St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26th JANUARY 2022
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
10.00	1.	Patient Story		Verbal	Assurance	Sue Redfern
10.15	2.	Employee of the Month - December 2021 - January 2022		Verbal	Assurance	Chair
10.20	3.	Apologies for Absence		Verbal	Assurance	Chair
10.25	4.	Declaration of Interests		Verbal		
10.30	5.	Minutes of the Board Meeting held on 24th November		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.35	6.	Integrated Performance Report		NHST(22) 001	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						
10.55	7.	Committee Report – Executive		NHST(22) 002	Assurance	Ann Marr
11.15	8.	Committee Report – Quality		NHST(22) 003	Assurance	Rani Thind
11.25	9.	Committee Report – Finance & Performance		NHST(22) 004	Assurance	Jeff Kozer
11.35	10.	Committee Report – Strategic People Committee		NHST(22) 005	Assurance	Lisa Knight

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.45	11.	Corporate Risk Register Quarterly Report	NHST(22) 006	Assurance	Nicola Bunce
11.55	12.	Board Assurance Framework Quarterly Review	NHST(22) 007	Approval	Nicola Bunce
12.05	13.	Aggregated Incidents, Complaints and Claims Report	NHST(22) 008	Assurance	Sue Redfern
12.15	14.	Winter Staffing Assurance Framework	NHST(22) 009	Approval	Sue Redfern
12.25	15.	2022/23 Budget Setting – Operational Guidance and Timetable	NHST(22) 010	Assurance	Nik Khashu
Closing Business					
12.50	16.	Effectiveness of Meeting	Verbal	Assurance	Chair
	17.	Any Other Business		Information	
	18.	Date of Next Meeting – Wednesday 23rd February 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 26 JANUARY 2022

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **Deferred due to COVID-19**	NB/NK	**TBC**
36	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **Deferred due to COVID-19**	AM	**TBC**
39	27.10.21 (5.2.17)	RC to report on the feedback and impact of the perfect week at a future meeting.	RC	**26.01.22**
40	24.11.21 (8.4)	NK to circulate the progress report on the revision of the IPR to all Board members	NK	**26.01.22**

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(22)001
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 December 2021. (YTD = 1).

There were no cases of MRSA in December 2021. (YTD = 1).

There were 2 C.Difficile (CDI) positive cases reported in December 2021 (2 hospital onset and 0 community onset). YTD there have been 43 cases (23 hospital onset and 20 community onset). Of the 43, there are a total of 21 RCAs currently in progress. The Trust has successfully appealed 3 cases, with a further 9 cases currently being appealed. The annual tolerance for CDI for 2021-22 has been set at 54.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2021 was 93.0%. 2021-22 YTD rate is 92.3%.

During the month of November 2021 there were 2 falls resulting in severe harm or death category . (YTD severe harm or above category falls = 15)

There were no validated grade 3 hospital acquired pressure ulcers with lapse in care in October 2021. (YTD (validated incidents) 2021-22 = 1). 13 validated category 2 pressure ulcer with lapse in care YTD.

The number of community incidents reported in November was 106 which is an increase from the previous month (84).

Performance for VTE assessment suspended by NHSE since March 2020.

YTD HSMR (April - August) for 2021-22 is 97.2

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 January 2022

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (November 2021) at 82.9%. YTD 85.3%. The 31 day target was achieved in November 2021 with 99.0% performance in month against a target of 96%, YTD 98.2%. The 2 week rule target was not achieved in November 2021 with 75.4% in month and 87.2% YTD against a target of 93.0%. The deterioration in performance for 2 week rule, is related to the 43% increase compared to the same period in 2019, coupled with capacity challenges.

Accident and Emergency Type 1 performance for December 2021 was 55.3% and YTD 57.2%. The all type mapped STHK Trust footprint performance for December 21 was 77.3% and YTD 77.8%**.** The Trust saw average daily attendances of 300, which is down compared to November, at 324. Total attendances for December 2021 was 9,305.

Total ambulance turnaround time was not achieved in December 2021 with 49 mins on average. There were 2,297 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,299 in November 21.

The UTC managed 4830 attendances in November 2021, which is a decrease of 7% (356) compared to the previous month. Overall 98% of patients were seen and treated within 4 hours.

There was a slight decrease in referrals received within the District Nursing Service in November; however the levels are still within average range (543 in November in comparison with 566 in October). Community matron caseloads have seen a slight decrease in the month of November to 161 compared to 169 in the month of October. There is still capacity within the service and is therefore continuing to engage with individual GP practices to support identification of appropriate patients.

The average daily number of super stranded patients in December 2021 was 109 compared with 112 in November. Note this excludes Duffy and Newton IMC beds. Work is ongoing both internally and externally, with all system partners, to improve the current position with acute bed occupancy remaining high with subsequent congestion in ED as a result.

The 18 week referral to treatment target (RTT) was not achieved in November 2021 with 72.4% compliance and YTD 72.4% (Target 92%). Performance in October 2021 was 72.9%. There were (1377) 52+ week waiters. The 6 week diagnostic target was not achieved in November 21 with 81.5% compliance. (Target 99%). Performance in October 2021 was 80.5%.

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. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust submitted a breakeven plan for H2. This included risk of approximately £13m relating to ERF income dependent on system performance (£6m) and other unidentified income required to offset planned expenditure to give a breakeven plan (£7m). Following confirmation of Elective Restoration funding and expenditure slippage, the forecast deficit against the H2 breakeven plan is now £5.0m, consisting of £6.2m planned H2 ERF income dependent on system performance, partly offset by £1.25m additional support from St Helens CCG. The year to date element of this gives a reported deficit at Month 9 of £4.1m. This is due to the profiling of the ERF plan, with £4.8m income planned for M7-M9 and the remaining £1.4m planned in M10-M12. Mitigation of this deficit is dependent on receipt of ERF income based on our organisational performance.

Surplus/Deficit - At the end of Month 9 the Trust has reported a £4.1m deficit, with £392.4m income and £396.6m expenditure.

Agency - Year to date agency expenditure is £7.4m, including agency costs incurred in relation to COVID and Mass Vaccination (£0.8m).

Cash - At the end of Month 9, the cash balance was £66.7m. The current NHSE/I assumption is for providers to utilise cash balances before accessing Emergency PDC to fund their capital programmes. This is expected to deteriorate the Trust's cash balance over time.

Capital - A capital programme of £10.97m (excluding PFI lifecycle expenditure), supported by £5.43m Emergency PDC, was submitted to NHSE/I. Emergency PDC must be agreed by DHSC before the Trust is able to draw funds. Currently, the Trust does not expect this to be agreed, as there is an assumption that providers utilise cash balances before accessing PDC funding.

Human Resources

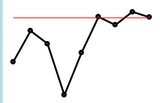
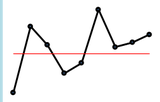
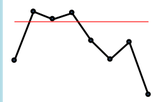
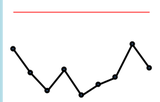
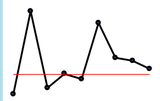
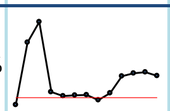
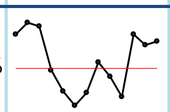
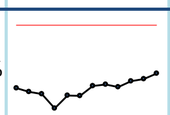
In December overall sickness has increased from 7.0% to 8.5% in the previous month. Front line Nursing, Midwifery and HCA's has increased by from 9.7% to 11.3%. Qualified Nursing and Midwifery Sickness Ward Areas Only is 8.7%.
N.B. This includes normal sickness and COVID19 sickness reasons only. These figures do not include, covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension. Appraisal compliance continues to improve, however is below target at 67.6%. Mandatory training compliance has remained unchanged in month and remains below the target at 74.3%.

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

Dec-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	Dec-21	3.0%	2.6%	No Target	3.1%		Post wave 3 of COVID, performance is encouraging.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits. We continue to independently benchmark performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Aug-21	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Aug-21	100.2	97.2	100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Aug-21	108.2	106.5	100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jul-21	90.2	95.1	100.0	98.8		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	Performance remains within expected range.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Aug-21	89.9	88.8	100.0	90.3		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	Aug-21	101.8	105.2	100.0	104.7					
% Medical Outliers	F&P	T	Dec-21	2.7%	1.9%	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	The current number of medical outliers is above target owing to the full occupancy of the medical bed base. Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Dec-21	65.7%	51.3%	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 although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Nov-21	79.3%	76.7%	90.0%	74.8%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team also being involved to find a sustainable solution particularly in A&E. OP attendance letters - deterioration reflects staff sickness and increased activity pressures has caused a backlog in typing. Action plan is in place with operational colleagues.		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 SDECC is moving discharges to the Medway system to support rapid, detailed discharges. We are working with CCG colleagues to confirm the change in policy before go-live with action plan in place to monitor impact and quality of summary being sent out	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Nov-21	78.0%	74.4%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Nov-21	98.0%	97.1%	95.0%	96.8%					

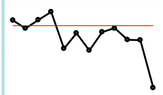
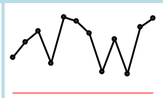
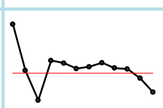
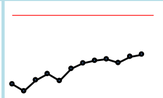
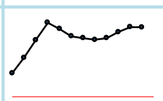
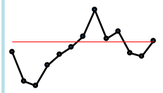
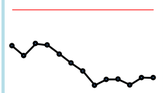
Dec-21

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 (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q2	86.0%	86.8%	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	▲ £	Dec-21	0	1	0	3		One never event reported in July 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	Dec-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	▲ £	Dec-21	0	1	0	2		There were no cases of MRSA in December 2021. YTD = 1.	Quality and patient safety	The annual tolerance for CDI for 2021-22 has been set at 54.	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Dec-21	2	43	54	28		There were 2 positive C Diff sample in December 2021. YTD there have been 46 cases of which 3 cases have been successfully appealed, leaving 43 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Dec-21	5	35	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	▲	Oct-21	3	4	No Contract target	1		1 validated category 3 presure ulcer YTD, 3 incidents awaiting RCA panel.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April 21.	SR
Number of falls resulting in severe harm or death	Q	▲	Nov-21	2	15	No Contract target	31		2 fall resulting in severe harm category in November 2021 (Ward 1D and Bevan 2). No falls resulting in death.	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 December 21 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway with thematic review expected. All cases reviewed. Appropriate prescribing and care identified.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-21	9	40	No Target	104					
To achieve and maintain CQC registration	Q		Dec-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	Dec-21	93.0%	92.3%	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	Dec-21	0	24	No Target	49					

Dec-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
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Nov-21	75.4%	87.2%	93.0%	94.3%		2WW referrals remain high and this has been accepted as the new norm. A trend in GPs inappropriately expediting referrals as an attempt to speed up treatment has been noted.	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity, including communication with GPs around correct process and management of waiting lists/patient hot lines. 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 7. Funding approved to support RDS implementation aligned to CDC	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Nov-21	99.0%	98.2%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Nov-21	82.9%	85.3%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Nov-21	72.4%	72.4%	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. urgent, cancers and long waiters remain the priority patients for surgery at Whiston with application of P- codes effectively implemented. Application of D-codes is on target for delivery.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Nov-21	81.5%	77.5%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Nov-21	1,377	1,377	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Dec-21	0.81%	0.82%	0.8%	0.4%		Year to date underperformance in cancelled ops has been due to staff sickness/absence, and theatre staff being re-deployed temporarily to support ITU. In December, a mixture of consultant and theatre staff sickness has impacted this metric. The team is confident that this will recover going forward, although performance remains at risk.	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	▲ £	Nov-21	100.0%	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	▲	Dec-21	55.3%	57.2%	95.0%	78.0%		Accident and Emergency Type 1 performance for December 2021 was 55.3% and YTD 57.2%. The all type mapped STHK Trust footprint performance for December 21 was 77.3% and YTD 77.8%. The Trust saw average daily attendances of 300, which is down compared to November, at 324. Total attendances for December 2021 was 9,305 Total ambulance turnaround time was not achieved in December 2021 with 49 mins on average. There were 2,297 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,299 in November 21. The volume of Category 1 calls (life threatening emergencies) was 31% for December 2021, compared with 12% in 2019 - reflective of the acuity of patients.	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. <u>Flow through the Hospital</u> COVID action plan to enhance discharges commenced in April 20 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. The continued absence of face to face assessments from social workers is causing some delays.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Dec-21	77.3%	77.8%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Dec-21	0	0	0	0					

Dec-21

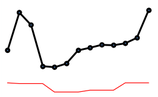
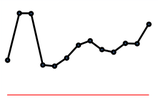
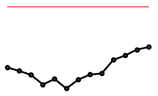
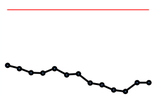
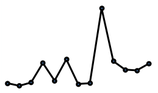
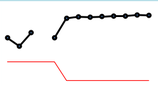
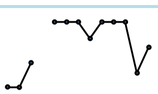
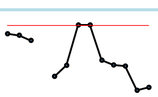
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Dec-21	0	0	0			Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Dec-21	16	203	No Target	242		% new (Stage 1) complaints resolved within agreed timescales dipped below the 90% target in quarter 1 & 2 and continues to remain extremely challenging in Q3.	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 have been 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%. Additional temporary resources will be in place mid January to increase response rates within the Medical Care Group, however the number of overdue responses closed in December will impact on performance for Q3 overall.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Dec-21	28	185	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Dec-21	60.7%	78.4%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to December 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. The absence of face to face assessments from social workers is causing some delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Dec-21	318	307		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Dec-21	109	99		72					
Friends and Family Test: % recommended - A&E	Q	▲	Dec-21	82.2%	78.1%	90.0%	88.4%		Year to date recommendation rates are above target for inpatients and postnatal ward and community, but remain below target for the remaining areas.	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. At least two members of staff have been identified in each area to produce 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. Waiting times in ED are continuing to cause a higher number of negative responses and comments, with work ongoing to reduce this, including regular updates on waiting times, redeploying additional staff to support flow at peak times and ongoing improvement weeks this quarter.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Dec-21	96.6%	95.8%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Dec-21	93.4%	96.5%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-21	90.7%	93.9%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Dec-21	100.0%	95.7%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Dec-21	90.0%	99.4%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-21	94.4%	93.8%	95.0%	94.2%					

