St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 30TH MARCH 2022
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
10.00	1.	Employee of the Month Film - March 2022		Verbal	Assurance	Chair
10.10	2.	Patient Story		Verbal	Assurance	Sue Redfern
10.25	3.	Apologies for Absence		Verbal	Assurance	Chair
10.30	4.	Declaration of Interests		Verbal		
10.35	5.	Minutes of the Board Meeting held on 23rd February 2022		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.40	6.	Integrated Performance Report		NHST(22) 015	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						
11.00	7.	Committee Report – Executive		NHST(22) 016	Assurance	Ann Marr
11.10	8.	Committee Report – Quality		NHST(22) 017	Assurance	Rani Thind
11.20	9.	Committee Report – Finance & Performance		NHST(22) 018	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.30	10.	Approval of 2022/23 Budget	NHST(22) 019	Approval	Nik Khashu
11.40	11.	Trust Objectives 2022/23 Approval	NHST(22) 020	Approval	Ann Marr
11.50	12.	CQC Registration Annual Declaration	NHST(22) 021	Assurance	Sue Redfern
11.55	13.	Mixed Sex Accommodation Annual Declaration	NHST(22) 022	Assurance	Sue Redfern
12.00	14.	Gender Pay Gap 2021/22 Annual Declaration	NHST(22) 023	Assurance	Anne-Marie Stretch
12.15	15.	Workforce Indicators Report (July 21 – February 2022)	NHST(22) 024	Assurance	Anne-Marie Stretch
12.25	16.	Workforce Safeguards – Nursing Establishment Review	NHST(22) 025	Approval	Sue Redfern
12.35	17.	Ockenden – One Year On Review of Immediate and Essential Actions	NHST(22) 026	Assurance	Sue Redfern
Closing Business					
12.45	18.	Effectiveness of Meeting	Verbal	Assurance	Chair
	19.	Any Other Business		Information	
	20.	Date of Next Meeting – Wednesday 27th April 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

Title of paper: – Supporting a patient through sudden grief and bereavement.

Date of meeting: 30/03/2022

Background

The wife of the patient was admitted to hospital. Whilst an in-patient she deteriorated and died. The traumatic experience caused the patient to become extremely confused, The sudden and unexpected death precipitated an acute decline in the patient's own physical health and it was necessary for him to be admitted. Due to the patient's lack of capacity, the patient had a Deprivation of Liberty Safeguard put in place.

This story focusses on the partnerships between family/ ward team/ the trust Mental Capacity Specialist Practitioner and communication with Local Authority to ensure that the safeguards that are in place are least restrictive to enable the patient to attend his wife's funeral whilst remaining an in-patient.

Lessons learned.

The six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability were clearly evidenced within this experience. Safeguarding was person centred and outcome focussed and was in the patients best interest .There was clear appreciation of both short term and longer term impact on the patient as part of bereavement care.

Reflecting on what could be done differently/replicated in the future, the ward manager would /advise others in similar situations to

- Earlier involvement of Dementia & Delirium Nurse Specialist.
- True group discussion rather than liaison with specialties involved in silo.
- Peer involvement (matrons and ward managers) - has anyone had a similar experience?
- Instigate the Carer passport at the first opportunity.

The medical & nursing teams are in no doubt that they would do this again and both spoke of the positive impact on both patient and family. The FY1 Dr regards this experience as her proudest moment of her career to date. As part of the emergency team that responded to his wife's clinical condition, to then play a part in facilitating his attendance at her funeral was a significant event and something she will never forget. The ward team spoke of the immense gratification they received from their efforts and having confidence in the future to do the right thing in complex/difficult situations.

- The experience has helped to consolidate safeguarding training.
- The junior Dr on the ward had treated the patients wife before she died, she describes then being able to assist her husband to attend her funeral was one of the proudest achievements of her career to date.
- Closer links forged with the Trust mental capacity specialist practitioner.
- Having gone through this process, the ward manager would be able to assist managers in similar positions.
- Increased confidence of ward team members involved with DoLS and sharing the process in the ward meeting.

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens & Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 23rd February 2022 via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chair
Members:	Ms A Marr	(AM)	Chief Executive
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs L Knight	(LK)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters	(CW)	Director of Informatics
	Dr R Thind	(RT)	Associate Non-Executive Director
	Mr G Appleton	(GA)	Board Adviser
	Mr A Sharples	(AS)	Board Adviser
	Ms N Bunce	(NB)	Director of Corporate Services
In Attendance:	Mr G Lawrence	(GL)	Designate Director of Finance *(obo NK)*
	Dr J Bussin	(JBu)	Responsible Officer & Consultant in Medicine for Older People *(Observer)*
	Mr J Howard	(JH)	Business Development Manager, Acacium Group *(Observer)*
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
Apologies:	Mrs V Davies	(VD)	Non-Executive Director
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Prof R Pritchard-Jones	(RPJ)	Medical Director
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mr N Khashu	(NK)	Director of Finance

1 Employee of the Month Awards

1.1 Awards were presented to:

1.1.1 December 2021: Laura Bannister, Staff Nurse, Self-Isolation Team; and
1.1.2 February 2022: Amanda Hay, Staff Nurse, Ward 5D Stroke Rehabilitation.

