Flowers Judgement which meant that regular overtime pay should be taken into account when calculating annual leave payments. Nationally an agreement had been reached for NHS staff with the Trade Unions for retrospective payments to affected staff for 2019/20 and 2020/21 which would be calculated via ESR and paid by September 2021.

5.2 Parafricta booties – benefits realisation

The Director of Nursing, Midwifery and Governance presented an analysis of the benefits of the investment in parafricta booties in March 2020, to reduce pressure ulcers. The analysis demonstrated that the increased availability of the booties prevented an increase in heel and ankle pressure ulcers but had not reduced the numbers that were caused by lapses in care. There was therefore an optimal investment level that maximised the benefits that could be achieved. In addition there was an opportunity for increased value for money by decontaminating and re-using the booties. The committee agreed temporary funding to establish a tracking and decontamination process and the impact would continue to be monitored.

5.3 Site Development Plans and Feasibility Study

The Director of Corporate Services reviewed the progress that had been made against the strategic site development plans and other capital developments in response to the pandemic, during 2020/21. Also presented were the feasibility studies to increase theatre capacity at the Whiston Hospital site. The studies demonstrated that two additional theatres could be accommodated utilising existing space, although this would be dependent on relocating the current functions. The pressure on essential infrastructure was also noted and a step change in capacity would be needed to support

all the potential development plans. It was agreed to move to detailed design and tender for two theatres and further feasibility reviews for the remainder of the accommodation in this area to support clinical activity and in particular elective recovery.

5.4 Upper gastrointestinal surgery consultant

The Director of Operations and Performance outlined an opportunity to increase upper GI surgeon consultant capacity to help reduce the COVID-19 backlog, also support bariatric surgery and the general surgery rota. This was acknowledged as an opportunity but under block contract arrangements could be a cost pressure for the Trust. It was agreed to approve the post for a 12 month fixed term period, as this was the right thing to do for patients on the waiting list and discussions were on going about how the future funding flows would recognise referral growth and service developments.

6. 29th April 2021

6.1 Ockenden Maternity Investment Bid

The Director of Nursing, Midwifery and Governance presented the bid that was being submitted by the Trust in relation to the additional £96m of national investment that had been announced for Maternity Services. There were specific criteria to bid for additional posts to support the key recommendations in the Ockenden Report. It was noted that for 2021/22 there would be direct allocations to Trusts, but in subsequent years this investment would be included in commissioning baselines, so there was a risk to securing the recurrent funding.

6.2 Digital Aspirant Programme (DAP) Report

The Director of Integration presented the DAP quarterly progress report. Of the 9 major work streams 3 were reported as complete, 4 on track to deliver within the planned timescales and 2 were experiencing some delays as a result of COVID-19. Overall the DAP remained green rated. The upgrade of Careflow EPR was now scheduled for July 2021.

Committee discussed the actions that were being taken to improve the process for sending discharge letters to GPs.

6.3 COVID Issues

The Director of Operations and Performance reported that there were now only 5 COVID positive inpatients in the hospital.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)026

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

Date of Committee Meeting: 18th May 2021

Reporting to: Trust Board

1. Matters Discussed:

1.1 Ian Clayton, Non-Executive Director and Barney Baguley 5th year Medical Student observed the meeting.

1.2 Action Log

1.2.1 It was reported that the safety culture questionnaire in Theatres had now closed, with over 150 responses being received, which were now being analysed

1.2.2 There had been a reduction in Pressure Ulcers in 2020/21, which were being analysed and a full report would be made to the Committee in June

1.2.3 The deteriorating patient group had now met and data collected to inform earlier detection and intervention, noting that the effective use of enhanced technology had a key role to play going forward

1.3 Quality Performance - Integrated Performance Report (IPR)

Review of the quality, performance and workforce indicators. Committee discussed falls and noted that retrospective review had confirmed there were 31 resulting in severe harm during 2020/21, with a review of the causes being undertaken. Committee also discussed the increase in HSMR which had been investigated by the Medical Director and Business Information team. Part of the increase was as a result of the third wave of COVID-19 but in addition a technical error had been found which meant the patient comorbidities had not been factored into the monthly calculation, which had significantly skewed the figures. The impact of both factors was being investigated and if possible corrected on the national system. There was assurance that the technical problem had been resolved so this would not be repeated next month. Committee also discussed the increase in ED attendances and the actions that were being taken by the system to ensure patients could access primary care appointments where this was more appropriate. Committee also discussed the e-discharge performance and it was accepted that this was the contractual target reflecting discharges from ICE, however more work was being undertaken by the Executive to ensure that all discharge summaries were tracked and reported. The Director of Nursing, Midwifery and Governance reported on the actions taken in response to the recent prevention of future deaths order and the formal response that had been sent to the Coroner. The Committee asked for an update on the project to refresh the IPR.

1.4 Quality Account 2020/21

Committee reviewed the draft Quality Account and noted the process for independent audit and review by stakeholders. The Quality Account was approved and is recommended to the Board.

1.5 Maternity IPR Dashboard Review
The report provided assurance in respect of the maternity IPR dashboard indicators that had been rated "red" during 2020/21. Benchmarking data and changes in guidance had not been reflected in the IPR from 2019/20 to 2020/21 because of COVID-19 which resulted in some of the tolerances being out of date. The Ockenden Report recommendations had also changed some expectations. Committee was assured that services continued to be safe and benchmarked favorably against regional and national comparators.

1.6 Maternity Staffing – Quarter 3
The quarter 3 report provided assurance that maternity staffing levels continued to be within the Birthrate plus recommendations with a rolling midwife to birth ration of 1:26. There was assurance that all staffing red flag incidents are triangulated with staffing and acuity levels. The new birth rate plus review had now commenced and would be completed by July 2021, which would provide a new baseline aligned to the latest national guidance.

1.7 Maternity – Perinatal Clinical Quality Surveillance Model
The report detailed the actions being taken by the Trust to implement the revised surveillance model which had been published in December 2020, all the identified actions were due to be completed by September 2021 and progress would continue to be monitored.

1.8 Patient Safety Council (PSC) Chair's Assurance Report
The PSC had received reports on serious incident action plans, the infection prevention report for Q4, safeguarding activity Q4, maternity Q3 incidents, Medical Care Group patient safety, learning from claims and inquests in Q3 and Q4, Clinical Support Services Care Group pathology results audit, medical devices report Q3 and Q4 and a VTE thematic deep dive. The Council had also reviewed falls and compared 2019/20 with 2020/21 noting the number of falls resulting in severe harm had increased to 9 per 1000 bed days. The Committee discussed concerns relating to the lack of tier 4 beds for young people with mental health issues and the ongoing work at regional level to review local capacity.

1.9 Patient Experience Council (PEC) Chair's Assurance Report
The Council had heard a patient story relating to the Macmillan Information Centre and the impact this had on patients newly diagnosed with cancer. The Council received positive feedback from Knowsley Healthwatch. There were also reports on the care provided to patients with mental health issues and learning disabilities during the pandemic and feedback from the Bereavement Group. The PEC had undertaken an annual meeting effectiveness review.

1.10 Workforce Strategy – Action Plan
The report provided a progress report on the 2020/21 Workforce Strategy action plan, which had been carried forward to 2021/22. All the actions had either been completed or were on track from completion by the revised deadlines.

1.11 Clinical Effectiveness Council (CEC) Chair's Assurance Report
CEC had received a presentation from the Medical Emergency Team (MET) analysing the demand for the service during 2020/21, and a report from the Department of Medicine for the Elderly (DMOP), including the stroke and frailty services. There was also a service report from Sexual Health which detailed how services had been transformed during COVID-19 to ensure access was maintained.

It was noted that there was a backlog of clinical policies were review had been postponed during COVID-19. CEC had also discussed the increase in HSMR reported for January 2021.

1.12 NICE Guidance Compliance Reports Q2 and Q3
101 new pieces of guidance had been received of which 51 were applicable to the Trust. For 21 of these the Trust was fully compliant, for 9 there was partial compliance and for 21 the assessment was still being undertaken by clinical leads.

1.13 Quality Committee annual effectiveness review
The Committee received the report and agreed the recommendations. The principle concern of members remained papers being issued late and the length of the agenda. The review had highlighted the need for a separate Workforce Committee, which would take some pressure off the Quality Committee.

Matters for escalation:

Committee felt the increased HSMR figure should be highlighted to the Board, noting that the cause of the spike had been identified and work was ongoing to correct the data

Recommendation(s): To note the report

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

Date of Meeting: 26th May 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)027

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 20th May 2021

Summary:

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
P Growney – NED
AM Stretch – Deputy Chief Exec & Director of HR
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
R Pritchard Jones – Medical Director
G Lawrence – Deputy Director of Finance & Information
A Bassi – Divisional Medical Director
J Foo – Assistant Director of Operations – Medical Care
D Stafford – Assistant Director of Operations – Medical Care
A Matson – Assistant Director of Finance – Financial Management
S Burrows – Operational Manager
B Bagguley – Medical Student

Agenda Items

For Assurance

A) Integrated Performance Report

- Target 2 week wait cancer performance was achieved in March, at 96.9%. 62 day and 31 day targets were also met, at 85.9% and 97.1% respectively.
- The committee is assured that data recording issues affecting the HSMR score have now been resolved.
- Non-elective attendances have continued to increase. Accident & Emergency Type 1 performance was 69.1% in April but there have been significant increases in attendances compared to 2019/20.
- The ambulance turnaround time target was achieved in April.
- Sickness continues to improve, with an overall Trust reduction of 0.1% from March to April. Front line Nursing, Midwifery and HCA sickness has also reduced by 0.1%.
- The committee is assured that plans are in progress to address underachievement of appraisal compliance through introduction of appraisal windows.

B) Finance Report Month 1

- No external reporting will be submitted for April as system funding is not yet finalised.
- The system level assumption is that a breakeven position will be achieved and this is therefore reflected in the Trust reporting a breakeven position for Month 1.
- The Month 1 position includes £2.5m Elective Recovery Fund (ERF) income based on activity performance.
- Month 1 activity performance by other organisations across the system is not yet known

so this income remains a risk. A marginal rate of 25% will be recovered from organisations not achieving activity performance targets. The committee discussed potential inconsistencies in approach across organisations.
- As at Month 1, the Trust had a cash balance of £67.4m and Better Payment Practice Code targets had been achieved in the month.
- The Trust has a total 2021/22 capital plan of £17.7m.

For Approval

A) H1 (April to September 2021) financial plan

- Financial arrangements for H2 onwards not confirmed
- A draft 2021/22 plan of £501m (full year effect) was previously approved by the Board. This has been amended to reflect revised inflation assumptions, £8.3m ERF income offset by expenditure and a CIP target of £15m (3%)
- Key risks to H1 plan:
    - System funding gap not yet finalised – may require savings in excess of 3%
    - System has not yet allocated income therefore breakeven Trust position cannot be guaranteed at this stage
    - ERF income is dependent on achievement of activity plans
- The committee agreed to recommend approval of the final expenditure plan by the Board, subject to income values being confirmed by the Health & Care Partnership and agreement of the system gap with savings less than or equal to 3%
- The committee authorised delegation of authority to the Chief Executive and Director of Finance for approval of any adjustments to the final plan prior to submission on 24th May

C) Meeting Effectiveness Review

- A review of the 2020/21 Finance and Performance Committee meetings has now been completed.
- Minor adjustments have been made to the Terms of Reference and annual workplan as a result of the review. The updated Terms of Reference will be submitted to the Board for approval.

For Information

N/A

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: 20th May 2021

Trust Board

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)028
Title of paper: Incidents, Complaints, Concerns & Claims – Quarters 3 & 4 2020-21
Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarters 3 & 4 2020-21.

Summary
• Total incidents reported in Q3 = 4229 (5.2% increase on Q3 2019-20) and Q4 = 4052 (7.74% increase on Q4 2019-20)
• Total patient incidents in Q3 = 3621 (8.03% increase on Q3 2019-20) and Q4 = 3416 (9.18% increase on Q4 2019-20)
• Total patient incidents graded as moderate/severe/death in Q3 = 47 (7.84% decrease on Q3 2019-20) and Q4 = 35 (20.69% increase on Q4 2019-20)
• The highest number of incidents reported relate to:
  ○ Pressure ulcers (Q3 = 791 and Q4 833) this includes pressure ulcers acquired prior to admission to Trust services
  ○ Patient slips, trips or falls (Q3 = 588 Q4 = 604)
• 63 complaints received in Q3 and 71 in Q4, both representing a decrease from the previous year's quarterly figures of 85 and 88 respectively
• 1082 PALS contacts received in Q3 and 1252 in Q4, both representing a significant increase from previous year's quarterly figures of 739 and 813 respectively
• 13 new claims received in Q3 compared to 19 in Q3 2019-20 and 7 new claims received in Q4 compared to 12 in Q4 2019-20
• The top reasons for patient complaints, PALS contacts and claims were consistent with previous reports and were clinical care, communications, admissions & discharges, appointments, patient care/nursing care and values and behaviours of staff

Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 26th May 2021

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarters 3 & 4 2020 -21, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

During Q3 there were 4229 incidents reported, of which 3621 were patient safety incidents. This represents an increase from Q2 of 9.16% in all incidents and 9.99% increase in patient incidents. During Q4, there were 4052 incidents reported (a decrease of 4.19% from Q3) with 3416 of those incidents affecting patients (a 5.66% decrease on Q3).

Q3 had 19 incidents reported to StEIS whilst Q4 had 20 incidents reported to StEIS compared to 21 incidents reported in Q2. During Q3 there were 47 patient safety incidents categorised as moderate harm, severe harm or death whilst in Q4 there were 35 incidents reported. Again, in comparison, there were 30 categorised as moderate harm, severe harm or death in Q2. In comparison to the same periods for the previous financial year, Q3 2019-20 had 51 incidents of moderate harm or above and Q4 2019-20 had 29.

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories are pressure ulcers (791 during Q3 and 833 during Q4), which includes all patients who are admitted with pre -existing pressure ulcers and slips, trips and falls (588 during Q3 and 604 during Q4). These are consistently the highest reported incidents as in Q2 2020-21 there were 707 pressure sores reported and 507 falls.

Pressure ulcer figures include those acquired in the community and Trust acquired as detailed in the table below. Pressure ulcers have seen a rise of 32.05% in 2020-21 where 2987 incidents were reported, compared with 2262 incidents in 2019-20; this is largely due to the new Community Services taken on from 1st April 2020. This includes both Trust acquired and non-Trust acquired pressure ulcers and skin damage incidents.

Pressure ulcers by quarter 2019-2021

	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	20-21 Q3	20-21 Q4
Not STHK acquired	453	447	519	461	561	625	642	611
STHK Acquired	72	104	107	99	95	84	149	222

2.1. Review of incidents reported to StEIS in Q3 and Q4 2020-21

In Q3, the Trust reported 19 incidents to StEIS and 20 in Q4, as outlined in the table below.

Q3	Total	Q4	Total
Inpatient falls sustaining fractured neck of femur	9	Inpatient falls sustaining fractured neck of femur	5

Alleged abuse of patient by staff	2	Baby cooling incident meeting Healthcare Safety Investigation Branch (HSIB) criteria	3
	2	Failure to escalate deteriorating patient	3
Fall resulting in head injury	1	31 day cancer target breach	1
SCC Histology Delayed cancer diagnosis	1	Alleged abuse on patient by staff	1
Delayed cancer diagnosis	1	Inpatient fall suffering brain haemorrhage	1
Delay in escalation to senior	1	Inadequate fluid resuscitation	1
Anticoagulation omission	1	Left eye blindness due to TCI missed	1
Failure to rescue	1	NIV tubing disconnected	1
		Patient removed from melanoma surveillance pathway in error	1
		Delay in urgent blood results	1
		Inpatient fall suffering tibial haematoma	1

During Q3 there were 12 StEIS reports submitted to the CCG whilst during Q4 there were 14 reports submitted, all of which were submitted within the agreed timeframe. Actions taken and lessons learned are shared both internally and with the CCG.

2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS in the table above. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm incidents and Level 1 incidents are monitored within the Care Group.

2.3. Benchmarking

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

	October 2018 to March 2019		October 2019 to March 2020	
	Trust %	National %	Trust %	National %
No harm	86.9%	76.3%	82.4%	74.2%
Low	12.1%	21.7%	17.0%	23.6%
Moderate	0.7%	1.7%	0.4%	1.8%
Severe	0.2%	0.2%	0.1%	0.2%
Death	0.02%	0.1%	0.02%	0.1%

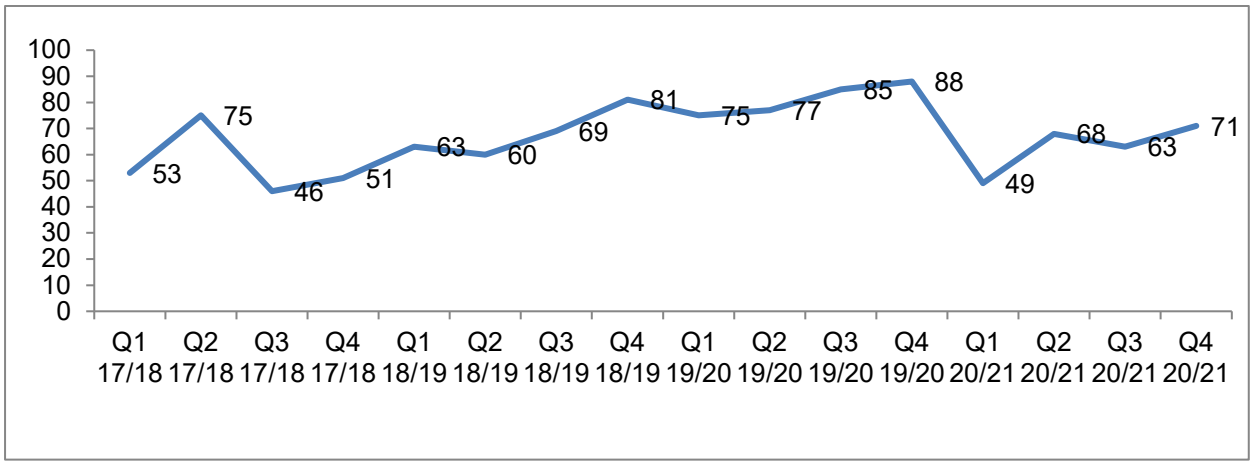
3. Complaints

The table below shows the number of received and opened first stage complaints in for 2020-21 by quarter. There has been a 23% decrease compared to the previous year and an 8% decrease compared to 2018-19. There has been a pleasing 36% reduction in second stage complaints compared to the previous two years. The main reasons that complainants lodge second stage complaints are because they want further information or do not agree with the findings.

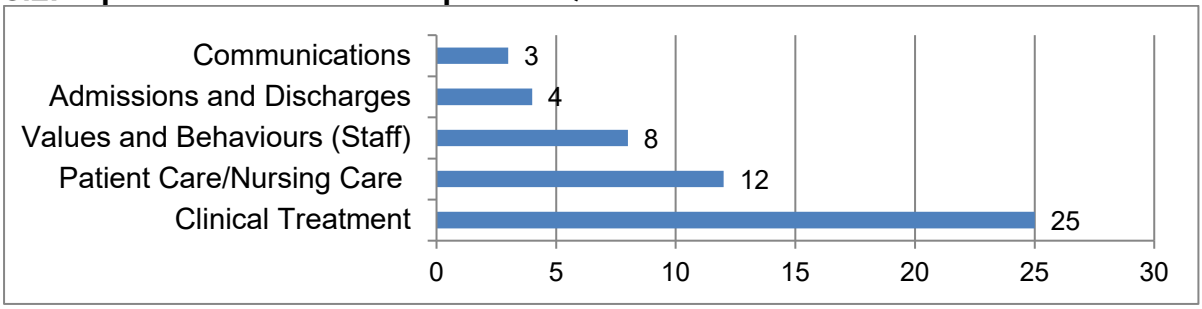
The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved in 2019-20. The Trust's response time to first stage complaints decreased to 89% in Q3, due mainly to the impact of the pandemic in being able to fully investigate and respond to complaints, however this recovered to over 96% in the final quarter. The Trust continues to sustain the improvements made to complaints handling in recent years.

Indicator	2018-19	2019-20	2020-21				
			Q1	Q2	Q3	Q4	Total
Total number of new complaints including community services	273	325	49	68	63	71	251
Total number of new complaints (excluding community services)	267	320	46	66	63	67	242
Acknowledged within 3 days – target 100%	99.3%	100%	100%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	92.1%	93.4%	98.8%	91.9%	89%	96.3%	94%
Number of overdue complaints	1	1	3	4	3	5	4
Second stage complaints	36	36	7	7	6	2	23

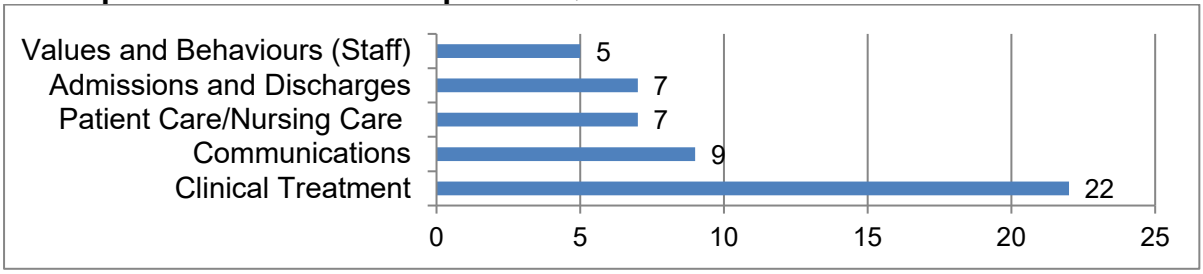
3.1. Complaints activity - first stage complaints received by quarter



3.2. Top five reasons for complaints Q3 2020-21



3.3. Top five reasons for complaints Q4 2020-21



The top five reasons have remained consistent throughout 2020-21, with clinical treatment giving rise to the most complaints.

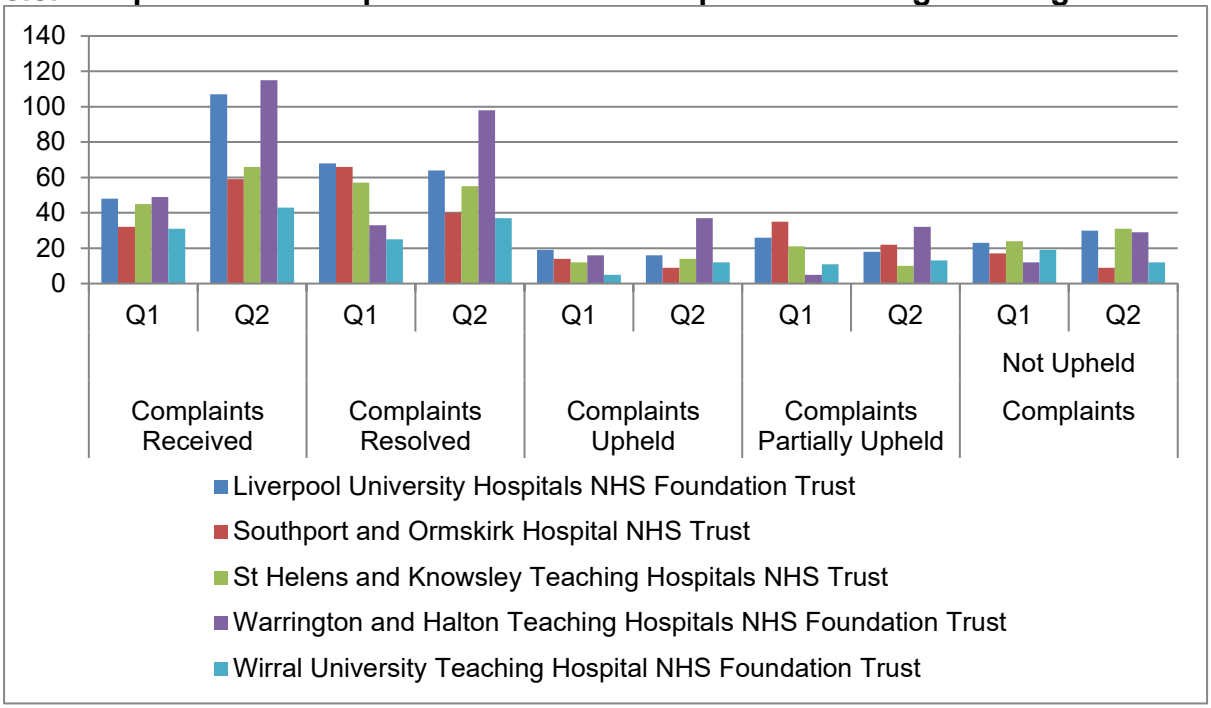
3.4. Complaints by top location

The Emergency Department received the highest number of complaints which can be attributed to the high levels of activity.

Location	Care Group	Q3	Q4	Total
Accident and Emergency	Medical Care Group	10	13	23
Ward 1C AMU	Medical Care Group	3	4	7
Ward 4A General Surgery	Surgical Care Group	0	4	4
Delivery Suite	Surgical Care Group	2	3	5
Ward 2 B Respiratory	Medical Care Group	3	3	6
Ward 2E Obstetrics	Surgical Care Group	2	3	5
Ward 2D General Medicine	Medical Care Group	2	3	5
Ward 1 B GPAU	Medical Care Group	2	2	4
Ward 3 C General Medicine	Medical Care Group	1	2	3
Ward 5A Medicine for Older people	Medical Care Group	2	2	4
Total		27	39	66

There are no emerging themes relating to the complaints received in the other wards.

3.5. Comparison of complaints received and upheld with neighbouring trusts



NHS Digital publishes data on written complaints for each of the NHS trusts in the country on a quarterly basis. The latest figures to be published are for Q1 and 2 2020-21. Please note the figures do not include verbal complaints.

3.6. Closed complaints

58 complaints were closed in Q3 and 32 in Q4, which is a significant decrease, due to the impact of the pandemic. It should be noted that majority of the complaints relating to clinical treatment are not upheld. Additional information on complaints is contained in Appendix 1.

3.7. Dissemination of learning

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

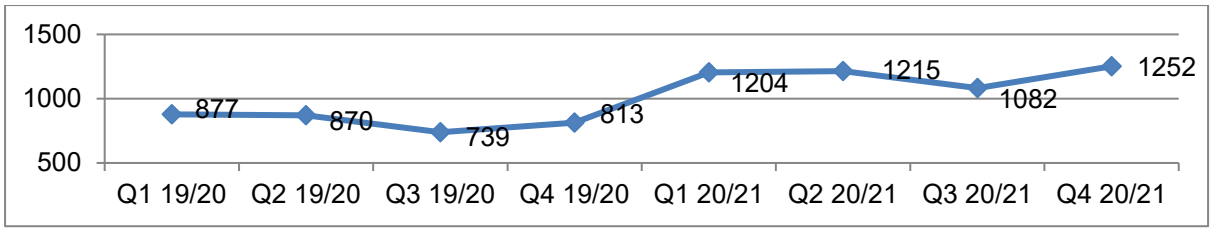
3.8. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

There were no PHSO enquiries or investigations opened in quarters 3 or 4 2020-21. However, an outstanding PHSO investigation from 2019-20 was concluded, with the complaint being partly upheld and financial remedy to the complainant was recommended and paid.

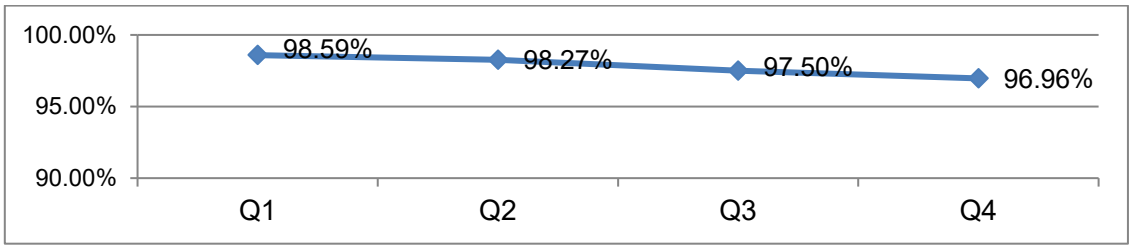
4. PALS

4.1. Number of PALS enquiries by quarter

The number of PALS contacts has continued to increase significantly in quarters 3 & 4 compared to previous years.