Dec-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	▲	Dec-21	8.5%	6.7%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In December overall sickness has increased by 1.5% from 7.0% to 8.5% in the previous month. Front line Nursing, Midwifery and HCA's has increased by 1.6% from 9.7% to 11.3%. 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.	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 to try to analyse the hotspots and HWWB are contacting employees who are absent with Covid to provide support.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Dec-21	11.3%	9.4%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Dec-21	67.6%	67.6%	85.0%	51.3%		Appraisal compliance has increased by 1.2% and is below target by 17.4%. Mandatory training compliance has remained unchanged and is below the target by 10.7%. In particular, Mandatory training continues to be impacted by operational activity, recovery plans and significant staff absence.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance for Mandatory Training continues to be impacted by operational pressures and high staff absence. Appraisal has seen increasing compliance in month with both remaining below target. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area and continues to be monitored through Workforce Council.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Dec-21	74.3%	74.3%	85.0%	75.7%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			No Contract Target			NHSE/NHSI to resume from Q2 (July)	Staff engagement, recruitment and retention.	The annual staff survey launched in October and will close on 26th November with result expected to be published in early 2022.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Dec-21	1.2%		No Target	12.9%		Staff turnover remains stable and below the national average of 14%.			AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Dec-21	Discontinued	Discontinued	N/A				Delivery of Control Total	The 2021 financial plan has been put on hold and a system introduced where Trusts will breakeven for the first six months of 2021/22.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Dec-21	8,745	8,745	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Dec-21	(4,137)	(4,137)	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Dec-21	30	30	10						
Capital spend £ YTD (000's)	F&P	T	Dec-21	6,100	6,100	17,600						
Financial forecast outturn & performance against plan	F&P	T	Dec-21	(4,994)	(4,994)	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Dec-21	77.1%	77.1%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	2021-22 YTD	2021-22 Target	FOT	2020-21	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	96.3%	100.0%	97.4%	100.0%	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.7%	85.0%		91.1%		
	Total > 62 days		0.0	0.0	0.5	0.0	0.5	0.0	1.0	1.0	1.0	0.0	0.5	0.5	0.0	4.0			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	0.5	0.0	0.5			0.0		
Lower GI	% Within 62 days	▲ £	80.0%	82.6%	78.9%	58.6%	87.5%	61.1%	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	79.4%	85.0%		78.7%		
	Total > 62 days		2.0	2.0	2.0	6.0	1.0	3.5	3.5	0.0	1.0	2.5	0.0	3.0	4.0	17.5			22.0		
	Total > 104 days		0.0	0.0	0.0	2.0	1.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	1.5	3.0			6.0		
Upper GI	% Within 62 days	▲ £	81.8%	83.3%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	88.2%	85.0%		83.1%		
	Total > 62 days		1.0	1.0	0.0	0.0	3.5	0.0	0.0	0.0	1.0	3.0	1.0	0.0	0.0	5.0			11.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	2.0			4.0		
Urological	% Within 62 days	▲ £	79.5%	88.2%	82.8%	92.3%	79.2%	80.0%	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	79.7%	85.0%		85.6%		
	Total > 62 days		4.0	2.0	2.5	1.0	2.5	2.0	2.0	4.5	1.5	4.5	2.0	1.0	3.5	21.0			21.0		
	Total > 104 days		1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	2.0	0.0	0.5	3.0			6.0		
Head & Neck	% Within 62 days	▲ £	100.0%	0.0%	33.3%	57.1%	50.0%	0.0%	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	23.3%	85.0%		51.4%		
	Total > 62 days		0.0	1.0	1.0	1.5	1.0	1.0	3.0	1.0	2.0	1.0	1.0	2.0	0.5	11.5			9.0		
	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	0.0	2.0			0.0		
Sarcoma	% Within 62 days	▲ £	0.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%					100.0%	85.0%		83.3%		
	Total > 62 days		1.0	0.0	0.0	0.0		0.0	0.0		0.0					0.0			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0		0.0	0.0		0.0					0.0			0.0		
Gynaecological	% Within 62 days	▲ £	69.2%	66.7%	55.0%	60.0%	57.1%	83.3%	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	76.7%	85.0%		66.3%		
	Total > 62 days		2.0	1.0	4.5	1.0	3.0	0.5	0.0	0.5	0.0	2.5	2.0	1.0	0.5	7.0			17.5		
	Total > 104 days		1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	▲ £	81.8%	75.0%	100.0%	80.0%	100.0%	100.0%	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	78.8%	85.0%		83.9%		RC
	Total > 62 days		1.0	2.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	0.0	2.5	3.0	1.5	11.0			10.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0			1.0		
Haematological	% Within 62 days	▲ £		100.0%	50.0%		75.0%	57.1%	100.0%	37.5%	37.5%	100.0%	100.0%	100.0%	50.0%	57.6%	85.0%		77.9%		
	Total > 62 days			0.0	3.0		1.0	3.0	0.0	5.0	5.0	0.0	0.0	0.0	1.0	14.0			8.0		
	Total > 104 days			0.0	0.0		0.0	1.0		1.0	2.0					4.0			1.0		
Skin	% Within 62 days	▲ £	93.9%	100.0%	96.8%	86.0%	94.6%	92.9%	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	92.8%	85.0%		93.6%		
	Total > 62 days		2.0	0.0	1.0	4.0	2.5	2.5	3.0	3.0	0.0	1.0	3.5	4.0	4.5	21.5			25.5		
	Total > 104 days		0.0	0.0	0.0	1.0	0.5		1.0				0.5			1.5			3.0		
Unknown	% Within 62 days	▲ £	66.7%	100.0%	100.0%	100.0%	80.0%			50.0%		100.0%		100.0%	100.0%	84.6%	85.0%		92.3%		
	Total > 62 days		0.5	0.0	0.0	0.0	0.5			1.0		0.0		0.0	0.0	1.0			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.5			0.0		0.0		0.0	0.0	0.0			0.5		
All Tumour Sites	% Within 62 days	▲ £	85.2%	90.4%	85.3%	82.0%	86.4%	86.1%	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.3%	85.0%		86.7%		
	Total > 62 days		13.5	9.0	14.5	14.5	15.5	12.5	14.5	16.0	13.5	14.5	12.5	14.5	15.5	113.5			137.5		
	Total > 104 days		2.0	0.0	1.0	3.0	3.0	2.0	1.0	1.0	4.0	3.0	2.5	1.5	2.0	17.0			23.5		
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%	100.0%		100.0%	85.0%		100.0%		
	Total > 31 days			0.0	0.0	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		0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				
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(22)002
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 November and December 2021. There were seven Executive Committee meetings held during this period, with no meetings on the 23rd or 30th December. The new investment decisions made were: 1. Whiston Hospital Additional Theatre Capacity 2. Mandatory Training and Appraisal Improvement Plan 3. Cellular Pathology Equipment Replacement – Revenue Consequences 4. Emergency Department – Low Rise Trolleys 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, the Integrated Performance Report, and mandatory training and appraisal performance reports.
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: 26th January 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were seven Executive Committee meetings in November and December 2021. There were no meetings on 23rd and 30th December.

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

2. 4th November 2021

2.1 Board Agendas - November

The Director of Corporate Services presented draft agendas for the November Trust Board meeting and set out the submission deadlines for papers to be submitted.

2.2 COVID Issues

The Director of Nursing, Midwifery and Governance reported that there had been 7 nosocomial infections reported in the previous week. There had been an increase in COVID admissions and patients requiring care in ICU, which reflected an increased community incidence. The challenges of keeping patients socially distanced in ED when it was extremely busy were acknowledged.

2.3 Southport and Ormskirk Hospitals (S&O) Update

The Deputy CEO/Director of HR provided feedback following the visit of David Flory and Sheena Cumiskey, the interim Chair and Chief Executive of the ICS, to S&O to discuss the backlog maintenance and service configuration challenges.

There had been meetings between the Medical Directors, Directors of Nursing and Directors of Operations from both trusts to explore actions that could be taken to support the S&O fragile services.

Members discussed preparations for the first joint meeting with NHSE/I in December and the information gathering and preparations to establish the resources and capacity needed to deliver the proposed transaction.

2.4 Strategic Issues

The Chief Executive reported that additional funding had been allocated to the region to increase bed capacity across the North West for winter 2021/22.

The Director of Nursing, Midwifery and Governance reported that staff from Bridgewater Community NHSFT had successfully transferred to the Trust as part of the change in provider of community midwifery services. She had visited the staff to formally welcome them to the organisation.

The Director of Nursing, Midwifery and Governance reported that the recent experience of the Trust in managing a CAHMS patient was to be used as a case study for the regional review of CAHMS. The support of Clare Duggan at NHSE/I North West to access an appropriate placement for these troubled young people was acknowledged.

3. 11th November 2021

3.1 Green Plan

The Director of Corporate Services presented the draft Green Plan which highlighted the current carbon footprint of the Trust and the actions that would be taken in the next five years to help meet the NHS zero carbon ambition. All NHS organisations had been asked to produce a Green Plan by January 2022 and for the Trust this built on the work that has been undertaken since the new hospitals at Whiston and St Helens had been opened. With some suggested amendments the committee endorsed the plan to be presented to the Trust Board at the November meeting.

3.2 Whiston Hospital Additional Theatre Capacity

The Director of Operations and Performance and the Director of Corporate Services presented the final case for change and proposed designs to create two additional theatres at Whiston hospital in line with the agreed strategic estate capital development plan. It was accepted that the uncertainty about the future NHS financial regime put the revenue assumptions for 2023/24 at risk and approval would be required from the Trust Board. The committee supported the case for change and the capacity and demand modelling which demonstrated that the need for increased capacity was on the acute site. The complexity of vacating the proposed development space and finding suitable alternative accommodation for displaced staff was also recognised but it was agreed the adjacency to the existing theatre complex made this the best location for the development. The paper was endorsed for presentation to the November Trust Board.

3.3 Mortuary Security

The Director of Corporate Services reported on the risk assessment of the Trust mortuary that had been undertaken following the guidance received from NHSE/I. The report covered the mortuaries at Southport and Ormskirk Hospitals also, as the Trust was the provider of their services as part of the pathology contract. Recommendations to enhance the CCTV coverage in line with the new guidance were approved and other recommendations to change operational policies were also supported. A review had also been instigated to verify that all staff with access to the mortuaries had current DBS checks.

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

The Director of Corporate Services presented the chair's assurance report from the November RMC meeting. There were 742 risks reported of which 23 had been escalated to the CRR, which included new risks relating to staffing capacity in the blood science laboratories due to absence and vacancies and Warrington and Halton Hospitals NHSFT withdrawing the non-obstetric ultrasound service at the Widnes UTC. Two other high risks had been de-escalated from the CRR. Assurance reports were received

in relation to the Clinical Risk Assessment of planned CIP schemes and from the Claims Governance Group. There was an update on the Freedom of Information (FOI) improvement plan which reported 65% compliance with the 20-day response target in October, with additional actions agreed to return to the planned improvement trajectory.

3.5 North West Leadership Development – Talent Pool

The Deputy CEO/Director of HR presented the plans to expand the North West talent pool of individuals who had the potential to be future Directors. Members were asked to nominate members of their senior teams who they felt should be included.

3.6 Integrated Performance Report (IPR)

The Director of Finance and Information presented the November IPR and members agreed changes to the narrative. The increase in reported cases of C.Diff, mandatory training compliance and the increase of referrals via the two-week cancer access rules were discussed in detail.

3.7 Southport and Ormskirk Hospital NHS Trust (S&O)

The Deputy CEO/Director of HR reported on developments with stroke and ophthalmology services. There had also been further discussion on the future of the Shaping Care Together programme as the current tripartite funding ended on 31st March 2022.

3.8 COVID Issues

The Director of Integration reported on the COVID incidence rates locally. The community infection rates had dropped in the previous two weeks by 23% and for Cheshire and Merseyside were now marginally lower than the national average. Highest infection rates were still being seen in younger (unvaccinated) people. The progress with the vaccine booster campaign for St Helens residents was also noted, with a need to focus on ensuring the older population and most vulnerable received the additional protection. The hospitalisation rates had increased by 3% across Cheshire and Merseyside but the number of patients in ICU had fallen.

The Director of Operations and Performance reported that 16 beds on ward 1A were planned to open to increase winter bed capacity.

Committee members discussed the announcement that COVID vaccination was to be made mandatory for patient facing healthcare staff from April 2022. The Deputy CEO/Director of HR reported that following the announcement detailed guidance and HR advice was due to be published.

4. 18th November 2021

4.1 Trust Objectives Mid-Year Progress Report

The Director of Corporate Services presented the draft report for review in advance of presentation to the November Trust Board meeting. There was detailed discussion on those objectives that were not on track and remedial actions were agreed.

4.2 Safer Staffing Report

The Director of Nursing, Midwifery and Governance presented the report which detailed the headline position for October and analysed the September position in more depth. In October the overall fill rate for Registered Nurses and Midwives had been 92.84% and for Health Care Assistants 106.90% which was an improved position compared to September. It was agreed that in future reports the need for additional staff to support supplementary care should be separated from the ward staffing establishments to give greater transparency. It was noted that ED is not part of the ward safer staffing mandatory reporting, but the current pressures were acknowledged, and committee reviewed the actions being taken to recruit into the current vacancies in the department. It was agreed that further energy needed to be committed to developing different roles and staffing models to create a more sustainable workforce.

4.3 H2 Financial Plan

The Director of Finance and Information reported on the Cheshire and Merseyside financial allocation process for H2 and the lack of transparency as to how the available resources had been distributed between trusts. The proposed allocation for the Trust represented an £18m reduction in income compared to H1, and circa £13m was rated as "red". It was agreed that submitting a balanced plan as had been requested was unrealistic with this level of inherent risk when the overall allocation for the system should have been sufficient for all trusts to break even. It was agreed that there needed to be further discussion with the Trust Board.

4.4 Southport and Ormskirk Hospital NHS Trust (S&O)

The Deputy CEO/Director of HR reported that S&O had been successful with some of the Targeted Investment Fund (TIF) bids to support elective recovery.

There had been a Shaping Care Together Programme Board on 17th November which had been chaired by Val Davies.

Committee also discussed how the changes at S&O were being perceived and what else could be done to support staff.

4.5 COVID Issues

It was reported that 11.6m doses of vaccine had been delivered in the North West as part of the COVID vaccination programme, with 250k of these delivered at the St Helens Mass Vaccination Centre (MVC). 21k boosters had been delivered to date for those people who could attend appointments at the MVC, and this number would increase as

the boosters were offered to people in the lower age ranges. Reconciliation was being undertaken between ESR records and the National Immunisation System (NIMs) for the 457 Trust staff who were not recorded as being vaccinated, and this had flagged staff who had been vaccinated by their own GP or at another vaccination centre.

The Director of Nursing, Midwifery and Governance reported that there had been 4 cases of confirmed nosocomial infections across two wards in the previous 7 days.

4.6 Strategic Issues

It was reported that in response to the concerns about deteriorating ambulance handover performance across the country some of the worst performing trusts would have intensive support to see if there lessons that could be universally adopted. STHK and two other trusts had been selected in the North West for this intervention.

The appointment of Graham Urwin as the Chief Executive designate of the Cheshire and Merseyside ICS had been confirmed with effect from 1st December.

The Provider Collaborative had engaged with the ICS Digital Lead and had held a second development session which had included member trust Chairs.

Following the recent terrorist attack at the Liverpool Women's Hospital it was agreed that the Executive team should undergo refresher training on major incident management and the responsibilities of the on-call Director in an out of hours situation.

5. 25th November 2021

5.1 Mandatory Training and Appraisals

The Deputy CEO/Director of HR presented the monthly mandatory training and appraisal compliance performance for the staff reporting to each Director. It was agreed that all options should be considered that would support managers and staff to improve on the current performance.

5.2 COVID Issues

The Director of Operations and Performance reported the recommendation from Gold Command that the Trust should not relax the current infection prevention control measures, despite changes to the national UK Health Security Agency guidance. This recommendation was based on the increase in local infection rates and relatively high levels of hospitalisation at the Trust.

The Director of Nursing, Midwifery and Governance reported one definite and one probable nosocomial infection in the previous 7 days.

The committee approved expenditure on Christmas window stickers which were fire retardant and could be wiped to comply with IPC requirements, in place of traditional jChristmas decorations.

Several boroughs in Cheshire and Merseyside had seen an increase in community infection rates, which was a cause for concern.

The booster vaccination programme for St Helens was making progress but there remained a high proportion of housebound patients who had yet to be vaccinated.

5.3 Locum Consultant Pay

The Deputy CEO/Director of HR and Director of Operations and Performance presented an update on the pay arrangements for locum consultants in hard to fill posts. Of particular concern was the Dermatology service which had experienced an increase in demand as the services at surrounding trusts had closed to referrals, and was dependant on locum consultants. Most of these are signed up to agencies, and many claimed off-payroll tax status. It was agreed that further discussion was needed with potential candidates to understand the reasons for this.

5.4 Outcomes data – Fractured Neck of Femur and Emergency Laparotomy

The Medical Director presented analysis of the outcomes data following review of the recent CQC Insight Report. The reported data from CRAB was interesting but not conclusive and it was agreed that further work was required before it would be appropriate to agree actions.

5.5 Southport and Ormskirk Hospital NHS Trust – Update

The Deputy CEO/Director of HR reported on the actions being taken to take forward a programme of works to address the Trust's backlog maintenance issues, on the basis that additional capital would be allocated by the ICS following the feedback from David Flory (ICS Interim Chair).

The MP for Sefton had written to the Trust with queries about the Agreement for Long Term Collaboration and a response was being drafted.

The Director of Finance and Information presented the proposals from consultancy firms to provide support for the transaction process and members discussed the internal resources that would also be needed.

6. 2nd December 2021

6.1 Deteriorating Patient Project Update

The Medical Director introduced the paper which provided an update on the work that had started with a multidisciplinary workshop in May 2021. The aim of the project was to focus the Trust resources on detecting deteriorating patients as soon as possible and supporting ward staff to deliver the appropriate interventions, rather than responding when the patient was in crisis, e.g. MET calls. It was agreed that the initial phase of the project needed to re-establish the consistent use of NEWS2 and create electronic alert and monitoring functionality at ward level and for the central team. Once the best

practice use of NEWS2 was embedded it would be possible to look at the optimal deployment of the deteriorating patient teams and resources to improve outcomes.

6.2 Health Inequalities Improvement Dashboard

Further to a recent letter received from NHSE/I and a presentation at the North West Senior Leaders briefing, committee members reviewed how the Trust could analyse waiting lists by ethnicity and deprivation index to understand more about the health inequalities that the Trust could directly influence. The Director of Finance and Information and Director of Informatics agreed to gather all the information the Trust could access and present the initial findings for discussion in January.

6.3 CQC Report Lessons

The Director of Integration presented a summary of the recently published CQC report for a local acute trust. Members reviewed the key findings and reflected on any lessons for STHK and the follow up actions that needed to be taken so the Trust would be ready for a future CQC inspection.

6.4 Mandatory Training and Appraisal Improvement Plan

The Deputy CEO/Director of HR presented the findings of a review which had been undertaken asking staff and managers to identify the barriers to timely completion of mandatory training and appraisals. The principal reason given was operational pressures leading to a lack of time, but there were other issues that staff experienced. The paper therefore proposed a number of actions to remove all these other barriers to training, such as improving the interface between Moodle and ESR, developing an e-learning package for the remaining training subjects, e.g. safeguarding level 2, and increasing the capacity to ensure ESR was up to date with staff moves and contractual changes which could impact their individual training matrix. These measures were approved.

6.5 Cellular Pathology Equipment Replacement

The Director of Operations and Performance presented the business case to replace obsolete tissue processing equipment. Technological advances meant that more advanced automated equipment was now available which could increase capacity and improve turnaround times. The capital for the replacement had already been approved as part of the 2021/22 capital programme, but the preferred equipment resulted in a cost pressure of £108k per annum mainly for reagents. It was recognised that as more of the processing could be overseen by biomedical scientists this would free up capacity from the Consultant Histopathologists however this would not be cash releasing. It was agreed that the purchase of this equipment would modernise and future proof the department and the business case for additional revenue was approved.

6.7 COVID Issues

The Director of Operations and Performance reported that the revised government travel guidance had been communicated to staff and managers and it had been clarified that

PCR tests for returning travellers had to be purchased from a government approved supplier and could not be undertaken by the Trust.