1.2 Following some technical difficulties in the meeting, NB confirmed the videos would be uploaded to the Trust intranet, should members wish to view them again in full.

1.3 RF commented on how humbling the citations were showcasing the dedication and bravery of so many teams during the pandemic.

2 Apologies for Absence / Welcome and Introductions

2.1 Apologies for absence were received as noted above. RF noted that VD was supporting young entrepreneurs at a local event.

2.2 RF welcomed GL to the meeting and congratulated him on being appointed as the Director of Finance with effect from 1st April 2022.

2.3 RF welcomed back JBy as minute taker for the meeting.

3 Declarations of Interest

3.1 None, other than those already recorded.

4 Minutes of the Board Meeting held on 26th January 2022

The minutes were approved.

4.1 There were no matters arising.

4.2 Action Log - RF confirmed both actions 30 and 36 were still **DEFERRED** due to COVID-19.

4.3 GB identified several actions from the minutes that had not been recorded on the action log. NB took an action to update the action log ahead of the next Board meeting. **ACTION: NB**

5 Integrated Performance Report - NHST(22)006

5.1 **Quality Indicators**

AMS presented the latest update on behalf of SR

There had been 4 CDiff cases in January (3 hospital onset and 1 community onset). Year-to-date, there had been a total of 47 cases, 26 hospital onset and 21 community onset against the Trust tolerance level for 2022/23 of 54. It was noted that 21 RCAs were currently in progress and there were 9 appeals outstanding, and if no lapses in care were found the numbers could reduce.

There had been no never events reported in January

Safer Staffing fill rate (combined day and night) for December 2021 was 93.0%, year to date 92.3%. AMS commented that staffing in January had been extremely challenging as a result of the Omicron surge of COVID and commended the senior nursing team for their constant efforts to fill rotas and make staffing as safe as possible across all the wards and departments

There had been one validated grade 3 hospital acquired pressure ulcer, with a lapse in care recorded in November 2021 (the latest month reported). Year to date there had been 2 grade 3 pressure ulcers.

In December there had been no falls resulting in severe harm or death and year to date 15 had been reported.

Performance for VTE assessment remained suspended nationally.

Year to date HMSR (April to September) for 2021/22 was 97.7.

5.2 **Operational Indicators**
GL presented the update on behalf of RC.

Performance against the 62-day cancer standard was 85.02% in December against the target of 85%, Year to date performance was 85.2%.

The 31-day target was achieved with 98.2% performance in month, against a target of 96%, the year to date performance was 98.2%

The 2-week rule target was not achieved in December 2021 at 78.5% against the target of 93%. Year to date performance was 86.3%. This was a slight improvement on November 2021 but the Trust was still receiving a large increase in two week wait referrals, compared to the 2019/20 baseline, which was resulting in capacity challenges.

Accident and Emergency Type 1 performance for January was 55.7% (year to date 57.1%) and the all-types mapped Trust footprint performance was 78.1% (Year to date 77.9%).

The ambulance 30 minute turnaround time was not achieved in January 2022 with the average being 53 minutes. There had been 2,159 ambulance conveyances in the month and the average daily attendance had been 298, which was a slight reduction compared to December.

St Helens UTC had 4,869 attendances in December and 98% of patients were seen and treated within 4 hours.

The average number of super stranded patients in January 2022 was 132 compared with 109 in December 2021, excluding the intermediate care bed base (Newton and Duffy wards). Work continued internally and with system partners to reduce these numbers and improve patient flow.

The 18-week referral to treatment target (RTT) was not achieved in December 2021 with 70.7% against the target of 92%, this was a deterioration compared to November 2021(72.4%). There were now 1,383 52+ week waiters as a result of the backlog from the pandemic. The 6-week diagnostic target was not achieved in December at 74.9% against the 99% target.

Community nursing referrals were 572 in December and the community matron caseload was 143.

5.3 **Financial Indicators**
GL reported the Trust had submitted a breakeven plan for the second half of the financial year, which included risk of approximately £13m relating to ERF income dependent on system performance. Following a regional system meeting the previous week, the Trust was now forecasting a breakeven outturn position, as the ERF income and other system allocations had now been confirmed.

At the end of month 10, the Trust had reported a breakeven position, with £438,554k income and expenditure year to date.