4.2. Percentage of PALS contacts resolved by quarter 2020-21



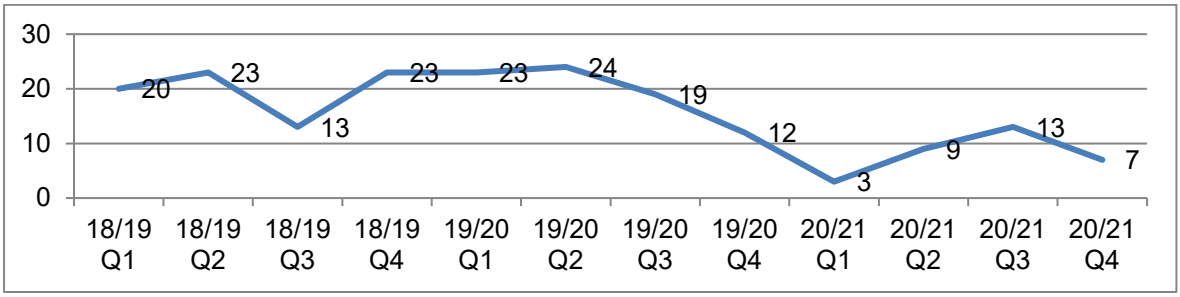
In Q4 2020-21, 96.96% of PALS enquiries were resolved as shown in the table above. 38 PALS enquiries converted to formal complaints, a 3.04% conversion rate, which is a slight increase from Q3 when 2.5% of PALS enquiries were converted to formal complaints. This will be closely monitored because it is starting to increase as performance for Q1 and 2 was 1.5% and 1.7% respectively, whilst noting that it represents a small proportion of contacts.

4.3. PALS enquiries by subject

The top 5 themes remain consistent with previous reports in the financial year. There has been an increase in PALS enquiries relating to communication in Q4 (n422) compared to Q3 when there were 362 enquiries.

		2020-21				
No	Theme	Q1	Q2	Q3	Q4	Total
1	Communications	590	372	362	422	1746
2	Signposting/compliments	118	147	131	103	499
3	Appointments	109	154	124	159	546
4	Clinical treatment	66	107	76	109	358
5	Patient care/nursing care	63	87	84	91	325

5. Clinical Negligence Claims



The number of new clinical negligence claims received in Q4 compared to Q3 has decreased by 46.1%, from 13 to 7, with a notable decrease from the 19 and 12 claims received in the previous year for Q3 & 4. It is anticipated that this will return to more usual levels following the pandemic.

The major reason for claims in Q 3 & 4 remains failure to diagnose or delay in diagnosis.

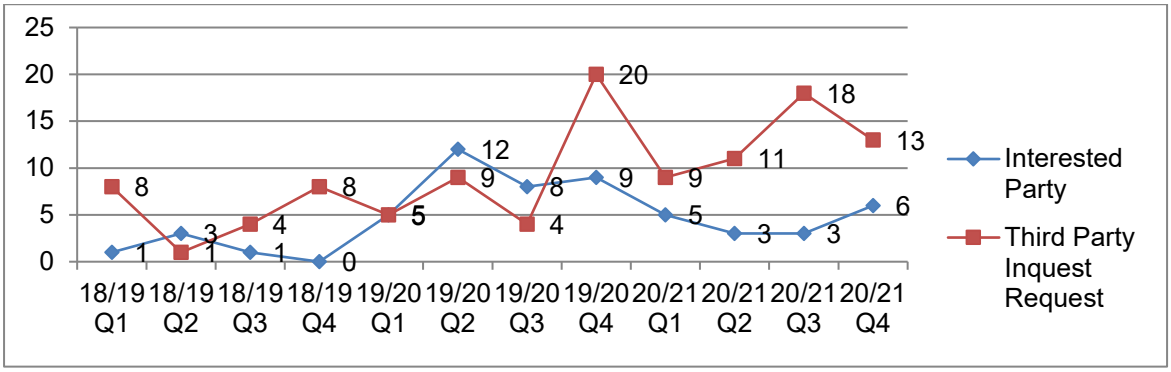
The highest number of claims in Q3 was in Obstetrics and Gynaecology = 3
The highest number of claims in Q4 was in Orthopaedic = 4

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

10 claims were settled with damages, 1 defended and 4 closed following file review. The Quality Committee report includes details of the actions taken following receipt of a claim.

6. Inquests

The table below illustrates the number of inquest requests received by quarter, noting that there were 21 inquests opened in Q3 and 19 in Q4. 2 Inquests were closed in Q3 for which narrative verdicts were given. 6 inquests were closed in Q4 for which 5 narrative verdicts were given and 1 Prevention of Future Deaths Order relating to a discharge summary which was not received by the deceased patient's GP.

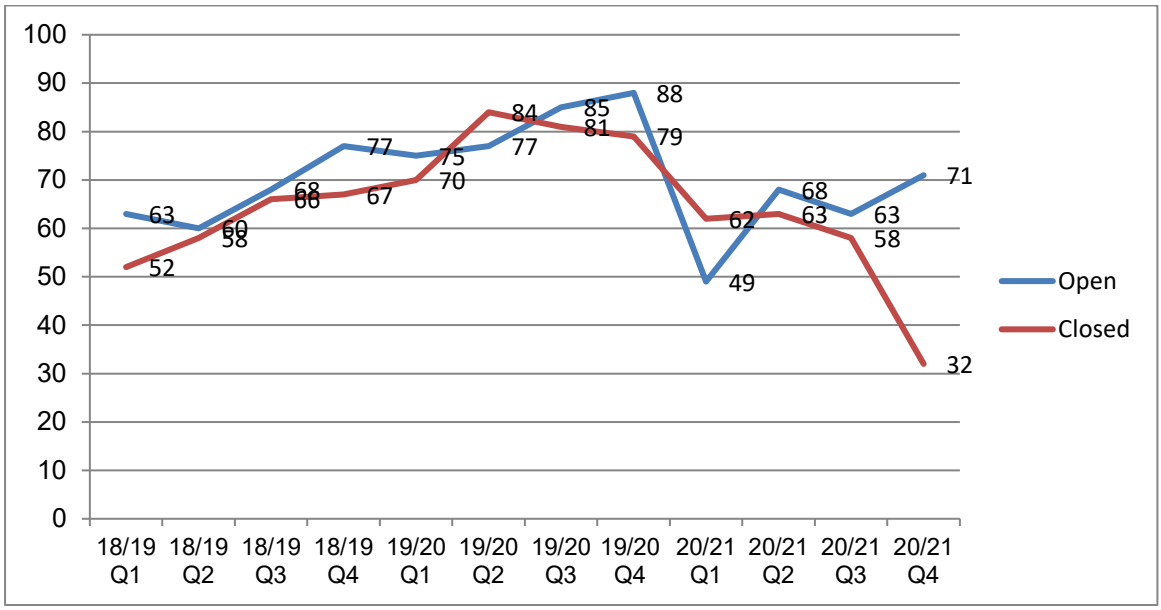


7. Recommendations

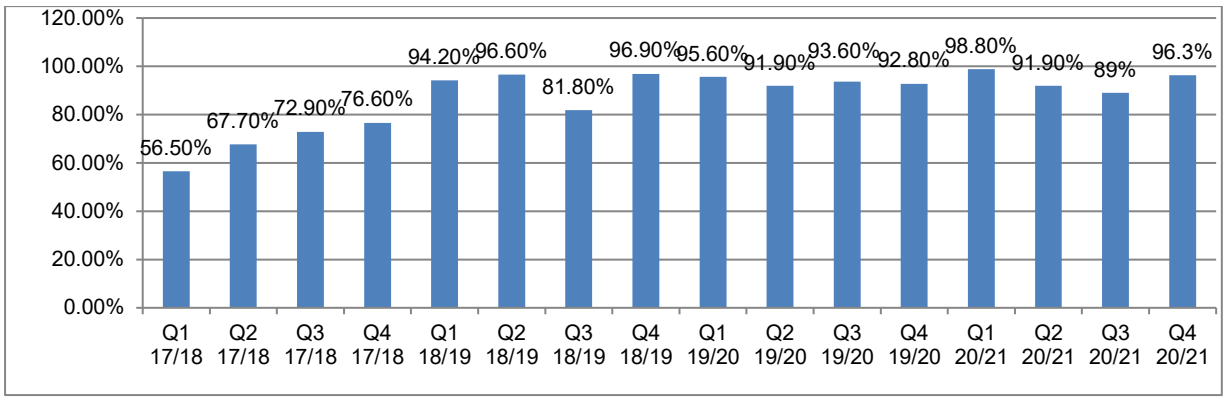
It is recommended that the Board note the report and the systems in place to manage incidents, complaints and claims.
ENDS

Appendix 1 – Summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in 2020-21

	Q1	Q2	Q3	Q4
Not Upheld Locally	27	36	22	9
Partially Upheld Locally	23	11	28	12
Upheld Locally	12	16	8	11
Total	62	63	58	32

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: **NHST(21)029**
Title of paper: Quality Account 2020-21
Purpose: To submit to the Board the final draft version of the Quality Account for 2020-21 for review and approval.
Summary: The final draft of this year's Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012. The deadline to publish the Account is 30th June. Both the Quality Committee and the Executive Committee have reviewed and approved the draft at their respective meetings held on 18th May and 13th May 2021. The Director of Nursing, Midwifery and Governance and Deputy Director of Governance will present the draft Account to a number of partners including CCGs at an event that is yet to be scheduled. The feedback from our partners will be included in the final published account. There was no requirement for the Account to be reviewed by our External Auditors this year, however, it is currently being reviewed by Mersey Internal Audit Agency to confirm compliance with the regulations. The final draft is attached as Appendix 1.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch
Recommendation(s): Members are asked to review and approve the Quality Account.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 26th May 2021

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Quality Account 2020-21

What our patients said about us in 2020-21

Sanderson Suite, day case surgery
I would just like to say a massive thank you to ALL the staff in the Sanderson Suite. I had a minor procedure there in November and from the moment I stepped through the door I was immediately made to feel safe and relaxed. The attention and kindness from the staff was second to none, from the lady on the reception desk to the surgeon and every member of the team in between, I can't thank them enough. The NHS are having a really tough time at the moment but the service at St Helens was not compromised in anyway at all. Thank you all again, you're all great!

A&E and medical wards
My husband was admitted to A&E just after 6 a.m. on Sunday XX Sept 2020. He was moved to Zone 1, then onto the Acute Medical Unit where he received excellent treatment for a bleeding duodenal ulcer. All the staff were brilliant, and due to their care and expertise, his life was saved. He is now on Ward 3D where the staff are also excellent, polite, pleasant, helpful and nothing is too much trouble, and he is progressing well, and seeming much better. I and all the family are relieved and less stressed. ALL your staff are brilliant, and deserve nothing but praise for the job they do.

District Nursing Team at Four Acre Health Centre
We wanted to let you know just how much we appreciated the support, love and care you gave to C and all our family.
You treated him with such care and dignity, and with every step you took control of all the heart-breaking aspects.
From the moment we met you, we could see you totally understood us. During his life he's seen hundreds of doctors and nurses and yet you were able to make such an incredible impression at such an awful time, which is testament to you and for which we can't thank you enough.
We want to thank all the nursing team that have taken care of C and our family; it would have been totally unbearable without you.

Marshalls Cross Medical Centre
This is the GP practice for my mum. She is 85 with dementia and as her next of kin I therefore have direct contact with the practice on her behalf. I can honestly say that everyone I speak to is super helpful and adaptable to the circumstances at any given time…This level of support to me as a dementia carer is absolutely invaluable. Thank you.

Paediatric team on Ward 4F and the Anaesthetics Team
I would like to say a massive thank you to Ward 4F who were absolutely fantastic when my little boy came in for surgery. Every single member of the team were outstanding, from the wonderful nurses, doctors and anaesthetists to the play specialists, care assistants and the cleaners.
Each and every one of them made a very tough day much easier. Words do not do justice to the level of care my son received. The way they tapped into his interest of Harry Potter and engaged with him at every stage of his hospital journey was fantastic.
Never have I seen a little boy so relaxed as he walked down to theatre, thanks to the child friendly way everything was explained. He was even laughing as the needle was put in his hand and he was put to sleep.
I can honestly say the care he received was the best I have ever experienced. Thank you!

Intensive Care Unit
Our mum was admitted to A and E in April 2020. Completely floored when we found out she had COVID as she had no COVID symptoms and after a few days on a ward she was admitted to ICU. Critically ill we were told she may not recover. 8 weeks on she's won the COVID battle and although still with ICU she is slowly but surely improving. Because of visiting restrictions we've had daily updates every morning which has been done between 3 nurses who have made the effort to conduct these calls whilst still doing their everyday nursing job. We have regular doctors' updates. My mum has had and continues to have the absolute best care and dedication from all the team in ICU. The doctors and nurses have done everything and anything they could to try and get her through her battle. Whilst we haven't been able to visit we have never had any doubts about how well she's has been cared for and will be forever grateful for the efforts of this fantastic team.

Surgery and support services
I cannot thank enough the staff, support and treatment I have recently received between St Helen's and Whiston Hospital. Following my referral to St Helen's from my local hospital I've experienced first class care and compassion from the dedicated teams I've been involved with. I've seen so many people all with their own area of expertise who guided me through what has been a very scary process… The team on the day of the surgery were amazing. From the moment I entered the ward I was put at ease. The domestic lady was friendly and took time to have a chat with me, the Porter was lovely and the team responsible for my operation all came to see me to explain what would be happening. It was so well organised and I felt like I was in safe hands. The theatre team were ace and the recovery team too. The ward was lovely and clean and the whole experience has been less scary than I had anticipated. There's still a way to go yet but knowing that I'm in such good hands is helping me stay positive and optimistic. So thank you all for the dedication to your role because it makes a massive positive difference to your patients.

Contents

1. Section 1

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

We are pleased to present the Trust's 12th annual Quality Account, which reviews our performance and achievements over the past year, as well as outlining the priorities for improving quality in the coming year.

2020-21 has been the most challenging year we have ever experienced, during which staff have had to work in different ways and in difficult circumstances as the COVID-19 pandemic unfolded. Providing the best care and treatment for our patients remained a priority. We developed flexibly to maintain essential services, as well as meeting the needs of patients with the virus, for example by expanding telehealth and developing virtual wards to enable patients to be treated at home, thus avoiding a hospital admission.

The Trust has maintained its outstanding CQC rating and has been in regular contact with our CQC relationship manager throughout the year. A number of routine systems and processes, including some nationally reported quality metrics were suspended, however the Trust has continued to monitor key quality indicators via the monthly comprehensive integrated performance report (IPR).

We continue to receive exceptional staff survey results including the top scores for an acute trust for staff engagement for the fifth year running and the quality of care theme for the sixth consecutive year. I was, however, extremely disappointed that during the year there were two methicillin-resistant staphylococcus aureus (MRSA) bacteraemia and three never events, two relating to wrong site nerve blocks and one medication error. I was also disappointed that the Trust received a prevention of future deaths Regulation 28 report from the Coroner in relation to discharge letters. As a Trust, we are committed to learning from these incidents and putting measures in place to improve the care we provide, which are outlined in more detail in section 3 below.

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

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

1.1.1. St Helens and Knowsley Teaching Hospitals NHS Trust's Vision

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

The Trust's vision is the driving force for our focus on providing the best possible care for patients and for continuous improvement in all areas. Due to the suspension of business as usual activities to release staff capacity to respond to the COVID-19 pandemic, scheduled public Trust Board meetings did not take place, but to ensure good governance was maintained papers were circulated to Board members, including the integrated performance report and there were short Trust Board briefings of essential items throughout the year, with virtual meetings being held from July 2020 onwards.

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

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils, both of which report to the Trust Board's Quality Committee, and the Equality and Diversity Steering Group. This ensures effective external representation in the oversight and governance structure of the Trust. Some of the planned meetings had to be cancelled during the pandemic, however the majority have

been able to continue and have been held virtually to ensure social distancing could be maintained.

The Trust has a Patient Engagement Group and whilst the Group has not met in person, regular contact has continued to gain their views on developments, including the cancer portal which enables patients with cancer to directly access their own information. Patients have continued to share their experiences of their care via documented patient stories for the Board and the Patient Experience Council's virtual meetings.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the particular challenges faced during the year. It outlines our quality improvement priorities for 2021-22.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2020-21 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and services we have continued to deliver during the challenges presented in 2020-21.

I remain extremely proud of all our staff who have displayed immense courage and unwavering commitment during the pandemic. They have continued to work tirelessly to both provide the best possible care for our patients and their families and to support each other. I would like to offer my sincere gratitude and ongoing thanks to all our staff for everything they continue to deliver during the most challenging times we have faced.

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

1.2. Summary of quality achievements in 2020-21

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

Well-led
- Awarded a prestigious High Sheriff Award, in recognition of the great and valuable services which enhance the life of the community on behalf of the people of Merseyside
- Nominated to receive the prestigious 'Freedom of the Borough' for both St Helens and Knowsley Councils. The nomination was put forward by each local council to thank and celebrate all the staff, for their tireless work caring for the people of our local community throughout the COVID-19 pandemic
- Successfully secured the Disability Confident Leader status (in place until 2023)

National staff survey
When compared to organisations in our benchmarking group the Trust has the highest national score for the following 4 themes:
- Quality of care
- Staff engagement
- Immediate managers
- Safe environment – bullying and harassment

The Trust has the second best national score for the following 4 themes:
- Team working
- Morale
- Equality, diversity and inclusion
- Safety culture

Staff
- The Trust's dedicated Volunteers Department have been honoured with the Queen's Award for Voluntary Service, the highest award a voluntary group can receive in the UK. The Award aims to recognise outstanding work by volunteer groups to benefit their local communities
- Greg Barton, Specialist Pharmacist in Critical Care and Burns was awarded an MBE for services to pharmacy in the Queen's New Year Honours List. Greg played a crucial role in a range of national pharmacy initiatives during the pandemic, including supporting pharmacists new to critical care, through to supporting NHS England and the wider critical care community with advice on the use of medicines within intensive care units
- Jennifer O'Neill was named 'NMC Midwives' Midwife of the Year 2020 by the Royal College of Midwives. Jenny was nominated by her fellow colleagues for her clinical expertise, excellent leadership skills and outstanding support to both the women she cares for and her wider maternity team
- Sarah Robinson from the Finance Team was awarded the prestigious Sue Rosson Award, by the Healthcare Financial Management Association North West branch. The award is presented to a finance student working in the NHS who has made a significant contribution to their employing organisation. Sarah was commended for her work with procurement during COVID-19 whilst maintaining her studies, her work with the Trust and North West finance teams supporting

student groups and her general helpful, friendly and can do attitude
- Marie Smith, Ward Clerk was shortlisted as Operational Services Support Worker of the year in the national Skills for Health 2021 Our Health Heroes Awards, which celebrate the significant contribution made by this group of staff

Patient safety
- No patients experienced a hospital acquired category 4 pressure ulcer
- Achieved overall reduction in hospital acquired pressure ulcers
- Reductions in incidents resulting in harm in 2020-21 compared with 2019-20:
  - 53.13% reduction in theatre-related incidents causing harm, decreasing from 64 incidents reported in 2019-20 to 30 in 2020-21
  - 0 prescribing incidents resulting in moderate or severe harm
  - 60.87% reduction in prescribing incidents causing harm, decreasing from 23 incidents reported in 2019-20 to 9 in 2020-21
  - 20.1% reduction in medication administration errors reported, decreasing from 562 incidents reported in 2019-20 to 449 in 2020-21
  - 42.11% reduction in omitted doses of medicines administered causing harm, decreasing from 38 in 2019-20 to 22 in 2020-21
- 94.95% of frontline staff received their flu vaccination, above the target of 90
- 92.2% average registered nurse/midwife safer staffing fill rate for the year, above the 90% target

Patient experience
- 95.83% of inpatients would recommend our services, as recorded by the Friends and Family Test
- Responded to 94% of first stage complaints within the agreed timeframe
- Rheumatology Service maintained the Customer Service Accreditation award
- Finalists in the National Dementia Awards for the most dementia friendly hospital for the second year running
- Ranked second best acute trust for overall patient care in the latest national cancer patient experience survey (NCPES)

Clinical effectiveness
- The Cardiac Rehabilitation Service was successfully accredited by the National Certification Programme for Cardiac Rehabilitation, which aims to increase the availability and uptake of cardiovascular prevention and rehabilitation, promote best practice and improve service quality in cardiovascular prevention and rehabilitation services. The team has worked tirelessly to provide a high quality service to their patients during the pandemic which has involved adapting the service and adopting completely different working patterns
- Cancer Symptoms Advice Line poster presentation awarded second place at the UK's virtual Oncology Nursing Society conference in November 2020, for the section on the cancer nurses' response to the COVID-19 pandemic
- Consistently maintained high rating overall in the Sentinel Stroke National Audit Programme (SSNAP)
- 96.8% of electronic E-attendance summaries sent for patients attending the Emergency Department (ED) within 24 hours
- Gastroenterology Service successfully maintained Joint Advisory Group (JAG) accreditation

1.3. Celebrating success

The Trust has continued to nominate an Employee of the Month, as an important way of recognising and rewarding the ongoing dedication and commitment of staff throughout the year. In wave one of the pandemic COVID heroes were recognised each day, to highlight the contributions that staff and teams from different departments across the Trust were making. In addition, positive comments received from patients continued to be shared via a weekly 'Thank You Thursday' email sent to all members of staff.

Unfortunately due to the pandemic the annual staff awards were not held during the year. However, the event will be held as soon as this is possible to continue with the tradition of celebrating the many achievements of staff.

2. Section 2

2.1. About us

2.1.1. Our services

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

The Trust has over 700 inpatient beds, with circa up to 40 additional escalation beds and provides the majority of its services from two main sites at Whiston and St Helens hospitals, both of which are state-of-the-art, purpose built modern facilities that are well-maintained. Whiston Hospital houses the Emergency Department, the Maternity Unit, children and young people's service and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, rehabilitation beds, the Lilac Centre (a dedicated cancer unit, linked to Clatterbridge Centre for Oncology) and Marshalls Cross Medical Centre (primary care services). The Trust provides community adult nursing services in St Helens and a number of outpatient and diagnostic services in a small range of other settings.

The Trust also provides an Urgent Treatment Centre at the Millennium Centre in St Helens and intermediate care services at Newton Hospital, which has 30 inpatient beds. In addition, the Trust delivers a range of community services, including Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy.

The Trust Board is committed to continuing to deliver safe and high quality care, set within the on-going demand and financial challenges facing the NHS. The Trust continues to be one of the busiest acute hospital trusts in the North West of England. It has an excellent track record of providing high standards of care to its population of over 350,000 people across St Helens, Knowsley, Halton and South Liverpool, as well as further afield, including Warrington, West Lancashire, Wigan and the Isle of Man.

The pandemic had a significant impact on the attendances and admissions as shown in the table below, making meaningful comparisons with previous years difficult. The first wave of the pandemic and initial lockdown saw a reduction in non-essential services and patients reluctant to attend appointments or the Emergency Department. This was less marked in the second and third waves, during which the Trust maintained as many services as possible and patients were advised via national media to continue to access health services.

	2018-19	2019-20	% change 2018-19 to 2019-20	2020-21	% change 2019-20 to 2020-21
Outpatient attendances (seen)	451,043	467,812	3.72%	387,646	-17.14%
Non-elective admissions	57,446	56,458	-1.72%	49,781	-11.83%
Elective admissions	50,444	52,141	3.36%	34,588	-33.66%
Births	4,051	3,983	-1.68%	3,738	-6.15%
Emergency Department attendances (as reported)	115,734	119,158	2.96%	102,427	-14.04%
Emergency Department attendances (excluding GP Assessment Unit)	109,605	112,720	2.84%	97,908	-13.14%

The average length of stay for non-elective admissions was 6.5 days in 2019-20 and 5.9 in 2020-21.

2.1.2. Our staff and resources

The Trust's annual total income for 2020-21 was £511 million.

We employ more than 6,500 members of staff. In addition, we are the lead employer for Health Education North West, Health Education Midlands, Health Education East of England and Palliative Care London and are responsible for over 11,000 trainee specialty doctors based in hospitals and general practice (GP) placements throughout England.

The average staff turnover rate in the Trust for 2020-21 was 10.92%, which is slightly higher than the national rate of 9.21% for the national acute teaching sector (latest data available is January 2021).

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

Significant recruitment challenges remain within specific specialties and for specific roles, in particular: nursing and medical staff. The Trust has a successful and well-established international recruitment programme, which brings on average 50 new international nurses into the Trust per year to supplement the existing nursing workforce. Despite the recent challenges of COVID, the Trust recruited 45 additional nurses via this route during 2020-21. The Trust is constantly looking for new ways to address workforce gaps and as such we are a founding member of the newly

created Pan Merseyside International Collaboration programme, which aims to deliver international nurses across most of the Merseyside region. This pipeline will bolster existing recruitment plans with a total of 77 new international nurses expected to start within the Trust during the 2021-22 financial year.

The Trust has facilitated the wide scale roll out of e-rostering across the workforce with 97% of the organisation now compliant. The last few departments will be implemented shortly and the roll out of this system improves efficiency of rostering and supports improved demand and capacity modelling to ensure the most effective use of the Trust's workforce.

There have been on average 37.13 medical gaps from April 2020 to March 2021 and a number of actions have been taken to address these, including developing new roles such as advanced clinical practitioners. In addition, the Trust hosts regular recruitment events and uses international recruitment to ensure vacancies are filled. The Trust has collaborated with Masaryk University, Brno, Czech Republic in the recruitment of newly qualified doctors who trained in Brno using the English syllabus since 2014. On average the Trust has recruited an additional 14 doctors through these means since 2014. These new recruits join the Trust for two years as Clinical Fellows at foundation year one and two, to support our wards and fill the gaps and vacancies resulting from reduced numbers of allocated posts from the North West Deanery. The scheme returned to Brno in March 2021, to recruit more newly qualified doctors for the August 2021 intake. Agreement was reached to increase this cohort to 22, to maintain a constant stream of medical support for the Trust. This programme provides the opportunity to reduce agency spend and maintain continuity of care for our patients.

The doctors have the same opportunities to access further training in the North West, which keeps the talent pool local. They are a valuable asset to the Trust and our delivery of patient care

The Trust is aligning workforce plans to the NHS People Plan to ensure sustainable pipelines to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals (AHPs), including:

- On-boarding and retention of new and existing staff including flexible working, internal staff transfer scheme, itchy feet discussions, assigning a buddy, welcome packs/information and encouraging retire and return
- An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally
- Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and ODP apprenticeships
- Implementation of the nursing associate role with 15 trainees completing their training in March 2021 and further trainees commencing training in 2021
- Implementation of e-rostering and e-job planning for specialist nurses to ensure the most effective rostering and planning of work and extending e-rostering to non-clinical areas
- Launch of a new online appraisal and personal development plan system which includes an enhanced focus on health, well-being and staff support
- Equality, Diversity & Inclusion champions appointed to lead new staff networks

created e.g. Carers, Building a Multi-Cultural Environment, Lesbian, gay, bisexual, transgender and questioning (LGBTQ+), Menopause, Armed Forces and supporting a healthy workforce.

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours for registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with the guidance. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can have an impact on the quality of care provided.

The acceptable monthly fill rate is 90% and over, which throughout the COVID-19 pandemic has been very challenging to achieve. Senior nurses, led by the Director of Nursing, Midwifery and Governance held twice daily staffing meetings at times of increased pressure to redeploy staff across the Trust to maintain patient safety. The average registered nurse/midwife safer staffing fill rate for the year was 92.2%, above the 90% target, but below the 94.95% rate achieved last year.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total inpatients in the ward at midnight. The Trust's position is reported monthly as part of the mandated safer staffing report. The wards facing ongoing challenges with recruitment are generally the wards that are unable to meet the safer staffing 90% fill rate consistently.