Plans to expand the capacity of the Mass Vaccination Centre and reinstall a staff vaccination facility at the Whiston Hospital site had also been discussed at Gold Command, in response to the announcement of an expansion of the vaccination and booster programmes as a result of the Omicron variant.

Members approved a two-month extension of the Trust paying Hospedia to provide free access to TV for inpatients, as it was now unlikely visiting restrictions would be relaxed as a result of the new variant.

The Director of Integration reported that locally COVID infection rates currently remained below the national average, but it was noted that this was likely to change if Omicron was as transmissible as feared.

6.8 Southport and Ormskirk Hospital NHST Update

The Deputy CEO/Director of HR reported that Southport Hospital had suffered considerable damage as a result of storm Arwen, which was being repaired.

There had been a meeting with staff representatives where the ALTC had been explained. It was agreed that there needed to be more communication to staff in both trusts about the ALTC and future plans.

7. 9th December 2021

7.1 Mortuary Security Action Plan

The Director of Corporate Services presented an update on the actions taken in response to the review of mortuary and body store security at the Trust following guidance from NHSE/I. Additional swipe access points and CCTV cameras had been installed and a review of all staff with legitimate access completed. A process for monitoring CCTV footage had also been agreed and the appropriate support for staff undertaking this role put in place. Further CCTV cameras and alarms for other areas around the bereavement centre were on order and would be fitted as soon as possible. The Trust process to ensure DBS checks were renewed every three years was being finalised. A further report on the outstanding actions would be presented in January.

7.2 Emergency Department (ED) – Low Rise Trolleys

The Director of Operations and Performance presented a business case seeking funding to replace the existing trolleys with more modern equipment which was height adjustable. It was recognised that patients were currently spending longer in ED due to operational pressures and these new trolleys would support patient safety as they could be lowered for patients at risk of a fall and had knee breaks for patients at risk of developing pressure ulcers.

The purchase of new low-rise trolleys for ED was approved and the existing stock would be rotated to other areas in the Trust.

7.3 Estates Return Information Collection (ERIC) – 2020/21

The Director of Corporate Services presented the ERIC benchmark data for the previous year. This demonstrated that for the most of key Estate and Facilities Management metrics the Trust performed in the best quartile compared to other large acute trusts. There were two areas where this was not the case, which were the same as previous years: portering costs per 1000m2 (Upper quartile) and linen cost per item (Median). In both cases there was an understanding of the cost drivers, but further work would be undertaken to optimise value for money.

7.4 Robotic Process Automation (RPA) Programme – Employment Services

The Deputy CEO/Director of HR introduced a presentation which summarised the progress made with the RPA programme in HR, the benefits realised to date and the planned next stages of development. The presentation also detailed the collaboration with other trusts that were introducing RPA and the potential to use this for other administrative rules based tasks outside of the HR environment. The measures of success to date included increase in accuracy and timeliness of processing, leading to increased productivity. The committee congratulated the programme team on their achievements to date and endorsed the further role out of the technology to other areas with the appropriate governance.

7.5 COVID Issues

The most recent population infection figures had increased by 14% in the previous seven days for the local area, but this had not yet impacted hospitalisations.

Cases of Omicron had been detected locally and it was anticipated that these would now increase rapidly.

In St Helens 97% of the over 70s were now double vaccinated and 83% of these had also received a booster.

Gold Command was being stepped up to meet more frequently to be able to respond quickly to any changes impacting the Trust and to continuing operational pressures for urgent and emergency care.

The committee also discussed the detailed guidance that had now been received in relation to the mandatory vaccination of staff providing patient care and the plans for communicating with staff. The regulations were due to be approved by parliament on 6th January 2022.

8. 16th December 2021

8.1 Southport and Ormskirk Hospital NHST – Update

The Deputy CEO/Director of HR reported that there had been a meeting with the local MPs the previous week to brief them on progress.

It was reported that the ALTC Quarterly Joint Meeting scheduled for 15th December had been postponed by NHSE/I and was being rearranged for January.

Discussions were taking place about the future of medical education at S&O and opportunities for collaboration with the Trust in this area.

S&O was seeing an increase in COVID positive patients and admissions to ICU (which in S&O also includes CPAP beds).

8.2 Managed Equipment Service (MES) Contract Variation

The Director of Finance and Information explained that GE, NewHospitals and the Trust had been working to agree a variation to the MES contract for imaging equipment to bring all relevant equipment under the main contract, where some of this had been previously been out of scope. The terms of the variation had now been agreed and were with NewHospitals Project Co funders for approval. This variation was important to ensure that all equipment was in scope when the current contract ends in 2026/27. There was no impact on the current costs, but the terminal value would increase to reflect the additional equipment.

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

The Director of Corporate Services presented the Chair's assurance report from the December RMC meeting. The total number of risks on the Trust risk register was 766 of which 24 were escalated to the CRR, this included three new high risks; the first related to the capacity of the dermatology service to keep pace with the increasing number of referrals; the second was in relation to the risk of avoidable harm when patients had to be cared for in the ED corridor as a result of congested patient flow and the third was the risk if patients had to "forward wait" on a ward, also as a result of the pressure on beds. The report also included feedback on the risk assessments completed for CIP schemes; from the Claims Governance Group; the Information Governance Steering Group and the Major Incident Planning Group.

8.4 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for November and confirmed that although there is not a Board meeting in December the report will still be circulated to all members. Amendments and additions to the explanatory text in the IPR were agreed.

8.5 Log4j Cyber Alert

The Director of Informatics briefed the committee on the emerging situation and the actions that were being taken to prevent an attack on the NHS. The Director of Nursing, Midwifery and Governance outlined the steps being taken to review business continuity and contingency plans in case of an attack on the Trust IT systems to safeguard patient care.

8.6 COVID Issues

The Director of Integration presented the latest information which showed that community incidence was increasing nationally and Cheshire and Merseyside was also now showing an increase, although the rates remained low amongst the older population. There had not yet been a significant impact on hospitalisation rates. Vaccination rates (two doses and a booster) were increasing in St Helens which had achieved an 8% increase in the previous week.

The Director of Operations reported the discussions at Gold Command about the revised UKHSA self-isolation guidance and preparations for the introduction of mandatory COVID vaccination for NHS staff.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)003

Reporting from: Quality Committee

Date of Committee Meeting: 18th January 2022

Reporting to: Trust Board

Attendance:
Rani Thind, Non-Executive Director (Chair)
Gill Brown, Non-Executive Director
Sue Redfern, Director of Nursing, Midwifery & Governance
Rowan Pritchard-Jones, Medical Director
Rob Cooper, Director of Operations
Nicola Bunce, Director of Corporate Services
Nikhil Khashu, Director of Finance
Debbie Stanway, Head of Nursing & Quality, Medical Care Group
Tracey Greenwood, Head of Nursing & Quality, Surgical Care Group

In Attendance:
Rajesh Karimbath, Assistant Director of Patient Safety
Teresa Keyes, Deputy Director of Nursing and Quality
Anne Rosbotham-Williams, Deputy Director of Governance
Su Hobbs, Associate Head of Nursing & Quality, Urgent Care
Brendan Prescott, Deputy Director of Quality, Risk and Assurance, Southport and Ormskirk Hospital NHS Trust (Observer)

Matters Discussed:

- Noted the on-going work relating to deteriorating patients and embedding new ways of working to ensure maximum benefit derived from electronic national early warning score (eNEWS) system
- Commissioners confirmed that the Trust's root cause analysis (RCA) process for infections is comprehensive and, therefore, future Clostridium difficile (C difficile) cases do not need to go through the Clinical Commissioning Group (CCG) appeal process
- Confirmed that all but one NICE guidance publications have been reviewed and that there is minimal clinical risk arising from the one outstanding

Integrated Performance Report highlighting:

- No new Never Events or MRSA bacteraemia
- 2 hospital onset C difficile, with 43 cases reported year to date; 3 have been successfully appealed, 9 pending appeal and 21 RCAs in progress
- Registered nurse/midwife safer staffing fill rate for combined day and night was 93% in December and 92.3% year-to-date
- 2 falls resulting in severe harm or above in December, with 15 year-to-date; members of the Committee sought assurance that the audits reported in the IPR

reviewed all required elements of falls care. It was noted that these are currently being updated on the Tendable audit app (formerly known as Perfect Ward) in line with best practice and will provide more challenge going forward to increase the level of assurance provided. The results of these audits will be reported in March
- There were no validated grade 3 hospital acquired pressure ulcers with lapse in care in October 2021 and 1 year-to-date
- HSMR was 97.2 year-to-date (April - August), with weekend rate remaining within expected limits
- 150 COVID positive inpatients, with none currently in Critical Care and lower rate of nosocomial infections compared to Cheshire and Merseyside region (9.7 compared to 14.9)
- Recently released national guidance on vaccination requirement for staff is currently being reviewed
- Continue to experience challenges in meeting the 62 day target, although 31 day target was achieved with 99% in month against a target of 96% and year-to-date of 98.2%, noting that the Trust achieved 74% against the 75% target for the planned 28 day faster diagnosis standard
- 43% increase in referrals compared to the same period in 2019, coupled with capacity challenges, has adversely impacted on achievement of the two week rule, with 75.4% in month and 87.2% year-to-date against a target of 93%
- Continue to face challenges in meeting emergency care access targets, however 98% of patients were seen and treated within 4 hours at the Urgent Treatment Centre
- District nursing and community matron caseloads remain fairly consistent
- Average daily number of super stranded patients in December 2021 was 109 compared with 112 in November

Patient Experience Council report noted the following:
- Meeting focussed on essential items only due to operational pressures
- Reports were received relating to Friends and Family Test, Complaints and PALS and Quality Committee Chair's assurance reports for October and November
- Policy for the Transition of Young People from Paediatric to Adult Services and Guidance for the Care and Treatment of People with Learning Disabilities and Autism were approved

Complaints, PALS, Claims and Friends and Family Test Quarter 3 report provided an update to the Committee on the ongoing management of these and the actions taken to improve services. The report noted:
- Slight decrease in the number of first stage complaints received in quarter 3 (64) compared to quarter 1 (77) and quarter 2 (73)
- Implementation of additional resources within the Complaints Department to support delivery of improved response times, which had dipped to 70% in quarter 3 due to the impact of the pandemic
- Slight increase in the number of new claims received where NHS Resolution have been instructed, from 6 to 9 in quarter 3, albeit lower numbers than previous years
- Significant decrease in the number of inquests from 34 in quarter 2 to 13 in quarter 3, although noted that there are a number of inquests involving patients who have fallen for which the Committee sought assurance that actions are being taken to reduce these. It was noted that this has continued focus with additional input from the newly seconded Assistant Directors of Patient Safety

- Slight decrease in the number of PALS contacts compared to the previous quarter, with continued performance of less than 5% conversion to formal complaints
- Friends and Family Test inpatient recommendation rates remain above target, with the vast majority of comments received being positive and focussed work taking place with the Emergency Department to improve their recommendation rates

Results of the 2020 inpatient survey report, which highlighted that the Trust's results overall showed an improvement in a number of key areas, including the information questions that were targeted following last year's survey. The Trust ranked 4th nationally when compared to other acute trusts on the question relating to overall quality of the care provided, with a score of 8.7/10.

An action plan has been developed to address areas where improvements are required, which is monitored by the Patient Experience Council.

Winter 2021 preparedness: nursing and midwifery safer staffing report confirmed that the Trust was compliant with the requirements of NHS England's assurance framework following completion of the self-assessment tool. The tool indicated that the Trust had processes in place to ensure it was prepared for the challenges anticipated in Winter 2021, with effective decision making and escalation processes to support safer nursing and midwifery staffing. The report outlined evidence of compliance and highlighted three areas that would further strengthen the position:

- Review quality impact assessments on an annual basis and when decisions are made to change estate or ward function or staff roles and base staffing levels
- Devise and implement a deployment checklist for staff who are moved on an ad hoc basis
- Include nurse handover as part of suite of audits in Tendable

The paper outlined how the Trust's risk management, Board Assurance Framework and escalation processes are effective in proving assurance the Trust is meeting the requirements.

Maternity staffing for safety report April 2021 to September 2021 highlighted the following key points:

- Staffing ratio in September was 1:30 which is below national recommendation of 1:28 midwifery staffing ratio, however rolling recruitment is in place
- Higher sickness levels during the reporting period were mitigated by offering extra shifts, bank hours, overtime and agency staff. Staff are redeployed across the service to ensure safe staffing, with overall co-ordination being undertaken by the bleep holder
- Issues are escalated in line with Cheshire and Merseyside's escalation process
- Full review and action plan to achieve continuity of carer requirement to be completed, which will support an increase in midwife led births
- 100% of women in labour had 1-1 midwifery care each month

The Committee noted the increase in red flags, recognising the impact of recent challenges and the number of closures due to the acuity of the women and staffing levels. The Committee noted the steps taken to ensure safety.

Committee members questioned if it would be possible to recruit additional midwives if the Birthrate Plus® report (due February 2022) identified the need to increase staffing levels. It was noted that there is rolling recruitment in place, with good uptake in the last two programmes, as well as the opportunity to look at skill mix and how to use maternity support workers to best effect.

Review of Q3 2020-21 incidents graded as death report reviewed incidents previously been reported to the Board as part of the monthly serious incident report. The report noted that eight had been reported externally and one resulted from a rare complication of a procedure that could not have been avoided. It was agreed that future reports to the Board would include the level of harm for further clarity.

Infection Control Report, Quarter 2 & 3 2021-22 noted:

- Increased levels of COVID in local community
- Slight increase in nosocomial infection rates 1st April to 31December 2021 at 9.7% compared to 8.6% in the same reporting period the previous year
- Lessons learned as a result of RCAs for bacteraemia cases, with action plans monitored within the Care Groups
- Work is underway to improve compliance with infection prevention level 2 training and to continue to ensure staff are focussed on all infection prevention measures
- Updated infection prevention board assurance framework has been completed and will be presented to the Board

Assurance Provided:

- Action plan in place following inpatient survey to improve patient experience
- Comprehensive process in place to review care of patients following incidents graded as death and the actions taken as a result
- Low levels of COVID nosocomial infections compared to Cheshire and Merseyside average and 99.8% compliance with MRSA screening
- Lower level of C difficile cases in quarter 3 (6) compared to quarter 1 (19) and quarter 2 (21) of which 3 have been successfully appealed
- Feedback about the effectiveness of the meeting from the observers indicated that appropriate time was given to discuss key issues, with report authors providing assurance where required

Decisions Taken:

No formal approvals were required.

Risks identified and action taken: The Committee requested the following actions be taken:

- Continued focus on reducing falls, noting the number of outstanding inquests relating to falls and risk of findings against the Trust. Work to be undertaken by the newly seconded Assistant Directors of Patient Safety, who are completing Advancing Quality Alliance (AQuA) training in relation to patient safety and falls
- Findings from updated falls audit to be presented to a future Quality Committee
- Further investigation to be completed on reasons for the decrease in the % of stroke patients who were thrombolysed within 1 hour
- Updated action plan to deliver continuity of care in maternity services to be presented to future Quality Committee
- Quarterly report to be provided detailing actions taken following incidents graded as death

Matters for escalation: Number of inquests relating to falls
Recommendation(s): That the Board note the report, the assurances provided and the actions being taken to address areas of concern.
Committee Chair: Rani Thind, Non-Executive Director
Date of Meeting: 18th January 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No:NHST(22)004

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 20th Jan 2022

Summary

Meeting attended by:

I Clayton – NED & Chair
P Growney – NED
A Sharples – Board Advisor
G Appleton – Board Advisor
N Khashu – Director of Finance & Information
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
R Pritchard Jones – Medical Director
A Bassi – Divisional Medical Director
J McCabe - Divisional Medical Director
A Matson – Assistant Director of Finance – Financial Management

Agenda Items

For Assurance

A) Integrated Performance Report

- Target 62 day performance was not achieved in November, at 82.9% against a target of 85.0%.
- Target 31 day performance was met in November, at 99.0% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in November, at 75.4% delivery against a target of 93.0%. The deterioration from the October performance of 88.9% is related to increased activity coupled with capacity challenges.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 55.3% in December and 57.2% year to date. All type mapped STHK Trust footprint performance was 77.3% in December and is 77.8% year to date. The Trust saw average daily attendances of 300, which is a decrease compared to November at 324. Total attendances for December 2021 were 9,305.
- The ambulance turnaround time target was not achieved in December, at 49 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- In December, overall sickness had increased to 8.5%, from 7.0% in November. Front line Nursing, Midwifery and HCA sickness was 11.3%, which is an increase of 1.5% since November.

B) Finance Report Month 9

- At Month 9, the Trust is reporting a year to date deficit of £4.1m and a 21/22 forecast deficit of £5.0m.
- The deficit relates to planned Elective Recovery Fund (ERF) income (£6m), the receipt of which will be dependent on overall C&M system performance. This income has therefore not been reflected in the year to date or forecast position as system performance is below threshold.

- This is partly offset by additional support from St Helens CCG of £1.25m.
- The 21/22 HCP CIP target of £10m has been met. We continue to work towards the internal Trust CIP target of £15m (3%).
- The Trust's full capital allocation is expected to be utilised by the end of the 21/22 financial year.
- At Month 9, the Trust has a cash balance of £67m and is achieving 97.6% Better Payment Practice Code (BPPC) performance against the 95% national target.
- The committee discussed the rationale for reporting a 21/22 forecast deficit, relating to ERF income dependant on system performance. Although it is possible further funding may be available from the system, without written assurances of additional funding flowing to the Trust it was agreed that it is appropriate to reflect this risk by reporting a £5.0m forecast deficit. This would would be worste case scenario with NK advising other options to bridge this deficit will be explored and the drive was to achieve break even.