The 2021/22 system CIP target of £10m had been achieved and the Trust continued to work towards the Trust's internal target of £15m. GB asked why the Trust had an additional internal target and GL explained that the schemes had been identified and if achieved improved the momentum for 2022/23.

At the end of month 10, cash balances were consistent (£66.1m).

The capital programme of £10.97m (excluding PFI lifecycle expenditure) remained on track to deliver by the end of the year.

AS asked if the Trust stance in relation to the H2 allocations had been effective. GL responded that he felt it had been the right approach and he felt that the system had now moved on with a more transparent approach and better communication about the 2022/23 financial planning process.AM supported this and felt it had been an important principle, which hopefully would help shape the culture of partnership working with the ICB.

AS queried the 'better payment practice code" compliance against the non-NHS % indicator in the detailed finance section of the IPR, and why it was 78.1%. GL confirmed that this related to the volume of invoices rather than the value of payments which was rated green. This had been discussed at the Finance & Performance Committee and an improvement plan was being put in place to return to 95% of volume as well as value.

Board members joined RF in congratulating GL and the finance team for achieving this outcome in a difficult financial environment, as a result of the emergency financial regime during the pandemic.

5.4 **Workforce indicators**

AMS presented the report. In January 2022 the absence rate (excluding COVID-related absences) decreased to 6.16% from 6.70% in December 2021. However, the overall absence rate (including COVID-related absences) increased to 9.6% from 8.5% in the previous month. The Additional Clinical Services staff had the highest absence rate at 14.8% in January. . These figures did not include COVID absence reasons for staff in isolation, or pregnant workers over 28 weeks on medical suspension. This level of absence was clearly exceptional and had the impact of safer staffing levels reported in the Quality section.

The recent changes relaxing the COVID rules for the general public, announced by government had not yet translated into any changes in the IPC requirements for healthcare settings e.g. Healthcare staff with COVID were still required to self- isolate, so the pressures on staff absence was likely to continue.

RF had attended a Cheshire & Merseyside Chairs' meeting the previous day and there had been frustration that organisations were still waiting for clarity on how the COVID changes would affect them.

Appraisal compliance was at 66.9% and Mandatory Training compliance at 73.5% remained below target. Following discussion in the Executive Committee a number of measures had been put in place to try and improve the situation, but the issue remained that clinical staff were needed on the front line to care for patients and protected time for appraisals and mandatory training was very difficult to maintain in the current circumstances.

AS thanked AMS and her team for the information they had provided that explained the 85% compliance targets for mandatory training and appraisals.

Board members noted the update.

6 Committee Report – Executive - NHST(22)007

AM presented a summary of the issues discussed at the Executive Committee during January 2022.

6.1 There had been two investment decisions, firstly the creation of a Clinical Director of Research, Development and Innovation (RD&I) post for the Trust. The aim was to increase the academic and clinical research portfolio of the Trust and there would be metrics agreed to measure the achievement of the ambition. Both GB and LK welcomed this initiative and believed it was extremely important that the Trust maximised the patients who could be offered participation in trials.

6.2 The second investment decision was the creation of an endoscopy staff bank on behalf of the Cheshire and Merseyside Cancer Alliance. The Trust would be reimbursed for the costs of providing this service, but there were lots of issues to be resolved, however the importance of a collaborative approach to the staffing needed to support elective and diagnostic recovery without escalating costs was important.

6.3 AM commented on the reports of the Trusts plans to implement Vaccinations as a Condition of Deployment (VCOD). Board members noted the amount of wasted time that had been spent trying to resolve the issue and the distress caused for some staff, only for it to be paused at the 11th hour.

Board members noted the other items in the report.

7 Committee Report – Quality - NHST(22)008

RT presented the committee report and highlighted key issues for the attention of the Board.

7.1 The committee had asked for a in depth review of maternity services and the causes of the recent diverts and closures, alongside the escalation procedures across the system to maintain the safety of women in labour. Assurance had been provided that all closures were reported via StEIS and a full RCA conducted. No harm had come to any patients as a result of the recent diverts. A new Birth Rate Plus staffing assessment had been commissioned and this independent review would provide further guidance on the levels of staffing needed. Although it had been noted that not all the diverts related to staffing shortages, as the unit had been appropriately staffed at the time. Future reports from the service would include information on activity levels and closures at other units in Cheshire and Merseyside to allow for benchmarking.

The challenges for the maternity service during December and January when acuity of patients and staffing absence had increased were considerable but despite two closures to new admissions, safe services had been maintained.

Changes in guidance and maternal acuity appeared to be the underlying cause of the diverts, and it was not yet understood whether this would be permanent feature or would be resolved as COVID became less of an issue.