This year the Trust has worked incredibly hard to maintain patient safety during the pandemic, using a range of approaches to ensure available staff were deployed effectively across the whole Trust. The actions taken include:

- Identified staff from across the Trust redeployed for block periods to specialist areas needing additional capacity, including critical care and respiratory wards
- Ward managers cancelled management days to work clinically
- Matrons/specialist nurses worked clinical shifts where possible, including community staff wherever clinics were cancelled
- Increased the daily Matron staffing meetings to twice daily, led by the Director of Nursing, Midwifery and Governance, with members of the temporary workforce resourcing team attending. Staffing levels across the Trust were reviewed at each meeting, with every area identifying any gaps identified for the following 24 hours and the number of patients requiring supplementary care (1-1 or bay tagging) on each ward. Staff moves were then jointly agreed to provide the safest care possible
- A plan for further moves, should this be required for unexpected absence, was communicated by the matrons covering the late shift to the operational managers and the general manager on call each day
- Worked with the Trust's staff bank and external agencies to provide a pool of staff to cover each shift for areas experiencing last minute gaps due to sickness
- Block booked agency staff to provide continuity where possible
- Approached off framework agencies to cover any unfilled shifts (subject to Executive approval)

- Contracts in place for over 30 medical students for 12 hours per week to work as band 3 healthcare assistants (HCAs) and for over 40 third year nursing students to work as band 4 student nurses (final year extended clinical placements)
- Successfully secured £77k funding from NHS England/Improvement (NHSE/I) to support the fast tracking of international nurse arrivals
- 235 bank HCAs offered positions
- 39 international nurses commenced their training for the national Nursing and Midwifery Council's (NMC) Objective Structured Clinical Examination (OSCE) test
- Established a redeployment hub to identify staff who were able to be moved to support other areas
- Proactive support for staff who were absent to ensure they were able to return to work as soon as possible
- Utilised staff who were absent from the work place due to shielding/self-isolation to undertake work that could be completed from home wherever possible

Ensuring safe staffing levels remained a priority for the Trust throughout the year, with concerns escalated to the thrice daily bed meetings, daily silver and gold command and the weekly Executive Committee meeting.

2.1.2.1. Supporting our staff

The Trust appreciated the huge impact that the pandemic had on all staff and hosted a special week to thank staff in November 2020, with a number of activities and opportunities to show staff how much they were valued. This included random acts of kindness, with bouquets of flowers, gifts and lunches handed out to various groups of staff, including staff working from home, thank you messages and thank you videos posted on the intranet and StHK branded hoodies available for all staff.


STHK
THANK YOU
150 LUNCHES
250 BALLOONS
110 BOUQUETS OF FLOWERS
550 mugs
100 WELLBEING BAGS
OVER 4800 HOODIES ORDERED
600 KIT KATS
100 BOXES OF BISCUITS
300 BOXES OF CHOCOLATES
100 CAKES
450 COFFEES ON US
4000 THANK YOU CARDS
HAPPY STAFF
TOO MANY TO COUNT
STHK


THANK YOU
STHK

In February and March, the Trust also held a virtual Time for You festival, which had a series of live talks, workshops and pre-recorded sessions to give mental and physical health and wellbeing a boost. This included great advice from a range of celebrity speakers, local experts, and in-house support who know what it takes to overcome obstacles in high pressure situations. The event was aimed at providing a range of ideas, tips, and practical techniques to make living and working during a pandemic that little bit easier to manage.

In addition, staff continued to have access to our Health, Work and Wellbeing Department who provide a range of supportive services, including Occupational Health and those listed below:

- Wellbeing Hub, which supports staff affected by physical or non-physical health matters, that can have an impact both in and outside of work. Support is available for all staff, including those that have been affected by COVID-19. This includes:
  - Mental wellbeing delivered by counsellors, mental health nurses and psychologists for stress, anxiety, depression and other diagnosed conditions, including round the clock support through an employee assistance programme (EAP) service provider
  - Physical wellbeing delivered by PhysioMed, physiotherapists and occupational health clinicians for musculoskeletal conditions, injury or other diagnosed conditions
  - General health delivered by occupational health clinicians or onward referrals to specialist support for any other health related condition(s) that may impact on work
- Trust staff engagement application (app) and the staff COVID website which have specific wellbeing sections
- Wellbeing apps including, meditation, mental health in the workplace, mindfulness and sleep aides
- Staff wellbeing events to promote and support wellbeing and resilience, these included, mindfulness, sleep hygiene, stress, relaxation and building resilience

There are a number of staff networks in existence as part of the Trust's Everyone Matters programme to ensure that staff are able to share experiences and access the right support. These are:

- Black, Asian and minority ethnic (BAME) - Building a Multicultural Environment
- Building Abilities@STHK (disability and wellbeing)
- Lesbian, gay, bisexual, transgender and questioning (LGBTQ+)
- Armed Forces
- Carers
- Menopause Café

2.1.3. Our communities

The Trust provides services to the communities of St Helens, Knowsley, Halton and attracts some patients from Liverpool and parts of Warrington. The Trust is the regional burns centre providing specialist care for the whole of Cheshire and Merseyside, as well as North Wales and the Isle of Man. The communities served by the Trust are characterised by their industrial past, with the local population being generally less healthy than the rest of England, with a higher proportion having at least one long-term health condition.

Our local communities are not ethnically diverse, but do have high levels of deprivation. This contributes to high levels of health inequalities, leading to poorer health and high demands for health and social care services. Rates of obesity, smoking, cancer and heart disease are higher than the national average. Our local communities were hit hard by COVID-19 with some of the highest community infection rates in the country.

2.1.1. Our partners

Although many of the planned collaborative projects and work programmes were curtailed during the COVID-19 pandemic, the Trust has continued to work closely with its health partners across Cheshire and Merseyside and in social care in the response to the pandemic. The Trust has worked as part of the Cheshire and Merseyside Hospital Cell, which has coordinated the collective response of acute hospitals to be in the best position to cope with the peaks in demand for acute medical and critical care beds caused by the different waves of COVID-19 infections. This has involved providing mutual aid across the system, both in respect of critical care capacity but also ensuring the most clinically urgent cancer patients continued to be seen and treated.

The Trust also worked very closely with community, primary and social care throughout the pandemic to ensure that patients received the care they needed in the most appropriate setting.

The Trust has worked in collaboration with the Primary Care Networks in St Helens to deliver the COVID-19 vaccine programme since December 2020 and the mass vaccination site at St Helens Saints Rugby Ground will continue to deliver this programme to reach government targets for vaccinating the local population into 2021-22.

2.1.2. Technology and information

This year, the Trust has made giant steps in improving its digital maturity in line with NHS plans to have fully digitised hospitals.

Clinical functionality has been added to enrich the quality and quantity of information at the fingertips of our clinicians, to improve patient experience, safety and outcomes, as well as improving the way in which patients can communicate with the Trust in line with our vision for 5 star patient care.

In February 2020, the Trust was awarded £6m funding from NHSX (joint unit of NHSE and the Department of Health and Social Care) Digital Aspirant Programme (DAP), the only Trust in the North West of England to be included in this 1st wave of Digital Aspirants. This funding has enabled the Trust to realise our digital ambitions at a much faster pace, whilst aligning with the digital ambitions of our neighbouring health and social care partners.

In 2020-21 a lot of focus was directed towards utilising existing and deploying new technology to keep the staff and patients safe, requiring timely and flexible deployment for a number of solutions and applications to support this aim.

2.1.2.1. Achievements

An electronic patient record (EPR) called Careflow EPR was deployed in 2018 and is now at the heart of the care staff provide. In 2020-21 the Trust deployed a number of Careflow EPR modules in tandem with a number of other key systems, which demonstrate significant digital progress:

- **Careflow Vitals** enables the recording of patient observations (Early Warning

Scores) on hand-held devices at the point of care. This application alerts our clinicians to the sickest patients, ensuring resources are used where they are most needed so faster action can be taken by our clinicians. Careflow Vitals was rolled out across all inpatient wards and in ED. It has been pivotal in ensuring national standards of care are provided, reducing the likelihood of incidents, avoiding high cost care transfers to critical care, providing better patient outcomes in general but specifically for sepsis and cardiac arrest and helping to reduce length of stay

- **Careflow Connect** has been implemented across a number of teams to improve the handover of care of patients between departments. It also enables structured digital communications between clinicians to allocate patient care within their own teams and refer to colleagues in other teams for specialist advice. Importantly, Careflow Connect works on mobile devices and patient information follows the patient on their journey through the hospital, so any clinician involved in their care has access to the right information at their fingertips. Additional functionality has been added to enable our clinicians to view and acknowledge patient results through Careflow Connect, providing further ability for our doctors and nurses to work in an agile way, providing care for their patients from any location
- **Careflow EPR Cardiotocography** (CTG) Monitoring system was deployed to enable the monitoring of babies' heartbeats within Maternity, contributing to better outcomes
- Roll out of the award winning **Telehealth** solution (video conferencing for outpatient appointments) to over 40 additional services during the pandemic, which helped to reduce the risks for patients by the prevention of unnecessary visits to the hospital. To date, over 2,000 patient appointments have been conducted over Telehealth. This is only provided where it is safe to do so and any patient that requires or prefers a face to face appointment is able to do so
- Further deployment of the Trust's **electronic prescribing and medicines administration (ePMA) system** across outpatient departments, in line with ED and inpatient areas. This system ensures legible prescriptions, 100% availability of the patient's drugs record from multiple locations simultaneously, reduction in allergy and drug interaction never incidents, removal of the need for transcription and rewriting of the prescription chart as the patient moves from location to location, therefore improving patient safety and clinical decision-making
- **2-way text messaging** was rolled-out to enable patients to receive reminders about their appointments and confirm or decline their attendance, reducing Did Not Attend (DNA) episodes by 2%
- A **drive through pharmacy** prescription collection service was established to dispense drugs prescribed electronically during an outpatient visit. Patients can drive to the hospital and their prescription is safely delivered to their car by the Pharmacy Team

  The **Trust Switchboard** underwent a major upgrade, improving communication internally and for external callers telephoning into the Trust. The automated virtual operator now transfers callers to the right person or department, freeing up the Switchboard Team to manage the increase in calls resulting from the pandemic

2.1.2.2. Infrastructure

The safety of the infrastructure is an ongoing priority and any clinical system

deployments can only be successful if the underlying technical infrastructure is robust. The Informatics Team has continued to strengthen the infrastructure and IT platforms on which all the Trust's critical systems reside, to ensure the Trust's systems are accessible, safe, secure and reliable. This has included upgrading the network, replacing the storage area network and upgrading all desktops to Windows 10. Office 365 was rolled out and all Trust staff can now access their email and Trust applications both on and off the Trust's premises, without impacting on security of the Trust network. Microsoft Teams was deployed across the Trust to ensure that staff could communicate virtually from wherever they were located.

2.1.2.3. Our response to the COVID-19 pandemic

COVID-19 presented the IT Team with a particular set of challenges that required an agile response to keep patients and clinicians safe and socially distanced during the pandemic. This included:

- Efficiently supporting over 1,000 members of staff to work remotely, ensuring staff were able to securely connect into the systems and applications needed to do their jobs as well as communicating with their managers and team members. The upgrade of the Trust's network ensured it was able to facilitate the extra volume of calls, video calls and access to Trust systems from remote locations
- Supporting wards with technology and devices to enable patients to keep in touch with their friends and loved ones, as visiting was suspended
- Working with system partners to implement a number of alerts on our clinical systems, which highlighted COVID positive patients, enabling these patients to be treated accordingly and keeping other patients safe
- Working with Primary Care partners to add a shielded patient alert to Careflow to ensure these patients were appropriately treated to protect their shielded patient status

2.1.2.4. Vaccination centres

The Informatics teams supported the implementation of both the staff vaccination site at Nightingale House and the Large Vaccination Site (LVS) at the local Saints Rugby Stadium. This included testing and deployment of two booking systems, IT infrastructure and equipment. Work with the supplier enabled nursing staff providing the vaccinations to update information regarding the patient, vaccination batch and location of vaccine, to support wider reporting on progress of the vaccination roll-out both locally and nationally.

The team continue to support the vaccination sites including changes to booking slots and systems, providing support and guidance for staff using these systems and helping with administrative responsibilities for the sites.

2.1.2.5. Place-based care

The St Helens Shared Care Record is the local solution at the leading edge of place-based care. In 2020-21 it has been developed to include multi-agency care plans and business intelligence to facilitate preventative population health management to focus on the needs of the citizens of St Helens. This ensured that all organisations had access to key information relating to patients to facilitate the discharge process

at a time when activity in the Trust was extremely high.

The population health dashboards provide critical information down to street level about the health of St Helens citizens, which will support a more effective transition out of lockdown.

2.2. Summary of how we did against our 2020-21 Quality Account priorities

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

2.2.1. Progress in achieving 2020-21 quality goals

Objective	Measurement	Status
Continue to ensure the timely and effective assessment and care of patients in the emergency department	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Partially achieved - to be rolled over to 2021-22
Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of hospital-acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Partially achieved - to be rolled over to 2021-22
Reduce avoidable harm by preventing pressure ulcers	• Quarterly audit to confirm compliance with Trust policy in the identification of patients at risk of developing pressure ulcers and in the provision of appropriate equipment to support prevention • 10% reduction in category 2 pressure ulcer incidents with possible lapses in care from 2019-20 baseline	Achieved
Improve the effectiveness of the	• Ensure sufficient and appropriate information is provided to all	National Patient

Objective	Measurement	Status
discharge process for patients and carers	patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information • Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards • Implementation of standardised patient equipment ordering process for aides required at home	surveys did not take place. Project suspended due to COVID, to be rolled over to 2021-22
Increase the proportion of patients who report that they have received an appropriate amount of information about their care	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	All national patient surveys were suspended during 2020-21 - to be rolled over to 2021-22

2.3. Quality priorities for improvement for 2021-22

The impact of the pandemic led to a number of business as usual activities being suspended so that resources could focus on providing an effective response, in line with national directions. This led to limited and delayed progress in achieving the quality objectives and, therefore, the Board took the decision in agreement with partners to roll forward the majority of the quality priorities to 2021-22. However, the objective to reduce pressure ulcers was achieved and so the agreed objective will be to reduce avoidable harm by preventing falls.

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Continue to ensure the timely and effective assessment and care of patients in the emergency department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety, whilst also responding to increased demand for services	Director of Operations and Performance	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24 hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Quality Committee
Reduce avoidable harm by preventing falls	A key Trust priority is patient safety and embedding a culture of safety improvement that reduces harm. In 2020-21 there has been an increase in the number of falls resulting in severe harm, as well as falls per 1000 bed days	Director of Nursing, Midwifery and Governance	• Reduction in the number of inpatient falls per 1000 bed days from 9.03 to 7.7 or less • All patients to have a documented falls risk assessment within 6 hours of admission, which is reviewed at least every 7 days or sooner if the patient's condition indicates • Audit to demonstrate that all preventative actions are implemented following falls risk assessments	Quality Committee

Quality Domain: Clinical Effectiveness				
Objective	Rationale	Lead Director	Measurement	Governance Route
Ensure patients in hospital remain hydrated	Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls.	Director of Nursing, Midwifery and Governance	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of hospital-acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
Increase the proportion of patients who report that they have received an appropriate amount of information about their care	Findings from the national inpatient survey indicate that a significant proportion of patients do not receive the right level of information at the right time to meet their needs	Director of Nursing, Midwifery and Governance	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	Quality Committee
Improve the effectiveness of the discharge process for patients and	A key theme from patient feedback and engagement events during 2019-20 has been a need to improve the discharge	Director of Operations and Performance	• Ensure sufficient and appropriate information is provided to all patients on discharge • Improved Inpatient Survey	Quality Committee

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
carers	experience for patients and their carers		satisfaction rates for receiving discharge information • Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards • Implementation of standardised patient equipment ordering process for aides required at home	

2.4. Statements of assurance from the Board

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

2.4.1. Review of services

During 2020-21, the Trust provided and/or sub- contracted £398m NHS services.

St Helens and Knowsley Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2020-21 represents 97% of the total income generated from the provision of NHS services by St Helens and Knowsley Teaching Hospitals NHS Trust for 2020-21.

The above figures relate to income from patient care activities. The remaining total operating income mainly arose from NHS North West Deanery for the education and training of junior doctors, services provided to other organisations, such as IT, HR and Pathology Services, and Private Finance Initiative (PFI) support funding.

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2020-21

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

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

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) = 4 individual audits
- Chronic Obstructive Pulmonary Disease (COPD) audit programme = 2
- National Gastro-Intestinal Cancer Programme = 2

During 2020-21, 37 national clinical audits and 2 national confidential enquiries covered relevant health services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

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

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust was eligible to participate in during 2020-21
- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in during 2020-21
- The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2020-21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
1.	British Association of Urological Surgeons (BAUS): Female stress urinary incontinence	Yes	Yes	Continuous monitoring
2.	British Association of Urological Surgeons (BAUS): Renal colic	Yes	Yes	Continuous monitoring
3.	Royal College of Emergency Medicine (RCEM): Pain in children	Yes	Yes	Active
4.	Royal College of Emergency Medicine (RCEM): Infection control	Yes	Yes	Active
5.	Royal College of Emergency Medicine (RCEM): Neck of femur fracture (#s)	Yes	Yes	Active
6.	National Asthma (adults) and COPD Audit Programme (NACAP): secondary care work-stream NACAP asthma (children)	Yes	Yes	Continuous monitoring
7.	National hip fracture database	Yes	Yes	Continuous monitoring
8.	UK cystic fibrosis registry	Yes	Yes	Continuous monitoring
9.	Elective surgery national Patient Reported Outcome Measures (PROMs) programme	Yes	Yes	Continuous monitoring
10.	Epilepsy 12- (round 3) - paediatrics	Yes	Yes	100%
11.	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	Continuous monitoring

	case mix programme			
12.	Inflammatory bowel disease (IBD) programme (registry)	Yes	Yes	Continuous monitoring
13.	Learning disability mortality review programme	Yes	Yes	Continuous monitoring
14.	National audit-breast cancer in older patients (NABCOP)	Yes	Yes	Active
15.	National audit of cardiac rehab	Yes	Yes	Continuous monitoring
16.	National audit of dementia	Yes	Yes	Active
17.	National cardiac arrest audit (NCAA)	Yes	Yes	Continuous monitoring
18.	National cardiac audit programme (NCAP) (includes the myocardial infarction national audit programme - MINAP)	Yes	Yes	Continuous monitoring
19.	National heart failure audit	Yes	Yes	Continuous monitoring
20.	National diabetes audit (NDA) (19-20 data set)	Yes	Yes	
21.	National paediatric diabetes audit (NPDA) 19-20	Yes	Yes	100%
22.	National emergency laparotomy audit (NELA)	Yes	Yes	Continuous monitoring
23.	National gastro-intestinal cancer programme: oesophago-gastric cancer (NAOGC)	Yes	Yes	Continuous monitoring
24.	National gastro-intestinal cancer programme: • Bowel cancer (NBOCA) • Oesophago-gastric cancer (NAOGC)	Yes	Yes	Continuous monitoring
25.	National Joint Registry (NJR)	Yes	Yes	Continuous monitoring
26.	National lung cancer audit (NLCA)	Yes	Yes	Continuous monitoring
27.	National maternity and perinatal audit (NMPA)	Yes	Yes	Continuous monitoring
28.	National neonatal audit programme (NNAP)	Yes	Yes	Continuous monitoring
29.	National ophthalmology audit (NOA)	Yes	Yes	Continuous monitoring
30.	National prostate cancer (NPCA)	Yes	Yes	Continuous monitoring
31.	Rheumatoid/early inflammatory arthritis national clinical audit rheumatoid and early inflammatory arthritis	Yes	Yes	Continuous monitoring

	(NCAREIA)			
32.	Sentinel stroke national audit programme (SSNAP)	Yes	Yes	Continuous monitoring
33.	Society acute medicine benchmarking audit (SAMBA) 2020	Yes	Yes	100%
34.	Serious Hazards of Transfusion: (SHOT) UK national haemo-vigilance scheme	Yes	Yes	Continuous monitoring
35.	Surgical site infection surveillance service	Yes	Yes	Continuous monitoring
36.	mandatory surveillance of healthcare acquired infections (HCAI)	Yes	Yes	Continuous monitoring
37.	Trauma Audit Research Network (TARN): major trauma audit-ED	Yes	Yes	Continuous monitoring
National Confidential Enquiries				
1	Mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE – UK) – maternal infant and newborn	Yes	Yes	Continuous monitoring
2	NCEPOD • Dysphagia in people with Parkinson's disease study • Out of Hospital Cardiac Arrests (OHCA) - organisation questionnaire • Alcohol related liver disease study - follow on questionnaire • Pulmonary embolism - organisational questionnaire	Yes	Yes	100%

2.4.2.2. Other National Audits participated in during 2020-21 (Not on Quality Account list 2020-21)

National audits
National diabetes audit (Adults) 2019-20
Magseed® and wire/roll localisation (Magseed® is a tiny seed designed to accurately mark the site of a cancer)
Annual safe, effective, quality Occupational Health Service (SEQOHS) accreditation audit
Breast cancer management pathways during the COVID-19 pandemic

Audit of maternity records for antenatal screening quality assurance
National audit of dementia 2020-2021 pilot in acute general hospitals
Flash glucose monitoring audit – paediatrics (FreeStyle Libre system)
Flash glucose monitoring audit – adults (FreeStyle Libre system)
National diabetes foot care audit
Advancing Quality Alliance (AQuA) acute kidney injury focus area
Global Surgical Audit (COVIDSURG) week
Sepsis review health & care partnership for Cheshire & Merseyside through AQuA
Tranexamic acid in hip fracture surgery
National audit of non-melanoma skin cancer excisions by plastic surgery (NMSC: PLASTUK)
Filtering Face Piece (FFP3) mask fit testing project for black, Asian, and minority ethnic (BAME) staff in secondary care
Diverticular abscess management: an international snapshot audit (DAMASCUS)
RECAP audit: rectal cancer management during the COVID-19 pandemic
MAMMA: mastitis and mammary abscess management - multicentre national audit
Growth Assessment Protocol Standardised Case Outcome Review and Evaluation (GAP SCORE) missed case audit
Perinatal mortality review tool (PMRT) programme
National children and young people (NCYP) diabetes and quality programme
Breast and cosmetic implant surgery
Each baby counts – national quality improvement programme (QIP)
National 3rd corrective jaw treatment audit
Reducing the impact of serious infections (antimicrobial resistance and sepsis)

During 2020-21 due to the Pandemic, some national audit bodies took the decision to temporarily suspend the submission of data.

The reports of 51 national clinical audits were reviewed by the provider in 2020-21 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Emergency Department	
Severe Trauma: Trauma Audit & Research Network (TARN)	Reports and TARN dashboard are continuously reviewed locally and by the Cheshire & Mersey Major Trauma Network /Operational Delivery Network - no further clinical actions required.
General Medicine - Cardiology	
National heart failure audit	The latest report 2018-19 demonstrated that the Trust was above the national average in all but one of the measured areas
Myocardial ischaemia national audit project (MINAP)	The 2018-19 Myocardial ischaemia national audit project (MINAP) report on cases of heart attack – either ST-segment elevation myocardial infarction (STEMI) or non-ST-segment elevation myocardial infarction (NSTEMI) admitted to hospitals in England, Wales and Northern Ireland. The report finds that there has been a 2.4% fall from numbers recorded in 2017-18. Care provided is expressed through 11 ‘quality

	improvement metrics', each of which is supported by national and/or international guidelines. As part of this Trust's continuous monitoring, compliance with the provision of Secondary Prevention Medication on discharge is reported, our Trust consistently achieves a high standard with compliance and systems are in place to ensure that any deviation from this is addressed without delay.
NCEPOD: (National Confidential Enquiry into Patient Outcome and Death)/Child Heath Programme	
The Trust has participated in all eligible studies. During 2020-21, one completed study report was received and disseminated. Completed Studies: • Dysphagia in Parkinsons Disease	
Audit Title	**Outcome/actions**
NCEPOD: out of hospital cardiac arrests	A review of the quality of care provided to patients aged 16 years and over who were admitted to hospital following an out-of-hospital cardiac arrest The report was published in early 2021. Following a review, the Trust is compliant with the recommendations of the report. Additional local audits will be planned.
NCEPOD (Surgical & Medical) & NCEPOD (Child Health) have the following studies planned for 2021-22 • Epilepsy (starting April 21) • Crohns • Transition from Child to Adult Health Services	
Burns & Plastics	
National service evaluation project to assess change in management of hand injury patients in view of COVID-19 pandemic	The study demonstrated that wide-awake local anaesthesia, no tourniquet (WALANT) surgery had proved useful in cases where previously a general anaesthetic was undertaken. Same day operation improved efficiency and reduced patient contact with the hospital. Remote consult/follow-up has proven useful in improving efficiency and reducing exposure/travel. The feasibility of continuing with these findings for suitable patients will be reviewed going forward.
Department of Medicine for Older People (DMOP)	
Sentinel Stroke National Audit Programme (SSNAP)	Stroke performance has been broadly maintained throughout the pandemic. Since becoming a regional centre in April 2019, The Trust has now seen approximately 1,050 confirmed strokes per year; and assesses approximately 3,500-4,000 suspected strokes per year. The number of patients receiving thrombectomy has progressively increased, a key intervention to improve the

	outcomes for the most severe ischaemic strokes. Also introduced is advanced imaging (CT angiography and CT perfusion). This enables staff to potentially provide thrombolysis or thrombectomy in groups of patients who previously would not have been able to be treated; or to identify patients where such interventions may cause more harm than benefit and therefore reduce the risk of harm in these circumstances. These new imaging types are supported by the use of machine learning to analyse the images as well as review by consultant stroke physicians so the Trust is using the latest innovations to provide world class stroke care.