C) CIP Programme Update (CIP)

- The committee received the report on the Trust's CIP programme.
- The committee was assured of progress and that the £10m required CIP will be met in 21/22 and recurrently.
- The Trust continues to work towards identifying schemes to meet the internal target of £15m, in order to give the best opportunity of meeting challenging 22/23 efficiency requirements.

D) Estates Return Information Collection (ERIC) 2020/21

- The committee noted the content of the report and thanked the contributors to this piece of work.
- The expected increase in energy costs was discussed by the committee. The Trust's energy contract includes fixed prices to 2023/24. However, it was noted that increasing energy costs may affect other service contracts. The committee was assured that this would be monitored and any pressures addressed or escalated as appropriate.

For Approval

N/A

For Information

E) 22/23 Financial Planning Update

- Operational planning guidance gives 10 key national priorities, including tackling elective backlogs, delivery of the COVID-19 vaccination programme and addressing pressures in urgent and emergency care
- Challenging operational targets, with highest risks around:
    - Delivery of 10% more elective activity than before the pandemic
    - Reduction of outpatient follow ups by 25% against 19/20 levels
    - Delivery of 20% more diagnostic activity than before the pandemic
- Key messages from draft financial planning guidance:
    - Systems required to breakeven
    - 'Convergence adjustment' for each system to replace FIT targets which were in place before the pandemic to bring Trusts with underlying deficits back to balance – C&M estimated 1.1% reduction
    - 2.8% national growth assumption

- 1.1% national efficiency assumption
- Reduction in Covid-19 funding

- Estimated CIP requirement 3-5%, including national efficiency assumption (1.1%), convergence adjustment (1.1%) and Covid-19 funding reduction (1-3%)
- Elective activity will be funded under Aligned Payment and Incentive (API) mechanism:
  - 75% of tariff paid for activity above plan
  - 50% of tariff deducted for activity below plan
- The committee discussed the high level of risk associated with the above requirements, including the challenging operational targets and expected CIP of up to 5%
- These risks and the need for funding allocations which are equitable across provider organisations will continue to be raised with the HCP during the 22/23 planning process

Risks noted/items to be raised at Board

- Risks associated with delivery of challenging 22/23 operational targets an significant CIP target.
- Reporting of a forecast £5m deficit until guaranteed assurances are received that funding will be available to cover this ERF shortfall or alternative resources are secured.

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: Ian Clayton, Non-Executive Director
Date of meeting: 20th January 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)005
Reporting from: Strategic People Committee
Date of Committee Meeting: 17th January 2022
Reporting to: Trust Board
Attendance: Lisa Knight, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Ian Clayton, Non-Executive Director Anne-Marie Stretch, Deputy CEO & Dir of HR Sue Redfern, Director of Nursing, Midwifery & Governance Rob Cooper, Director of Operations & Performance Nicola Bunce, Director of Corporate Services Claire Scrafton, Deputy Director of HR Gareth Lawrence, Deputy Director of Finance and Information **In Attendance:** Malise Szpakowska, Deputy Director of HR Jennie Dwerryhouse, Assistant Director of Employment Services
Matters Discussed: • As a result of COVID-19 escalation level 4 the agenda for the meeting had been streamlined • Governance - The changes to the membership agreed at the previous meeting were noted in the revised Terms of Reference • Committee noted that work was underway to review the Terms of Reference and work plan for the Workforce Council, which included increasing the frequency of meetings and these would be circulated to SPC members for comments and reported for formal ratification at the next SPC meeting • Workforce Strategy Pillar - Equality Diversity and Inclusion
Assurance Provided: • The SPC received a presentation that detailed information on the equality, diversity and inclusion challenges facing the organisation and the wider NHS. There was discussion on how this work could be taken forward to achieve maximum impact in the Trust. Assurance was provided that the Executive were sighted on the issues and progress was being made to address priority areas of concern as identified from recent staff surveys and WDES and WRES reports.
Decisions Taken: No formal decisions were taken by the SPC at this meeting
Risks identified and action taken: The committee identified the risk of not being able to invest sufficiently to impact on equality, diversity and inclusion

Matters for escalation: There were no matters to escalate from the committee.
Recommendation(s): The Trust Board note the report
Committee Chair: Lisa Knight, Non-Executive Director
Date of Meeting: 26th January 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)006

Title of paper: Corporate Risk Register Report

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

Summary:

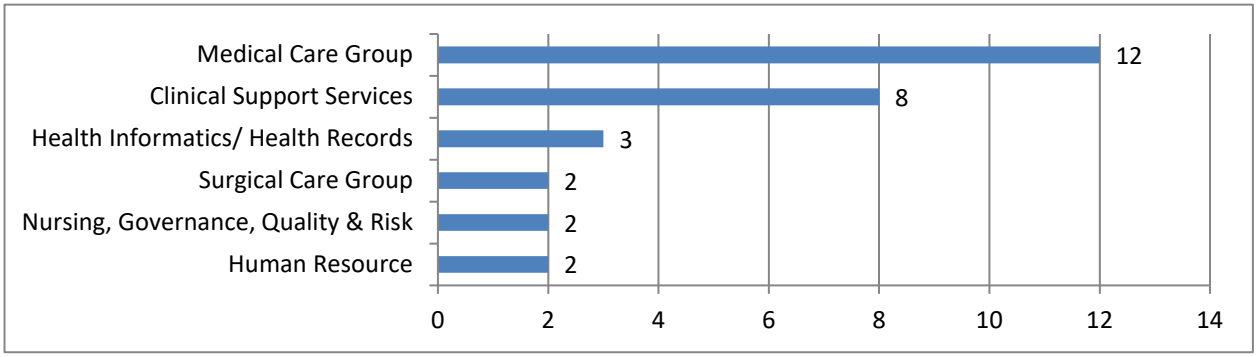
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

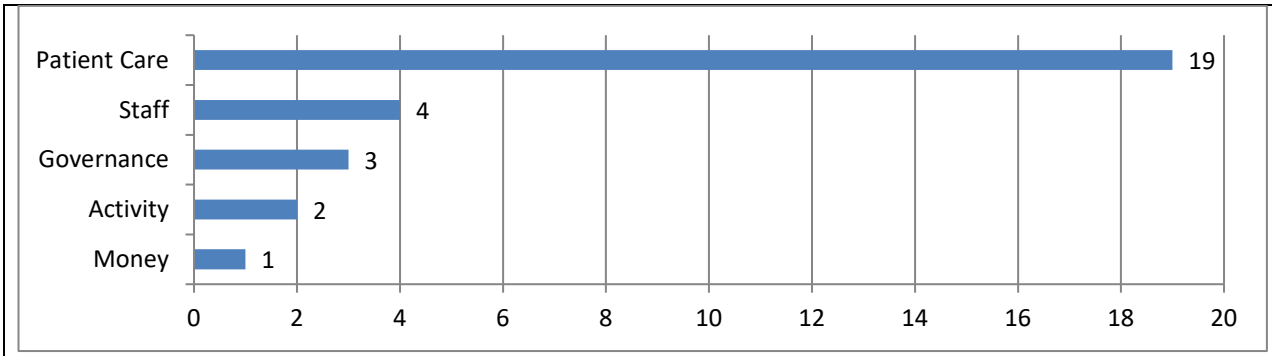
This report (appendix 1) is based on Datix information and covers the risks reported and reviewed during December 2021. The report shows;

- The total number of risks on the risk register was 772 compared to 736 in October
- 58.15% (442) of the Trusts reviewed risks are rated as moderate or high compared to 60% (435) in October.
- 29 high/extreme risks (appendix 2) were escalated to the CRR compared to 22 in October.

The spread of high/extreme risks across the organisation is;



The risk categories of the CRR risks are;



The report also includes comparisons of the Trust risk profile with the previous quarterly report (October 2021) and against the same period last year – January 2021 (Appendix 3).

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

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Risk Management Council, Trust Board, Commissioners and Regulators.

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 26th January 2022

Appendix 1

CORPORATE RISK REGISTER REPORT – DECEMBER 2021

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 04/01/2022	Previous Reporting Period 02/12/2021	Previous Reporting Period 01/11/2021
Number of new risks reported	17	33	16
Number of risks closed or removed	11	9	13
Number of increased risk scores	3	8	7
Number of decreased risk scores	9	14	12
Number of risks overdue for review	77	100	61
Total Number of Datix risks	**772***	**766**	**742**

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

The RMC periodically monitors how many risks have missed more than one planned review date and these are escalated to the Care Group Heads of Nursing and Quality.

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
35	**26**	**14**	**88**	**8**	**147**	**67**	**163**	**36**	**147**	**6**	**13**	**9**	**1**
75 = 9.87%			**243 = 31.97%**			**413 = 54.34%**				**29 = 3.82%**			

**Based on 760 scored and approved risks*

The risk profiles for each of the Trust Care Groups and for the collective Corporate Services are:

5.1 Surgical Care Group – 152 risks reported 20% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**5**	**1**	**14**	**3**	**35**	**20**	**33**	**10**	**27**	**0**	**1**	**1**	**0**
8 = 5.26%			**52 = 34.21%**			**90 = 59.21%**				**2 = 1.32%**			

5.2 Medical Care Group – 129 risks reported 16.97% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
21	**7**	**1**	**10**	**0**	**23**	**6**	**20**	**14**	**15**	**2**	**2**	**7**	**1**
29 = 22.48%			**33 = 25.58%**			**55 = 42.64%**				**12 = 9.30%**			

5.3 Clinical Support Care Group – 122 risks reported 16.05% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**3**	**0**	**13**	**0**	**25**	**12**	**27**	**4**	**25**	**3**	**4**	**1**	**0**
8 = 6.56%			**38 = 31.15%**			**68 = 55.74%**				**8 = 6.56%**			

5.4 Primary Care and Community Services Care Group – 40 risks reported 5.26% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**0**	**0**	**5**	**0**	**6**	**6**	**9**	**3**	**11**	**0**	**0**	**0**	**0**
0			**11 = 27.50%**			**29 = 72.50%**				**0**			

5.5 Corporate – 317 risks reported 41.71% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
7	**11**	**12**	**46**	**5**	**58**	**23**	**74**	**5**	**69**	**1**	**6**	**0**	**0**
30 = 9.46%			**109 = 34.38%**			**171 = 53.94%**				**7 = 2.21%**			

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

Department	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	3	17	19	4	**43**
Estates and Facilities Management	0	8	15	4	**27**
Nursing, Governance, Quality & Risk	2	16	9	3	**30**
Finance	0	9	12	6	**27**
Medicines Management	0	24	33	5	**62**
Human Resource	2	97	21	8	**128**
Total	**7**	**171**	**109**	**30**	**317**

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

Risks of 15 or above are escalated to the CRR (Appendix 2).

Appendix 2 - Summary of the Corporate Risk Register – January 2022

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	12/11/2021	4 x 2 = 8	Action plan in place	Strategic People Committee
2	Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 4 = 16	3 x 5 = 15	17/03/2020 Sue Redfern	14/12/2021	4 x 2 = 8	Action plan in place	Executive Committee
3	Money	1152	**If** there is an increase in bank and agency **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	12/11/2021	4 x 3 = 8	Action plan in place	Quality Committee
4	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	20/12/2021	4 x 3 = 12	Action plan in place	Executive Committee
5	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	16/12/2021	4 x 2 = 8	Action plan in place	Finance and Performance Committee
6	Staff	1944	**If** the Trust cannot recruit sufficient dermatology consultants to meet the increasing demand **then** the service may have to close to new referrals.	4 x 3 = 12	4 x 5 = 20	18/11/2021 Rowan Pritchard Jones	23/12/2021	4 x 2 = 8	Action plan in place	Executive Committee
7	Patient Care	2080	**If** patients have to be cared for in the ED corridor **then** there is an increased risk of patient harm.	5 x 4 = 20	5 x 4 = 20	03/11/2021 Rob Cooper	17/12/2021	5 x 2 = 10	Action plan in place	Quality Committee
8	Patient Care	2082	**If** there is no robust established daily process for review of all medical patients who remain in the ED/EAU due to the lack of an available bed on the ward **then** there is a risk to patient safety and experience	4 x 3 = 12	3 x 5 = 15	19/05/2021 Rob Cooper	21/12/2021	3 x 2 = 6	Action plan in place	Executive Committee
9	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	23/12/2021	2 x 2 = 4	Action plan in place	Executive Committee
10	Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 3 = 12	4 x 5 = 20	09/12/2021 Rob Cooper	23/12/2021	2 x 4 = 8	Action plan in place	Executive Committee
11	Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	5 x 5 = 25	30/03/2020 Rob Cooper	29/12/2021	3 x 2 = 6	Action plan in place	Strategic People Committee
12	Patient Care	2545	**If** the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, **then** there is a risk that compliance with this standard may not be maintained	4 x 4 = 16	4 x 4 = 16	21/07/2021 Sue Redfern	24/21/2021	4 x 2 = 8	Action plan not recorded in Datix	Quality Committee
13	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	23/09/2021	5 x 2 = 10	Action plan in place	Executive Committee
14	Patient Care	2932	**If** a patient's fluid balance is not recorded, **then** there is a risk that the patient could become dehydrated or fluid overloaded.	4 x 5 =20	4 x 5 = 20	30/09/2020 Rowan Pritchard	10/11/2021	4 x 2 = 8	Action plan in place	Quality Committee

						Jones				
15	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.	5 x 4 = 20	5 x 4 = 20	21/10/2020 Rob Cooper	14/12/2021	5 x1= 5	Action plan in place	Executive Committee
16	Patient Care	2964	**If** there are not sufficient dieticians to meet the increased incidence of gastro-intestinal cancers **then** this could impact on their treatment outcomes	3 x 5 = 15	3 x 5 = 15	13/10/2020 Sue Redfern	17/12/2021	3 x 1 = 3	Action plan in place	Executive Committee
17	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	03/09/2021	3 x 2 = 6	Action plan in place	Executive Committee
18	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	29/10/2020 Sue Redfern	09/11/2021	3 x 2 = 6	Action plan in place	Executive Committee
19	Patient Care	3046	**If** Cardio-Respiratory is unable to provide sufficient staff to cover ECG provision throughout the whole of the Trust **then** here is a risk that ECG's are not undertaken in a timely manner.	4 x 5 = 20	4 x 4 = 16	21/04/2021 Rowan Pritchard Jones	09/12/2021	4 x 2 = 8	Action plan in place	Executive Committee
20	Patient Care	3057	**If** the stroke service does not have 8 consultants in post **then** there is a risk to the level of service provision based on predicted activity	4 x 5 = 20	4 x 5 = 20	25/05/2021 Rob Cooper	09/11/2021	2 x 3 = 6	Action plan in place	Executive Committee
21	Patient Care	3060	**If** the Trust is unable to deliver its contribution to the COVID vaccine booster programme **then** the incidence of COVID infections and hospitalisations could increase	4 x 3 = 12	4 x 4 = 16	17/12/2021 Rob Cooper	17/12/2021	4 x 1 = 4	Action plan in place	Executive Committee
22	Patient Care	3161	**If** there are not sufficient staff to meet the demand for vaccination, **then** the Mass Vaccination site will not be able to deliver the planned activity	4 x 4 = 16	4 x 4 = 16	23/06/2021 Rob Cooper	17/12/2021	4 x 3 = 12	Action plan in place	Executive Committee
23	Patient Care	3166	**If** Bevan Court 2 is unable to provide appropriate Registered Nurse & HCA levels for patient care **then** there is a risk to patient safety, quality of care and experience	4 x 5 = 20	4 x 5 = 20	23/09/2021 Sue Redfern	23/12/2021	2 x 4 = 8	Action plan in place	Executive Committee
24	Staff	3178	**If** there are not sufficient staff in post **then** there is a risk to service delivery	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	07/12/2021	4 x 2 = 8	Action plan recorded	Executive Committee
25	Patient Care	3180	**If** the Trust cannot secure sufficient staff to undertake supplementary care for the patients who need it, **then** there is a risk to the quality and safety of care	4 X 5 = 20	4 x 4 = 16	21/07/2021 Sue Redfern	23/11/2021	4 x 2 = 8	Action plan in place	Strategic People Committee
26	Patient Care	3199	**If** medical patients are to 'forward wait' on a medical ward **then** there is a risk to patient safety, dignity and experience	4 x 4 = 16	4 x 4 = 16	02/11/2021 Sue Redfern	23/12/2021	4 x 2= 8	Action plan in place	Executive Committee
27	Activity	3238	**If** the STHK sonographer staffing cannot be increased to provide the service at Widnes HCRC **then** there is a risk that there will be delays in providing non-obstetric ultrasound.	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	15/12/2021	2 x 1 = 2	Action plan in place	Executive Committee
28	Governance	3298	**If** the Trust IT systems are infiltrated by Apache Log4j **then** data will be vulnerable and systems may have to be shut down	4 x 4 = 16	4 x 4 = 16	14/12/2021 Christine Walters	04/01/2022	3 x 3 = 9	Action plan in place	Executive Committee
29	Governance	3302	**If** the Trust subject access request process is not standardised **then** there is increased risk of ICO Infringement Orders.	4 x 4 = 16	4 x 4 = 16	15/12/2021 Christine Walters	20/12/2021	2 x 2 = 4	Action plan in place	Executive Committee

**blue text denotes new risks escalated or re-escalated to the CRR since the October Trust Board report.*

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

New Risk Category	Datix Ref	Risk
Patient Care	2708	**If** a large number of senior medical staff are adversely impacted by the NHS pension tax rules **then** the Trust could experience reduced senior clinical capacity
Patient Care	2671	**If** there is not robust Consultant cover on Ward 3C **then** there is a risk to patient safety, quality of care and experience
Patient Care	2848	**If** the trust does not have sufficient anaesthetic and obstetric on call cover, **then** there is a risk of delayed medical management if there should be simultaneous medical emergencies.