7.2 RT reported that a previous incident report had highlighted an increase in needle stick injuries and the committee had asked for detail of these to be incorporated into the regular infection control reports.

7.3 There had been a review of progress for the Trust objectives aligned to the Quality Committee. Although there had been a reduction in falls in Q3 the numbers remained a concern. The committee noted the actions being taken, including a patient safety pilot with weekly reviews of the 72 hour serious incident reports to enable quicker learning and dissemination of key safety messages.

7.4 There had been an excellent report and the increase in demand for safeguarding interventions and patients who required a DoLs application.

7.5 Members had received feedback from the 'Perfect Week' project, which had focussed on internal discharge and flow. The initiative had highlighted that the Trust's use of the Discharge Lounge had improved; a reduction in the number of people attending ED for over 12 hours; and there was now an emphasis on ensuring these improvements were sustained.

7.6 RT also highlighted the findings of the safety 'climate' review in theatres. The results were generally positive, but there was a slightly lower score in relation to management support for safety issues, therefore managers and clinicians were to be engaged in monthly focus groups. Two associate directors would support this process.

7.7 The committee had also received and reviewed the updated IPC Board Assurance Framework that was an item later on the agenda.

7.8 RF was encouraged to see improvement work being undertaken via the "perfect week" project and that initiatives had been identified to support better patient flow. RT confirmed that the committee would continue to monitor the impact of these initiatives.

The remainder of the report was noted.

8 Committee Report – Finance & Performance - NHST(22)009

JK presented the committee report and highlighted issues not previously discussed as part of the IPR reports.

8.1 The committee had received a report on the latest benchmarking and 'Get it Right First Time' information and progress in delivering the action plans from previous reports.

8.2 The committee had also discussed the latest information about the draft financial plan and operational plan for 2022/23 and the high-level assumptions.

8.3 JK reported that although the planned presentation to the committee from the ED team had been cancelled due to operational pressures there had been a useful briefing on the proposed new national urgent and emergency care targets.

8.4 RF observed that the delivery of the Cost Improvement Plans (CIPs) had already been mentioned during the meeting but he felt it was important to recognise the importance of the Trusts "can do" culture and buy in from all staff groups across the organisation to drive efficiencies and keep patients safe.

The report was noted.

9 Committee Report – Audit - NHST(22)010

IC presented the committee report.

9.1 IC highlighted that outstanding audit actions were being progressed and aged debt continued to reduce. No issues were anticipated when CCGs ceased to exist, and we moved to the Integrated Care Systems (ICSs) on 1st July 2022. RF thanked IC for the update.

9.2 The committee had reviewed the Anti-Fraud, Bribery and Corruption Policy and recommended it for approval by the Board, once all members had the opportunity to review the draft. **ACTION:** NB to circulate the policy to all Board members

9.3 AMS provided more information to Board members on the internal audit report for Mandatory Training which had been assessed as moderate assurance. This was

because MIAA had identified a high risk in relation to the Trusts subject matter experts who had not all signed the training provision contracts. The issue was being addressed and there would be further discussion at the Executive Committee to ensure this issue was resolved.

RF observed mandatory training was a big issue nationally, not just for the Trust. AM felt it was important the Board led by example and all members should be up to date with their mandatory training. **ACTION:** NB to send training compliance reports to each Director

10 Committee Report – Charitable Funds - NHST(22)011

PG presented highlights from the meeting.

10.1 Committee members had discussed the investment portfolio and had received assurance on the investment decisions.

10.2 Members had noted some areas of the Trust, e.g., Lilac Centre, received a large proportion of donations. There had been discussion in relation to how the Trust could raise the profile of fundraising in other areas, e.g., Care of the Elderly. The Director of Communications was meeting with LK to draft a branding proposal for review by the Committee before being presented to Board.

10.3 Committee members noted the current Charity Fundraising Manager was due to leave the Trust and thanked her for her contribution, made more difficult due to the pandemic, which had curtailed many initiatives.

10.4 Approval had been given for the staff 'thank you week' expenditure.

10.5 PG informed Board members that Miss Leena Chagla, Clinical Director for Breast Care, would be joining the Charitable Funds Committee as the new clinical staff member.

RF thanked PG for his efforts and noted that PG's experience brought particular expertise to this committee that he was very grateful for. RF confirmed he still intended to write a letters to local businesses to try and obtain corporate sponsorship for the Hospital Charity. RF also thanked the head of fundraising and wished her all the best for the future.

11 Freedom to Speak Up (FTSU) - Annual Board Self-Assessment – NHST(22)012

11.1 AMS presented the report which provided assurance that the Trusts FTSU arrangements complied with the best pro-active guidance.