2.4.2.3. Local clinical audit information

The reports of 150 local clinical audits were reviewed by the provider in 2020-21 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Emergency Department (ED)	
Record keeping	Improvements were demonstrated this year in several aspects measured.
Audit of the same day emergency care (SDEC) Magnetic Resonance Imaging (MRI) spine in managing cauda equina	This audit identified that the Ambulatory Pathway was functioning well and has reduced admission numbers.
Post exposure management	Patients are being seen in a timely manner following presentation with needle stick injuries. Redesign of ED pro forma into shorter components to aid accurate record keeping.
Management of cardiac chest pain (CP)	Actions included improvements to CP form, review of Coronary Care Unit (CCU) pathway and further audits reviewing admissions to Acute Medical Unit (AMU) and CCU from Emergency Department (ED).
Lower limb open fracture management	All ED patients received antibiotics as per protocol. Further actions include the introduction of an open fracture pro forma to provide more information.
General Surgery	
Timely prescribing of regular medications in general surgery	Following several interventions the re-audit showed significant improvements in critical medications prescribed on admission and administration of regular medication doses. Patients who had their regular medications prescribed prior to medicines

Audit Title	Outcome/actions
	reconciliation also demonstrated an increase.
General Medicine:	
Acute Medical Unit (AMU)	
QIP: Prevention and management of acute kidney iinjury (AKI) in patients (admitted to hospital with suspected or confirmed COVID-19)	The audit found that NICE guidelines were being followed in terms of suspension of nephrotoxic agents and prescribing fluids. Further quality improvement project is planned to look into improving recording of fluid balance and documented cause.
Cardiology	
Acute heart failure (HF) audit	This audit has highlighted that good numbers of patients having biomechanical markers checked on admission as well as patients on a beta blocker. Discussions have taken place with Cardiorespiratory and AMU Consultants regarding further improvements. Actions suggest in future this audit could be run alongside the HF nurse discharge audit
Prophylactic antibiotic prescribing for insertion of cardiac devices	This audit found that all patients are receiving the correct antibiotics. Actions: Pharmacy department to make pre-prepared Teicoplanin. New pro forma to be used.
Cardiology – Community Services	
Chronic Heart Failure NICE quality standards - St Helens Community Heart Failure Service audit	This audit has established that 100% patients were prescribed angiotensin-converting enzyme **(**ACE) and Betablockers. Patients had medication increased to target or maximum tolerated dose as per NICE guidance and NICE standards. Actions: HF nurses to record when cardiac rehabilitation exercise programme is discussed with a patient with an aim to increase the numbers of referrals.
Department of Medicine for Older People	
Driving advice in medical patients	This audit identified an improvement in Driver and Vehicle Licensing Agency (DVLA) documentation. Planned actions to update hospital system and pro forma with DVLA advice related prompts. To share information with staff on common DVLA relevant conditions and DVLA information. Also include in teaching to all doctor groups.
Dermatology	
Regional audit of dupilumab for eczema	This audit showed that prescribing and managing patients appropriately with excellent clinical outcomes.
Skin cancer: 2-week wait (2WW) clinic referrals	This audit has highlighted that targets were hit consistently. The increasing 2WW skin cancer referral rate over time and the benefit for patients in the development of “see and treat”

Audit Title	Outcome/actions
	sessions to facilitate biopsies and excision at the time of first consultation.
Palliative Care	
Advance care planning (ACP)	ACP can and does reduce hospital admissions and also allows patients to die in their preferred place of death (PPD). Actions: Department to work cross boundary to improve uptake of ACP. Patients are to continue to be given a choice and opportunity to create ACP. Delivery of ongoing education of End of Life Care (EoLC).
Paediatrics	
Chest pain referrals to paediatrics cardiology clinic	This audit identified that high risk patients were identified and referred to tertiary care appropriately. Actions: implementation of traffic light system for prioritisation and distribute locally. Plan to design a referral pro forma
Evaluation of care provided to patient with diabetes admitted to Paediatrics Ward	High compliance was demonstrated in this latest round of the audit. Actions: the diabetes keto-acidosis (DKA) pathway has been updated and awareness training sessions have been delivered to Paediatric and Emergency Department staff.
Auditing the occurrence of contaminated blood culture (BC) in Paediatrics	The audit identified compliance was met with the target set for positive blood cultures growing pathogens likely to be contaminants. Actions: further QI project blood culture packs with implementation aiming to reduce BC contamination further.
Umbilical granuloma audit	Good compliance and record keeping was demonstrated with departmental guideline for treatment of children with umbilical granulomas. Positive success was noted with salt treatment. Plan: awareness sessions for staff on the management. Design of a pro forma to be used by the Hospital at Home Team for management.
Obstetrics & Gynaecology	
Record keeping - gynaecology	The audits consistently show that the quality of record keeping was high and continues to be undertaken regularly as part of the Trust programme to maintain high standards.
Audit of manual vacuum aspiration procedure	The audit demonstrated 100% success rate. Planned actions: Study sessions for staff to increase awareness of procedure and increase rate of offering to patients.
Amniocentesis re-audit	This audit has showed a good level of compliance with standards. Planned annual/biennial audit.
Born before arrival (BBA) or unplanned homebirth audit	A BBA admission to Delivery Suite form is to be developed to capture all relevant information about the delivery and assist with audit information.
Day-case rehydration for women with	All patients were triaged appropriately for inpatient or outpatient care and documentation had improved.

Audit Title	Outcome/actions
moderate hyperemesis gravidarum in pregnancy (re-audit)	Actions: development of a new hyperemesis pathway, blood order set specific for hyperemesis and amendment of the hyperemesis protocol.
Management of mid-trimester intrauterine death or termination of pregnancy (ToP)	100% was scored for 5 standards reviewed. Actions: development of a fail-safe system to ensure that de-brief appointments are not delayed and that a permanent debrief room is available.
Outpatient medical management of miscarriage: re-audit	The success rate of procedure demonstrated in this audit was in keeping with the data from recent studies' success rate using only misoprostol. Actions planned: change in guideline and pathway – to include an additional medication to improve success rate further as per new published studies.
Orthopaedics/Therapies	
Audit of consent form 4 (documentation)	Several areas audited reached high percentages rates with documentation. Actions: documentation of consent will be discussed further at junior doctor's induction teaching sessions to highlight the importance of good, accurate record keeping.
Re-audit - implementation of virtual fracture clinic as the sole referral pathway to fracture clinic from ED and walk-in centre	The Virtual Fracture Clinic was designed by the Orthopaedic Department in order to streamline the review of fractures. The re-audit found that the average waiting time had been dramatically reduced. Further amendments to the ED referral form are planned.
Administration of fascia iliac blocks to patients who have suffered fractured neck of femur	Actions: further training is to be planned for Orthopaedic and ED junior doctors on how to administer blocks.
Antibiotic prescription in orthopaedic patients	The dose of antibiotic prescribed met the NICE standards in 100% of patients. Actions planned: to improve documentation further, a stamp will be provided in each ward area with the headings of "indication", "dose" and "duration" for use in the patients' health records.
Accuracy of patient documentation regarding the responsible clinician	Actions included: further updates on Careflow system process delivered to doctors.
Quality Improvement-Clinical Audit Department (QICA): Quality & Risk (Q&R)	
Audit of compliance with the Clinical Audit Policy	The audit demonstrated some excellent results in terms of compliance with the Trust QICA Policy. Actions completed: • A 'missing information' checklist has been produced to facilitate the return of registration forms back to the clinic area to request any outstanding information • Certificates are issued to staff upon request as evidence

Audit Title	Outcome/actions
	of dissemination and discussion • A slight increase in the receipt of action plans was noted, however to facilitate this further a new role has been developed for the monitoring of action plan returns and national audits for 2020 • At the end of the current audit year 2020-21 significant improvements had been demonstrated in the return and quality of the content since the new person has been in post. Further key developments in this post are planned
Safeguarding/Maternity Services	
Sectioned patients understanding of their rights under the Mental Health Act	Planned actions are in place to ensure staff are aware of the requirement for patients to have had rights read and to inform Safeguarding Adults Team as required.
Sexual-Health	
Management of genital wart treatment audit	The audit noted good results where all cases were resolved within acceptable timeframes. Treatments will be reviewed for cases of multiple warts.
Anaesthetics/Theatres	
Record keeping - Theatres	Full compliance was met for quarter 1 across all criterion measured. The audit continues to be undertaken regularly as part of the Trust programme to maintain high standards.
Anaesthetic management of fractured neck of femur audit	Good compliance with standards was noted. Actions: A bitesize training session was delivered to staff during the presentation of the findings to cover the anaesthetic form and a review of the recommended standardised dosing.
Therapy Services	
The timing of hand therapy following administration of botulinum toxin (botox) in paediatric patients	Actions completed: Review pathway to ensure all patients are captured. Education on the pathway has been delivered to staff. Patient botox information leaflets containing contact details have been rolled out to patients. Further training of physiotherapy staff in progress.
Completion and accuracy of Malnutrition Universal Screen Tool (MUST) Tool on Seddon Suite	This audit showed all patients admitted to Seddon Suite were screened on admission. Actions: to ensure accurate and complete information is used to complete the screening tool (including past weight).
Urology	
Audit of management of patients with urinary retention trial without catheter (TWOC) clinic audit. Re-audit	This audit has identified that excellent service is being provided to patients when they attend TWOC clinic. Findings have been shared with ED to improve practices further.
Medicine/Pathology	
Review of laboratory requests for Hepatitis B testing	100% of maternal samples had correct test requested Actions: guidance circulated to staff regarding correct test requesting.

Audit Title	Outcome/actions
	Order set created on Careflow system for hepatitis B screen in immunocompetent patients.
Abnormal glandular cells in cervical cytology Audit	The results demonstrated in the audit were positive, and the audit is planned again for next year.
Reporting of melanoma in the histopathology department	The audit met with all the standards set and no further actions were needed.
Plastic Surgery	
Hand trauma pro forma re-audit	The audit demonstrated good compliance with documentation. Further updates have been made to the hand pro forma.
Re-audit consent documentation	There were improvements in some areas of documentation; actions will be implemented to further improve completion of the form.
Wrist arthrodesis experience using distal radius and wrist fusion plates in patients of upper limb spasticity	The audit found excellent patient compliance with the distal radius plates used with high patient satisfaction. Actions: recommended use of the implant in wrist fusion surgeries.
Hand washing audit during COVID pandemic	This audit has showed 100% of participating health care workers performing handwashing for at least 20 seconds using the modified Ayliff technique. Actions: training to be arranged with the Infection Prevention Department on a continued quarterly basis.

2.4.3. Participation in clinical research

Participation in research brings many benefits for the NHS, including improvements in the quality of care and health outcomes for our patients. The COVID-19 pandemic changed the landscape of research, with an increased focus on looking at ways to combat the virus.

> "The world faces an unprecedented challenge in our efforts to tackle the spread of COVID-19 and it is vital we harness our research capabilities to the fullest extent to limit the outbreak, and protect life".
> Professor Chris Whitty, Chief Medical Officer and National Institute for Health Research (NIHR) Co-Lead

The Trust responded at speed by setting up a number of COVID-19 urgent public health (UPH) studies investigating new treatments, vaccines and preventions. According to the NIHR this ground-breaking research is helping to save lives in the UK and around the world. It is informing government policy and providing NHS doctors and nurses with the tools they need to prevent and treat COVID-19.

Since March 2020 the research teams at St Helens and Knowsley Teaching Hospitals NHS Trust have worked tirelessly to support these crucial studies whilst maintaining some non-COVID-19 important research. The support from the Critical Care Unit and respiratory, pathology and pharmacy departments, as well as principal investigators research staff and patients, has been invaluable and without their support the research could not have taken place. Their hard work has helped combat the devastating effects of the COVID-19 pandemic and pave the route to recovery.

On 23rd June 2020 the Trust was the first trust in the Clinical Research Network, North West Coast (CRN NWC) to successfully recruit the first participant to an important UPH England study "SIREN" (SARS-COV2 Immunity and Reinfection Evaluation). One of the biggest questions SIREN sought to answer was whether individuals who had previously been infected with COVID-19 enjoyed protection from the virus in the future. As the rollout of vaccines began, the study was rapidly updated to include information about whether the participant had been vaccinated. By expanding the protocol of the study to include vaccine information, SIREN has been able to assess the effectiveness of vaccines. In February 2021, SIREN published findings that healthcare workers were 72% less likely to develop infection after one dose of the vaccine, rising to 86% after the second dose. (https://publichealthmatters.blog.gov.uk/2021/03/11/the-siren-study-answering-the-big-questions/)

The following table demonstrates recruitment to all the UPH COVID-19 studies conducted at the Trust:

Short title	Description	Number of participants recruited
SIREN	The impact of detectable anti SARS-COV2 antibody on the incidence of COVID-19 in	406

	healthcare workers	
RECOVERY	A clinical trial to test the effects of potential drug treatments for patients admitted to hospital with both suspected and confirmed COVID-19.	225
ISARIC	A study aiming to discover the background of the virus so attempts can be made to find better ways to manage and treat the infection in the future	844
Oxford Vaccine Study	The COVID-19 vaccine randomised controlled trial. This study assesses if people can be protected from COVID-19 with a new vaccine called ChAdOx1 nCoV-19. The Trust follows up patients recruited to this important study.	92
GenOMICC	A study aiming to find the genes that cause some people to be more vulnerable to COVID-19.	99
UKOSS	A maternal and perinatal outcomes of pandemic influenza or novel coronavirus in pregnancy study	Not available as StHK did not recruit to this study but did participate
PAN COVID	A global registry of women with suspected COVID-19 or confirmed SARS-CoV-2 infection in pregnancy and their neonates; understanding natural history to guide treatment and prevention	105
Neonatal complications of coronavirus disease (COVID-19) study	A study collecting data about babies who have Coronavirus infection and babies whose mothers have Coronavirus infection	Not available as StHK did not recruit to this study but did participate
MERMAIDS study	Multi-centre EuRopean study of MAjor Infectious Disease Syndromes: Acute Respiratory Infections in Adults (MERMAIDS-ARI)	4

The number of patients receiving relevant health services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2020-21 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 2092.

In addition to the hard work taking place on the COVID-19 studies, in June 2020 the Trust released a new Research Development and Innovation Strategy, which clearly states our aims and objectives for the next 3 years. One of the main aims is to increase the number of patients/participants who have access to research at the Trust, which was also included in the Trust objectives for 2020-2021. The Trust surpassed the recruitment target set for 2020-21 by successfully recruiting 2092 participants against a target of 1324. Currently the Trust ranks 8th out of 20 trusts across the CRN NWC. This is a great achievement and the result of a huge effort from all the Research Team, which demonstrates the commitment to offering patients and public the opportunity to take part in research.

In May 2020 the NIHR published a framework to support the restarting of research paused due to COVID-19. The goal was to restore a fully active portfolio of NIHR research while continuing to support important COVID-19 studies as part of the Government response to the pandemic. They set a target for trusts to open 80% of non-COVID-19 studies by the 31st March 2021. The Trust achieved this challenging target; however recruitment to some of these studies slowed down due to the disruption in clinical services caused by the pandemic.

Recruitment to cancer clinical trials is consistently a challenge; patients are only approached if there is a clinical trial available. The trials team lead on the expansion of the portfolio of trials available and support the clinical teams to broaden the scope of trials within each speciality. The team have worked consistently to ensure clinical trials are embedded in the multi-disciplinary team meetings as part of the decision-making around patient treatment options. 97 research studies were open to recruitment at the Trust during 2020-21, of which 18.56% were cancer research trials.

In 2020 the NIHR introduced an Associate Principal Investigator (PI) Scheme which aims to develop junior doctors, nurses and allied health professionals to become the PIs of the future and provides formal recognition of a trainee's engagement in NIHR portfolio research. The Trust is committed to developing future PIs, therefore we have engaged with this initiative and two members of staff have signed up to this scheme. Also in collaboration with Edge Hill University, Professor Rowan Pritchard-Jones is supervising two NIHR funded PhD studentships. The NIHR Doctoral Fellowship is a three year full-time award that supports individuals to undertake a PhD in an area of NIHR research; these fellowships have been designed to support individuals at various points of their development in becoming leading researchers. The NIHR also places emphasis on the Patient Research Experience Survey (PRES) high level objective, which opened in November 2020 and ran until 31st March 2021. The Trust introduced a number of methods for obtaining feedback and valued the patients' views on taking part in research and received the highest number of responses (184) across all the partner organisations in the CRN NWC. The feedback was extremely encouraging, with the majority of respondents confirming that they had a positive research experience, were treated with courtesy and would consider taking part in research again in the future. A re-occurring theme emerged where participants highlighted issues around the uncertainly of clinic appointments and, therefore, the Research Team have been allocated dedicated clinic space which will open during 2021.

2.4.3.1. Research aims for 2021-22

- Ensure that there are robust structures in place to initiate, deliver and manage research, thus increasing opportunities for patients to participate in high quality clinical research
- Achieve ambitious set up and delivery targets each year, including the development of a diverse portfolio of commercial trials
- Apply for NIHR Hyperacute Stroke Research Centre (HSRC) status, which will make the Trust a specialist centre for research in the 'hyper-acute' time period following a stroke (within a few hours), when treatment is most likely to be effective. It will also enable the Trust to be at the cutting edge of acute stroke

research and mean we can enrol more of our patients into the very latest clinical trials
- Secure dedicated research clinic space, thus optimising our capacity to invite participants to take part in research. This will also impact on the patient experience
- Develop a research-aware workforce, where all staff recognise the value of research in enhancing the quality of services and, therefore, growing staff capability and capacity to undertake research
- Engage and communicate with patients and service users. It is of great value to know about the opinions and experiences of the participants, ensuring that the NIHR Patient Research Experience Survey is embedded into the patient's research journey and feedback of both positive and negative experiences is considered
- Continue to strive to qualify for the minimum £20k Department of Health Research Capability Funding (recruiting 500 or more participants to non-commercial research)
- Explore opportunities for dedicated research appointments, including clinical academic posts, in order to address clinically-relevant research questions for the benefit of our patients
- Encourage more staff to take part in the NIHR Associate PI scheme with the aim of them becoming PIs in the future
- Continue to work in partnership with the CRN NWC to ensure that the NIHR high level objectives are met

2.4.4. Clinical Goals agreed with commissioners

In normal circumstances a proportion of St Helens and Knowsley Teaching Hospitals NHS Trust income in 2020-21 would have been conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. However, the COVID-19 pandemic resulted in NHS England/NHS Improvement (NHSE/I) suspending the operational delivery of CQuIN schemes for all NHS providers during the whole of the 2020-21 financial period (1st April 2020 – 31st March 2021). Instead NHS providers were awarded full payment of their CQuIN allowance. Financial sanctions associated with the delivery of all NHS national operational standards and national quality requirements were also suspended for the whole of 2020-21 financial period.

2.4.4.1. CQuIN Proposals 2021-22

As a consequence of the COVID-19 pandemic continuing into 2021-22, guidance released by NHSE/I confirms:

- No active 2021-22 CQuIN scheme (either Clinical Commissioning Group (CCG) or specialised) will be published at this stage. Detailed 2021-22 CQuIN indictors will be published in due course. NHS providers will automatically be awarded full payment of their 1.25% CQuIN allowance for the pro rata period of the first half (H1) of 2021-22 (1st April 2021 – 30th September 2021)
- Once 2021-22 CQuIN schemes are confirmed and become active, then as previously, commissioners will be able to claw back any underperformance, depending on the NHS provider's performance against the CQuIN indictors
- Financial sanctions associated with the delivery of NHS national operational standards and national quality requirements no longer exist. Instead commissioners will now use remedial action plans with agreed consequences to address failing standards and/or requirements. For H1 2021-22 commissioners are not allowed to withhold funding from NHS providers if remedial action plans are not delivered
- Further guidance will be published in due course for H2 2021-22 (1st October 2021 – 31st March 2022).

2.4.5. Statements from the Care Quality Commission (CQC)

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

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

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

The latest comprehensive CQC inspection, using the new approach, took place in July and August 2018. The Use of Resources review was undertaken on 5th July, the unannounced inspection took place during the week commencing 16th July, the inspection of Marshalls Cross Medical Centre was completed on 14th August and the planned well-led review was completed during the week commencing 20th August. Teams of inspectors visited Whiston, St Helens and Newton hospitals and the Trust's directly provided community and primary care services during the inspection period to talk to patients, carers and staff about the quality and safety of the care provided. They reviewed care records and observed the care provided. The Trust was able to

demonstrate to the inspection team the high standard of work that is undertaken on a daily basis to ensure patients receive excellent care.

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

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2020-21.

St Helens and Knowsley Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2020-21.

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

2.4.5.1. CQC ratings table for St Helens and Knowsley Teaching Hospitals NHS Trust, March 2019:

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

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

As part of the 2018 inspection, the CQC inspected Marshalls Cross Medical Centre, which was a new service that the Trust was contracted to provide from March 2018. The inspection identified three areas where the Trust had not met the requirements of the CQC regulations at that time. The Trust took action to address the issues identified at the time of the inspection in August 2018. Mersey Internal Audit Agency subsequently reviewed these actions and confirmed that they had been implemented.

The Trust is taking the following action to address the points made in the CQC's assessment:

- Delivery of comprehensive action plans in continuing attempts to achieve key national targets to enable timely care of patients in ED, including arrival to initial assessment times and the DH decision to admit, transfer or discharge target

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2021 in taking such action:

- Delivery of action plans to address the areas of non-compliance in Marshalls Cross Medical Centre and all the should do recommendations, including those areas where the Trust requires improvement in the ED, including ensuring all applicable staff receive level three children's safeguarding training and clarifying and monitoring the quality and completion of ligature and clinical risk assessments to ensure they are

completed as appropriate for all patients requiring them in ED

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

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

During 2020-21 the CQC implemented transitional monitoring arrangements and undertook a detailed review of infection prevention via the Trust's Infection Prevention Board Assurance Framework and the large vaccination centre at the St Helens Rugby Ground with no concerns raised.

2.4.6. Learning from deaths

2.4.6.1. Number of deaths

During Quarters 1-4 2020-21, 2,018 of St Helens and Knowsley Teaching Hospitals NHS Trust's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:
506 in the first quarter
341 in the second quarter
544 in the third quarter
627 in the fourth quarter

By end of Q4, 417 case record reviews and 10 investigations (reds and ambers) have been carried out in relation to the 2,018 deaths included in item 2.4.6.1
In 10 cases (reds and ambers), a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
142 in the first quarter
103 in the second quarter
119 in the third quarter
53 in the fourth quarter
[DN: Final figures to be confirmed as reviewers are still completing SJRs and March's SJRs have not yet been allocated]

1 representing 0.05% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient (red rated).
In relation to each quarter, this consisted of:
1 representing 0.2% for the first quarter
0 representing 0.0% for the second quarter
0 representing 0.0% for the third quarter
0 representing 0.0% for the fourth quarter

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

122 case record reviews and 2 (reds and ambers) investigations completed after 31-12-2019 which related to deaths which took place before the start of the reporting period.

2 representing 0.4% (reds) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the St Helens and Knowsley Teaching Hospitals NHS Trust Structured Judgement Review (SJR) (which uses NCEPOD quality score and red, amber, green (RAG) rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance. This represents the final position for Quarter 4 of 2019-20.

3 representing 0.2% of the patient deaths during 2019-20 are judged to be more likely than not to have been due to problems in the care provided to the patient. This represents all four quarters of 2019-20.

2.4.6.2. Summary of learning from case record reviews and investigations

The Trust has focussed on one or two key learning priorities for each quarterly report to the Trust Board. The key lessons shared were:

- Lactate Levels

High lactate levels MUST trigger urgent pursuit of a cause. Failure to improve requires escalation until an appropriate action plan is in place. Always consider the presence of ischaemia (bowel or other) if no other explanation is apparent

- Do not attempt cardiopulmonary resuscitation (DNACPR)

COVID-19 has highlighted a different concern for patients and families. Forms, completed on admission, with the COVID diagnosis in mind, were part of a multidisciplinary (MDT) approach to define plans to escalate or palliate patients on deterioration. However for patients surviving to discharge further discussion by the clinical team is essential as to whether such a form is required and exactly what it means with regards to their future healthcare

- Recognising End of Life

Acknowledging the difficulty of recognising a patient who is approaching the final stage of their life and requires support in a comfortable death rather than ongoing resuscitation and treatment continues to be a challenge in many areas of the Trust. In response to this we have put together a questionnaire to be sent to all staff in the next month – please respond and help direct the teaching and support required in order to improve the patient and bereaved family experience

- 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 (ACPs), including DNACPR and 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.

2.4.6.3. Actions taken resulting from learning

The Trust's Learning from Deaths Policy was refreshed in December 2019 and incorporates the principles laid down in the National Quality Board document "Learning from Death: Guidance for NHS trusts on working with bereaved families and carers".

Lessons identified from the structured judgement reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, Intranet home page, global email, Care Group governance and directorate meetings.

In addition to sharing the learning the following work streams have been initiated and are ongoing:

- A working group has been developed to determine the complexities clinicians face in engaging with patients and their families in determining ceilings of treatment and DNACPR decisions. These have been made even more evident by challenges faced during the COVID pandemic.
- Seminar to share with staff the learning so far from end of life cases, the changes achieved so far and ongoing work to be held in September 2021 (postponed from November 2020): Dying Matters – the next steps (insight to learning from deaths)
- Trust level project to evaluate and determine the best course of action in the management of the deteriorating patient at Whiston site, including aggregated, comprehensive review of patients who have required multiple calls to the Medical Emergency Team (MET)
- Case review sharing with junior doctors in line with the Royal College of Physicians Lessons Learned Programme https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6616793/
- Integration of the Medical Examiner role, established in October 2020, into learning from deaths, including accuracy of death certification
- Recognition of exceptionally good care, which is acknowledged by the Mortality Surveillance Group in writing and used by individual clinicians to support appraisal and revalidation

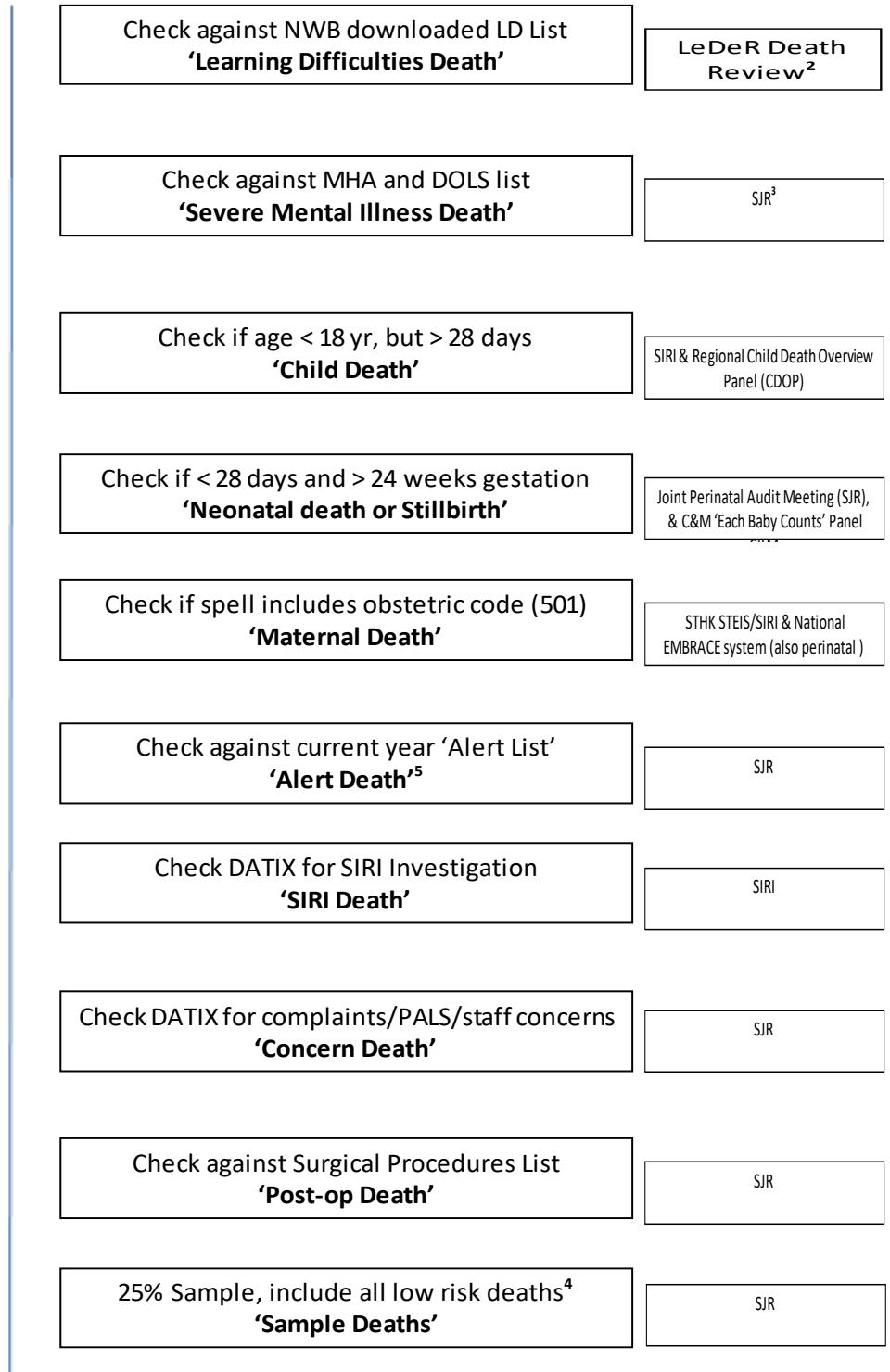
2.4.6.4. Impact of actions taken

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

2.4.6.5. Trust approach to learning from deaths

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

Total Deaths in Scope[1]



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

2.4.7. Priority clinical standards for seven day hospital services

The Seven Day Hospital Services (7DS) Programme aimed to ensure that patients requiring emergency admission received high-quality care every day of the week through early, consistent senior decision-making as outlined in the 10 7DS Clinical Standards (CS). Trust performance against the priority CS defined by NHS England (NHSE) was previously audited and reported to the Trust Board and NHSE to provide assurance of progress towards the target of full compliance with the standards.