Appendix 3

Trust Risk Profile – October 2021

Comparison of the Trust risk profile in the last Board Report

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**25**	**14**	**81**	**8**	**139**	**64**	**169**	**35**	**145**	**8**	**7**	**7**	**0**
64 = 8.80%			**228 = 31.36%**			**413 = 56.81%**				**22 = 3.03%**			

Trust Risk Profile – January 2021

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

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

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22) 007
Title of paper: Review of the Board Assurance Framework (BAF) – January 2022
Purpose: For the Board to review and agree changes to the BAF
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in October 2021. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** None proposed
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE/I, CQC, Commissioners.
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 26th January 2022

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2021/22 Objectives and Long Term Strategic Aims

2021/22 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSE/I Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20		Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, claims, inquests and mortality reviews Development of the 2020 – 2023 Nursing Strategy – currently subject to consultation (Revised to March 2022) ~~Development of ward quality accreditation tool and real time quality dashboard (Perfect Ward) (Revised to November 2021)~~ Reduce hospital acquired AKI (March 2022) Winter Staffing Assurance Framework (January 2022)	Review of patient information to improve accessibility and understanding (March 2022) Delivery of never event improvement plans and human factors training (May 2022) Complete and provide assurance of compliance with all Ockenden actions – March 2022 Deteriorating patient improvement project (revised to March 2022) ~~Development of the 2020 patient survey action plans (January 2022)~~ Birth Rate Plus review of maternity staffing (March 2022)	5 x 1 = 5	R P-J/ SR

Risk 2 –Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports (Inc. GIRFT) • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSE/I monthly reporting • Contract Monitoring Board • NHSE/I Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board • COVID-19 exceptional expenditure financial governance process	4 x 4= 16	Continue collaboration across C&M to deliver transformational CIP contribution ~~Reporting of management plans to deliver GiRFT recommendations to the F&P Committee~~	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances	Seek all possible sources of capital funding including national bids to support capacity planning (Ongoing) ~~Conclude H2 income allocation – September 2021~~ ~~Submit H2 financial plans – November 2021~~ Deliver the financial and activity plan agreed with C&M ICS for the second 6 months of 2021/22 (April 2022) Develop financial plans for 2022/23 based on the NHS Operational Planning Guidance Assess impact of Omicron COVID-19 surge on ability to deliver H2 financial and activity plans (March 2022)	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool • COVID-19 EPRR operational command and control structure in place	4 x 5=20	Implementation of routine capacity and demand modelling	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow for winter 2021/22 and beyond COVID-19 and restoration escalation plans to release capacity and trigger mutual aid in place and operational.	Implement new contractual arrangements for Widnes UTC (Revised to August 2021) Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) Achievement of the elective activity recovery trajectories agreed with C&M ICS (March 2022) Implement the new emergency care and cancer national performance standards and incorporate into the new IPR (Revised to April 2022) Implement winter and patient flow improvement plans (February 2022) Major Incident Escalation and Business Continuity Plans in response to COVID 19 Omicron surge (On going)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Strategic Workforce Committee • Quality Committee • ~~Workforce Council~~ • Audit Committee • Charitable funds committee • IPR • Staff Survey • COVID pandemic reflections staff feedback • Complaints reports • Friends and Family Ratings • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSE/I Segmentation Rating	4 x 3 = 12	Regular media activity reports , including social media, to the Executive Committee	~~Establishment of a Strategic Workforce Committee of the Board (Revised to November 2021)~~	Implement the 2020 staff survey action plan (March 2022) Maintain COVID staff communications bulletin and pandemic staff engagement, support and recovery initiatives (On-going) Work in partnership with S&O to send provide consistent messaging and communications channels for staff and stakeholders about the ALTC (April 2023) Launch of the new Trust Intranet site for Staff (February 2022) Continue to work with local media to spread NHS public health and safety messages relating to the pandemic and vaccination programme (On going)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending StHK Board and Trust NED attending Governing Body • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care System governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSE/I Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care partnerships in these Boroughs • Annual staff engagement events programme • COVID -19 Command and Control structure and Hospital Cell • ED&I Delivery Group	4 x 3 = 12	Work with the local Boroughs to develop plans for Integrated Care Partnerships (ICPs) from April 2022 Effective working with the Shaping Care Together programme in Southport and Formby and West Lancashire	C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks Understanding of the performance monitoring systems that will be established under the new NHS Bill that comes into effect on 1st July ~~April~~ 2022	Continue participation with the Collaboration at scale board and work streams (Suspended due to COVID-19) Continued engagement with C&M ICS senior leadership as part of the system response to COVID-19 and restoration and recovery. Continue as a full partner of St Helens cares, contributing to the delivery of the improvement objectives Work with NHSE/I and other Providers to provide management support for S&O fragile services	4 x 2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career and leadership development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management Strategy	To Board; • Strategic Workforce Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES , WDES and Gender Pay Gap reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Group Other • Annual workforce plans • HR benchmarking • Nurse & Midwifery staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment	5 x 4 = 20	Equality Delivery System 2 – action plan	Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3 Capacity to deliver the recovery and restoration plans for activities suspended due to COVID-19 Attendance management COVID-19 recovery plan Establish collaborative staff bank for C&M ICS for other services e.g. Radiology, Endoscopy, vaccination programme	Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going) Delivery of the NHS People Plan local action plans for 2021/22 (March 2022) C&M Lead Provider role for the COVID vaccination programme – including planned winter booster programme for staff and the school aged Children's vaccination programme (On going) Restoration of appraisal and mandatory training compliance with the 85% target (March 2022) Refresh the ED&I Strategy and Action Plan (March 2022) Implementation of the new regulations for mandatory COVID vaccination of NHS staff (April 2022)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning and social distancing (COVID-19) • Compliance with NHS Estates HTMs	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Premises Assurance Model benchmarking • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Maintain 10 year strategic estates development plan to support the Trusts service development and integration strategies.	Implementation of new National Standards of Cleaning (May 2022) Implementation of the national Hospital Food Review recommendations and mandatory standards (once published) Test compliance against HTM/HBN guidance revised as a result of COVID learning. Compliance with the new Protect legislation for premises security – Consultation closed in July and draft legislation not yet published ~~Development of s strategy to achieve the NHS Net Zero targets (January 2022)~~	3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2023) Delivery of approved 2021/22 capital schemes Delivery of the Whiston Additional Theatres Scheme (2023)	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Careflow/DAP benefits realisation programme monitoring	4 x 4= 16	~~Annual Cyber Security Business Case approval~~ Annual Corporate Governance Structure review Technical Development	ISO27001 Service Improvement Plans IT Communications Strategy Digital Maturity Assessment	ISO27001 (revised to March 2022 due to COVID) Careflow/ DAP benefits realisation programme delivery (revised to September 2022) ~~Implementation of IPS Intrusion Prevention System) that detects cyber-attacks within the network. 50% complete (December 2021)~~ Migration from end-of-life operating systems – 85% complete. Extended support in place for the remaining 15%, which will be migrated (Revised to October 2022) Delivery of the Digital Aspirant Programme (2020 - 2023) Delivery of Community EPR (Revised to September 2022) Respond to cyber threat alerts and update systems as required (on going)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)008

Title of paper: Incidents, Complaints, Concerns & Claims – Quarter 3

Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 3 2021-22

Summary

Incidents

- Total incidents reported in Q3 = 4292 (1.47% increase on Q2 = 4230)
- Total patient incidents in Q3 = 3642 (2.91% increase on Q2 = 3539)
- Total patient incidents graded as moderate/severe/death in Q3 = 47 (23.7% increase on Q2 = 38)
- The highest number of incidents reported relate to:
    - Pressure ulcers = 783 (which include pressure ulcers acquired prior to admission to Trust services)
    - Patient slips, trips or falls = 652

Complaints

- 64 first stage complaints were received in Q3, 12.3% decrease from Q2
- Clinical treatment was the main reason for complaints, in line with previous quarters
- There was a continuing slight decrease in the number of open complaints
- There was a decrease in response time performance against the 6 month target, to 70.3%

PALS

- 1161 contacts were received in Q3, which is a 7.3% increase from Q3 2020-21 and 5.22% decrease from Q2 2021-22
- 95.85% of PALS enquiries were resolved in Q3 (4.15% conversation rate to complaints)

Top 5 themes remain consistent with previous quarters, with a decrease in PALS enquiries relating to communication in Q3

Claims

- There were 56 claims in Q3, 10 more than Q2
- Pre-action claims (requests for records from solicitors) account for 47 of these, with 9 NHS Resolution (NHSR) instructed claims in Q3, an increase of 3 compared to Q2
- 13 inquests were notified by the coroner in Q3 compared to 34 in Q2, with 18 inquests concluded in Q3

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 January 2022

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during Q1 and 2 2021-22, 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 4292 incidents reported, of which 84.86% (3642) were patient safety incidents. This represents an increase from Q2 2021-22 of 1.47% in all incidents and 2.91% increase in patient incidents.

	2021-22 Q3
Incidents affecting Patients	3642
Incidents affecting Staff	373
Incidents affecting the Trust or other organisation	225
Incidents affecting Visitors, Contractors or Members of the Public	52
Total	4292

Q3 had 18 incidents reported to StEIS, compared to 22 in Q2 2021-22. During Q3 there were 47 patient safety incidents categorised as moderate harm, severe harm or death whilst in Q2 there were 38 incidents reported. In comparison, there were 47 incidents categorised as moderate harm, severe harm or death in the same period last year (Q3 2020-21).

	20-21 Q1	20-21 Q2	20-21 Q3	20-21 Q4	21-22 Q1	21-22 Q2	21-22 Q3
Moderate	19	17	26	31	23	33	39
Severe	11	12	12	3	8	5	5
Death	4	1	9	3	2	0	3
Total	34	30	47	37	33	38	47

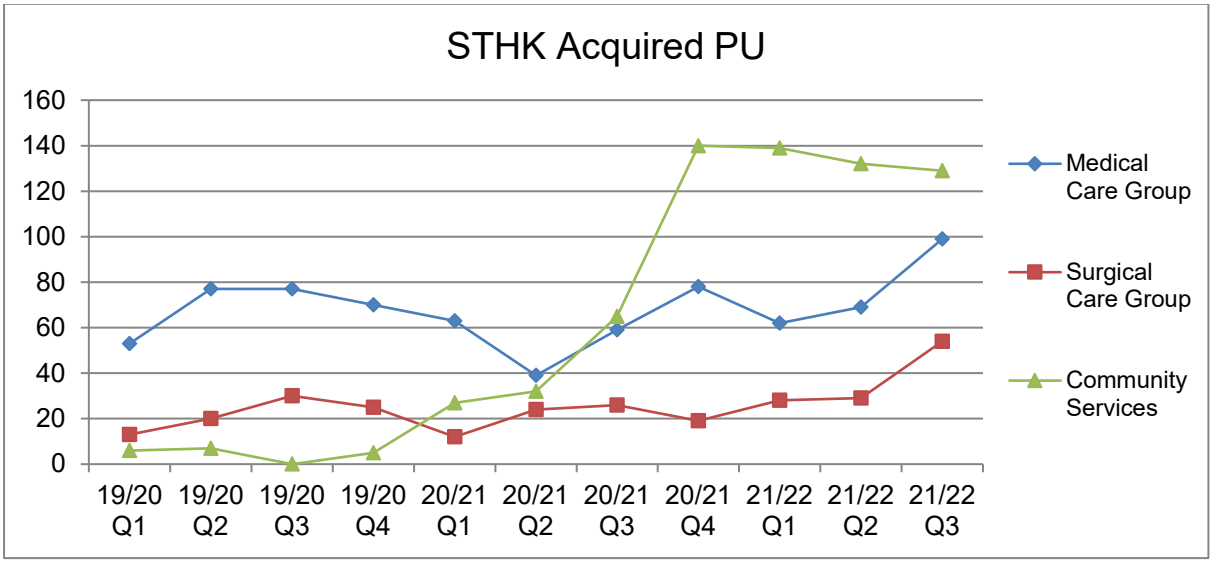
All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories during Q3 are pressure ulcers (783), which includes all patients who are admitted with pre-existing pressure ulcers, and slips, trips and falls (652). These are consistently the highest reported incidents as in Q2 there were 787 pressure sores reported and 607 falls.

Pressure ulcer figures include those acquired in the community and Trust acquired as detailed in the table below. Pressure ulcers saw a rise of 31.30% in 2020-21 where 2974 incidents were reported, compared with 2265 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 2019-20-2021-22

	2019-20				2020-21				2021-22		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Not STHK Acquired	455	447	519	461	557	610	628	595	579	557	501
STHK Acquired	72	104	107	100	102	95	150	237	229	230	282

STHK acquired pressure ulcers includes both acute services and Trust community care services. The increase in incidents from Q3 2020-21, is largely due to increase in community care group reporting, which has included new reporting criteria for community care, in line with Trust policy, to include moisture lesion and category 1 skin changes.

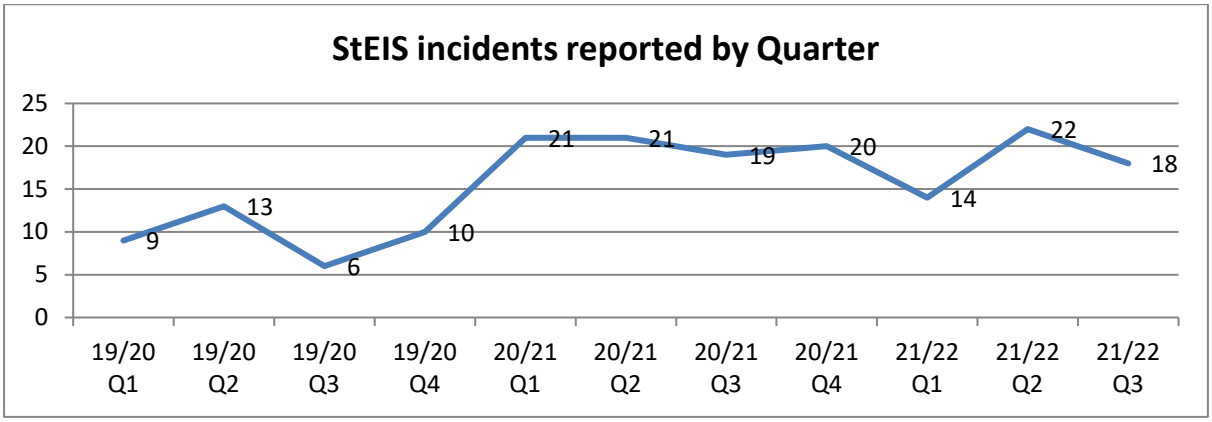


No severe harm Trust acquired pressure ulcers, with lapses in care were identified in Q3 2021-22.

STHK Acquired PU	2019/20				2020/21				2021/22		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
None	9	18	7	3	7	8	14	77	72	85	138
Low	56	79	94	95	87	87	130	154	155	131	99
Moderate	6	4	5	0	5	0	6	3	0	3	6
Severe	0	0	1	0	0	0	0	0	1	0	0
Ungraded to date	1	3	0	2	3	0	0	3	1	11	39
Total	72	104	107	100	102	95	150	237	229	230	282

2.1. Review of incidents reported to StEIS in Q3 2021-22

During Quarter 3 2021-22 the Trust had 18 incidents which were reported to StEIS. In comparison, the Trust reported 22 incidents during Q2 2021-22.



All 18 incidents reported to StEIS during Q3 are outlined in the table below.

Description	Total
Maternity divert on service	4
Baby cooling incident meeting Healthcare Safety Investigation Branch (HSIB) criteria	3
Inpatient fall suffering fractured neck of femur	2
Fall suffering subdural and subarachnoid haemorrhage	1
Fall suffering fractured trochanter right hip	1
Fall suffering intracranial bleed *	1
Court case - press interest	1
Failure to escalate to emergency laparotomy *	1
Maternal death*	1
Missed opportunities to identify differential diagnoses for deteriorating condition *	1
Failure to act on blood gases leading to the patient respiratory acidosis*	1
Wrong end small bowel exteriorisation	1

*Incident graded as death

During Q3 there were 19 StEIS reports submitted to the CCG, 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 during Q3. 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 Groups.

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 due to the relatively small numbers.