11.2 The self-assessment showed that the Trust fully achieved 9 of the 11 standards and partially met the other two.

11.3 The Trust FTSU reports are presented to the Quality Committee every 6 months and issues escalated to the Board. The Board agreed that they were assured that this arrangement remained appropriate.

11.4 The Trust has taken the approach of having multiple FTSU guardians rather than a single person undertaking the role. The Board continued to feel this approach had advantages. One of the FTSU guardian positions was now vacant and a open recruitment process was being undertaken to appoint their successor.

11.5 The annual self-assessment was approved.

12 Updated IPC Board Assurance Framework - NHST(22)013

NB presented the report on behalf of SR.

12.1 This was the third update of the IPC BAF to Board, as it had been updated regularly during the pandemic as national guidance had changed. NB noted that the most recent changes reflected an embedding of the COVID guidance into "normal" IPC practice.

12.2 NB highlighted areas of partial compliance to members;

12.2.1 Indicators 22.4 and 22.5: Additional touch point cleaning and cleaning frequencies in addition to the routine planned cleaning schedules were in place on COVID wards, escalation and other high risk areas, but not in every ward and department. The cleaning frequencies were being reviewed as part of the implementation of the new national standards of cleanliness which were due to go live in May 2022.

12.2.2 Indicator 26: Ventilation systems to meet the national recommendations for minimum air changes. New guidance had been issued in November 2021 (HTM04-01(2021) which recommended 6 air changes per hour in all inpatient bedded facilities. The Trust was establishing a Ventilation Safety Group which would access how the current ventilation systems could be enhanced and was also seeking additional assurance in respect of all the inpatient facilities used by the Trust. However it was acknowledged that this was a change from the previous requirements and the majority of hospital would not have been built to this specification and a cost benefit assessment would need to be undertaken.

12.2.3 Indicator 122: Related to face fit testing for staff. The Trust had systems in place and recorded the face fit testing and this would be reported via the Hospital Infection Prevention Group (HIPG) and any concerns could be brought to the attention of the Board via the established governance escalation routes.

The Board noted the report.

13 Effectiveness of Meeting

RF asked Dr Jacqui Bussin (JBu), Observer, for her view of the meeting. JBu noted the good timekeeping and she had been struck by the warmth of the Chair in leading the meeting. It had also been interesting to hear about the benefit of maintaining a firm approach in holding external organisations to account for their decision making. RF thanked JBu for her comments.

14 Any Other Business

14.1 RF reported that he had attended a Cheshire & Merseyside Chairs' meeting the previous day and would circulate the presentations and his notes to Board members.

14.2 RF also noted that the agenda had been minimised for this meeting and a number of reports deferred. He was confident they would all be picked up at a later date but if any members had concerns he asked them to contact him.

15 Date of Next Meeting

Wednesday 30th March 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 30TH MARCH 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**	NB/NK	TBC
36	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **DEFERRED**	AM	TBC
37	26.01.22 (6.2.9)	RC to share an example of care home bed capacity and how this was impacting on discharges. GB confirmed this had been completed. **CLOSED**	RC	23.02.22
38	26.01.22 (12.5)	CW agreed to develop a dashboard to be added to the IPR to provide assurance of the performance of the informatics service. IPR to be updated for 2022/23 and a briefing for Board members on the current status circulated 22/03/22. **COMPLETED**	CW	30.03.22
39	23.02.22 (9.2)	NB to circulate the draft Anti-Fraud, Bribery and Corruption Policy to Board members on behalf of the Audit Committee. **COMPLETED**	NB	30.03.22
40	23.02.22 (9.3)	NB to provide each Director with a report on their mandatory training compliance. **COMPLETED**	NB	30.03.22

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)015
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 February 2022. (YTD = 1).

There was 1 MRSA case in February 2022. The RCA findings indicated this case was unavoidable (YTD = 2).

There were 2 C.Difficile (CDI) positive cases reported in February 2022 (2 hospital onset and 0 community onset). YTD there have been 49 cases (28 hospital onset and 21 community onset). The Trust has successfully appealed 24 cases, 13 cases are not for appeal and there are a total of 12 RCAs currently in progress. 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 February 2022 was 92.3%. 2021-22 YTD rate is 92.2%.

During the month of January2022 there were 4 falls resulting in severe harm or death category . (YTD severe harm or above category falls = 19)

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

Community services reported a total of 76 incidents in the month of January; 14 were low harm, with no moderate harm reported and the remainder no harm.

Performance for VTE assessment suspended by NHSE since March 2020.

YTD HSMR (April - November) for 2021-22 is 97.7

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: 30th March 2022

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (January 2022) at 83.4%. YTD 85.03%. The 31 day target was achieved in January 2022 with 98.0% performance in month against a target of 96%, YTD 98.2%. The 2 week rule target was not achieved in January 2022 with 73.5% in month and 85.2% YTD against a target of 93.0%. The deterioration in performance for 2 week rule, is related to the significant increase in referrals, compared to the same period in 2019, resulting in capacity challenges.