The two priority standards were:

- CS2: Time to first consultant review - all emergency admissions must have a clinical assessment by a suitable consultant within 14 hours of the time of admission to hospital.
- CS8: Ongoing daily review by consultant (or their delegate)

Over the last 4 years, the Trust has shown consistent improvement against the 7DS clinical standards. The repeat audit was due to be reported to June 2020 Trust Board. However, in March 2020, NHSE/I issued an instruction that the Spring 2020 Board Assurance Framework (BAF) submission was to be deferred until September 2020. In June, subsequent instruction was given that the September BAF would not necessarily reflect business as usual in regards to the priority 7DS standards.

This reflects a change in the nature of clinical practice in many clinical areas across the Trust during the year, with the cancellation of elective activity and a largely Consultant delivered service spread across many wards. As such, an audit of clinical practice against 7DS during the pandemic response would not be comparable to previous or future audits.
There has been subsequent communication from NHSE/I to say that the regular monitoring and reporting of performance against the 7DS Standards would not be restarting following the COVID-19 Pandemic.

Throughout the pandemic, the Trust has continued to provide Consultant-delivered care as early as possible during a patient's hospital admission and consistently throughout their hospital stay.

Following the pandemic and implementation of the Trust's recovery plan we will continue to implement the actions from previous audits but there are no current plans to re-audit performance against the 7DS.

2.4.8. Information governance and toolkit attainment levels

Information Governance (IG) is the way in which the Trust manages its information, and ensures that all information, particularly personal and confidential data is handled legally, securely, efficiently and effectively. It provides both a consistent way and a framework for employees to deal with the many different information handling requirements in line with Data Protection legislation.

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG controls, also known as the IG Assessment Report. The DSPT is an annual online self-assessment tool that allows health and social care organisations to measure their performance against the National Data Guardian's 10 Data Security Standards (covering topics such as staff responsibilities, training and continuity planning) and reflects legal rules relevant to IG. The Trust must address all mandatory requirements within the DPST in order to publish a successful assessment.

The DSPT submission is usually required to be made in March, however the deadline for 2020-21 has been extended until the 30 June 2021, as NHS Digital recognised that COVID-19 required organisations to reprioritise many work-streams.

St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall submission position for 2020-21 has not yet been confirmed due to the deferred submission date as noted above.

To provide assurance that the Trust's DSPT is of a good standard it has been audited by Mersey Internal Audit Agency. The level of assurance is yet to be issued.

The Trust has assigned specific roles to ensure the IG framework continues to be adhered to and remains fully embedded:

- Christine Walters, Director of Informatics – Senior Information Risk Owner
- Mr Alex Benson, Assistant Medical Director - Caldicott Guardian
- Camilla Bhondoo – Head of Risk Assurance and Data Protection Officer

All staff are appropriately trained.

The Trust has a Data Breach Management Procedure in place which is adhered to when a personal data breach/incident occurs. All incidents are risk assessed and scored, where an incident is scored highly it must be reported to the Information Commissioner's Office (ICO).

There have been no reportable incidents for 2020-2021 for the Trust.

2.4.9. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2020-21 by the Audit Commission.

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security & Protection Toolkit 2020-21. The error rates reported in the latest published audit for that period of diagnoses and treatment coding (clinical coding) were:

2020-21 data reported in February 2021				
Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect

Data Security & Protection Toolkit	4.5%	5.37%	4.82%	3.02%

2.4.10. Data quality

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

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

There are a number of standard national data quality items, which are routinely monitored, including:

- Blank/invalid NHS numbers
- Unknown or dummy practice codes
- Blank or invalid registered GP practices
- Patient postcodes

The Trust implemented a new Patient Administration System (PAS), Careflow, in 2018 which has the functionality to allow for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier.

The Careflow configuration restricts the options available to users. Validation of this work is on-going and forms part of the annual data quality work plan.

2.4.10.1. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during 2020-21 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which includes the patient's valid NHS number and registered GP practice contributes to the overall Data Quality Maturity Index (DQMI) scores, which are shown in the table below:

DQMI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
STHK score	94.3	95.4	94.0	95.4	95.4	91.8	90.3	90.7	90.9
National average	81.1	81.7	81.6	82.3	83.0	81.0	80.9	84.4	82.3

(Source: DQMI)

The Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

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

- The Data Quality team will monitor the nationally mandated submissions via the NHS Digital toolkit and a formal report will be presented at the Information Steering Group meeting. Any elements requiring action will be agreed at this meeting
- Data Quality Team will continue to monitor data quality throughout the Trust via the regular suite of reports
- The Data Quality Team will identify areas within the Trust that would benefit from additional training on the PAS system to the Trust's training team
- Provide data quality awareness sessions about the importance of good quality patient data and the impact of inaccurate data recording

2.4.11. Benchmarking information

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

2.4.11.1. Benchmarking Information

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

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
SHMI	NHS Digital	Dec-19 to Nov-20	1.094	1.000	0.695	1.187	
SHMI	NHS Digital	Nov-19 to Oct-20	1.072	1.000	0.678	1.178	
SHMI	NHS Digital	Oct-19 to Sep-20	1.070	1.000	0.687	1.180	
SHMI	NHS Digital	Sep-19 to Aug-20	1.075	1.000	0.695	1.182	
SHMI Banding	NHS Digital	Dec-19 to Nov-20	2	2	3	1	
SHMI Banding	NHS Digital	Nov-19 to Oct-20	2	2	3	1	
SHMI Banding	NHS Digital	Oct-19 to Sep-20	2	2	3	1	
SHMI Banding	NHS Digital	Sep-19 to Aug-20	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Dec-19 to Nov-20	42.2%	36.3%	8.1%	59.2%	
% of patient deaths having palliative care coded	NHS Digital	Nov-19 to Oct-20	42.1%	36.3%	8.0%	59.4%	
% of patient deaths having palliative care coded	NHS Digital	Oct-19 to Sep-20	41.6%	36.3%	8.6%	60.1%	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
% of patient deaths having palliative care coded	NHS Digital	Sep-19 to Aug-20	41.5%	36.3%	8.5%	60.7%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (NHS Digital). St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by: Monthly monitoring of available measures of mortality. Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned.							
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-19 to Mar-20 (provisional)	N/A	N/A	N/A	N/A	The mandatory varicose vein surgery and groin-hernia surgery national PROMS collections have now ended * data suppressed due to small numbers
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-17 to Mar-18 (final)	0.076	0.089	0.029	0.137	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-19 to Mar-20 (provisional)	0.422	0.468	0.330	0.536	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.428	0.465	0.348	0.557	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-17 to Mar-18 (final)	0.411	0.468	0.376	0.566	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-19 to Mar-20 (provisional)	0.255	0.342	0.243	0.421	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.309	0.338	0.266	0.405	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-17 to Mar-18 (final)	0.280	0.338	0.234	0.417	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-19 to Mar-20 (provisional)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-17 to Mar-18 (final)	*	0.096	0.035	0.134	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health.							

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: Delivering a number of actions to improve patient experiences following surgery. Monitoring the PROMs data at the Trauma and Orthopaedic bi-monthly clinical effectiveness meeting.							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-11 to Mar-12	12.73	11.45	0.00	17.15	2011-12 still latest data available. Date of next version to be confirmed. Lowest and best national performance based on acute providers
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	12.60	11.43	0.00	17.10	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-11 to Mar-12	11.39	10.01	0.00	14.94	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	10.66	10.01	0.00	14.11	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The data was consistent with Dr Foster's standardised ratios for re-admissions. The readmissions: 30 day relative risk score is monitored monthly by the Trust Board. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by: Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2019-20	66.2	67.1	59.5	84.2	
Patient experience measured by scoring the results of a selection of questions from the national	NHS Digital	2018-19	69.5	67.2	58.9	85.0	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
inpatient survey focussing on the responsiveness to personal needs.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2017-18	70.5	68.6	60.5	85.0	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does. The Trust was rated outstanding overall for caring by the CQC following their latest inspection in 2018. The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by: Promoting a culture of patient-centred care. Responding to patient feedback received through national and local surveys, Friends and Family Test results, complaints and Patient Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning and patient information.							
Q18d. If a friend or relative needed treatment, I would be happy with the	NHS staff surveys	2020	88.1%	73.4%	50.0%	92.0%	Data for 2020 is for Acute and Acute & Community Providers only

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
standard of care provided by this Trust.							
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2019	87.4%	70.5%	39.7%	87.4%	Data for 2018 and 2019 Acute Providers only
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2018	87.3%	71.2%	39.7%	87.3%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2020	12.2%	19.8%	26.3%	12.2%	Low scores are better performing trusts
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2019	12.9%	20.3%	26.5%	12.9%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2018	11.8%	20.4%	28.4%	11.8%	
% believing the organisation provides	NHS staff surveys	2020	93.2%	84.9%	66.5%	94.3%	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
equal opportunities for career progression/ promotion							
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2019	91.9%	84.4%	70.7%	91.9%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2018	94.3%	84.0%	69.3%	94.3%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons; The Trust provides a positive working environment for staff with a proactive Health, Work and Wellbeing Service. An independent provider, Quality Health, provides the data. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Engagement of staff at all levels in the development of the vision and values of the Trust. Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.							
Friends & Family Test – A&E – Response Rate	NHS England	Mar-21	15.1%				
Friends & Family Test – A&E – Response Rate	NHS England	Feb-21	16.3%				

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Friends & Family Test – A&E – Response Rate	NHS England	Jan-21	15.6%				
Friends & Family Test – A&E – Response Rate	NHS England	Dec-20	13.4%				
Friends & Family Test – A&E – % recommended	NHS England	Mar-21	84.7%				
Friends & Family Test – A&E – % recommended	NHS England	Feb-21	89.3%				
Friends & Family Test – A&E – % recommended	NHS England	Jan-21	89.8%				
Friends & Family Test – A&E – % recommended	NHS England	Dec-20	90.6%				National average includes Independent Sector Providers National data for Dec-20 to Mar-21 not yet published
Friends & Family Test – Inpatients – Response Rate	NHS England	Mar-21	34.4%				
Friends & Family Test – Inpatients – Response Rate	NHS England	Feb-21	25.0%				
Friends & Family Test – Inpatients – Response Rate	NHS England	Jan-21	33.3%				
Friends & Family Test	NHS	Dec-20	28.1%				

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
– Inpatients – Response Rate	England						
Friends & Family Test – Inpatients – % recommended	NHS England	Mar-21	95.8%				
Friends & Family Test – Inpatients – % recommended	NHS England	Feb-21	94.9%				
Friends & Family Test – Inpatients – % recommended	NHS England	Jan-21	96.7%				
Friends & Family Test – Inpatients – % recommended	NHS England	Dec-20	95.6%				
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes the Friends and Family Test across all areas. The data was submitted monthly to NHS England (December 2020-March 2021. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology. Actively working with ward staff and the Trust's Patient Experience and Dignity Champions to improve levels of engagement with the system, to ensure the latest results are shared at local level.							
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2019-20	96.24%	95.25%	71.59%	100.00%	All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2019-20	95.23%	95.40%	71.72%	100.0%	Data for Q4 2019-20 onwards is suspended

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2019-20	95.23%	95.56%	69.76%	100.0%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Sustained delivery of the 95% target for patients having a VTE risk assessment within 24 hours of admission to ensure that they receive the most appropriate treatment, having achieved 95.4% for April 2019 to February 2020, prior to submissions being suspended nationally due to the pandemic. Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed. During 2020-21, 69 patients developed a hospital acquired thrombosis, of which 59 clinical reviews have been completed to date and 100% were found to have received appropriate care. 47 of the 59 patients reviewed who had developed a hospital acquired thrombosis tested positive for COVID-19 and were receiving treatment. COVID-19 related VTE has been identified nationally and internationally as a complication of the virus and, therefore, in response the Trust developed new guidance in 2020 for clinicians to consider in planning VTE prophylaxis. St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed. Sharing any learning from these reviews and providing ongoing training for clinical staff.							
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-19 to Mar-20	15.7	13.6	0	51.0	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years	GOV.UK	Apr-18 to Mar-19	10.2	12.2	0	79.7	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
and over (Trust apportioned cases)							
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-17 to Mar-18	11.4	13.6	0	90.4	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Infection prevention remains a priority for the Trust. All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory external reporting. The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea. Cases are thoroughly investigated using RCA, which is reported back to a multidisciplinary panel to ensure appropriate care was provided and lessons learned are disseminated across the Trust. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: Focussing on ensuring staff compliance with mandatory training for infection prevention. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.							
Incidents per 1,000 bed days	Internal	Oct-20 to Mar-21	29.92	-	-	-	Next data to be published in September 2021
Incidents per 1,000 bed days	Internal	Apr-20 to Sep-20	41.94	-	-	-	
Incidents per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	35.31	49.70	27.52	110.21	Based on acute (non-specialist) trusts with

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Incidents per 1,000 bed days	NHS Improvement	Apr-19 to Sep-19	35.70	48.80	26.29	103.84	complete data (6 months data)
Incidents per 1,000 bed days	NHS Improvement	Oct-18 to Mar-19	35.77	45.07	16.90	95.57	
Incidents per 1,000 bed days	NHS Improvement	Apr-18 to Sep-18	34.95	44.10	22.08	107.37	
Number of incidents	Internal	Oct-20 to Mar-21	3595	-	-	-	
Number of incidents	Internal	Apr-20 to Sep-20	4221	-	-	-	
Number of incidents	NHS Improvement	Oct-19 to Mar-20	4370	6607	1758	22340	
Number of incidents	NHS Improvement	Apr-19 to Sep-19	4429	6314	1392	21685	
Number of incidents	NHS Improvement	Oct-18 to Mar-19	4401	5881	1580	22048	
Number of incidents	nrls.npsa.co.uk	Apr-18 to Sep-18	4228	5714	1285	23692	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Oct-20 to Mar-21	0.15	-	-	-	
Incidents resulting in	Internal	Apr-20 to Sep-	0.27	-	-	-	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
severe harm or death per 1,000 bed days		20					
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	0.04	0.15	0.00	0.52	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-19 to Sep-19	0.01	0.15	0.00	0.67	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-18 to Mar-19	0.08	0.14	0.01	0.49	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Apr-18 to Sep-18	0.09	0.15	0.00	0.54	
Number of incidents resulting in severe harm or death	Internal	Oct-20 to Mar-21	18	-	-	-	
Number of incidents resulting in severe harm or death	Internal	Apr-20 to Sep-20	27	-	-	-	
Number of incidents resulting in severe harm or death	NHS Improvement	Oct-19 to Mar-20	5	19	0	93	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-19 to Sep-19	1	19	0	95	
Number of incidents resulting in severe	NHS Improveme	Oct-18 to Mar-19	10	19	1	72	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
harm or death	nt						
Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Apr-18 to Sep-18	11	19	0	87	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Oct-20 to Mar-21	0.50%	-	-	-	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-20 to Sep-20	0.64%	-	-	-	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-19 to Mar-20	0.1%	0.3%	0.0%	0.9%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-19 to Sep-19	0.02%	0.3%	0.0%	1.6%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-18 to Mar-19	0.2%	0.3%	0.0%	1.8%	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Apr-18 to Sep-18	0.3%	0.3%	0.0%	1.2%	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes a culture of open and honest reporting within a just culture framework. The data has been validated against National Reporting and Learning System (NRLS) and HSCIC figures. The latest data to be published is up to March 2020. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.1%. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by: Undertaking comprehensive investigations of incidents resulting in moderate or severe harm. Delivering simulation training to enhance team working in clinical areas. Providing staff training in incident reporting and risk management. Monitoring key performance indicators at the Patient Safety Council. Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.							
Due to reasons of confidentiality, NHS digital has supressed figures for those areas highlighted with an * (an asterisk). This is because the underlying data has small numbers (between 1 and 5)							

2.4.11.2. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2020-21 is shown in the table below:

Performance Indicator	2019-20 Target	2019-20 Performance	2020-21 Target	2020-21 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	100.0%	Not Achieved 98.3%	100.0%	97.3%	Apr20-Mar21
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	92%	Not Achieved 90.3%	92%	70.6%	Apr20-Mar21
Cancer: 31-day wait from diagnosis to first treatment	96%	Achieved 97.1%	96%	97.5%	Apr20-Mar21
Cancer: 31-day wait for second or subsequent treatment:					
- surgery	94%	Achieved 96.5%	94%	96.0%	Apr20-Mar21
- anti-cancer drug treatments	98%	Not Achieved 96.6%	98%	100.0%	Apr20-Mar21
Cancer: 62-day wait for first treatment:					
- from urgent GP referral	85%	Achieved 86.2%	85%	86.5%	Apr20-Mar21
- from consultant upgrade	85%	Achieved 87.4%	85%	88.8%	Apr20-Mar21
- from urgent screening referral	90%	Achieved 92.5%	90%	94.8%	Apr20-Mar21
Cancer: 2 week wait from referral to date first seen:					
- urgent GP suspected cancer referrals	93%	Not Achieved 91.0%	93%	94.3%	Apr20-Mar21
Emergency Department waiting times within 4 hours – all types	95%	Not Achieved 83.9%	95%	86.8%	Apr20-Mar21

Performance Indicator	2019-20 Target	2019-20 Performance	2020-21 Target	2020-21 Performance	Latest data
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	83%	Achieved 89.3%	83%	90.4%	Apr20-Mar21
Clostridium Difficile	48	Achieved 42 avoidable	48	40 (43 total and 3 appealed)	Apr20-Mar21
MRSA bacteraemia	0	Not Achieved 1 contaminant	0	2	Apr20-Mar21
Maximum 6-week wait for diagnostic procedures: % of diagnostic waits waited <6 weeks	99%	Achieved 99.7%	99%	67.6%	Apr20-Mar21

3. Additional information

3.1. Equality, Diversity and Inclusion Strategy

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally hard to reach groups are not disadvantaged when accessing the services the Trust provides.

The Trust's Equality, Diversity and Inclusion Steering Group meets regularly to ensure full compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and members of the Trust staff networks (LGBTQ+, Building Abilities, Building a Multi-Cultural Environment (BME), Carers and Menopause).

3.1.1. Equality Objectives 2019-23

In April 2021, the Trust held its Equality Delivery System (EDS2) panel assessment, which was attended by senior leaders in the Trust, representatives from all local Healthwatch groups and the CCGs' equality team. Progress on EDS2 goals and the Equality Objectives 2019-23 action plan were presented and the current grades outlined.

2021 EDS2 approved grades

Goal	Outcome	2018	2019	2021
Better health outcomes	1.1	Developing	Achieving	Achieving
	1.2	Developing	Achieving	Achieving
	1.3	Developing	Achieving	Achieving
	1.4	Achieving	Achieving	Achieving
	1.5	Developing	Achieving	Achieving
Improved patient access and experience	2.1	Achieving	Achieving	Achieving
	2.2	Developing	Achieving	Achieving
	2.3	Achieving	Achieving	Achieving
	2.4	Developing	Achieving	Achieving
A representative and supported workforce	3.1	Achieving	Achieving	Achieving
	3.2	Excelling	Excelling	Excelling
	3.3	Developing	Developing	Achieving
	3.4	Achieving	Achieving	Achieving
	3.5	Achieving	Achieving	Achieving
	3.6	Excelling	Excelling	Excelling
Inclusive leadership	4.1	Achieving	Achieving	Achieving
	4.2	Achieving	Achieving	Achieving
	4.3	Developing	Achieving	Achieving

All parties present at this assessment approved the Trust's self-assessment of their grades and congratulated the Trust on the work that had been carried out to support both patients and staff during what has been a very difficult 12 months for everyone. The patient goals/outcomes were assessed as remaining at 'achieving' based on the significant amount that was achieved during the last year and the need to address both the existing and newly emerging health inequalities in our local communities as highlighted by COVID, which require ongoing commitment to review and address. Progress of the Equality Objectives Action Plan is shown below:

3.1.1.1. Improving access and outcomes for patients and communities who experience disadvantage

Communication support for those with disabilities
We have increased the number of patients who told us they had additional communication needs due to their disability (in line with the Accessible Information Standard) by:

- Additional training for admissions staff to ensure they ask the right questions
- Increased publicity via GPs, social media, Healthwatch, posters
- Regularly auditing the alerts on patients' records to ensure the correct information is recorded
- Training with team from St Helens for our doctors in training

Increasing accessibility

- Introduction of 'virtual' foreign language interpreters
- Virtual BSL interpreters launched
- Additional 'virtual clinics' (telehealth) launched
- Introduction of 'carers' passport'
- Cancer symptoms advice line set up (2020)
- Virtual COVID ward established
- Access audits carried out with local community group members

Collaborative working

- Worked together to develop formal guidance for reasonable adjustments for patients and staff which is being incorporated into our policies and procedures (patients and staff)
- Developed quality standards for interpreting services, for inclusion in contracts with providers by all trusts and incorporated into this Trust's contracts with providers in January 2020
- More robust equality analysis toolkit developed, to meet all statutory requirements with more in-depth assessments being carried out
- Working as a collaborative on overcoming barriers to accessing healthcare for all people with protected characteristics (work carried out on disability, transgender, reasonable adjustments, interpreting services, military veterans and armed forces)
- Cultural sensitivity on the work plan for 2021

3.1.1.2. Engagement and consultation

Although the COVID pandemic greatly reduced our opportunities to consult and engage with our local communities, we did maintain activity where we were able to including:

- Patient participation group members consulted electronically as required for views on the cancer portal, bereavement website and Trust's new website
- Access audits – next audits on new discharge lounge and PALS offices
- Lay reader scheme for Trust leaflets and literature
- Focus groups for people from protected groups – most recently regarding the Trust's new website, which is currently being developed
- Healthwatch groups participated in focus groups for new website
- Advocate from Deafness Resource Centre participated in the recruitment of the

new Patient Experience Manager
- Advocate from Deafness Resource Centre advised/contributed towards interpreting quality standards
- Feedback surveys carried out with users of foreign language interpreting service, with the majority of responses being positive
- Surveys, for example, Every Experience Counts, based on inpatient survey questions
- Advice on policies and standard operating procedures from specialist groups

3.1.1.3. Improving the experience of disabled members of staff in the Trust

- Gained Disability Confident Leader Status accreditation and will participate in a working group of private and public sector organisations across Merseyside to share best practice and encourage other organisations to develop their Disability Confident status
- Completed the Workforce Disability Equality Standard and supporting action plan
- Celebrated International Day of Disabled Persons (December 2020) with personal blogs from staff
- Established and grew Building Abilities@STHK staff network, with representation from the network at key governance meetings (Equality, Diversity and Inclusion Group and Strategic Advisory Group)
- Revised, Redeployment and Flexible Working policies and guidance are being developed for staff and managers

3.1.1.4. Improving the experience of BAME staff in the Trust

- Completed the annual Workforce Race Equality Standard and supporting action plan
- Celebrated Black History Month with the staff network running an art contest for staff
- Established and grew the Building a Multicultural Environment staff network, with member representation at key governance meetings (Equality, Diversity and Inclusion Group and Strategic Advisory Group) and Chair involvement in the development of the workplace risk assessments throughout COVID

3.2. Workforce Strategy 2020-2021

The Trust's Workforce Strategy and action plan is built upon the principles and direction of the **NHS People Plan 2020-21** and the **NHS Long Term Plan**. The Trust is committed to developing the organisational culture and supporting our workforce. Our experiences during COVID-19 have given us focus and intent to drive forwards our aims and ambitions as a Trust. The Workforce Strategy outlines the six key workforce priorities and their interconnectivity with the regional and system landscape which are:

1. Health and wellbeing
2. Culture and leadership

3. Recruitment and retention
4. Flexible working
5. Workforce development and deployment
6. Equality and diversity

The Workforce Strategy action plan detailed our objectives and actions to deliver the plan in 2020-21 and beyond. The plan is a live document which will be used to provide oversight of and track delivery of the strategy.

Fundamental to the strategy is 'Our People Promise,' which sets out ambitions for what people working in the NHS will say about it by 2024. The people promise is central to the NHS People Plan and has been developed to help embed a consistent and enduring offer to all staff in the NHS.

The Trust's Workforce Strategy has been developed to support the Trust's **Vision and Values**, to deliver 5 Star Patient Care. The following diagram shows the six priorities of the strategy which are supporting the successful delivery of the strategy. In designing the plan it considers:

- Our current position in relation to objectives and actions
- How we mature our actions to meet our longer term goals
- Our drivers for change
- How the Trust works together to achieve our ambitions
- How we measure success

The diagram below describes the six workforce priorities and our overarching commitments within them.

STHK Workforce Priorities	We will…
Health and Wellbeing	•Ensure all staff have a health and wellbeing conversation and develop a personalised plan •Ensure all staff have a risk assessments, to keep our staff safe •Continue to support each other and access support when we need it
Culture and Leadership	•Create a compassionate, kind and inclusive work environment •Have common values and a shared purpose in line with our ACE behavioural standards •Sustain our focus and energy to meet the pace and scale of the challenges
Recruitment and Retention	• Roll out the working carers passport to support timely compassionate conversations about supporting carers • Overhaul recruitment and promotion practices to ensure staffing reflects the diversity of our local area • Ensure we are retaining our people – including offering more apprenticeships and continuing to grow our staff banks
Flexible Working	•Ensure leaders have the skills, values and attitudes to deliver efficient effective safe high quality services •Accelerate the rollout of e-rostering and e-job planning systems •Normalise conversations about flexible working and include this in our job advertising and induction programme
Workforce Development and Deployment	•Use technology to enhance our learning and development offer •Support safe deployment and redeployment for staff •Grow innovative, new and existing roles for UK and international staff
Equality and Diversity	•Create a culture that reduces inequalities for BAME staff, including tackling the disciplinary gap •Promoting active staff groups and networks of ED&I champions to support staff at all levels •Support BAME staff to access development and career opportunities

The Key Workforce Strategy achievements during 2020-21 were**:**

- An agile, adaptive and robust approach to risk assessing all staff – agile working guidance and alternative approaches to working arrangements developed to support the workforce during the pandemic
- Every member of staff offered a health and wellbeing conversation
- COVID risk assessments completed for all staff
- Additional staff support during the COVID pandemic to support well-being
- Enhancing flexible working opportunities with the development of a new policy
- Equality and inclusion for our BAME staff, with an Equality Advisory Group

established
- Ongoing international recruitment throughout the pandemic
- Internal staff transfer scheme launched as an aid to retention
- Quality of appraisals – new e-appraisal form implemented

3.2.1. Freedom to speak up

The Trust has continued with its commitment and support to ensure a culture where all staff feel empowered to speak up or raise concerns. The Trust values include being open and honest and listening and learning. There a number of supportive facilities in place across the Trust for staff to raise concerns, including:

- Freedom to Speak Up

All staff members across the organisation, including sub-contracted staff, have access to any of the Trust's four appointed Freedom to Speak Up Guardians, to raise concerns. The guardians are representative of various staff groups and backgrounds. They provide an alternative way for staff to discuss and raise concerns and act as an independent and impartial source of advice to staff at any stage of raising a concern.

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

During COVID-19, accessibility to information about speaking up was made widely available through displays and IT systems. Staff members were encouraged and supported to raise concerns, either personal or service-related to the Guardians or to use alternative raising concerns portals available. Improvements and changes have been made based on the concerns raised.

The Trust works in partnership with the National Guardian's Office and North West Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns. The Trust recorded a mean Freedom to Speak Up Index score (published in 2020) of 81.9% for the year 2019, an increase of 0.9% from 2018. The Trust score is significantly higher than the national mean score for acute trusts of 77.9%, confirming the positive culture for raising concerns. In the latest national staff survey results, published in 2021, the Trust has the national best scores compared to similar trusts in terms of staff engagement and safe environment and second best scores for staff morale, equality and diversity and safe culture.

- Speak in Confidence system

The Trust has continued to provide staff members with access to an anonymous reporting system, Speak in Confidence, which enables all staff, irrespective of their role, to raise concerns without disclosing their identity. The system uses a browser-based interface to ensure anonymity so that the concern raiser remains anonymous at all times. However, the manager receiving the concern is able to provide a response to the concern, to request further information and/or to provide assurances of actions taken to mitigate the risks associated with the concern raised via the online system. The

system has been used by staff members to raise concerns, which have been addressed.