% of all reported incidents	April 19 to March 20		April 20 to March 21	
	Trust %	National %	Trust %	National %
No harm	83.6%	74.7%	82.4%	72.7%
Low	15.9%	23.2%	17.0%	24.6%
Moderate	0.5%	1.8%	0.4%	2.2%
Severe	0.1%	0.2%	0.1%	0.3%
Death	0.01%	0.1%	0.02%	0.2%

2.4. Dissemination of learning

A summary of actions taken from incidents is provided to the Quality Committee and the Trust Board. Incidents are standing agenda items on the Patient Safety Council, Care Group and ward governance meetings to ensure that lessons identified are disseminated and that actions are taken to improve the quality of patient care are embedded. Lessons learned are also shared at the weekly incident review meetings, monthly safety huddles, safety newsletters and forums including ward manager and matrons meetings.

3. Complaints

The table below shows the number of received and opened first stage complaints by quarter. If this year continues at the same rate there will be a 13.6% increase compared to 2020-21, but a 12.3% decrease compared to 2019-20, pre-pandemic levels. There have been 20 2nd stage complaints so far this year. If this continues then this will represent a similar position to the previous year. The main reasons that complainants lodge second stage complaints are because they want further information or do not agree with the findings.

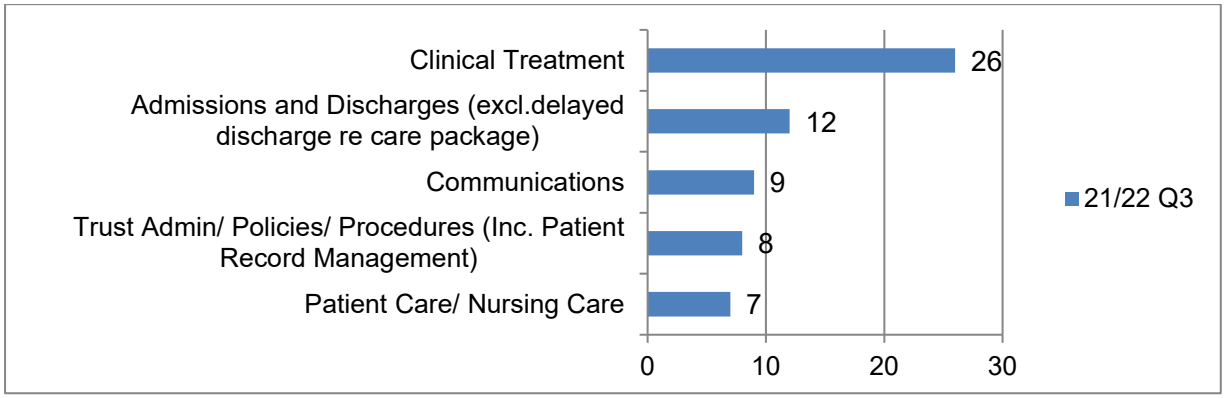
The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved in 2019-20 and 2020-21. The Trust's response time to first stage complaints decreased to 70.3% in Q3, due mainly to the impact of the pandemic and severe operational challenges; continued efforts are being made to improve the timeliness of responses. This includes the provision of additional temporary resources within the Complaints Team and additional hours for existing staff.

Indicator	2018-19	2019-20	2020-21	2021-22		
				Q1	Q2	Q3
Total number of new complaints including community services	273	325	251	77	73	64
Total number of new complaints received (excluding community services)	267	320	242	69	73	64
Acknowledged within 3 days – target 100%	99.3%	100%	100 %	100%	100%	100%

Response to first stage complaints within agreed timescale – target 90%	92.1%	93.4%	94%	81.1%	83.6%	70.3%
Number of overdue complaints	1	1	4	3	5	5
Second stage complaints	36	36	23	7	4	9

The above data was correct at the conclusion of the financial year to which it relates. There may be some subsequent changes if complaints are discontinued or reclassified.

3.1. Top five reasons for complaints Q3 2021-22

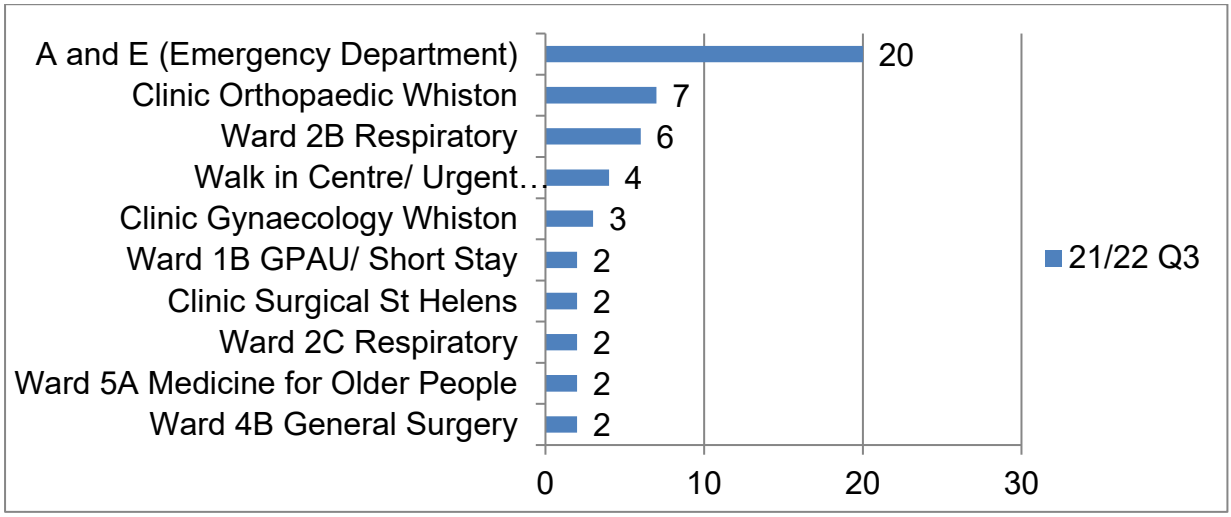


Clinical treatment remained the main reason for complaints; admissions and discharges, which was previously the 5th largest reason for complaints, was 2nd in Q3 (12). The rest of the top 5 reasons are consistent with the previous quarter.

3.2. Complaints by top location

The Emergency Department received the highest number of complaints in Q3 2021-22 with 20 (5 less than the previous quarter); this is consistent with previous quarters and can be attributed to the high levels of activity. There were 7 complaints related to the orthopaedic clinic in Whiston; this did not feature in the top 10 in the previous quarter. On review 5 of these have some element of dissatisfaction caused by the length of time they have had to wait for appointments/operations. There were 6 relating to Ward 2B, which also did not feature in the top 10 in the previous quarter. There is no clear pattern in the subject of these complaints.

There are a number of complaints around lost property, including where property documentation has not been completed correctly. A task and finish group has been established to look at further actions that can be taken to reduce this, including updating the policy and providing nursing staff with a flow chart to remind them of the correct procedure to follow.



3.3. Comparison of complaints received with neighbouring trusts

NHS Digital publishes data on written complaints for each of the NHS trusts in the country on a quarterly basis. The data has not been updated since the previous report to the Board and the latest data is due to be published mid-February and will be included in future reports.

3.4. Closed complaints

During Q3, 64 first stage complaints were closed. This was 3 less than were closed in Q2 2021-22, and 11 more than in the corresponding period in 2020-21. It should be noted that the majority of the complaints are not upheld. Additional information on complaints is contained in Appendix 1. The number of complaints closed within the timescales agreed with the complainant has decreased to 70.03% (from an average of 83% in Q3). In December the Trust signed off 28 1st stage responses, but only 17 of this were in date, which explains in part the drop off in overall performance.

3.5. 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 standing agenda items on the Care Group and ward governance meetings to ensure that lessons identified are disseminated and that actions taken to improve the quality of patient care are embedded.

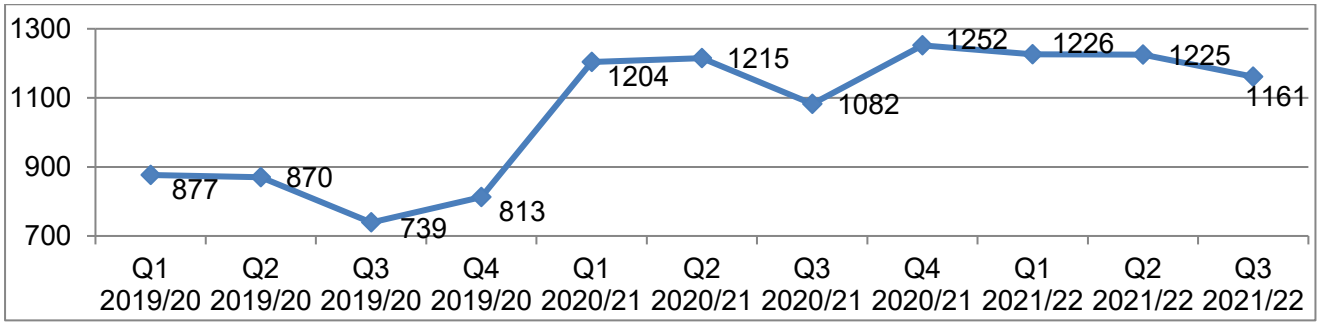
3.6. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

In Q3 the Trust has been provided with the provisional results of an investigation, which has concluded that there were some failings in the care provided. These are issues that the Trust had identified as part of its complaint response. Actions have been identified to improve the care provided following this case, including updating the end-of-life leaflet provided for patients and their carers.

4. PALS

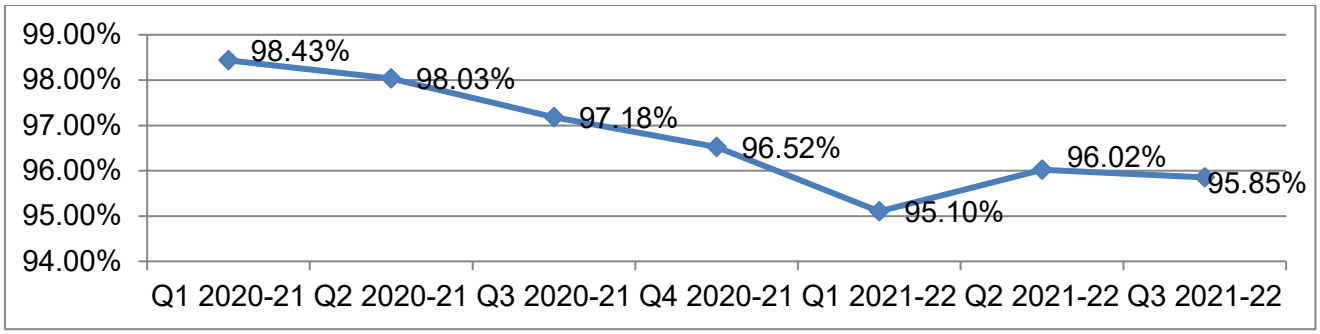
1161 contacts were received in Q3, which is a 7.30% increase from Q3 2020-21 and 5.22% decrease from Q2 2021-22.

4.1. Total contacts by quarter



4.2. Percentage of PALS contacts resolved by quarter

In Q3 2021-22, 95.85% of PALS enquiries were resolved, with 38 PALS enquiries being converted to formal complaints, a 4.15% conversion rate, which is a slight increase from 3.98% in Q2 2021-22.



4.3. PALS enquiries by subject

The top 5 themes remain consistent with previous reports. There has been a decrease in PALS enquiries relating to communication in Q2 (n275) and Q3 (260) compared to 335 received in Q1.

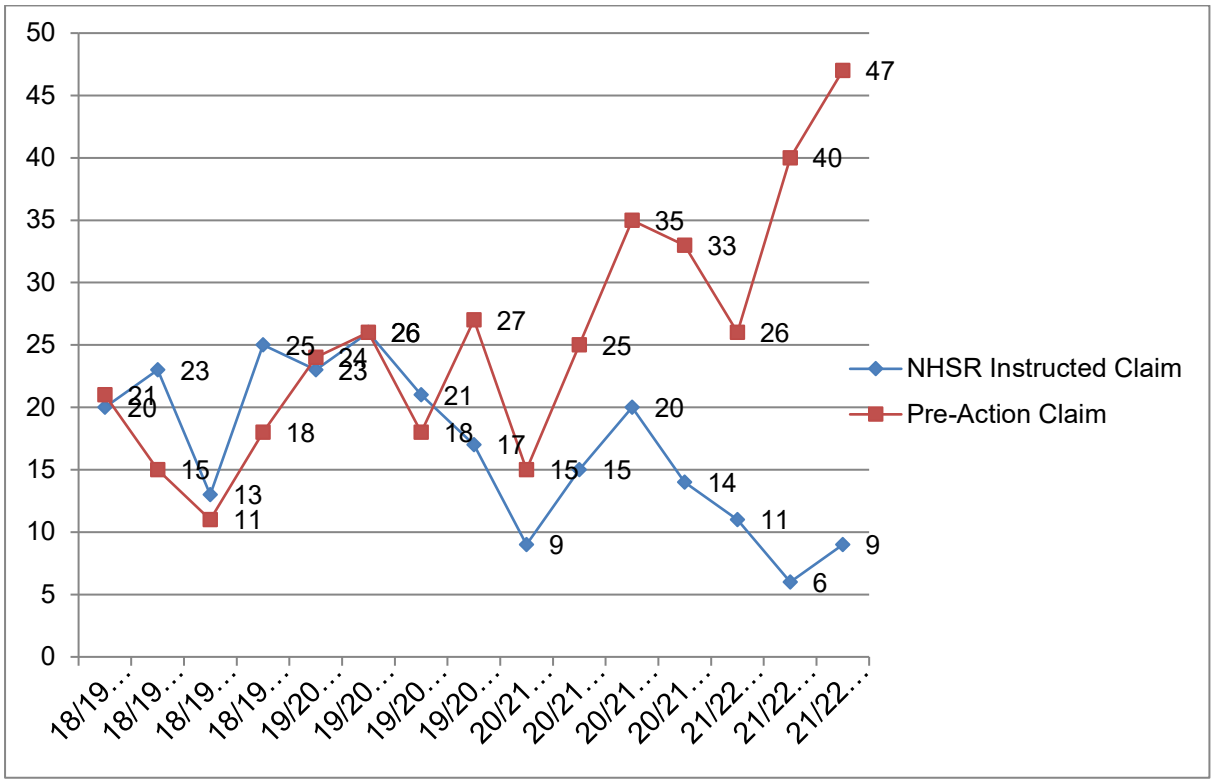
		Q3 top 5 themes (total concerns = 1161)		
No	Theme	Q1 Total	Q2 Total	Q3 Total
1	Communications	335	275	260
2	Signposting / Compliments	144	195	128
3	Appointments	138	149	256
4	Patient Care/ Nursing Care	125	128	90
5	Clinical Treatment	115	122	112

5. Clinical Negligence Claims

The graph below shows the total number of pre-action claims, for example, where the Trust has been asked for records and the total number where a letter of claim has been received or proceedings commenced (NHS Resolution (NHSR) instructed claim). There are some limited circumstances where NHSR are instructed before a

letter of claim, for example when there is clear evidence of breach of duty and causation.

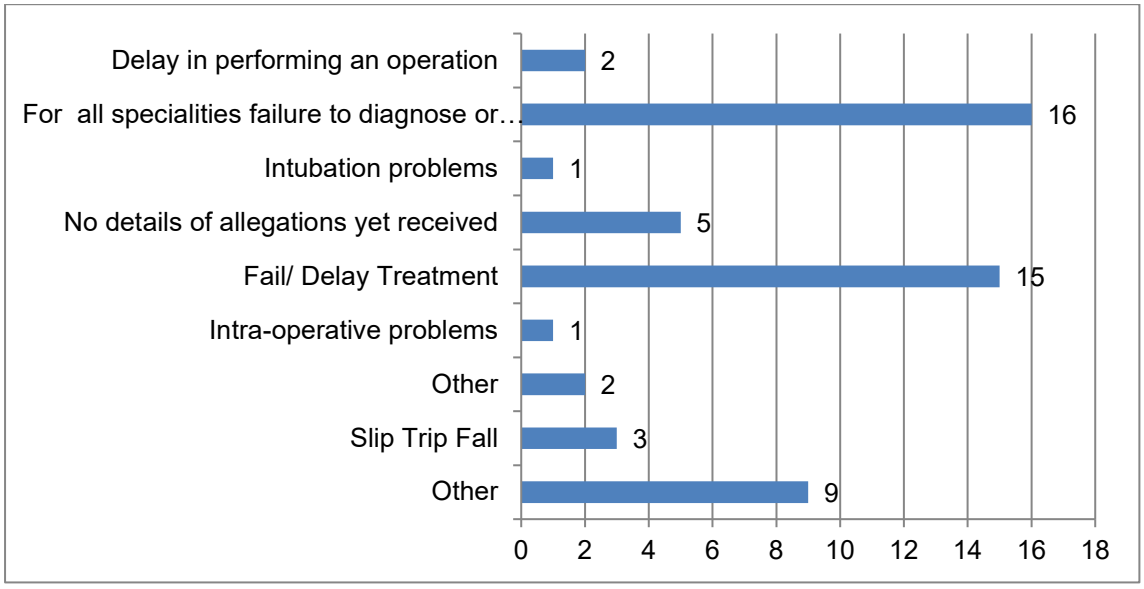
Pre-action and NHSR instructed claims



The total number of claims (pre-action and NHSR instructed) in Q3 was 56. This is 10 more than Q2, but only 1 more than Q3 in 2020-21 (55). There is no clear pattern in the overall number of claims received. Claimants are continuing to request extensions of limitation for potential claims (usually after they have requested records) since the start of the pandemic, which may result in more pre-action claims from Q1 2020-21 onwards being converted to NHSR instructed claims at a later date.