Accident and Emergency Type 1 performance for February 2022 was 49.7% and YTD 56.5%. The all type mapped STHK Trust footprint performance for February 22 was 73.7% and YTD 77.5%**.** The Trust saw average daily attendances of 319, which is up compared to January, at 298. Total attendances for February 2022 was 8,932.

Total ambulance turnaround time was not achieved in February 2022 with 57 mins on average. There were 2,058 ambulance conveyances (3rd busiest Trust in C+M and 5th in North West) compared with 2,159 in January 22.

The UTC had 4542 attendances in January 2022, which is a decrease of 6% (288) compared to the previous month. Overall 99% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in February 2022 was 138 compared with 132 in January. 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 January 2022 with 70.1% compliance and YTD 70.1% (Target 92%). Performance in December 2021 was 70.7%. There were (1389) 52+ week waiters. The 6 week diagnostic target was not achieved in February 22 with 87.3% compliance. (Target 99%). Performance in January 2022 was 73.7%.

There was a slight decrease in District Nursing referrals in January; however the levels are still within average range (562 in January in comparison with 572 in December). Caseload size is within normal range (1243 in January compared to 1212 in December). Community matron caseloads have seen a further decrease in the month of January to 138 compared to 143 in December. Work has been undertaken with individual PCNs to look at a collaborative approach to patient care.

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, in line with system guidance. This included risk of approximately £13m relating to Elective Recovery Fund (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, expenditure slippage and £3m additional system resources, along with inclusion of £1.1m ERF income allocated based on system performance, at Month 11 we are forecasting a breakeven outturn position.

Surplus/Deficit - At the end of Month 11, the Trust is reporting a breakeven position, with £480.1m income and expenditure year to date.

CIP - The 21/22 system CIP target of £10m has been achieved recurrently. 22/23 schemes are now in work up.

Cash - At the end of Month 11, the cash balance was £75.4m. 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. NHSE/I has indicated that due to high cash balances held by providers, Emergency PDC will not be approved, with an assumption that providers utilise their cash balances before PDC funding. The Trust is forecasting to spend its full 21/22 capital allocation by the end of the financial year.

Human Resources

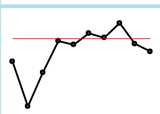
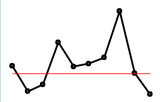
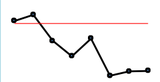
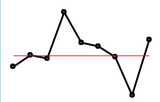
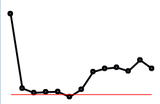
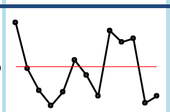
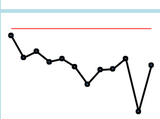
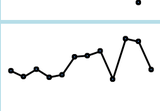
The overall absence rate for February 2022 decreased to 7% from January's figure of 9.6%. Excluding COVID absences, the rate reduced 0.97% to 5.64%. However, this remains above the Trust's target of 4.5%.
Long term sickness accounts for most absences at 69.08% with Stress and Anxiety remaining as the highest reason for absence at 29.70%
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.
Mandatory Training Compliance remains below the target of 85% of the available workforce at 74.2%. The Appraisal compliance is at 67.89%.

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

Feb-22

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	Feb-22	2.5%	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	▲	Oct-21	1.06		1.00						
Mortality: HSMR (HED)	Q	▲	Nov-21	94.6	97.7	100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Nov-21	90.1	105.5	100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Oct-21	89.6	94.4	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	Nov-21	84.5	88.1	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	Nov-21	101.1	102.0	100.0	104.7					
% Medical Outliers	F&P	T	Feb-22	2.8%	2.1%	1.0%	1.6%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	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	Feb-22	38.7%	48.9%	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	▲	Jan-22	69.1%	75.9%	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	▲	Jan-22	74.0%	71.9%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jan-22	96.9%	97.2%	95.0%	96.8%					

	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	▲	Q3	84.9%	85.6%	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	▲£	Feb-22	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	Feb-22	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	▲£	Feb-22	1	2	0	2		There was 1 MRSA case in February 2022. The MRSAb Executive panel determined that this case was unavoidable. YTD = 2.	Quality and patient safety	The annual tolerance for CDI for 2021-22 has been set at 54. Improvement actions in place and completed based upon RCA .	SR
Number of hospital onset and community onset C Diff	Q F&P	▲£	Feb-22	2	49	54	28		There were 2 positive C Diff samples in February 2022. YTD there have been 49 cases of which the Trust has successfully appealed 24 cases, 13 cases were not for appeal and there are a total of 12 RCAs currently in progress. The annual tolerance for CDI for 2021-22 has been set at 54.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Feb-22	3	44	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	▲	Dec-21	0	2	No Contract target	1		2 validated category 3 pressure ulcer YTD.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified.	SR
Number of falls resulting in severe harm or death	Q	▲	Jan-22	4	19	No Contract target	31		4 falls resulting in severe harm category in January 2022. 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 February 22 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	61					
To achieve and maintain CQC registration	Q		Feb-22	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-22	92.3%	92.2%	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	Feb-22	2	28	No Target	49					