- Raising concerns hotline

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

- Health, Work and Wellbeing hotline

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

- Hate crime reporting

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

- Policies and procedures

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

3.2.2. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. 510 completed questionnaires were returned from the initial sample of 1250 for the latest survey reported in 2021. This provided a 41% response rate (510 usable responses from a final sample of 1244), which is a slight reduction compared to last year.

It is important to note that this year saw some significant changes to the questionnaire content driven by the COVID pandemic. The questions and theme relating to personal development was replaced with a section on the COVID-19 pandemic, focusing on staff experience of working through this period. Furthermore, additional COVID questions included 2 free text questions;

- Q21a. Thinking about your experience of working through the COVID-19 pandemic, what lessons should be learned from this time?
  Q21b. What worked well during COVID-19 and should be continued?

The Survey Coordination Centre is working with text analytics specialists to process the free text data received in response to these questions and the release date is yet to be confirmed. Once we have received this analysis, any resultant actions will be

added into the overall action plan.

The survey compares results with similar trusts via the use of benchmarking groups, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. It should be noted that the Trust's benchmarking group was amended in 2020 to incorporate organisations that were previously in both the benchmarking groups for acute and acute & community trusts. This has increased the number of organisations in the Trust's benchmarking group from 85 in 2019, to 125 in 2020.

Results are reported both as individual question responses and as ten themes, which for 2020 are:
• Equality, diversity & inclusion
• Safe environment - bullying & harassment
• Health & wellbeing
• Safe environment - Violence
• Immediate managers
• Safety culture
• Morale
• Staff engagement
• Quality of care
• Team working

The themes are scored on a 0 to 10 point scale, a higher score indicating a better result. When compared to similar organisations STHK has the highest national score for the following 4 themes:
- Quality of care
- Staff engagement
- Immediate managers
- Safe environment – bullying & harassment

The Trust has the second best national score for the following 4 themes:
- Team Working
- Morale
- Equality, diversity & inclusion
- Safety culture

Following the successful implementation of the 2019-2020 survey action plan, the Trust now has the best national score recorded for a number of questions:
- My organisation encourages us to report errors, near misses or incidents
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again
- Staff experiencing musculoskeletal problems (MSK) as a result of work activities
- Staff feeling enthusiastic about their job

90.4% of staff agreed that care of patients/service users is the organisation's top priority, returning the best score regionally.

Whilst the overwhelming majority of responses are positive, consideration is being given to the areas with lower scores, work related stress and work related

improvements. Both of these areas have the potential to impact on staff morale and development. A deep dive has identified the specific areas and staff groups where focussed action will be taken and an action plan is being developed to support this work. Although quality of appraisals did not feature in the 2020 staff survey, work is continuing to improve this and it will remain as part of the updated action plan.

3.2.3. Clinical education and training

The pandemic led to unprecedented challenges for clinical education and the impact has required new methods of delivery with alternative education options, dynamic clinical placements and a degree of pragmatism.

The combination of reduced exposure to clinical sessions and the suspension or cancellation of attachments has had noticeable impacts, particularly on final year medical and nursing students. To support this the Trust, in collaboration with the Liverpool School of Medicine and with direction from the Nursing and Midwifery Council, developed final year student placements with a sub- foundation year 1 clinical placement and a final clinical nurse placement. This provided the opportunity to consolidate the required competencies and skills before commencing their careers, whilst practising as a core member of the healthcare team, providing direct patient care.

Clinical education also provided training to support the upskilling of the workforce who were redeployed in acute areas such as critical care and COVID-19 specific cohort wards. Simulation was used extensively to achieve this.

The Education Teams were required to develop education programmes that could be delivered remotely, providing education to learners whose clinical placements had been suspended. It is anticipated that more remote teaching will now be developed, building on this experience.

The Clinical Education Team, in collaboration with the Department for Education, has secured an external education centre at Vortex House. This has created an opportunity to support NHSE/I's international recruitment programme. The Trust, in partnership with the Pan-Mersey collaborative, will now provide objective structured clinical examination (OSCE preparation training) to over 200 internationally recruited nurses. The OSCE requires the candidates to complete scenarios they are expected to face when assessing, planning, delivering and evaluating care, in order to meet UK pre-registration nursing standards.

The Clinical Education Department have also been involved in the training of staff to become vaccinators, and in doing so, help enable the roll out of the vaccination programme at pace across the region.

3.3. Patient safety

One of the Trust's key priorities in 2020-21 was to continue to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. There was a particular focus on reducing avoidable harm by preventing pressure ulcers, with a target to reduce category 2 pressure ulcer incidents with

possible lapses in care by 10% from 2019-20 baseline, which was achieved.

3.3.1. Pressure ulcers

The Trust has continued to prevent any hospital acquired category 4 pressure ulcers, as a result of lapses in care since 2015. During 2020-21, there was one incidence of a hospital acquired category 3 pressure ulcer reported. A thorough and in-depth investigation was commissioned to identify the root cause of this incident, with improvement actions taken, including education for staff members to improve risk identification and appropriate action planning to prevent the development of a pressure ulcer on unusual body locations. The Trust also developed new transfer of care documentation from Critical Care to improve information about the care of pressure ulcers and wounds and support more effective handover of care.

The Trust is pleased to have achieved a reduction in the number of Trust-acquired category 2 pressure ulcers with lapses in care, decreasing from 59 in 2019-20 to 18 (validated up to January 2021), with a further 20 RCAs awaiting validation. The Trust has, therefore, achieved its priority for the reduction in the number of hospital acquired pressure ulcer by 10% in 2020-21.

A number of interventions and improvement actions were implemented to reduce the risk that a patient will develop pressure ulcers, which included improved access to preventative devices and specialist mattresses. The improvement was also supported by new documentation, development of care pathways and enhanced education.

3.3.2. Falls

The Falls Team continues to develop strategies to minimise the occurrence of inpatient falls. In 2020-21, the Trust reported:

- 3.1% increase in total falls from 1941 in 2019-20 to 2003 falls in 2020-21
- 5% increase in falls incidents resulting in moderate harm
- Increase in falls resulting in the severe harm or above category, from 12 in 2019-20 to 31 in 2020-21

Detailed investigations were undertaken for all falls resulting in severe harm, which identified that the COVID-19 pandemic had a major impact on the usual planning and delivery of patient care. This included staff being redeployed to work in unfamiliar areas, restricted visiting by relatives and carers and infection prevention measures, including staff being required to put on additional personal protective equipment.

The Trust has continued to implement its Falls Prevention Strategy 2018 to 2021. The strategy focuses on seven key areas for improvement:

- Using data to drive improvement
- Lesson learning and information sharing
- Procurement of equipment/services
- Changing culture
- Education and awareness
- Planning and implementation of falls prevention care
- Planning and implementation of post falls care

In addition, the senior nursing team, supported by the Falls Team, will provide intense support to the areas with the highest falls risks to ensure that risk assessments are completed fully, with individualised care planned and delivered based on the outcome of the risk assessment.

3.3.3. Venous thromboembolism (VTE)

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

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

National reporting for VTE risk assessment compliance has been suspended since April 2020.

The Trust responded to the scientific evidence on the higher risk of thrombo–embolic events in patients with COVID-19 and developed and implemented revised prescribing guidelines for clinicians for prophylaxis of VTE in patients with suspected or confirmed COVID-19 infection. The guideline has been integrated with the electronic prescribing and medicines administration (ePMA) system.

The Trust has continued to maintain the increase in the number of risk assessments completed and the appropriate prevention interventions by:

- Using an electronic VTE risk assessment tool, which is integrated into the patient administration system, enabling real time performance reviews
- Sharing compliance dashboards twice daily
- Undertaking a root cause analysis investigation of all cases of hospital acquired thrombosis in order to prevent it happening again
- Providing immediate feedback/education to ward staff, disseminating learning points and implementing any actions for improvement
- On-going VTE training for all clinical staff

3.3.4. Medicine safety

The inpatient electronic prescribing and medicines administration (ePMA) system is live in most inpatient locations in the Trust (with the exception of Sanderson Unit, Paediatrics, Critical Care and Maternity). The implementation of ePMA across the Trust has continued to deliver additional benefits during COVID-19 as shown below:

- ePMA supported remote consultation, virtual clinics and remote prescribing
- Removed the need for drug charts to be re-written thus reducing transcription errors
- Drug charts no longer have to leave the ward and can be accessed anywhere across the Trust, removing the need for them to be sent to pharmacy for example
- Information is available for ward rounds, supporting faster dispensing of drugs and

infection prevention measures
- Previous admissions are retained on the system which can be accessed to provide information regarding previous medication and any drug allergies
- Quality of the information is improved as it is legible and the prescriber can be easily identified and contacted as required
- Audit log allows the prescriptions to be reviewed to see why a drug has been stopped or suspended or why a drug has been modified
- Course lengths, for example, of antibiotics, can be added to the system and the prescription will stop automatically rather than requiring a doctor to stop it
- Enable prescribing and dosage guidance to be flagged for prescribers in COVID-19 treatment.

As a result of improved systems, the Trust saw a 20.1% decrease in administration errors reported, reducing from 562 reported in 2019-20 to 449 in 2020-21. There was also a 42.11% decrease in omitted doses causing harm, reducing from 38 in 2019-20 to 22 in 2020-21.

There was a reduction in the number of overall medication incidents by 35% in 2020-21 compared to 2019-20. In addition, there was a notable 60.87% reduction in prescribing incidents causing harm, decreasing from 23 incidents reported in 2019-20 to 9 in 2020-21. There were no severe harm incidents relating to medication administration or prescription. Pharmacy and the medicines safety team have supported an improvement project with clinical teams, to reduce the risk of wrong route administration of liquid medication and to reduce wastage of liquid controlled drugs intended for oral administration, by using bottle bungs and promoting the use of oral syringes.

Pharmacy has maintained the availability of medication for treatment and provided supportive information to develop treatment guidelines and protocols, throughout the pandemic.

3.3.5. Theatre safety

The Trust Operating Theatre Department has continued to implement a number of initiatives to improve safety which include implementation of National Safety Standards for Invasive Procedures (NatSSIPs) and of Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures.

The department reported 2 never events during 2020-21, relating to wrong site administration of nerve block prior to surgery. Intensive improvement work has been carried out across theatres and the anaesthetic department to embed robust safety checking processes during the administration of anaesthetic nerve block. Changes to anaesthetic documentation and recording of safety checks for nerve block administration have already been implemented, with high compliance noted.

The Operating Department has been able to achieve 53.1% reduction in all theatre related harm incidents, decreasing from 64 incidents reported in 2019-20 to 30 in 2020-21, with an overall 46.3% reduction in all theatre-related incidents decreasing from 456 incidents reported in 2019-20 to 245 in 2020-21. This is a further sustained

reduction in incidents from 2019-20, where a 17% reduction in all theatre related incidents were reported compared with 2018-19.

3.3.6. Being open – duty of candour

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

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

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

3.3.7. Never Events

Never Events are described by NHS England in its framework published in 2018 as serious incidents that are wholly preventable. Each Never Event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a Never Event. Never Events include incidents such as, wrong site surgery, retained foreign object post-surgical procedure and chest or neck entrapment in bedrails.

The Trust reported 3 Never Events in 2020-21, 1 relating to the administration of a drug via the wrong route and 2 incidents relating to wrong site surgery by administration of nerve block on the wrong side prior to surgery. The Trust remains committed to using Root Cause Analysis (RCA) to investigate adverse events. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and encouraged to feed back in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

Improvement actions undertaken in the operating department include strengthening of anaesthetics nerve block safety checking processes and enabling a safer theatre

working environment to provide assurance that lessons have been learned. Improvements have been made with the management and administration of liquid medication intended for oral use, especially controlled drugs, through the provision of safety bungs attached to liquid controlled drug bottles and the use of oral syringes for administration of oral medication in liquid form.

3.3.8. Coroner's Regulation 28 Prevention of Future Deaths Reports

Coroners are required to hold inquests to investigate certain deaths to establish a number of facts. The Coroner has a duty to issue a report, when a concern is identified as part of the inquest that there is a risk other deaths will occur, to a person, organisation, local authority or government department or agency. This is a Coroner 28 Report which sets out the concerns and requests that action is taken to prevent this. The Trust received a Regulation 28 report in March in relation to an electronic patient discharge summary not reaching the GP. The Trust provided assurance to the Coroner in April 2021 that the technical issue that had caused this had been resolved and that the error could not occur in the future.

3.3.9. Infection prevention

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

The Infection Prevention Team undertakes a rolling programme of infection prevention audits of each ward and department, with individual reports discussed with ward managers and teams for action.

The Trust's infection prevention priorities are to:

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

During the reporting period April 2020 to March 2021, the Trust reported the following:

- MRSA bacteraemia (MRSAb): two bacteraemia cases against a threshold of zero
- Due to the pandemic NHS Improvement (NHSI) did not set a threshold for Clostridium difficile infection (CDI) cases for 2020-21, therefore the Trust worked to the previous year's threshold of 48 cases, reporting 43 cases. 10 cases are awaiting appeal by the CCG, if successful the total will be 33 cases.
- Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb): The Trust had 29 cases of (MSSAb). Post-infection reviews (PIRs) were suspended for the majority of the year due to the pandemic

Lessons learned from the PIRs of MRSAb and CDI cases are shared Trust-wide via a monthly infection prevention report. Lessons learned include good practice identified, as well as areas for improvement. A new process for undertaking PIRs was initiated this year resulting in the care groups having increased ownership and targeted lessons learned. This information is also shared monthly with the CCGs.

The latest surgical site infection (SSI) rates related to elective hip and knee procedures from April to March 2021 are shown below:

- Hips 1.6% against a national average of 0.8%
- Knees 0.6% against a national average of 1.2%

In May 2016, the Government announced its ambition to halve gram-negative bloodstream HCAI by 2021. Approximately three-quarters of E. coli bloodstream infections (BSIs) occur before people are admitted to hospital and, therefore, reduction requires a whole health economy approach. The Trust, in collaboration with CCGs and partners, has developed a health economy action plan particularly focusing on a 10% in-year reduction in urinary tract infections and to learn and share lessons. The Trust continues to work closely with the infection prevention, patient safety and quality teams in the wider health economy, attending collaborative meetings across the region in order to improve infection prevention and control practices and monitoring.

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

Key achievements for 2020-21 were:

- 439 Aseptic Non-Touch Technique (ANTT) key trainers in the Trust who are responsible for ensuring all staff are compliant with ANTT
- 100% compliance with carbapenemase-producing enterobacteriaceae (CPE) and MRSA screening
- Ensured that there was infection prevention input into environmental monitoring systems and implementation of national standards for cleanliness and validation of standards
- Ensured there was infection prevention input into new builds and building modifications
- Bristol Stool Chart observations and CPE risk/screening assessment undertaken electronically via vitalpac
- Continued bi-weekly multi-disciplinary ward inspections with estates and facilities, Medirest, Vinci and new buildings to monitor ward cleanliness and estates and facilities provision
- Changes to the root cause analysis (RCA) processes to improve and prioritise cases that require oversight and input from the Executive Team and clinical teams. Timely RCA reviews for CDI cases has improved the dissemination of lessons learned and enabled the infection prevention team to target input to ward areas that required support

The Trust was pleased to report that 94.95% of frontline staff received their flu vaccination, above the target of 90%

3.3.9.1. COVID-19

Members of the Infection Prevention Team were responsible for the following during the pandemic:

- Advising the Trust on the most up-to-date and continually changing guidance from Public Health England (PHE) and NHS England via silver and gold command
- Education for staff on how to care for COVID patients, providing the highest quality care and protecting themselves while caring for them
- Working closely every day with the Procurement Department to ensure the provision of personal protective equipment (PPE) to wards and departments was available and fit for purpose
- Communicated Trust-wide any changes to PPE requirements issued by PHE and NHS England
- Working with estates and facilities in altering existing services and buildings to create additional non-invasive ventilation (NIV) and critical care unit beds, COVID wards, staff changing and break out rooms etc.
- Provided the fit test service and expertise throughout the pandemic, including training staff on the new quantitative fit testing machines purchased during the pandemic
- Visiting wards and departments providing support and reassurance for staff
- Provision of learning aids, posters on PPE, hand hygiene and environmental cleaning
- Providing advice to community colleagues and care homes
- Contributing to clinical protocols for COVID patients
- Providing a 7 day week infection prevention service on site
- Providing advice and support to our Medirest and Vinci colleagues
- Surveillance and reporting throughout the day on new COVID cases
- Providing support to staff self-isolating or at home with suspected/confirmed COVID

3.3.10. Safeguarding

The Trust takes its statutory responsibilities to safeguard patients of all ages very seriously and welcomes external scrutiny. The Trust submitted quarterly key performance indicator data to the CCGs from quarter 2 2020-21, with regular position statements being provided in place of key performance indicators during the COVID-19 pandemic between quarter 4 2019-20 and quarter 1 2020-21.

The Trust has a dedicated Safeguarding Team covering safeguarding children and the unborn child, safeguarding adults, domestic abuse, those with a learning disability or autism, those lacking capacity and those who require a Deprivation of Liberty authorisation. The Safeguarding Team provides support and advice to staff and delivers mandatory safeguarding supervision and training to all staff as per requirements throughout the Trust. The safeguarding team has remained on site during the pandemic and this year has seen a significant rise in activity across all areas of safeguarding.

The Safeguarding Assurance Group reports to the Patient Safety Council. Quarterly safeguarding activity reports are also presented at the Quality Committee. Designated Nurses from the CCG and Healthwatch colleagues are invited to the meetings for external scrutiny and to facilitate information sharing. A safeguarding annual report is approved by the Trust Board and shared with external safeguarding boards and CCGs.

Partnership work has continued during the pandemic with the majority of meetings held virtually. This has included Safeguarding Board meetings and Board sub-group attendance, strategy meetings, learning events and review meetings. Partnership working with external Community Learning Disability Teams has been significant and promoted improved communication and information flow for those patients with a Learning Disability, with significant numbers of Health Passports being updated and shared at the start of the pandemic, given the increased risk for this client group to ensure a smooth transition between community and hospital care.

3.4. Clinical effectiveness

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

3.4.1. National Institute for Health and Care Excellence Guidance

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

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

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

A total of 198 pieces of new or updated NICE guidance were released during 2020-21. 103 of these were identified as applicable to the Trust by the Assistant Medical Director. There is a system in place to ensure all relevant guidance is then distributed to the appropriate clinical lead to assess its relevance and the Trust's compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance will be rigorously assessed by mandatory departmental compliance audits reportable through the Trust audit meetings. The Trust is fully compliant with 51 of the relevant guidance issued and is working towards achieving the remainder.

3.4.2. Clinical audit

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

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

The Trust's Critical Care Unit performs well in the patient centred quality indicators, as externally benchmarked by the Intensive Care National Audit and Research Centre (ICNARC), which collects data from 100% of all Intensive Care Units in the country (https://www.icnarc.org).

3.4.4. Mortality

The Government's preferred measure for mortality is the Summary Hospital-level Mortality Indicator (SHMI). The latest published data is for the 12 month period December 2019 to November 2020. The Trust's SHMI for this period is 1.09, which is as expected.

For the same time period, the Trust's mortality is also within expected levels for both of the other commonly used measures, with the Standardised Mortality Ratio (SMR) at 98.9 and the Hospital Standardised Mortality Ratio (HSMR) at 97.5.

3.4.5. Copeland risk adjusted barometer (CRAB)

The Trust has used CRAB data for a number of years to review complications and mortality trends across the surgical specialties and has a CRAB Benchmarking Group in place, with representatives from each of the surgical specialties, who review the data on a monthly basis. With this powerful tool, surgical mortality and complications trends can be examined across the whole Trust, within surgical departments and even at the individual surgeon level. CRAB creates an accurate picture of surgical consultants' practice, adjusting for presenting risk, operation complexity and intra-operative complications. It prevents harmful misuse of crude mortality statistics and helps to identify best practice.

The CRAB methodology is based on the POSSUM system which is the clinical audit system of choice recommended by the Royal College of Surgeons of England and Scotland, NCEPOD, the Vascular Society of Great Britain and Ireland, the Association of Coloproctology of Great Britain and Ireland, and the Association of Upper Gastrointestinal Surgeons.

With the advent of clinical governance CRAB provides high quality clinical process and outcome information. It provides a wide range of reports based on extensive data captured before or at the time of operation documenting the patient's condition. For each case, the risk of mortality or morbidity is calculated using POSSUM algorithms and the raw data may be reviewed by looking at individual cases in the risk report. Any concerning trends or higher than expected complication or mortality rates are examined for potential causality within the CRAB Benchmarking Group and by each of the core members of the specialty in question.

Monthly reports for the benchmarking group meetings are prepared prior to the meetings taking place and distributed to the members for review. During the

meetings, the report is reviewed for performance at the Trust level and subspecialty level and recommendations for review are made. It is the responsibility of each CRAB specialty representative to feed back the review to the CRAB lead and the reports are amended accordingly. Action plans are generated for each of the monthly meetings and reviewed by all members of the CRAB team to ensure that the issues have been addressed.

Issues and concerns identified at the CRAB meetings are reviewed by the group as a whole and reviewed in more depth by specialty CRAB representative. This more detailed review is fed back to the CRAB lead and the reports are adjusted to reflect this. If improvements in performance are not seen then it is the responsibility of the CRAB representative to escalate to the clinical director of that specialty and persistent concerns are relayed to the Clinical Effectiveness Council. These can then be further escalated up to the Quality Committee.

Until recently, CRAB only reflected the activity of surgical in-patient episodes and did not reflect the management of medical patients within the Trust. However, owing to the success of CRAB Surgical, the Trust has now obtained CRAB Medical, thus broadening the benefits across both surgical and medical patients.

We are able to assess departmental performance, individual performance and crucially move to better support the consent process by accurately describing risk for individual patients. The system is being evolved by the Trust to stratify risk on the waiting list and identify those at highest risk of deterioration if their surgery is delayed.

We have used the system to triangulate our performance during COVID where HSMR/SMR/SHMI were unable to function with the new diagnosis, and thus confirm a quality performance benchmarked against a large number of trusts across the UK also using the CRAB methodology.

3.4.6. Promoting health

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

The Trust works in partnership with other agencies to provide holistic services throughout the patient's journey to ensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the

work of our Community Falls Team, who work collaboratively with the local council, primary and community care and our Infection Prevention Team who liaise closely with community teams and GP services.

The Trust has a robust and effective volunteer service, which was the recipient of the prestigious Queen's Awards for Voluntary Service in June 2020. A dedicated team of over 300 volunteers provide support and companionship to patients by donating their time, skills and enthusiasm to enhance patient experience.

Throughout COVID-19 many of our volunteers were required to shield or self-isolate, however, the Trust continued to recruit new volunteers, many of those being in the younger age bracket, who required hospital experience for their future career path. Volunteering is recognised as a key route into employment and, therefore, the Trust continues to offer volunteers an automatic interview for the temporary staffing bank once they have completed 6 months and 50 hours of volunteering.

Whist volunteers were not allowed to support clinical areas during the pandemic, the Trust continued to redeploy their services in other areas, for example, as volunteer pharmacy drivers. This facility was set up in April 2020 and is still very active 5 days a week; they have delivered over 900 prescriptions to vulnerable patients. Volunteer responders undertook duties that were vital to keeping up patient morale by delivering patients belongings that were dropped off by relatives to wards and by distributing over 500 messages received through the PenPALS scheme.

The Trust is the lead employer for the large scale vaccination programme across the Cheshire & Merseyside region. Many of the Trust's volunteers have been redeployed as stewards to provide effective marshalling, support for each patient and to improve the flow of people attending for vaccination.

3.5. Patient experience

The Trust acknowledges that patient experience is fundamental to quality healthcare and that a positive experience leads to better outcomes for patients, as well as improved morale for staff. Patient experience is at the heart of the Trust's vision to provide 5 star patient care and we continuously learn from patient and carer experience to drive improvements and share best practice.

Patient stories continue to be a critical part of the patient experience agenda throughout the Trust and whilst patients have not been able to present their stories in person this year, these have been shared in their own words in a number of forums across the Trust. These include the Trust Board, Patient Experience Council and the Patient Experience and Dignity Champions Group.

Patient stories have contributed to a number of service improvements including the further roll out of telehealth video consultations in many outpatient areas such as physiotherapy, dermatology, speech and language and orthopaedics.

The living with and beyond cancer event was delivered virtually this year, with really positive patient engagement and there are now plans to continue in this format. Many patients have reported that virtual appointments are more flexible and safer,

however to avoid digital exclusion the Trust continues to offer telephone or face to face consultations for those patients who prefer this.

The ongoing psychological impact of COVID-19 and the benefit of clinical psychology during rehabilitation was highlighted by a patient and shared with clinical staff across the Trust, noting that such sharing and learning is extremely valuable.

Prior to the pandemic, the Patient Experience Manager engaged with 5 patients or carers each day in a range of settings, including wards and outpatients clinics. This provided valuable, real-time feedback from patients and carers about their experience and allowed early identification and resolution of any individual problems. This will be reinstated when it is safe to do so.

The Trust promotes patient and family engagement through a number of forums, many of which have continued virtually during the year. These include collaboration with carers' centres as the Trust is committed to identifying carers and valuing their role as partners in care, supported by the carers' passport and our plans to introduce carers awareness training. Patient support groups take place within different specialities including gastroenterology, paediatrics, maternity, diabetes, continence, rheumatology and clinical psychology. The Trust-wide patient engagement group consists of patients, carers and members of the public and although they have not met formally during this period, they have provided feedback and supported service developments to ensure progress with the Patient Experience Strategy 2019 -22.

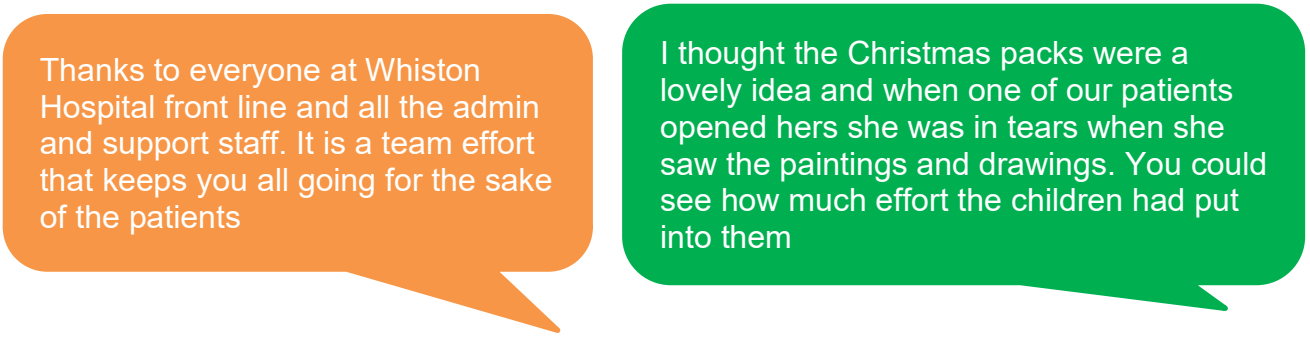
During 2020-21 the Trust expanded patient engagement and feedback by introducing a number of new initiatives and surveys. The Trust implemented a family support service using staff who required redeployment to a non-patient facing area during the first wave of the pandemic. The service consisted of welfare telephone calls to patients within 7 days of their discharge from hospital. The service proved to be very successful with over 95% of patients feeling listened to and supported and felt that the Trust was looking after their welfare.

A number of changes were made as a result of patient feedback, including, reviewing procedures for managing patient property. The Trust reviewed its procedures for communicating decisions about do not attempt cardiopulmonary resuscitation (DNACPR) following a number of concerns raised. This included reiterating to staff the Trust's guidance and the importance of liaising with families and carers, as well as ensuring decisions are reviewed by a senior clinician prior to the patient being discharged. In addition, a number of actions were taken to improve communication as outlined in the paragraphs below.

The Trust introduced a PenPALS initiative, with the support of the PALS team and Volunteers. Relatives of inpatients can email messages, cards and pictures to PALS and the team print and deliver the messages daily. Overall the service has received 100% positive feedback.

The Patient Experience Team implemented a new communication service for inpatients. Each inpatient area has a dedicated patient experience iPhone for communication needs. The iPhones allow patients to telephone or have virtual visits with their relatives, as well as being used for virtual interpreting services.