Failure/delay in diagnosis was the main reason for claims. This is consistent with previous quarters, other than Q2 2021-22 when failure/delay in treatment was the largest cause of claims.

Main reasons for new claim



The Quality Committee review the actions taken and lessons learned following claims presented in the quarterly report.

6. Inquests

13 inquest notifications were received in Q3, a significant decrease on 34 in Q2 and 24 in Q1. The Trust was an interested party in 8 and a 3rd party in 5.

18 inquests were closed in Q3, with no Prevention of Future Deaths Orders this quarter.

There continue to be a number of inquests involving patients who have experienced falls, which are being co-ordinated centrally by the Trust's appointed solicitors. The coroner has been made aware of the Trust-wide Prevention of Hospital Falls Strategic Action Plan 2021-2022.

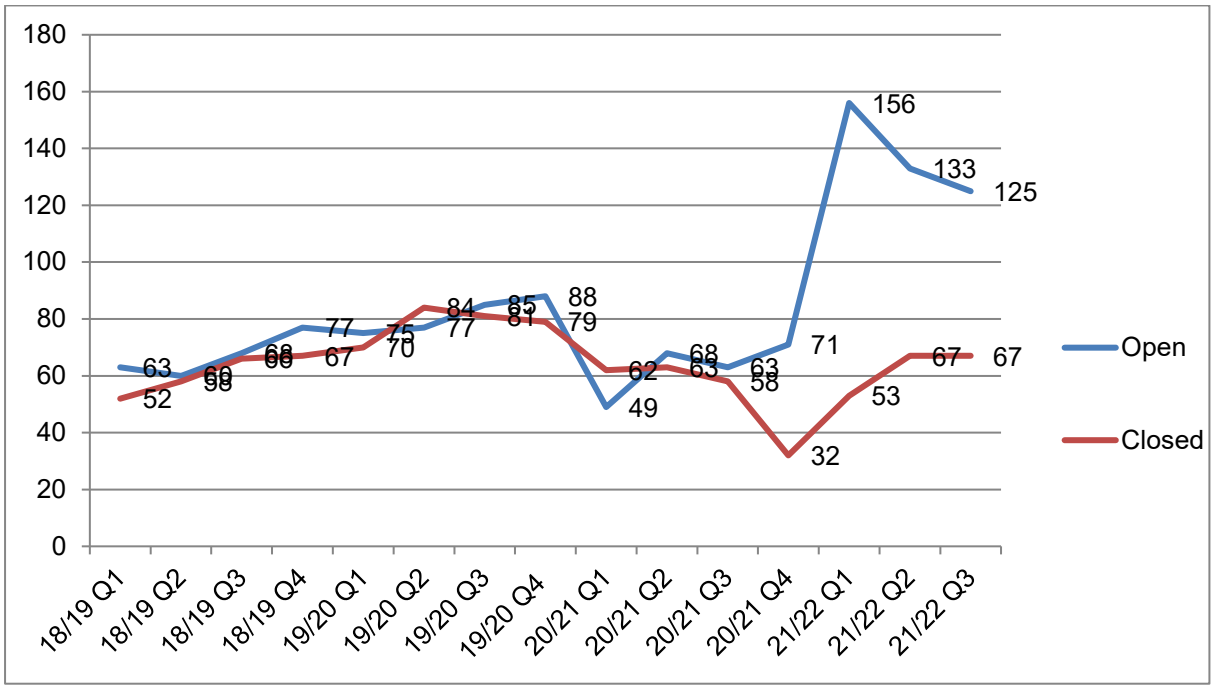
7. Recommendations

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

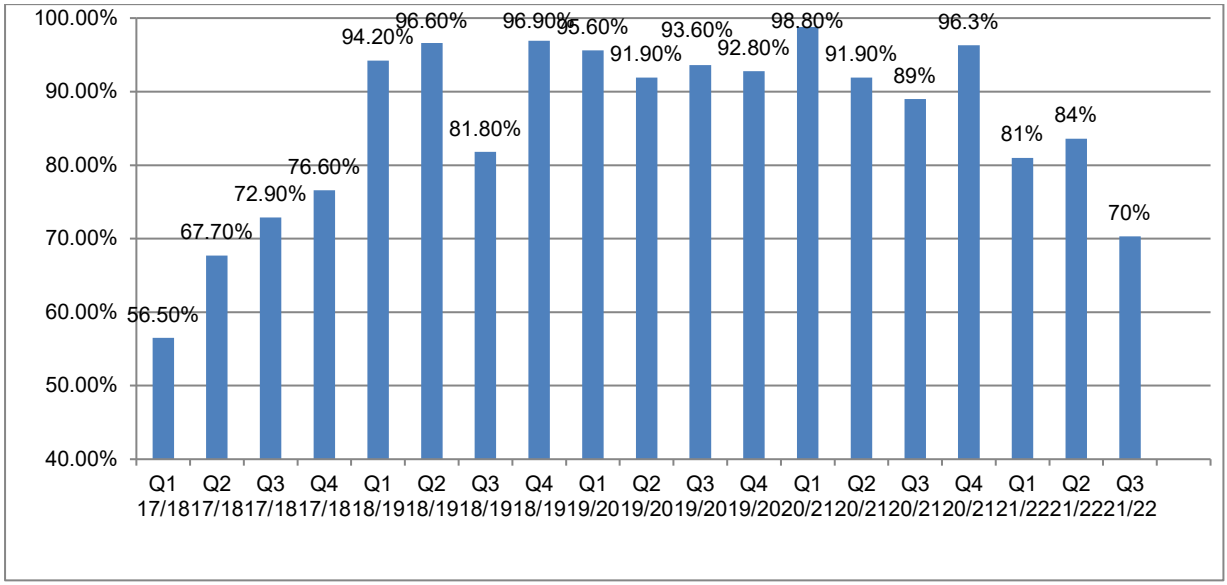
ENDS

Appendix 1 – summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in 2020-21 & 2021-22

	Q3	Q4	Q1	Q2	Q3
Not Upheld Locally	22	9	33	41	42
Partially Upheld Locally	28	12	11	25	31
Upheld Locally	8	11	9	6	8
Total	58	32	53	72	81

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)009

Title of paper: Winter 2021 preparedness: Nursing and midwifery safer staffing

Purpose: For the Trust board to receive and approve the Trusts winter assurance framework – nursing and midwifery staffing self-assessment, this has previously been discussed at both the Executive Committee and Quality Committee.

Summary

NHSE published the Winter 2021 preparedness: Nursing and midwifery safer staffing document on 12 November 2021.

The report highlighted that Trust board members are collectively responsible for workforce planning, practice, and safeguards. The aim was to focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approached. This was built on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

The 5 key areas of focus included:

- Planning
- Decision making and escalation
- Staff training and wellbeing
- Indemnity and regulation
- Governance and assurance

Appendix 5: Assurance framework – nursing and midwifery staffing self-assessment template has been completed to provide assurance to the Executive Committee and Trust board of the actions in place to address the staffing challenges faced and the potential impact this may have on patients.

The Trust can evidence compliance with all of the 29 indicators. There are 3 actions to be further implemented which are:

1. To review quality impact assessments on an annual basis and when decisions are made to change estate or ward function or staff roles (including base staffing levels)

2. A deployment checklist to be devised and implemented for staff who are moved on an adhoc basis

3. The Prefect ward app to include nurse handover question to audit data

Conclusion

The Trust has experienced significant pressures during the Covid-19 pandemic across all areas. This has become particularly acute during recent months as demand rises while inpatient capacity remains constrained. As expected, winter 2021/22 has seen an increase in these existing pressures related to COVID, flu, RSV and the increased attendances and acuity of patients which has further impact our bed base and staffing. This has at times resulted in wards working below their agreed staffing levels following a risk assessment of skill mix and patient acuity. The trust has utilised staffing solutions (bank, agency) and the nurse incentive scheme to support the staffing requirements

The Trust has robust processes in place to monitor, address and escalate nurse staffing challenges and gaps, this is coordinated through the twice daily staffing meeting supported by matrons, HRBP, staffing solutions to ensure safe staffing levels across the wards and ED.

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

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.

Recommendation(s):

The Trust Board approves the Trusts Winter Assurance Framework – nursing and midwifery staffing self-assessment

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

Date of meeting: 26 January 2022

NHS
St Helens and Knowsley Teaching Hospitals NHS Trust

Winter Preparedness Staffing Assurance Framework

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
1.	**Staffing Escalation / Surge and Super Surge Plans**						
1.1	Staffing Escalation plans have been defined to support surge and supersurge plans which includes triggersfor escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations wherestaffing levels are contrary to required ratios (i.e., Intensive care) oras per the NQB safe staffing guidance	• Detailed plans are in place as per NQB safe staffing guidance • Staffing standard Operating Procedures in place. • Staffing meetings take place twice a day - monitoring and escalation process. • Staffing is also discussed at 3 times per day bed meetings • Matron on Duty 7 days per week • Training for individuals being deployed to ITU including a buddy scheme and refresher training as required • Senior Nurse payment scheme for additional clinical shifts • Incentive scheme for staff and bank workers to pick up additional shifts • 12 monthly formal and 6 monthly internal Nursing establishment reviews. • Annual workforce safeguards report for nursing, Doctors and AHP	• Twice daily staffing meetings ensure that staffing is distributed across the wards to maintain patient safety. • Redeployment is discussed and agreed by Matrons prior to redeployment to identify individual's skill set and scope of practice. • Records of decision at staffing meetings are made on the matron staffing template. • Safe staffing levels including trends are reported monthly to executive committee, quality committee and Trust board. • Safer staffing including CHPPD are included in IPR • Gaps still exist within the staffing of the wards, but safety is maintained utilising skill mix and swapping staff. • Patient safety / harms / falls and staffing incidents are incorporated in staffing reports and steis report which are reported via QC to board • Deep dive thematic reviews have been conducted into falls and pressure ulcers • Staffing shortfall process reviewed and updated via Safe Staffing Steering Group and approved at Workforce Council • IPR includes mandatory training and sickness absence data	5 x 4 = 20 BAF Risk 1 BAF Risk 6 Corporate risk register includes safe staffing risk Risk 2996			Daily staffing meetings Weekly Gold Meetings Monthly safe staffing reporting

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
		• Opening additional bed capacity where able and judged safe to do so. • Staffing risks are included on the risk register by speciality and included in Corporate Risk register for all risks above 15 ,which are agreed by the lead Executive Director • Staffing escalation plans are in place for surge and super surge as per business continuity plans for ED, ICU ,NIV, maternity and inpatient wards					

1.2	Staffing escalation plans have been reviewed and refreshed with learningincorporated into revised version in preparation for winter.	• Safe Staffing SOP approved at Workforce Council implemented 2021
		• COVID debrief and lessons learned programme
		• Trust winter plan included requirements for additional workforce
		• The winter plan included:
		  • AMU Outreach
		  • ED Corridor Nurse
		  • ICU Senior Leadership
		  • Additional Pharmacy cover for Emergency and Acute Medicine to support Winter Patient Flows
		  • Operational Support Services
		  • Transfer Team
		  • ED Quality Lead
		  • Opening of Ward 1A
			• Staffing shortfall process reviewed and updated via Safe Staffing Steering Group and approved at Workforce Council
			• Feedback received from 40 departments following the first COVID surge.
			• Feedback used to make amendments to existing processes.
			• Further review required to gain additional feedback
							SOP review and update every 3 years unless changes required

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
1.3	Staffing escalation plans have been widely consulted and agreed with trust staff side committee	• Safe Staffing SOP approved at Workforce Council implemented 2021 • Staff side engagement at both JNCC and TJLNC • Involvement in working groups and decision making forums • Staffing and escalation plans are discussed monthly at Executive committee	• Staff Side Committee invited to Workforce Council – plans shared • Updates on workforce appear on both the JNCC and TJLNC agenda • Safe Staffing SOP approved at Workforce Council implemented 2021 • Staffing shortfall process reviewed and updated via Safe Staffing Steering Group and approved at Workforce Council				
1.4	Quality impact assessments are undertaken where there are changesin estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	• QIA are undertaken • Changes are reviewed and agreed / signed off at Gold Command • Staffing levels for new wards/ services are discussed at Executive Committee with sign off by DON, MD and COO • Checklist in place for opening of additional ward/ capacity	• Services undertake quality impact assessments and review/ update where changes are made. These are signed off by Director of Nursing and Medical Director. • Multi-disciplinary attendance at Gold to ensure that decisions have input from a range of teams. •		QIA are in place and under review		Plan for annual review of QIA Reports to safer staffing steering group

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	• Staffing standard Operating Procedures in place. • Daily staffing meetings take place twice a day - monitoring and escalation process. • Any concerns are immediately escalated to DDON/DON for review and actioning • In hours staffing issues are managed through the daily safer staffing meeting with a route of escalation through the Staffing Shortfall process if the situation deteriorates • Out of hours there is an on-call framework in place 24/7 to support with any staffing issues • Matron On Duty 7 days per week • Bed meetings take place 3 times per day and staffing is discussed as an agenda item at this meeting. • Procedures in place to step down other activity via Gold Command if staffing requires it.	• Twice daily staffing meetings ensure that staffing is distributed across the wards to maintain patient safety. • Records of decision at staffing meetings are made on the daily safer staffing template • All deployments followed up to record if actually took place and deployment data reported in monthly Safe Staffing report • Safer staffing levels are reported via the Trust governance process and any escalation immediately addressed to maintain patient safety • The trust target is to achieve more than 90% RN fill rate in all wards • Gaps may exist within the staffing of the wards, but safety is maintained utilising skill mix and swapping staff. • NSI's reviewed and reported in monthly Safe Staffing report and triangulated with staffing data • Gold Command meets 1 time per week but is able to be called as required for decision making.	5 x 4 = 20 BAF Risk 1 BAF Risk 6			Daily staffing meetings Weekly Gold Meetings Monthly safe staffing reporting

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in theincident logs and assurance is gained that this is successful and that safe care is sustained.	• Daily forecast position is risk assessed and mitigated where possible via Daily Staffing Meeting. 3 shifts in advance looked at weekend staffing reviewed at least 2 days in advance. • Weekly forecasts carried out at directorate level led by Heads of Nursing Weekly forecasts carried out at directorate level led by Heads of Nursing	• Forecasts shared at Silver / Gold discussions • Deployments recorded on Daily Safe Staffing Spreadsheet to evidence that safe care is maintained. • All deployments followed up to record if actually took place and deployment data reported in monthly Safe Staffing report • NSI's reviewed and reported in monthly Safe Staffing report and triangulated with staffing data		Deployment checklist to be devised and implemented for staff who are moved on an adhoc basis		Daily staffing meetings Weekly Gold Meetings Monthly safe staffing reporting Business continuity plans to ensure redeployment plans are included to support safe care delivery
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	• Nurse In Charge checklist used to review • Checklist in place for handover of care. • SBAR tool used • Guideline for Handover of Care in place	Staff are required to work within their scope of professional practice. Staff provide care in a variety of settings, shift patterns and clinical specialties and the complexity of the provision of care puts extra emphasis on the quality of information shared when one team or clinician hands over responsibility of care to the next. Minimal Registered Nurse to patient ratio is reviewed and escalated as required to support redeployment of suitably trained staff, • Nurse in charge provides in depth handover • Electronic handover for nursing has been implemented as part of care flow connect roll out.		Prefect ward app to include handover question to audit data		Ward audit of NIC
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skillsto adequately care for the patients being handed over.	• Checklist in place for handover of care. • SBAR tool used • Guideline for Handover of Care in place	• Trust wide safe staffing SOP clearly describes staff responsibilities for patient care handover and escalation process. • Staff have the required skills to meet patient needs. • Induction programmes in all areas are reviewed and enhanced		Deployment checklist to be devised and implemented for staff who are moved on an adhoc basis		Prefect ward daily checklist audit Monthly mandatory training compliance, clinical, managerial & safeguarding supervision monitored.