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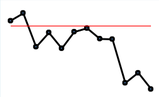
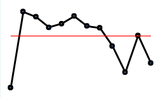
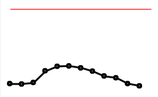
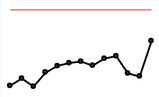
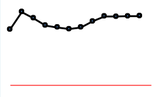
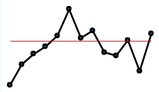
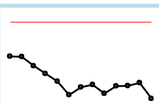
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲ £	Jan-22	73.5%	85.2%	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 8. Cancer Specific PTL supporting to expedite delays prior to patient breaches.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jan-22	98.0%	98.2%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jan-22	83.4%	85.0%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jan-22	70.1%	70.1%	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. Amodalities. This is being worked through. Removal of P5 is on target and of D5 is complete.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-22	87.3%	77.8%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jan-22	1,389	1,389	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Feb-22	0.9%	0.79%	0.8%	0.4%		Underperformance in cancelled ops has been due to staff sickness/absence, and theatre staff being re-deployed temporarily to support ITU. In December and January, a mixture of consultant and theatre staff sickness 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	▲ £	Jan-22	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	▲	Feb-22	49.7%	56.5%	95.0%	78.0%		Accident and Emergency Type 1 performance for February 2022 was 49.7% and YTD 56.5%. The all type mapped STHK Trust footprint performance for February 22 was 73.7% and YTD 77.5%. The Trust saw average daily attendances of 319, which is up compared to January, at 298. Total attendances for February 2022 was 8,932. Total ambulance turnaround time was not achieved in February 2022 with 57 mins on average. There were 2,058 ambulance conveyances (3rd busiest Trust in C+M and 5th in North West) compared with 2,159 in January 22.	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	▲	Feb-22	73.7%	77.5%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Feb-22	0	0	0	0					

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CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-22	0	0	0			Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Feb-22	16	233	No Target	242		% new (Stage 1) complaints resolved within agreed timescales remains below the target, though improved to above 90% in January and 100% in February 2022.	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 are currently in place to increase response rates within the Medical Care Group.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Feb-22	17	225	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Feb-22	100.0%	81.3%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to February 22 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	Feb-22	360	315		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Feb-22	138	106		72					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-22	81.6%	79.1%	90.0%	88.4%		Year to date recommendation rates are above target for inpatients and postnatal ward , but remain below target for the remaining areas. Recommendation rates for ED have improved for each of the previous three months but dipped in February 2022.	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.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-22	95.0%	95.7%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-22	89.3%	96.3%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-22	88.9%	93.3%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-22	92.3%	95.2%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-22	95.5%	97.5%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-22	94.0%	93.8%	95.0%	94.2%					