During the Christmas period the Patient Experience Team launched an appeal for school pictures/messages for our inpatients to receive on Christmas Eve. The appeal was very successful and the team received over 3000 messages. These were included in the packs distributed to all inpatients, with a Christmas message from the Trust and quizzes. The packs were delivered with the support of the volunteers, on Christmas Eve at Whiston, St Helens and Newton Hospitals. In total there were approximately 600 packs created and delivered to each inpatient. The Patient Experience Team has written to every child and school who sent pictures in with a thank you from the Trust. The team also worked with the Digital Alliance Team regarding supporting the wards with virtual visiting and telephone calls, throughout the Christmas and New Year period. Staff from all over the Trust volunteered their personal time to support this initiative and were allocated wards to attend.



New patient experience surveys have been developed Trust-wide and via specialities. The Trust introduced an Every Experience Matters survey, surveying discharged patients following their inpatient stay. The Open and Honest Care survey has been redesigned to align with services.

In January 2021 the Trust developed a COVID virtual ward whereby COVID patients can be cared for at home supported by an agreed escalation plan (details of monitoring arrangements, oximeter, leaflets, instructions and diary, designated telephone number). Patients are then discussed on the daily virtual ward round and proactively contacted by phone every day. 100% of patients who responded to feedback said they understood why they were asked to monitor their oxygen saturations. 89% felt fully supported by the team with 100% feeling they had some degree of support from the team. 90% of patients felt they benefitted from being discharged with the support of the Virtual Ward team. 95% were happy to be discharged to COVID Virtual Ward rather than staying in hospital.

3.5.1. What our patients said about us in 2020-21

Accident & Emergency

I was seen very quickly and despite the added pressure for medical staff everybody was very warm, professional and kind and did their best to make me feel comfortable and in safe hands, staff at Whiston hospital are absolutely outstanding and a credit to the NHS

General Surgery

With the current pandemic of COVID-19, I was extremely anxious with going into a hospital environment. I had absolutely nothing to be worried about. All staff where polite and very helpful, the hospital was quiet, extremely clean like always. Staff where all caring and answered any questions with care, thank you

Ward 3D

From the moment I was admitted until I was discharged I have been amazed at the care, patience, sympathy and understanding given to me and every other patient despite the staff being exceptionally busy. Everyone was treated with enormous dignity and made to feel valued and not just another patient. Mere words are inadequate at expressing my sincere thanks and gratitude at the way I was dealt with by everyone. Ten out of ten is not a high enough mark for this ward.

3.5.2. Friends and Family Test

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

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

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

The Trust's inpatient recommended care rate at the end of March 2021 was 95.83%. Wards and departments across the Trust monitor the patient feedback and create 'you said we did' posters for display. These posters reflect our response as a result of patient comments and are invaluable in maintaining staff motivation and influencing change.

You Said	We Did
Questions about weight became repetitive and intrusive and it was felt that we were not being listened to. Otherwise, standard of care was very good, from all members of the ward team, from domestics to consultant, thank you. **(Ward 3F)**	Sorry you felt like this. Unfortunately, various professionals are involved who need to clarify information. However, good that team work was recognised as positive.
It's been a long time since having an appointment due to COVID the staff are always friendly very helpful & offer lots of advice, I was given new Libra 2 which will be a tremendous help for me living alone to get my blood sugars to normal **(Diabetes Centre)**	Unfortunately due to the COVID-19 pandemic we had to put a lot of measures in place to keep everyone safe which did cause a delay in some patients being seen face to face – this included switching some clinics to telephone clinics, providing advice & guidance via post rather than face to face appointments and delaying some appointments.
Staff fabulous, very busy and overworked! I would have appreciated more information what was happening to me and the reasons why. **(Ward 4C)**	We are working on our written patient information and restocking the ward with our current information leaflets.

In April 2020, the Trust implemented the new NHS England Guidance 'Using the Friends and Family Test to improve patient experience'. NHS England no longer publish response rates as there is no limit on the number of times someone can leave feedback, the focus is now on the quality of feedback received. However, the Trust continues to monitor response rates internally to ensure that the feedback is representative of the number of patients using our services.

3.5.3. Complaints

The Trust takes patients' complaints extremely seriously. Staff work hard to ensure that patients and carers concerns are acted on as soon as they are identified and that there is a timely response to rectify any issues that are raised at a local level, through the Trust's PALS Team, or through the AskAnn email. Ward and departmental managers and matrons are available for patients and their carers to

discuss any concerns and to provide timely resolution to ensure patients receive the highest standards of care. Each area has a patient experience notice board to highlight how patients and carers can raise a concern and this is also included on the information table placemats available for patients. At times, however, patients and their carers may wish to raise a formal complaint, and these are thoroughly investigated so that patients are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust internet.

In 2020-21, the Trust received 251 new complaints that were opened for investigation. This represents a decrease of 22.8% in comparison to 2019-20, when the Trust received 325 new complaints.

There were 23 complainants that were dissatisfied with the initial response and raised a stage two complaint in 2020-21, a 36.1% reduction compared to the 36 in 2019-20.

Despite the challenges of the COVID-19 pandemic work remains ongoing to improve the timeliness of responses to those who made the effort to highlight concerns about their care. The average in responding to new complaints within the agreed timescale has increased from 93.4% in 2019-20 to 94% in 2020-21.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2020-21, with a copy of the survey sent out with all response letters. There were 18 responses in total received in 2020 -21, a 7.1% response rate. A summary of the findings is below, noting that the % figures provided are based on the number of respondents answering the specific question:

- 88.8% (16 respondents) confirmed that the written response included a clear explanation of the options available to them if they were not satisfied with the findings
- 83.3% (15 respondents) found it very or fairly easy to complain, with two finding it fairly difficult and one said it was inapplicable
- 61.1% (11 respondents) felt that their complaint had been responded to in a reasonable timescale whilst 38.9% (7 respondents) felt that their complaint had not been responded to in a reasonable timescale
- 61.1% (11 respondents) confirmed that they felt that they had been treated with respect throughout the process whilst 22.2% (4 respondents) confirmed that they had been treated with respect some of the time in the process
- 66.6% (12 respondents) were very or fairly satisfied with the way the complaint was handled
- 50% (9 respondents) confirmed that the reasons for the Trust's decision was made clear to them whilst 38.8% (7 respondents) stated that the decision was not made clear to them

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

A number of actions were taken as a result of complaints made in 2020-21:

- A new pathway has been implemented within Maternity Services to ensure patient referrals for women requesting or offered a debrief are managed from a central

point and then referred on to the most appropriate professional for appointment
- Patients are now provided with an advice leaflet on how to manage the latent phase of labour, when to call the midwife and the contact numbers for Maternity Triage Unit
- Staff were reminded in ED of the 'Bleeding in Early Pregnancy Pathway' to ensure that patients who experience bleeding in early pregnancy are transferred to the gynaecology ward after review from an ED doctor
- Refresher training arranged for staff in ward 3C around tissue viability and wound care
- Ward Manager in ward 1C has set up a system with the housekeeping team to ensure that nebuliser masks are checked on a daily basis and changed accordingly
- A number of initiatives have been introduced in the Trust including Patient Experience 'I phones' that were donated to ward areas. These allow virtual calls, as well as phone calls for patients to speak directly to their relatives
- During the peak of the COVID pandemic, a scheme was launched in the Trust where relatives received a daily telephone call from a member of staff nominated as the 'family support ward link' on participating wards
- Virtual Fracture Clinic guidelines were re-worded to be made clearer for the staff who need to refer to them
- A new information leaflet regarding squint surgery was produced by the Ophthalmology Clinic to be given to patients at their initial consultation so they can read about the options and risks of treatment

3.6. Care Group Summary

3.6.1. Surgical Care Group

The past year has presented unprecedented challenges for the NHS, for the Trust and particularly for surgical care services.

Key achievements during this difficult period include the rapid and successful establishment of staff and patient COVID testing services, not only internally, but also through the establishment of home swabbing services, enabling an increased number of patients to safely access services. A further key achievement was the rapid establishment of a clean cancer hub at St Helens Hospital, enabling the Trust to continue with urological, colorectal, breast and skin cancer procedures. The hub also provided mutual aid for other local trusts to enable patients to receive their cancer surgery in a timely manner and in a safe, COVID-free environment.

Although some routine elective activity was maintained through the use of the independent sector, all routine elective activity was cancelled at St Helens and Whiston hospital sites, with theatre and anaesthetic staff deployed in large numbers to support the required expansion in critical care capacity. This enabled the Trust to increase capacity in critical care up to 21 beds, which included the establishment of the theatre recovery as an critical care annex.

The Care Group also established a 4-bedded post-operative care unit in recovery (POCU) to further support critical care, which incorporated the provision of resident anaesthetic cover. Surgical wards (4A and 3Alpha) were subsequently converted to

COVID medical wards, 3F Gynaecology was converted into a discharge lounge and 3E clean orthopaedics was converted to an orthopaedic trauma ward. In addition, medical patients were housed on 3E Gynaecology, 3A plastics and 3B orthopaedics. Surgical staff also compiled a rota in order to act as 'proning' teams within critical care, consisting of ward nurses, nurse clinicians, surgeons, anaesthetists and operational managers.

During this period, outpatient activity continued, albeit at reduced levels due to social distancing requirements. Expansions to telephone and virtual consultations were introduced and full non-elective and maternity services were able to be maintained throughout the year.

Other key achievements included the facilitation of home working for large numbers of administrative staff, with a full risk assessment programme to support this, the setting up of a Bronze command centre and the provision of staffing rotas for the mass vaccination centre.

As COVID-19 rates reduce the priority going forward will be to re-establish operating capacity and to address the waiting list pressures facing all NHS organisations.

3.6.2. Medical Care Group

The response from the staff within the Medical Care Group (and entire Trust) has been phenomenal in doing everything possible to continue to provide the highest standards and safest care possible to our patients during the extraordinary circumstances brought about by the pandemic.

Right from the very beginning of the pandemic, all disciplines of staff had to adapt to a changing environment and learn new clinical skills and protocols in caring for COVID-19 patients whilst also managing their own and their families' anxiety and safety. The courage and commitment displayed by all our staff is commendable.

Our first achievement was to safely manage the first few very scared COVID-19 inpatients which quickly grew in numbers as the pandemic took hold in the first wave and was then repeated in a smaller local second wave. The third wave (January to March 2021) was even more challenging owing to cases reaching nearly 300 inpatients (almost double that of wave one) and the usual winter pressures.

Strict adherence to infection prevention procedures led to a bespoke patient flow arrangement with all patients who were potentially COVID positive being nursed in single rooms as isolation cubicles to minimise hospital onset (nosocomial) COVID-19 infections. As the volume of COVID-19 positive patients increased a number of wards were reconfigured to become COVID-19 cohort wards to continue to meet infection prevention requirements. The medical wards that became COVID-19 positive wards were, Ward 2C, Ward 5A, Ward 2A, Ward 2D, Ward 3C and the surgical wards as outlined in the section above.

The physical layout of Ward 2C was adjusted so that we could safely deliver Non-invasive ventilation (NIV) and continuous positive airway pressure (CPAP) therapy in a safe physical environment owing to the high risk of spread of airborne infection

whilst delivering NIV and CPAP which are aerosol generating procedures. The usual capacity of 3 beds was increased up to a peak of 19 to manage the surge in demand from positive COVID-19 patients. The staffing of this area was hugely challenging, requiring the key skills of the respiratory ward nursing staff, NIV nurses and respiratory medical staff, who rose to the challenge with support from colleagues across the Trust.

Staffing in all areas was also a significant challenge owing to increased sickness, staff having to shield or self-isolate, the need to manage the increased complexity and acuity of the patients with COVID-19 and an overall increased medical bed occupancy that needed to be cared for by medical consultants. This could only be achieved through the cancellation of some planned activity such as outpatients and through many of our nursing, medical staff and non-clinical staff cancelling leave and working additional hours.

The use of technology helped the Trust maintain as much outpatient activity as possible with telephone clinics replacing traditional face-to-face appointments and virtual media supporting other reviews. This has been so successful for some groups of patients, such as in Parkinson's clinics, that this will continue.

In recent months, technology has also supported a 'virtual ward' whereby COVID-19 positive patients who would otherwise have needed to stay in hospital owing to the need to have oxygen, have been able to be discharged home using home pulse oximetry (measures oxygen concentration) and monitored by respiratory nurses with the support of the medical consultants and the collaborative work with our neighbouring Trust, Liverpool Heart and Chest Hospital NHS Foundation Trust.

The immense efforts and personal sacrifice made by our staff to manage the often heart breaking care delivery for our patients and their distressed relatives is an incredible achievement to celebrate in what has been the most difficult of times for all of us. So much so a number of local and national media reports have been made over the last year reflecting this.

During the year there have been a number of achievements within directorates, including maintaining accreditation for Joint Advisory Group (JAG) on gastrointestinal endoscopy (JAG) and introduction of the Endoscopy Pre-swabbing service to ensure patients are COVID-19 swab tested 48-72 hours before attending for their procedure. There has been an additional room added to the endoscopy suite at St Helens Hospital, which will help to support the Trust's recovery plan.

The Cardiology service established a Rapid Access Acute Heart failure referral system for GPs based on NICE guidelines. The service continued to perform well in the national cardiac audit programme, achieving above national average scores.

The Dermatology Service worked hard to meet the 93% 2 week wait target during the pandemic, achieving this for the last 10 months. A see and treat clinic for suspected cancers was introduced which is recognised as gold standard and meets NICE recommendations. The development of nurse-led clinics and increased use of advice and guidance to provide education and advice to local GPs and Advanced Nurse Practitioners has also ensured increased access and appropriate treatment.

The Rheumatology Service developed a day-case ward to facilitate intravenous infusions with specialist biologic medicines and used telephone/virtual clinics to meet patients' needs during the pandemic where appropriate. The service improved access by introducing a nurse-led osteoporosis service and by continuing the expansion of the spinal ambulatory clinics to prevent re-admissions to the ED. They have maintained the Customer Service Accreditation award.

The Diabetes and Endocrinology Team developed an ante-natal service to reduce a variety of foetal and maternal complications including shoulder dystocia and neonatal death in line with NICE guidance and successfully implemented the offer of continuous glucose monitoring to all pregnant women. The Diabetes Inpatient Nursing Team devised a number of educational videos, now uploaded to the online educational hub.

All paediatric outpatient clinics continued throughout pandemic either through virtual/telephone clinics or face-to-face for urgent cases, maintaining pre-pandemic waiting times. Working closely with commissioners the service has delivered consultant paediatric outpatient clinics, children's phlebotomy and a pilot paediatric GP with extended role (GPwER) service at Lowe House Women & Children's Community Hub. The GPwER service was the first of its kind in the country and has been extended due to its success. These new services improved access and provided a one-stop shop for paediatrics. In addition, the service provides regular webinar awareness/teaching sessions to local GPs and has introduced an Advanced Neonatal Nurse Practitioner role on the neonatal unit.

The Stroke Service maintained an overall Sentinel Stroke National Audit Programme (SSNAP) score of A for both the hyper-acute and acute stroke units in the latest ratings. They have fully implemented tele-medicine to support out-of-hours thrombolysis and collaboration with the Walton Centre shows an increasing number of patients are benefiting from thrombectomy treatment, leading to better outcomes.

The Emergency Department has significantly invested in medical and nursing workforces to reduce the time to triage and time to initial clinical assessment for patients attending. The resuscitation area has been remodelled to convert all bays to glazed cubicles to enhance infection prevention and privacy. The embedding of Same Day Emergency Care (SDEC) principles and pathways within designated facilities in the department has supported the Trust in providing the right care, in the right place, at the right time for patients, by reducing waiting times and hospital admissions, where appropriate. In addition, work has been undertaken to enhance mental health pathways to improve assessment times for patients.

Within Critical Care all bays have been converted to glazed cubicles and gold standard dialysis machines have been purchased. In response to the pandemic, during which visiting was severely restricted, there has been an increase in provision of family liaison and bereavement counselling. The appointment of three new consultants and two Critical Care Network funded nurse advocate posts has enhanced the staffing within the unit.

The 'Shape of Training Review' was carried out by the General Medical Council

(GMC) in 2013 to ensure the NHS continues to train effective doctors who are fit to practise in the UK, provide high quality care and meet the needs of patients and the public. The review led to the introduction of a new training programme known as Internal Medicine Training (IMT). The IMT3 post replaces the old Specialty Trainee Level 3 posts (ST3) within the medical specialities.

The changes to training are mandatory and investment is essential in additional trainees/Advanced Care Practitioners (ACP) within the Medical Care Group to ensure the successful implementation of IMT3 training posts in August 2021 as part of the national 'Shape of Training' strategy but also to ensure safer staffing levels as set out by the Royal College of Physicians.

The mandatory requirements of the IMT3 rota allow for 2 x Tier 2 trainees on-call 24 hours, 7 days per week with the pairing of an IMT3 trainee with an ST4-ST7 therefore always supported and supervised. Also all Higher Specialist Trainees (HST) are to have only 25% of their work schedule dedicated to the acute take/on-call. There has been a significant investment agreed in the new financial year with recruitment and new rotas commencing from August 2021. This increased staffing will not only the support requirements of IMT training but also ensure the Trust continues to deliver high quality safe patient care alongside excellence in training for all doctors of the future within the Medical Care Group.

3.6.3. Primary and Community Services Care Group

As noted above, this year has been like no other with regards to the demands on health and social care teams and the need for services to respond flexibly to the changing picture.

Over 250 staff transferred into the Primary and Community Services Care Group from two other NHS providers, North West Boroughs Healthcare NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust, as the pandemic was coming to its peak in Wave 1. These included children's services, GP with special interest (GPSI) outpatients' team and community nursing services.

All of our services were involved in changing the provision of their services to meet the changing needs of their care delivery or to support other areas. A national document provided guidance as to which service should stop completely, which should scale back and which should remain unchanged other than within COVID secure rules.

Some of the larger changes included:

- Maintaining care for high priority groups within sexual health services, with the wider staff group supporting maternity, critical care and inpatient wards
- Suspension of most treatment room appointments with a focus on providing the domiciliary district nursing services across the Borough
- Relocation of one of our Intermediate Care Units, Duffy Suite, to open up a brand new medical ward of 32 beds in Ward 1A on the Whiston site

Many of our services then moved to remote and virtual monitoring, keeping in touch with patients and care homes to try and maintain a level of input whilst many

vulnerable people where shielding at home.

The demand on our district nursing services has been relentless throughout this period with high levels of activity and more complex visits post COVID, whilst managing the impact of staff shielding to meet this demand.

Marshalls Cross Medical Centre successfully recruited to become fully established with permeant GPs and a Lead GP for the practice which will further support the development of this service.

3.6.4. Clinical Support Services Care Group

The Clinical Support Services Care Group includes Pathology, Radiology, Clinical Psychology, Therapy Services, Neurophysiology, Outpatient Services, Patient Booking Services and Cancer Support Services. These services have been integral to the Trust's response to the pandemic and in the delivery of key achievements during this time.

Successful implementation of telehealth and virtual appointments within clinical psychology, cancer and therapy services has maximised the ability to maintain both in and out-patient activity during the restrictions imposed by social distancing and the suspension of non-urgent face-to-face outpatients. It has also enabled health and wellbeing patient education to support self-care. This was particularly beneficial in allowing clinicians who were required to shield in line with national guidance to continue to work from home, as well as maximising clinical space required for urgent care.

Cancer Support Workers in haematology and colorectal services have now secured recurrent funding following the successful roll out of Personalised Supported Self-management.

Two-way texting has been expanded across radiology outpatients to reduce the number of did not attends (DNAs) in line with therapy, cancer services and outpatient appointments across the other Care Groups. This ensures that available capacity is used more efficiently.

Maximising service capacity in order to continue with timely support has been pivotal and an exciting pilot project is now underway with GE Medical to improve patient pathways. This project has already started to yield beneficial outcomes in utilisation of available capacity, including the development of one-stop clinics to streamline care. Neurophysiology has continued to develop services and improve turnaround times, in particular with GP access to physiologist led carpal tunnel/ulnar neuropathy clinics with a 4 week turnaround.

Pathology continues to strive towards forming a network across the Cheshire and Merseyside footprint. The Trust has maintained ISO15189:2012 accreditation in all departments, with the inspections being undertaken virtually. Much of the emphasis for the year has been focused on the introduction and scaling up of COVID testing, with the department going from a capacity of 0 to 2,000 requests per day across 4 platforms.

Radiology Services have retained their Quality Standard for Imaging (QSI) accreditation. Capacity was increased with an extra ultrasound room at the St Helens Urgent Treatment Centre, which supports the community deep vein thrombosis (DVT) pathway and reduces the need for patients to attend the acute hospital. In addition, an extra CT scanner funded from the region to support post COVID recovery within the radiology network (currently supporting network activity 2 days a week) has helped to reduce wait times across the region. The service has also reported into a national research database which is researching the effects of COVID-19.

Therapy services worked together collectively to respond flexibly to demand. Fast track staff development was employed to upskill competencies safely, developing additional skills, where appropriate, outside of the usual scope of practice to support critical care and to buddy with nursing staff.

Therapy services joined forces with community colleagues to utilise mutual aid in order to maximise patient flow in line with the discharge to assess model, breaking down barriers and working in a truly integrated fashion with external organisations. Services proactively responded to the real time risk of insufficient feeding pump supply to meet demand by developing and ratifying a standard operating procedure for gravity feeding to prevent this having an impact on patient management.

Cancer services have continued to maintain performance in contrast to the local and national picture. A Cancer Symptoms Advice Line was implemented in May 2020 in response to the significant reduction in cancer referrals from GPs during the pandemic. This enabled patients who were anxious about potential cancer symptoms to discuss these with a member of the team and the Trust was awarded second place at the UK's virtual Oncology Nursing Society conference in November 2020, for the section on the cancer nurses' response to the COVID-19 pandemic for this initiative. The roll out of the Faecal Immunochemical Test (FIT) test project to all CCGs in the catchment area during COVID-19 has improved endoscopy prioritisation and capacity utilisation. The Lilac Centre retained the Macmillan Quality Environment Award, achieving the highest possible score.

Outpatient services devised an asymptotic COVID swabbing clinic for cancer patients undergoing surgery and increased clinic capacity to include more evenings and weekends. This was put in place to support other Care Groups in maximising capacity, as well as creating two additional consultation rooms by redesigning existing floorplans. Outpatients have also supported the set-up of staff swabbing clinics. In line with this, Patient Booking Services have worked seamlessly to review amended process and clinic templates to incorporate the move to telephone and telehealth appointments. They have also supported social distancing within outpatient clinic areas, ensuring the continuation of urgent outpatient appointments and procedures during COVID-19 and implemented temperature checks provided for patients within outpatient departments.

The priority going forwards is to build on these efficiencies to support the care groups to optimise service delivery, improve patient flow and to deliver truly integrated patient pathways to support recovery and the Integrated Care System

agenda.

3.6.5. Covid Vaccination Programme

The Trust provided first dose vaccinations for staff commencing in December 2020 and vaccinated nearly 7000 Trust and health & social care staff over a 4 week period. Second doses were completed by the end of March 2021. In addition, the Trust was commissioned to deliver the first Mass Vaccination Site (MVS) in Cheshire & Merseyside at St Helens Rugby Club and commenced vaccinating the general population using the AstraZeneca (Oxford) vaccine on 18th January 2021 providing a 7 day 8am to 7pm service. Second doses started in early April and on the 13th April 2021 the service was the first of 20 sites nationwide to introduce the Moderna vaccine.

The MVS has been used as an exemplar site in the UK with other MVS providers visiting to support the development of their local services. The service is proud of its multidisciplinary approach to service design and delivery. It has developed its own training faculty and has worked closely and collaboratively with a range of health professionals, volunteers, St John Ambulance, Mersey Fire and Rescue Service and Armed Forces as well as supporting our local Primary Care Network (PCN) vaccination programme. The Trust was also the lead employer/provider for the workforce supplied to the vaccination programme for Cheshire and Merseyside.

3.7. Summary of national patient surveys reported in 2020-21

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

3.7.1. National Inpatient Survey

The Trust participated in the annual National Inpatient Survey 2019 coordinated by the Care Quality Commission. The results were published in July 2020 and the Trust's response rate was 39% compared to the national response rate of 45%.

The Trust scored better for the following areas compared to most other trusts that took part in the survey:

- Cleanliness of rooms or wards
- For doctors not talking in front of them as if they were not there

The Trust was rated about the same as other trusts for the remaining indicators other than for waiting a long time from arrival to get a bed on a ward.

The Trust has taken a number of actions to improve patient care including:

- Building an additional inpatient facility and recruitment of a patient flow matron to reduce waiting time for beds
- Continuing to improve the information provided to patients
- Further developing opportunities to gather real-time patient feedback to support timely improvements
- Enhancing the integrated discharge processes to promote patient centred discharge planning

- Continuing to maintain safe staffing levels with increased visibility of nursing staff on wards
- Developing and implementing a programme of role specific communication skills training for Trust staff

3.7.2. National cancer patient experience survey (NCPES)

The NCPES provides the organisation with a picture of the cancer patient's experience. It highlights areas of good practice and provides an opportunity to focus on the priorities for the year ahead. The 2019 NCPES report was published in June 2020, with feedback from the 281 patients who took part in the survey (58% response rate).

The Trust was ranked as second best acute trust for overall patient care with a score of 9.1.

Key achievements include:
- The site specific cancer teams scored 9.0 for overall care, with the colorectal service achieving an excellent 9.4 and the breast services maintaining their high standard at 9.3
- In top10 for three questions and top 20 for 20 questions
- The results demonstrated that there had been a significant improvement on previous year's results with 58% (n30) questions scoring higher than in 2018, 11% (n6) no change and 31% (n16) lower

The priorities for 2020-2021 were:
- Celebration and shared learning
- Engagement with the ward teams to help them understand patient experience
- Engagement with teams to understand their own results, with teams taking accountability for their patients' experiences
- Recognising the need for a skilled workforce to undertake patient engagement, focus groups, patient stories and to provide support for patient experience across all teams

The Cancer Patient Experience Delivery Plan 2020-2021 confirmed that each cancer team needed a work programme specifically for cancer patient experience, underpinned by an effective governance structure within the care group, evidencing clinical and managerial accountability for patient experience and developed collaboratively with outpatients, wards, Directorate Managers, members of the multidisciplinary team and patients.

Trust-wide there was a focus on providing easy to understand information with the introduction of information ward rounds, which were further developed to include support by providing personalised health needs assessment (HNA) and care planning. Teams developed information boards in clinical areas and the Cancer Nurse Specialists were present daily on the wards. Further actions include the development of a standard operating procedure for documentation and establishing key performance indicators for the teams with a Cancer Support Worker, supported through clinical supervision. A further phase of this work is to extend the information and support ward rounds to non-cancer wards.