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
			• Registered Nurses report safe staffing incidents and escalate concerns to line manager/ manager on call (out of hours), where a lack of skills to care safely for a patient has been identified immediate review of staffing and patient needs/ acuity/ dependency levels. • Preceptorship programmes in place for newly qualified staff. • New staff are provided with an induction programme, and this includes undertaking mandatory core training and role essential training. Staff are supported/ supervised (where applicable) to ensure competencies are met. • Safe staffing models implemented across services. Evidence based Safer Staffing Establishment reviews are undertaken and identify gaps in staffing - propose safe staffing models and include training needs, Registered Nurse to patient ratio and continuous care delivery hours per patient per day. • Current staffing absences resulting from Covid -19 can result in staff being redeployed to areas of the Trust whether they haven't worked previously, and this requires individual assessment on arrival to an area by NIC. • Electronic handover for nursing will be implemented as part of care flow connect roll out				Review of safe staffing incidents undertaken by Matrons& Lead Nurses
2.5	There is a clear induction policy for agency staff.	• There is a clear induction policy and checklist in place	• Local inductions are provided to agency staff on arrival to the area of				Agency spot checks by

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	with facility to enable agency staff to access IT systems • Paperwork completed on wards for "new to area" agency workers	work to include a full handover at the beginning of the shift. Induction checklist is completed with individual agency staff members and an orientation to the ward environment is conducted by a substantive staff member. • Paperwork held on "new to area" checklists needs to be audited via dip sampling. • Over recruited into a permanent pool to provide permanent flexible staff				Framework Audit of agency induction checklist across inpatient areas
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	• Raising Concerns • Freedom to Speak Up (FTSU) • Datix • Board Rounds • Ward Buddies	• Formal routes are available for raising staffing concerns -line manager- through the Datix reporting system, Daily staffing meeting • Board level involvement in FTSU and Raising Concerns schemes • Datix risks and incidents reviewed at Care Group and Corporate Levels. • Safe Staffing SOP formally guides the staffing shortfall escalation tool				Exec / Board overview incidents/ staff concerns and measures in place to mitigate
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.	• Raising Concerns • Freedom to Speak Up (FTSU) • Datix • Board Rounds • Ward Buddies	• Board level involvement in FTSU and Raising Concerns schemes • Datix risks and incidents reviewed at Care Group and Corporate Levels. • Actions taken recorded in systems and reports. • Datix's reviewed at directorate level. Datix's reviewed and reported in monthly Safe Staffing report to identify if any harm caused and shared with executives				Exec / Board overview Q&R reviews via datix RMC re risks

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
2.8	The Trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	• Wellbeing Hub delivers sessions on: Drop-In Clinics Referral service for support Mindfulness Supporting Mental Health Suicide Awareness Menopause Bereavement • Employee Assistance Programme accessible 24/7 • Mental Health First Aiders • Wellbeing conversations built into appraisals • Staff engagement app – wellbeing hub section • Management Referrals to the HWWB team • Self-Referral to the HWWB team • Self-Isolation Hub to support staff with COVID testing and advice	• Comprehensive health and wellbeing offer is in place both at a Trust level and a system level through the mental health and wellbeing hub • Initiatives implemented at the start of C-19 to support staff wellbeing continue to be in place and staff encouraged to access. • Effectiveness of HWB is measured through the staff survey • Feedback on the Wellbeing Hub sessions states that there is an overall improvement in how individuals felt following attendance at a session. • Absence continues to be a concern as it is across the NHS and work is ongoing to reduce levels of sickness absence. • Workforce resource continues to be impacted by COVID self-isolation and the Trust continues to be proactive in managing cases and sourcing alternative staffing where possible.	5 x 4 = 20 BAF Risk 1 BAF Risk 6			Workforce Council Strategic People Committee Monthly review of staff absence and analysis of themes.
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.	• Electronic rostering implemented enabling oversight of staffing levels including gaps, sickness absence and location of redeployed staff • Staffing standard Operating Procedures in place. • Daily staffing meetings take place twice a day - monitoring and escalation process. • Electronic COVID risk assessment process in place to assess the need to redeploy staff. • MDTs undertaken to review	• Twice daily staffing meetings ensure that staffing is distributed across the wards to maintain patient safety. • Records of decision at staffing meetings are made on the matron staffing template. • Monthly holistic triangulated safer staffing review is reported to Trust Board. This includes staffing levels across all areas, sickness/ absence rates and bank and agency usage • Information is shared at local level, silver, and Directorate DMT. • Risk assessments and reporting are undertaken for all staff who test positive or have C-19 symptoms • Monthly workforce meeting provides a				Daily staffing meetings Weekly Gold Meetings Monthly safe staffing reporting Monthly IPR reporting

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
		high risk staff following COVID risk assessment or changes to health.	report of staff members who are self-isolating. • HR representatives attend Daily Staffing meeting to discuss Covid- 19 issues • Gaps may exist within the ward staffing; safety is maintained utilising skill mix and swapping staff. • Gold Command meets 1 time per week but is able to be called as required for decision making. • IPR includes Sickness absence data for the Trust including specifically reporting on the Nursing staff group Vaccination uptake data COVID operational updates				
2.10	Staff are encouraged to report incidents in line with the normal trustprocesses. Due to staffing pressures, the trust considers novel mechanisms outsideof incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g, use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.	• Raising Concerns • Freedom to Speak Up (FTSU) • Datix • Board Rounds • Ward Buddies • MET debriefs • ED investment, listening events • ED HOT and COLD debriefs • COVID Debrief across the Trust	• Datix supports reporting of all incidents, and the Trust policy guides all staff follow incident reporting process. • Review of data and themes from absence reporting and actions taken to support practitioners. • Team Huddles, forums for teams to feed into. • Board level involvement in FTSU and Raising Concerns schemes • Datix risks and incidents reviewed at Care Group and Corporate Levels. • Actions taken recorded in systems and reports. • Further COVID debrief required • The Trust HWWB have a process in place to support staff to feel confident in raising concerns about their mental health and impact of lived experience throughout the pandemic. • Listening events				Exec / Board overview FTSU report to board

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisorygroup that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	• Twice daily staffing meetings attended by Nursing, Operational and Workforce colleagues. • Gold – Multi-disciplinary	• Notes and log of actions taken and stored for all meetings • Actions followed up until completion and recorded appropriately	5 x 4 = 20 BAF Risk 1 BAF Risk 6			Daily staffing meetings Weekly Gold Meetings
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	• Staffing standard Operating Procedures in place. • Daily staffing meetings take place twice a day - monitoring and escalation process. • Matron On Duty 7 days per week • Bed meetings take place 3 times per day and staffing is discussed as an agenda item at this meeting. • Procedures in place to step down other activity via Gold Command if staffing requires it. • Gold command meetings	• Twice daily staffing meetings ensure that staffing is distributed across the wards to maintain patient safety. • Records of decision at staffing meetings are made on the matron staffing template. • Gaps still exist within the staffing of the wards but safety is maintained utilising skill mix and swapping staff. • Gold Command meets 1 time per week but is able to be called as required for decision making. • Business continuity plans are in place for all services and updated as change occurs.				Daily staffing meetings Weekly Gold Meetings Monthly safe staffing reporting

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	• Maternity mutual aid as required • Diversion policy and procedures in place • Mutual aid via Directors of Nursing • Business Continuity Plans • Gold Command	• SafeCare system provides live, accurate data on staffing levels and pressure areas • Daily staffing meeting provides accurate data on staffing levels and highlights pressure areas via rag rating system				Exec / Board overview
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	• Electronic rostering implemented enabling oversight of staffing levels including gaps, sickness absence and location of redeployed staff • Daily staffing meetings take place twice a day - monitoring and escalation process. • Monthly safe staffing report to Execs, Quality Committee and Board • Gold Command	• Twice daily staffing meetings ensure that staffing is distributed across the wards to maintain patient safety. • Records of decision at staffing meetings are made on the daily staffing template. • Safe staffing levels at the Trust have been reviewed establishment reviews using safe care Shelford and professional judgement models • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding • Gaps still exist within the staffing of the wards but safety is maintained utilising skill mix and swapping staff. • Gold Command meets 1 time per week but is able to be called as required for decision making. • IPR includes Sickness absence data for the Trust including specifically reporting on the Nursing staff group Vaccination uptake data • COVID operational updates	5 x 4 = 20 BAF Risk 1 BAF Risk 6			Daily staffing meetings Weekly Gold Meetings Monthly safe staffing reporting

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffingreport that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	• Monthly safe staffing report to Execs, Quality Committee and Board • STIES report to closed board monthly	• Safe staffing levels at the Trust are reported monthly and have continued throughout the Covid -19 pandemic • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding • STIES report to closed board on a monthly basis	5 x 4 = 20 BAF Risk 1 BAF Risk 6			Monthly safe staffing reporting to Exec Committee / Quality Committee with onward reporting to Board
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	• Monthly safe staffing report to Execs, Quality Committee and Board	• Safe staffing levels are reported to Trust board monthly • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding				Monthly safe staffing reporting to Exec Committee / Quality Committee with onward reporting to Board
4.3	The trusts Integrated Performance Dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.	• IPR includes a summary section which covers specific seasonal and pandemic related issues	• IPR reported to Board on a monthly basis • COVID/winter related staffing challenges are assessed are included in the safer staffing report regarding their impact on thequality of care alongside staff wellbeing and operational challenges				Monthly IPR reporting to Exec Committee and Board

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
4.4	The Board (via reports from the qualitycommittee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structuresand are assured that high quality care is at the centre of decision making.	• Monthly safe staffing report to Execs, Quality Committee and Board • STIES report to closed board monthly	• Safe staffing levels are reported monthly to Trust board • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding • STIES report to closed board on a monthly basis				Monthly safe staffing reporting to Exec Committee / Quality Committee with onward reporting to Board
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.	• Monthly safe staffing report to Execs, Quality Committee and Board • STIES report to closed board monthly	• Safe staffing levels are reported monthly to the Trust board • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding • STIES report to closed board on a monthly basis				Monthly safe staffing reporting to Exec Committee / Quality Committee with onward reporting to Board
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	• Monthly safe staffing report to Execs, Quality Committee and Board • STIES report to closed board monthly	• Safe staffing levels are reported monthly to the Trust board • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding • STIES report to closed board on a monthly basis				Monthly safe staffing reporting to Exec Committee / Quality Committee with onward reporting to Board Routine annual effectiveness review of all committees and the Trust Board

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	• Monthly safe staffing report to Execs, Quality Committee and Board • STIES report to closed board monthly • BAF details risks and actions • Risk Management Policy / Training / Datix System / routine reporting	• Safe staffing levels are reported to Trust board monthly • Monthly safe staffing report includes patient harms, falls, pressure ulcers and issues raised by staff regarding safeguarding • STIES report to closed board on a monthly basis				Monthly safe staffing reporting to Exec Committee / Quality Committee with onward reporting to Board
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and islived by local leaders and the Board (i.e. risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	• BAF details risks and actions • Gold Command for escalated issues / decisions • Risk register updated and regularly monitored	• Risks and actions outlined in the BAF	5 x 4 = 20 BAF Risk 1 BAF Risk 6			Board overview of BAF Gold Command
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	• BAF details risks and actions	• Staffing related risks are documented on the risk register, their impact is reviewed and discussed by committees. • Risks and actions outlined in the BAF				Board overview of BAF

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	• The risk register and regular staffing reports are received by the Trust Board at each meeting. Additional items are discussed at agenda planning meetings which include executive director level input and the Chair of the Trust to ensure that significant risks are adequately addressed on the Trust Board agenda. • BAF details risks and actions • Corporate risk register reported quarterly to Trust board	• The Trust Board is assured over the arrangements in place to determine the agenda, and receive assurance over the management of workforce risks on the risk register • Staffing related risks are documented on the risk register; their impact is reviewed and discussed by committees. • Risks and actions outlined in the BAF				Board overview of BAF
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	• CQC notifications reported through Exec • BAF details risks and actions	• There is a clear process for formal notification to quality concerns. • There are regular engagement meetings with the CQC, CEO and Director of Nursing AHP's and Quality where concerns can be raised. • The CQC are informed of any quality summits the Trust is undertaking. Furthermore, where concerns are raised by staff or patients directly to CQC or FTSU • Risks and actions outlined in the BAF				Board overview of BAF

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)010
Title of paper: Presentation outlining the key elements of the 2022/23 priorities and operational planning guidance.
Purpose: To inform and update the Board of the key elements and risks arising from the initial 2022/23 priorities and operational planning guidance.
Summary: The presentation updates the Trust board to the 10 key priorities noted in the 2022/23 guidance. It identifies the core KPIs expected to be delivered operationally and provides an indicative risk rating to those KPIs being achieve. Finally, it outlines the potential financial implications of the guidance for StHK with areas of consideration from the centre on what providers could consider in achieving financial targets. Further guidance is due out and any significant changes and updates will be presented to the Board between now and March 2022.
Corporate objectives met or risks addressed: Financial performance, efficiency and productivity
Financial implications: None from this paper
Stakeholders: Trust Board
Recommendation(s): To note the briefing paper/presentation.
Presenting officer: Nikhil Khashu
Date of meeting: 26th January 2022

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Financial Planning 2022/23 Update

Trust Board

26th January 2022

Operational Planning - Priorities

St Helens and Knowsley Teaching Hospitals NHS Trust

Ten system priorities:

- Investing in the workforce and strengthening a compassionate and inclusive culture
- Delivering the NHS COVID-19 vaccination programme
- Tackling the elective backlog
- Improving the responsiveness of urgent and emergency care and community care
- Improving timely access to primary care
- Improving mental health services and services for people with a learning disability and/or autistic people
- Developing approach to population health management, prevent ill-health, and address health inequalities
- Exploiting the potential of digital technologies
- Moving back to and beyond pre-pandemic levels of productivity
- Establishing ICBs and enabling collaborative system working

Operational Planning - Metrics

St Helens and Knowsley Teaching Hospitals NHS Trust

System requirement	STHK current performance	Risk
Deliver over 10% more elective activity than before the pandemic*	21/22 YTD 10% lower than 19/20 activity	High
Reduce long waits	Currently 1388 52+ week waits	Medium
Reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels	21/22 YTD 8% higher than 19/20 activity	High
Fully operational patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by early 2022/23	Fully implemented PSFU pathways for breast, prostate, colorectal & skin	Low
Increase diagnostic activity to a minimum of 120% of pre-pandemic levels	21/22 YTD 12% lower than 19/20 activity (M8 7% above 19/20 demonstrating improvement)	High
Reduce 12-hour waits in EDs towards zero and no more than 2%**		
Rollout virtual wards, aiming for 40-50 virtual wards per 100,000 population	Currently three virtual wards (Covid, frailty & COPD)	Low

*Assumes all elective activity included

**Definition of metric TBC - out for consultation

Draft Financial Planning Guidance

St Helens and Knowsley Teaching Hospitals NHS Trust

- Each system required to breakeven, with system funding adjusted towards 'fair share' funding allocation based on population
  - Fair share allocation calculated based on population size, unmet need/health inequalities, PFI financing costs etc. - replaces Financial Improvement Trajectories that were in place to bring trusts with underlying deficits back in line pre-pandemic
  - Convergence adjustment for C&M system 1.1%
  - Impact to STHK not yet known as dependent on method of allocating across C&M

- Elective activity funded under aligned payment and incentive (API) rules:
  - 75% of tariff paid for activity above plan
  - 50% of tariff deducted for underperformance against plan
  - Applies to all elective/day case/outpatient procedures/outpatient first attendances
  - Replaces the Elective Recovery Fund, Elective Restoration and Targeted Investment Fund income received non-recurrently in 21/22

- Inflation 2.8% and efficiency requirement 1.1%

- Reduction in Covid-19 funding. Additional funding available for Community Diagnostic Centres and virtual wards.

Total Savings Required

St Helens and Knowsley Teaching Hospitals NHS Trust

Three elements of CIP:

- 1.1% national efficiency assumption
- 1.1% C&M convergence adjustment
- 1-3% Covid top up reduction

Estimated total CIP of 3-5%

National CIP focus	STHK Opportunities
Theatres productivity to address elective backlogs	STHK cases per list currently 2.4 compared to 2.7 pre-pandemic – ability to improve beyond 2.7 dependant on case mix/IPC
Outpatient transformation through advice and guidance/patient-initiated follow up (PIFU)	Follow ups to be initally replaced with first attendances to recover waiting times, then focus on CIP through released follow up capacity
Reduction in agency expenditure	STHK YTD agency spend 3% of total pay costs – limited opportunity for reduction due to current staffing pressures
Medicines optimisation	Opportunities include ophthalmology (AMD) drugs, Botox vial share
Corporate services	STHK Corporate Benchmarking exercise highlighted opportunities across Corporate functions to be explored further

Risks

St Helens and Knowsley Teaching Hospitals NHS Trust

Risk	Description	Mitigation
Funding allocation not yet received from HCP/ICS	Removal of top ups and other non-recurrent funding. Income allocations and impact on CIP to be reflected in plan once funding allocations issued.	Activity planning and expenditure budget setting in progress. Ongoing engagement with HCP/ICS.
Final financial planning guidance not yet received	Potential impact may change if any further changes to guidance	Planning in progress and will be updated as further guidance is made available
Potential cost pressures due to Covid-19	Ongoing impact uncertain - reduced Covid-19 funding allocation may be insufficient. E.g. activity impact, redeployment of unvaccinated staff, car parking income	Review of expected 22/23 Covid-19 costs as part of budget setting process. Continue to engage with HCP/ICS for appropriate funding allocation based on costs
Other pressures - e.g. PFI contract inflation, Ward 1A	Risk to 22/23 plan if cost pressures not funded in system allocation	Ongoing engagement with HCP/ICS on system allocations
Agreement of contracts with commissioners	Impact of transition from CCGs to ICSs in July 2022	Engagement with commissioning as soon as possible and throughout transition
Implementation of IFRS 16 Leases standard	Movement from revenue to capital costs	Assessment of full impact underway for 22/23 planning

Timetable

St Helens and Knowsley Teaching Hospitals NHS Trust

Milestone	Date Due
Final 2022/23 financial planning guidance released	Jan-22
Draft 2022/23 plan (including activity plans, details of pressures and 21/22 to 22/23 bridge) to Finance & Performance Committee	Feb-22
Board approval of draft 2022/23 financial plan	Feb-22
Submission of draft 2022/23 financial plan to C&M HCP/NHSEI	Mar-22
Final 2022/23 plan to Finance & Performance Committee	Mar-22
Board approval of final 2022/23 financial plan	Mar-22
Submission of final 2022/23 financial plan to C&M HCP/NHSEI	Apr-22