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

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

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

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

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

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2020-2021
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Richard Fraser Chairman

Ann Marr OBE Chief Executive

5. Written statements by other bodies

5.1. Amendments made to the Quality Account following feedback and written statements from other bodies

6. Abbreviations

ACE	Angiotensin-converting enzyme
ACP	Advance care planning
AF	Atrial fibrillation
AHPs	Allied Health Professionals
AI	Artificial Intelligence
AKI	Acute Kidney Injury
AMD	Age-related Macular Degeneration
AMU	Acute Medical Unit
ANTT	Aseptic Non-Touch Technique
App	Application
AQuA	Advancing Quality Alliance
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BAPEN	British Association of Parenteral and Enteral Nutrition
BAUN	British Association of Urology Nurses
BAUS	British Association of Urological Surgeons
BBA	Born before arrival
BC	Blood culture
BPH	Benign prostatic hyperplasia
BSI	Blood stream infection
BSL	British Sign Language
BTS	British Thoracic Society
CaSH	Contraception and Sexual Health
CBT	Cognitive behavioural therapy
CCGs	Clinical Commissioning Groups
CDI	Clostridium difficile infection
CHPPD	Care Hours per Patient per Day
CMPA	Cow's milk protein allergy
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Airways Disease
CPAP	Continuous Positive Airway Pressure
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRAB	Copeland Risk Adjusted Barometer
CRN, NWC	Clinical Research Network, North West Coast Research
CS	Clinical standards
CT	Computerised tomography
CTG	Cardiotocography
DAP	Digital Aspirant Programme
Datix	Integrated Risk Management, Incident Reporting, Complaints Management System
DIPC	Director of Infection Prevention and Control
DKA	Diabetes keto-acidosis
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation

DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
DVLA	Driver and Vehicle Licensing Agency
DVT	Deep vein thrombosis
EAP	Employee Assistance Programme
ED	Emergency Department
EDS or EDS2	Equality Delivery System
EoLC	End of life care
ePMA	Electronic Prescribing and Medicines Administration
ePR	Electronic Prescribing Record
eTCP	Electronic Transfer of Care to Pharmacy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
FFP3	Filtering Face Piece
FIT	Faecal Immunochemical Test
GAP SCORE	Growth Assessment Protocol Standardised Case Outcome Review and Evaluation
GI	Gastrointestinal
GIRFT	Get It Right First Time
GNBSIs	Gram-negative bloodstream infections
GORD	Gastroesophageal reflux disease
GP	General Practitioner
GPSI	GP with special interest
GPwER	GP with Extended Role
HASU	Hyper-acute Stroke Unit
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HF	Heart Failure
HNA	Holistic Needs Assessment
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
HSRC	Hyper-acute Stroke Research Centre
HWWB	Health, Work and Well-being
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
IDDSI	International Dysphagia Descriptor Standardisation Initiative
IQILS	Improving quality in liver services
JAG	Joint Advisory Group
LARC	Long-acting reversible contraception
LGBT	Lesbian, gay, bisexual, transgender
LGBTQ+	Lesbian, gay, bisexual, transgender and questioning
LSCB	Local Safeguarding Children Board
LUTS	Lower urinary tract symptoms
MAMMA	Mastitis and mammary abscess management
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE-	Mothers and Babies - Reducing Risk through Audits and

UK	Confidential Enquiries across the UK
MDT	Multi-disciplinary Team
MEOWS	Modified Early Obstetric Warning System
MINAP	Myocardial Ischaemia National Audit Project
MLU	Midwife-led Unit
MMU	Manchester Metropolitan University
MOP	Medicine for Older People
MR	Magnetic Resonance
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MTI	Medical Training Initiative
MVS	Mass Vaccination Centre
NABCOP	National audit-breast cancer in older patients
NACAP	National asthma (adults) and COPD audit programme
NAOGC	National Audit Oesophago-Gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCAP	National Cardiac Arrest Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NDA	National Diabetes Audit
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NG	Naso-gastric
NHSE	National Health Service England
NHSE/I	National Health Service England/Improvement
NHSI	National Health Service Improvement
NHSX	National Health Service X - joint unit of NHS England and the Department of Health and Social Care
NICE	National Institute for Health and Care Excellence
NIPE	Newborn and Infant Physical Examination
NIHR	National Institute for Health Research
NIV	Non-Invasive Ventilation
NJ	Naso-jejunal
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMC	Nursing and Midwifery Council
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NOAC	New oral anticoagulant
NoF	Neck of femur
NPCA	National Prostate Cancer Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting Learning System
NSTEMI	Non-ST-segment elevation myocardial infarction
NWAS	North West Ambulance Service
OBE	Order of the British Empire

ODPs	Operating Department Practitioners
OHCA	Out of hospital cardiac arrests
OT	Occupational Therapist/Therapy
OSCE	Objective Structured Clinical Examination
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PBS	Patient Booking Services
PCN	Primary Care Networks
PCNL	Percutaneous Nephrolithotomy
PE	Pulmonary Embolus
PEG	Percutaneous Endoscopic Gastrostomy
PEWS	Paediatric Early Warning Score
PFI	Private Finance Initiative
PHE	Public Health England
PI	Principal Investigator
PIR	Post infection review
PLACE	Patient-Led Assessments of the Care Environment
PNMR	Perinatal mortality review tool
PN	Parenteral Nutrition
PoCT	Point of Care Testing
PPD	Preferred place of death
PPE	Personal Protective Equipment
PRES	Patient Research Experience Survey
PROMs	Patient Reported Outcome Measures
QCAT	Quality Care Accreditation Tool
QIP	Quality Improvement Project
QOF	Quality Outcomes Framework
QSI	Quality Standard for Imaging
RACPC	Rapid Access Chest Pain Clinic
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RCM	Royal College of Midwives
RN	Registered Nurse
SALT	Speech and Language Therapy Team
SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit
SAU	Surgical Assessment Unit
SDEC	Same Day Emergency Care
SEQOHS	Safe Effective Quality Occupational Health Services
SCR	Summary Care Record
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SHSCR	St Helens Shared Care Record
SIREN	SARS-COV2 Immunity and Reinfection Evaluation
SIRO	Senior Information Risk Owner
SJR	Structured Judgement Review
SLA	Service level agreement
SMR	Standardised Mortality Ratio
SSI	Surgical Site Infection

SSNAP	Sentinel Stroke National Audit Programme
STEMI	ST-segment elevation myocardial infarction
STI	Sexually Transmitted Disease
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
ToP	Termination of pregnancy
TPN	Total Parenteral Nutrition
TWOC	Trial without catheter
UKAS	United Kingdom Accreditation Services
UPH	Urgent Public Health
US	Ultrasound
VTE	Venous Thromboembolism
WALANT	Wide-Awake Local Anaesthesia, No Tourniquet
2WW	Two week waits
7DS	Seven day hospital services

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)030

Title of paper: Trust Board and committee effectiveness review – Revised Terms of Reference (ToR).

Purpose: To provide the Board with a pack of revised Board and Committee ToR that reflect the outcomes of the 2020/21 meeting effectiveness review process.

Summary:

1. The annual effectiveness review of the Board and its Committees has been undertaken, reflecting the meetings that took place in 2020/21.
2. The detailed review of each committee has been shared with the committee chair and has or will be reported at its next scheduled meeting.
3. A summary of the findings of each review will be reported to the next Audit Committee meeting in June.
4. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement.
5. The feedback from Quality Committee members highlighted the broad range and complexity of issues discussed at the committee and suggested that the Board consider establishing a separate Workforce Committee. Many other trusts have now created a separate Board level forum for discussing strategic workforce issues and this has been discussed with the Chair and Chief Executive who are supportive of the proposal.
6. If the Board accepts this recommendation the Deputy CEO/Director of HR and Director of Corporate Services will develop draft ToR and a work plan for the new committee to be brought back to the Board for formal ratification, plus the consequent changes to the Quality Committee ToR and work plan.
7. The final part of this review is the issuing of revised ToR incorporating any agreed changes from the reviews (in red text). These currently do not reflect the proposals outlined in points 5 and 6 above.
8. The changes ensure that as a whole the Board governance structure remains comprehensive and there are clear lines of accountability.

Trust objective met or risk addressed: Supports the Trust to maintain effective systems of governance to meet best practice and regulatory requirements

Financial implications: None directly from this report.

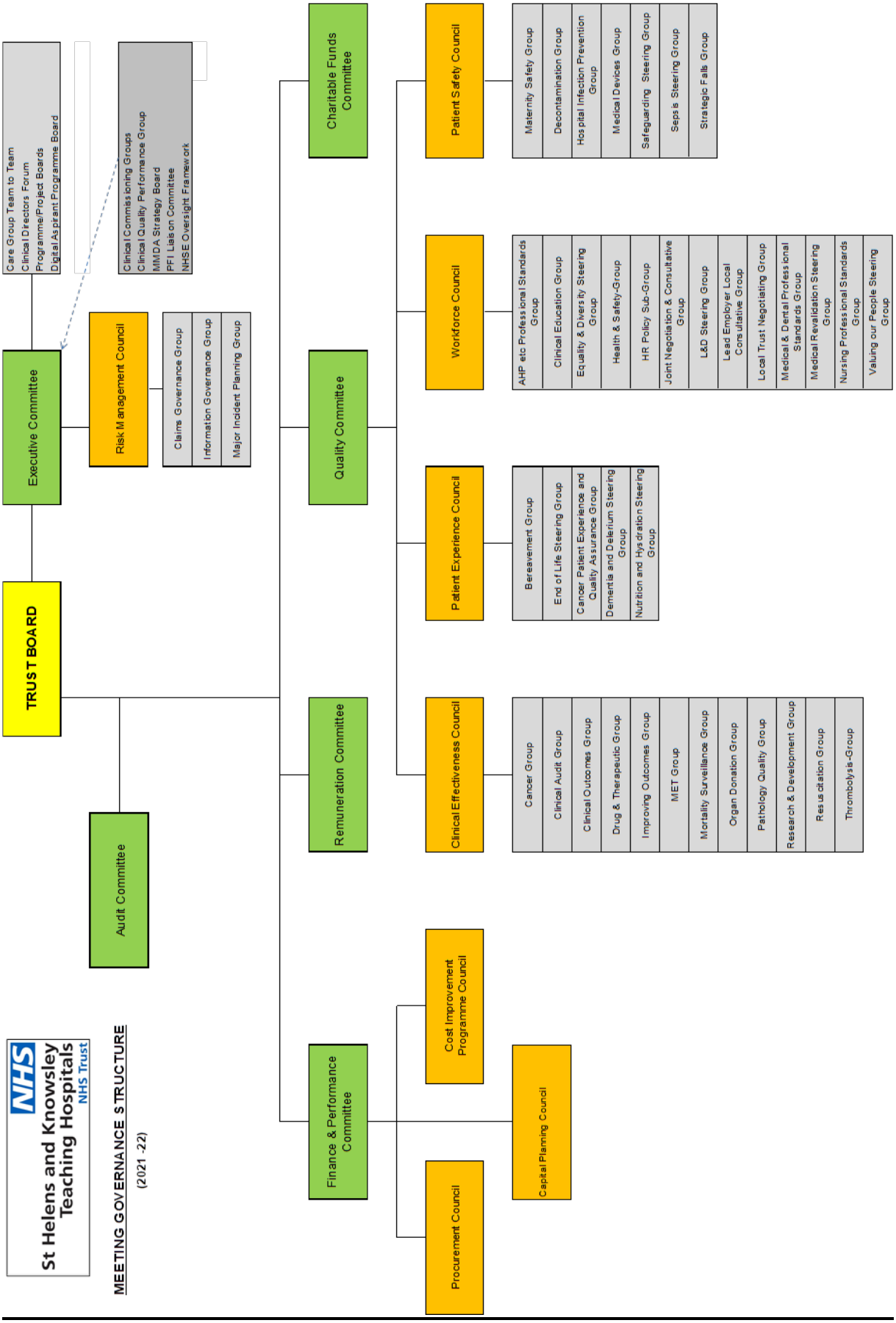
Stakeholders: Directors, Staff, Patients, Regulators and other stakeholders.

Recommendation(s):

1. Approve the updated ToR that reflect the outcome of the 2020/21 Board and

Committee effectiveness reviews. 2. Establish a new Board committee to provide assurance on workforce issues
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 26th May 2021.

GOVERNANCE STRUCTURE 2021/22



TERMS OF REFERENCE 2020/21

TRUST BOARD – Terms of Reference (2021-22)	
Authority	St Helens and Knowsley Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 2446) amended by 1999 (No 632) (the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board, and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Charitable Funds Committee vi) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman a minimum of 10 days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are

	not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	Each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the ToR.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 5 Non-executive Directors (one of which will be appointed Vice Chair, and one appointed Senior Independent Director) Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be the nominated Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.

Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference (2021/22)	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: - All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. - The structures, processes and responsibilities for identifying and managing key risks facing the organisation. - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. - The operational effectiveness of policies and procedures via internal audit reviews. - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Agency (NHSCFA) 2. The Committee will: - Provide an overview of the effectiveness of the assurance framework; - Provide an oversight role in respect of the governance structure and the linkages with other committees; - Consider the findings of other significant assurance functions (e.g.

	regulators, professional bodies, external reviews); - Review the arrangements and their effectiveness for which staff may raise, in confidence, any concerns; - Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity; - Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility; - Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Establish an auditor panel with formal terms of reference to consider the appointment of the External Auditor and to ensure the on-going independence of the Auditor, making recommendations to the Trust Board. (See Appendix A.) (The Audit Committee should assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement and by a number of factors – for example, recent employment with the Trust, close family ties to its directors, members, advisors or senior employees or a material business relationship with the Trust.) 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account in line with DHSC guidance. 11. Ensuring that there is in place a clear policy for the engagement of external

	auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. Financial Reporting and Governance 12. Review the Annual Report and Accounts before recommendation to the Board, focusing particularly on: - The Annual Governance Statement; - Changes in, and compliance with, accounting policies and practices; - Unadjusted mis-statements in the Financial Statements; - Letters of representation; - Major judgemental areas, and; - Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board. 15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.
Membership	Core Members The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members. In attendance The Director of Finance, the Head of Internal Audit and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to

	attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be 2 members.
Accountability & Reporting	The committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

QUALITY COMMITTEE – Terms of Reference (2021/22)	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on patient safety, clinical effectiveness, patient experience and workforce issues 2. Identify, prioritise and monitor risk arising from clinical care 3. Ensure the effective and efficient use of resources through evidence-based clinical practice 4. Protect the health and safety and wellbeing of Trust employees 5. Ensure compliance with legal, regulatory and other obligations.
Duties	The Committee will undertake the following duties:- 1. To provide assurance to the Board on the delivery of the Trust's Clinical and Quality Strategy, based on the Trust's vision for 5-star patient care, through scrutiny of relevant quality indicators in the IPR 2. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes 3. To monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances 4. To identify areas for action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board 5. To oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval 6. To provide assurance on the delivery of the agreed Annual Quality Account priorities through Council reports 7. To approve policies and procedures in respect of quality and if necessary make recommendation to the Board 8. To agree the ToR and the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately 9. To receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews or commission

	independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. complaints, infection control, safeguarding, medicines management, mixed-sex declaration, CQC compliance, the clinical audit programme, and medical revalidation 10. To assess the equality impact of proposed service developments or service changes 11. To undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils 12. To provide assurance that appropriate quality governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each.
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Directors x 2 Chief Executive Director of Human Resources /Deputy CEO Director of Finance Medical Director Director of Nursing, Midwifery and Governance Director of Operations & Performance Director of Corporate Services Care Groups Head of Nursing and Quality or other senior representation – Care Group Medical Director or Assistant Director of Operations. The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to core members the Deputy Medical Director, Care Group and Assistant Medical Directors, Deputy Director of Nursing & Quality, Deputy Director of Governance, Deputy Director of Human Resources, Deputy Director of Operations, Head of Safeguarding, Assistant Director of Patient Safety, Head of Midwifery may be asked to be in attendance. The Committee shall also be able to require the attendance of any other Director or member of staff for specific agenda items. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.

Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair and Director of Nursing, Midwifery and Governance will be in the accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution is via the office of the Director of Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2021/22)	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance and Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives, and maintain the Trust as a going concern. To contribute to the overall governance framework, and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties:- 1. To review and make recommendations to the Board on the annual financial and business/activity plan and the assumptions which underpin it, and the Trust's longer-term financial and operational strategies 2. To review the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Integrated Performance Report (IPR) including against national and contractual waiting time and access standards. To make recommendations to the Board on key risks, and actions to ensure the Trust performs to the optimum level and operates within the resources available 3. To oversee the Trust's commercial activity and the decision making underpinning service developments and market strategy 4. To review proposed cost improvement programme and to monitor implementation and report, to the Board, proposals for corrective actions considered if required 5. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment 6. To approve policies and procedures in respect of finance and performance and if necessary make recommendations to the Board 7. Based on forecast resources available, to plan the five year rolling capital programme and in year delivery of the agreed capital programme 8. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability; escalating any concerns to the Board 9. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 10. To review the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately 11. To receive assurance reports from the Council chairs following each meeting of the Procurement, CIP and Capital Planning councils and to

	request in-depth reviews or commission independent audits where necessary. 12. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils 13. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external benchmarking reports (including Model Hospital and GIRFT report recommendations) and assessing the Trust's performance against each
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-executive Director x 2 Director of Finance Deputy CEO/Director of HR Medical Director Director of Operations & Performance The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to core members the Director of Corporate Services, Deputy Director of Finance, Assistant Director(s) of Finance and nominated deputy to the Director of Operations may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

REMUNERATION COMMITTEE – Terms of Reference (2021-22)	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Directors and Associate Directors with due regard to market rates, NHS guidance, affordability and equal value.
Terms of Reference	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene including: - Guidance on Executive remuneration from the Department of Health or NHS England. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice). 5. Ratify the appointment of new Directors and approve the remuneration and terms of service if outside the parameters agreed for previous appointments to the role.
Review	In March each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Members Membership will comprise the Chairman and all Non-Executive Directors. In attendance The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. The Director of Human Resources shall be Secretary to the Committee and shall attend to take minutes of the meeting. The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible,

	- Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Deputy Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Remuneration Committee is a Non-Executive function and its decisions must be agreed by a majority of the Non-Executive Directors and reported in accordance with the Trust's publication scheme, via the annual report and accounts.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Human Resources will be responsible for all administrative arrangements.

CHARITABLE FUNDS COMMITTEE – Terms of Reference (2021/22)	
Delegated Authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in these terms of reference.
Terms of Reference	The Committee will oversee the administration of charitable funds in line with the Charities Commission requirements and relevant legislation. The Committee will undertake the following duties: • To manage the affairs of the St Helens and Knowsley Hospitals Charitable Fund within the terms of its declaration of Trust. • Develop policies in respect of the management of charitable funds including investments, donated income, spending, fundraising, use of reserves and other relevant matters. • Appoint an investment advisor to advise on investment arrangements for Charitable Funds. • Approval of expenditure requests in accordance with charitable funds expenditure approval procedures reviewing the financial position of charitable funds on at least a four monthly basis. • To ensure funding decisions are appropriate and are consistent with the St Helens and Knowsley Hospitals Charitable Fund objectives, to ensure such funding provides added value and benefit to the patients and staff of the trust, above those afforded by the Exchequer funds. • To implement as appropriate, procedures and policies to ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate. • To approve the annual accounts and report and to ensure that all relevant information is disclosed.
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Membership Core membership will comprise; two Non-Executive Director one of whom will chair meetings of the Committee; the Director of Finance or his nominated officer, two Trust senior officers (preferably clinical). In attendance The Charitable Funds Financial Accountant, Charitable Funds Officer, Head of Media and Communications and the Hospital Charity Fundraiser will be in attendance. The Chairman and Chief Executive are invited to attend the Charitable Funds Committee at any time. Representatives of Internal and External Audit and other Trust Senior Managers may be invited to attend meetings in an ex-officio capacity. In addition, the Committee may establish appropriate time limited working groups to consider specific issues on a project basis. The terms of reference of such groups will be agreed by the Committee with minutes of such groups presented to the Committee.
Attendance	Core Members are expected to attend a minimum of 60% (2 of the 3 meetings) of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible,

	- Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Committee would be considered quorate with 50% attendance, with at least one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and will provide a written report setting out the basis of recommendations made.
Meeting Frequency	The Committee will meet at least three times per year. Meetings may also be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Finance will be responsible for all administrative arrangements.

EXECUTIVE COMMITTEE – Terms of Reference (2021-22)	
Delegated Authority	The Trust shall establish a Committee to be known as the Executive Committee which will formally be constituted as a Committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year. 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant tender/bid documents submitted by the Trust for new services 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council and other appropriate supporting groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee
Review	Each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee Terms of Reference.
Membership	Core membership of the meeting will comprise: - Chief Executive (chair) - Deputy CEO/Director of Human Resources (vice chair) - Medical Director

	- Director of Nursing, Midwifery and Governance - Director of Finance and Information - Director of Operations and Performance - Director of Corporate Services - Director of Informatics - Director of Integration The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is envisaged for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)031
Title of paper: Appointment and role of the Wellbeing Guardian
Purpose: For the Board to better understand the role and purpose of the Wellbeing Guardian
Summary: In recent years there has been increasing recognition of the importance of promoting the physical and mental wellbeing of staff working in the NHS. This has led NHS Employers to recommend that every Trust Board appoints a Wellbeing Guardian. The impact of the COVID-19 pandemic and the huge challenges of restoration and recovery mean that the role of NHS organisations in supporting the wellbeing of their staff has become more crucial than ever. The purpose of the Wellbeing Guardian is to "routinely challenge the organisation's activities and performance to create a compassionate environment which promotes the culture of wellbeing of our NHS people, where organisational activities empower the holistic health and wellbeing of its NHS people." Lisa Knight has been nominated as the first Wellbeing Guardian and the Board is asked to formally ratify this appointment.
Corporate objectives met or risks addressed: Attract and develop caring highly skilled staff
Financial implications: Non as a direct result of this paper
Stakeholders: Staff, Patients, Regulators
Recommendation(s): 1. The Board note the role of the Wellbeing Guardian 2. The Board formally ratifies Lisa Knight as the Wellbeing Guardian for the Trust
Presenting officer: Anne-Marie Stretch, Deputy CEO/Director of HR
Date of meeting: 26th May 2021

Health Work & Wellbeing

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Wellbeing Guardian

Wellbeing Guardians

‘’Protecting the health and wellbeing of our staff is vital, without staff being well at work, our organisation could not deliver quality and effective patient care.’’

NHS Employers, March 2021.

Wellbeing Guardian – Background

Background

- **2019** - Health Education England published a mental wellbeing commissioning report that introduced the idea of a wellbeing guardian
- **2020** – NHS England and Improvement introduced the role of a wellbeing guardian as part of the ‘’NHS People Plan’’
- **2021** - NHS E&I reemphasised the importance for all NHS organisations to appoint a wellbeing guardian as per any restart/recovery plans
- **April 2021** – StHK appoint Non - Executive Director Lisa Knight for the Role of Wellbeing Guardian

Health and Wellbeing Statistics - NHS

- The **cost of poor mental health** in the NHS workforce equates to: **£1,794 - £2,174** per employee per year.
- **Top FOUR factors** which affect mental wellbeing: fear of being judged, stress, finding the confidence to tell people and facing the stigma.
- **One in THREE** of the NHS workforce have felt unwell due to work-related stress and **one in two** attended work feeling unwell due to pressure from their manager, colleagues or themselves.
- The **rates of depression** among training grade doctors has been estimated at about **30%.**

HEE – NHS Staff and Learners Mental Wellbeing Commission 2019.

Health and Wellbeing Statistics - NHS

- **25% of organisations** said staff poor financial wellbeing was a significant cause of employee stress
- **Toxic behaviour** costs the NHS more than £2.bn a year, staff who see incivility have a 20% decrease in their performance & a 50% decrease in wanting to help others.
- **80%** of NHS staff believe health and wellbeing impacts patient care.
- **1 in 6 NHS** absences was because of a MSK disorder.

CIPD Health and Wellbeing Survey 2019 (1,000 organisations and 3.3 million employees, identified.
NHS England, The Price of Fear (Kline and Lewis 2018).
Personnel Today, Occupational Health in NHS, MSK disorders 2015.

Health and Wellbeing Statistics - Trust

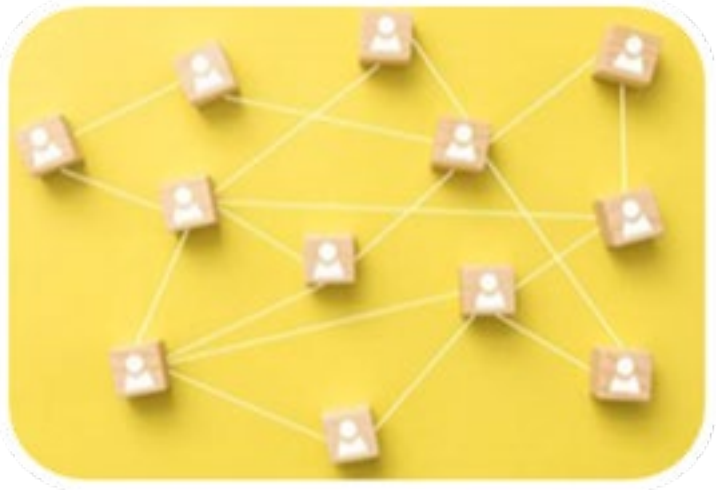
- **<0.8%** decrease in days lost due to **MSK sickness absences** YOY (19/20)
- The **peaks in reportable sickness absence** days lost due to Stress, Anxiety, Depression and Mental Health, have tracked the same YOY (19/20): April, August & October
- **73.8%** of line managers take a positive interest in there own staff health & wellbeing
- **37.9%** of staff felt unwell as a result of work related stress, the **highest** score in **4 years**, >6.5% YOY (19/20)
- Staff **harassment, bullying** or **abuse at work** from **managers;** second highest score in 4 years **>2.3%** and a **lowest** score in 4 years, staff or colleagues reporting these incidences <2.8% YOY (19/20)

Staff survey 2020

Wellbeing Guardians – The Role

The overriding purpose of the Wellbeing Guardian is to routinely **challenge** the **organisation's activities** and performance to create a compassionate environment which promotes the culture of wellbeing of our NHS people, where organisational activities empower the holistic health and wellbeing of its NHS people.

- ✓ **Promoting Holistic Wellbeing** – Social & emotional, mental & physical, equality & inclusion, civility & respect, financial
- ✓ **Seeking Assurances**
- ✓ **Diversity of people**
- ✓ **Connectivity**



Wellbeing Guardians – The Role

The role of a wellbeing guardian: focused around **nine Trust board principles**, the wellbeing guardian will support, HR Directors, Health and Wellbeing leads, Line Managers to integrate these nine principles:

One	• The health and wellbeing of NHS people will not be compromised by the work they do
Two	• The board and guardian will check the wellbeing of any staff member exposed to distressing clinical events
Three	• All new NHS staff will receive a wellbeing induction
Four	• The NHS people will have ready access to self-referral and confidential occupational health services
Five	• Death by suicide of any NHS people will be independently examined

Wellbeing Guardian – The Role

The role of a wellbeing guardian: continued

Six	• The NHS will ensure a supportive, safe environment to promote psychological and physical wellbeing
Seven	• The NHS will protect the cultural and spiritual needs of its people, ensuring appropriate support is in place for overseas NHS people
Eight	• Necessary adjustments for the nine groups under the Equality Act 2021 will be made
Nine	• The wellbeing guardian will suitably challenge the Board

Wellbeing Guardians – Integration Plan

Trust Health & Wellbeing Network:

Board & Executives

Senior Leaders

Professional Support Services

Trained Staff

Employees

Policies

Appraisals

Wellbeing Conversations

Training for Leaders

Engagement

Wellbeing Guardians – Integration Plan

Operational integration plan – check list:

Item.	Action	Update	BRAG Status	Timeline 2021/2022
1	Identify the role and appoint a wellbeing guardian	April 2021 – appointed NED Lisa Knight	Complete	Q1
2	Wellbeing Guardian and Trust Board buy-in and support	To present to the Trust Board the wellbeing guardian role and seek buy-in with Q&A for direction and support	In-progress	Q1
3	Communicate to the wider workforce, the wellbeing network and guardian role	Once item 1&2 have been actioned, communications team can then publicise.	In -Progress	Q1
4	Set up a health and wellbeing forum to support, key wellbeing agendas with wellbeing guardian support	The ''putting our people first group'' will be a key driver to help facilitate these agendas and discussions	In-progress	Q2
5	Use the ''NHS wellbeing diagnostic tool'' to work with senior leaders to ensure health and wellbeing effectiveness	The NHS WDT, will be shared with senior leaders and used with relevant stakeholders to monitor and measure performance.	In-progress	Q2-4

Wellbeing Guardians – Integration Plan

Operational integration plan – check list:

Item.	Action	Update	BRAG Status	Timeline 2021/2022
6	Agree with relevant stakeholders and Board the metrics used to measure and monitor performance, more specifically: • The impact of the role wellbeing guardian • Intelligence gathering – staffs feedback, improvements and performance	The implementation of the role and various agendas, with feedback will need to happen first, before this action can start to be measured or be shaped.	In-progress	Q3-4

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Questions?