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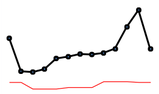
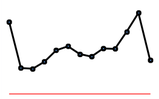
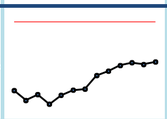
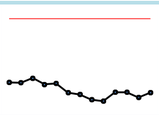
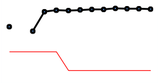
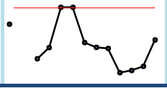
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲	Feb-22	7.0%	7.0%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In February 2022 all staff sickness decreased from 9.6% in January to 7.0%. All Nursing & Midwifery ward areas was 8.6% which is a decrease of 4.5% in January. 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 analyse the hotspots and provide targeted support to managers. HWWB are contacting employees who are absent with Covid to provide support. In addition, there's a bi-weekly review of absence matters between the HR Operations Team and the Clinical Lead to ensure that the wellbeing of staff remains a priority.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Feb-22	8.6%	9.7%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Feb-22	67.9%	67.9%	85.0%	51.3%		The Appraisal compliance is at 67.89% and has risen by 1.0% since January, however remains below target by 17.1%. Mandatory training compliance has risen by 0.7% and is below the target by 10.8% and is below the target of 85% of the available workforce at 74.2%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Recovery of both Appraisal and Mandatory Training continue to be impacted by operational pressures and staff absence, 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 to be monitored through Workforce Council and Quality Committee.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Feb-22	74.2%	74.2%	85.0%	75.7%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			No Contract Target			Staff Friends and Family test superseded by the Quarterly staff survey in Q3	Staff engagement, recruitment and retention.	Publication of results is expected on the 30th March 2022.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Feb-22	1.1%		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	Feb-22	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	Feb-22	10,776	10,776	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Feb-22	-	-	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Feb-22	30	30	10						
Capital spend £ YTD (000's)	F&P	T	Feb-22	6,500	6,500	17,600						
Financial forecast outturn & performance against plan	F&P	T	Feb-22	-	-	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Feb-22	85.7%	85.7%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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	▲£	96.3%	100.0%	97.4%	100.0%	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	95.1%	85.0%		91.1%		
	Total > 62 days		0.5	0.0	0.5	0.0	1.0	1.0	1.0	0.0	0.5	0.5	0.0	1.0	1.0	6.0			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5			0.0		
Lower GI	% Within 62 days	▲£	78.9%	58.6%	87.5%	61.1%	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	79.2%	85.0%		78.7%		
	Total > 62 days		2.0	6.0	1.0	3.5	3.5	0.0	1.0	2.5	0.0	3.0	4.0	3.0	2.0	22.5			22.0		
	Total > 104 days		0.0	2.0	1.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	1.5	1.0	0.0	4.0			6.0		
Upper GI	% Within 62 days	▲£	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	87.8%	85.0%		83.1%		
	Total > 62 days		0.0	0.0	3.5	0.0	0.0	0.0	1.0	3.0	1.0	0.0	0.0	1.0	0.0	6.0			11.5		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0			4.0		
Urological	% Within 62 days	▲£	82.8%	92.3%	79.2%	80.0%	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	78.3%	85.0%		85.6%		
	Total > 62 days		2.5	1.0	2.5	2.0	2.0	4.5	1.5	4.5	2.0	1.0	3.5	0.5	8.5	30.0			21.0		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	2.0	0.0	0.5	0.5	0.0	3.5			6.0		
Head & Neck	% Within 62 days	▲£	33.3%	57.1%	50.0%	0.0%	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	22.9%	85.0%		51.4%		
	Total > 62 days		1.0	1.5	1.0	1.0	3.0	1.0	2.0	1.0	1.0	2.0	0.5	2.0	0.0	13.5			9.0		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0			0.0		
Sarcoma	% Within 62 days	▲£	100.0%	100.0%		100.0%	100.0%		100.0%							100.0%	85.0%		83.3%		
	Total > 62 days		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		
Gynaecological	% Within 62 days	▲£	55.0%	60.0%	57.1%	83.3%	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	74.4%	85.0%		66.3%		
	Total > 62 days		4.5	1.0	3.0	0.5	0.0	0.5	0.0	2.5	2.0	1.0	0.5	3.0	0.0	10.0			17.5		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	▲£	100.0%	80.0%	100.0%	100.0%	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	78.7%	85.0%		83.9%		RC
	Total > 62 days		0.0	1.0	0.0	0.0	2.0	0.0	2.0	0.0	2.5	3.0	1.5	1.0	2.5	14.5			10.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.5	1.5			1.0		
Haematological	% Within 62 days	▲£	50.0%		75.0%	57.1%	100.0%	37.5%	37.5%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	59.5%	85.0%		77.9%		
	Total > 62 days		3.0		1.0	3.0	0.0	5.0	5.0	0.0	0.0	0.0	1.0	1.0	0.0	15.0			8.0		
	Total > 104 days		0.0		0.0	1.0	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0			1.0		
Skin	% Within 62 days	▲£	96.8%	86.0%	94.6%	92.9%	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	92.7%	85.0%		93.6%		
	Total > 62 days		1.0	4.0	2.5	2.5	3.0	3.0	0.0	1.0	3.5	4.0	4.5	3.0	3.0	27.5			25.5		
	Total > 104 days		0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	1.5			3.0		
Unknown	% Within 62 days	▲£	100.0%	100.0%	80.0%			50.0%		100.0%		100.0%	100.0%		100.0%	86.7%	85.0%		92.3%		
	Total > 62 days		0.0	0.0	0.5			1.0		0.0		0.0	0.0		0.0	1.0			1.0		
	Total > 104 days		0.0	0.0	0.5			0.0		0.0		0.0	0.0		0.0	0.0			0.5		
All Tumour Sites	% Within 62 days	▲£	85.3%	82.0%	86.4%	86.1%	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.0%	85.0%		86.7%		
	Total > 62 days		14.5	14.5	15.5	12.5	14.5	16.0	13.5	14.5	12.5	14.5	15.5	15.5	17.0	146.0			137.5		
	Total > 104 days		1.0	3.0	3.0	2.0	1.0	1.0	4.0	3.0	2.5	1.5	2.0	1.5	0.5	19.0			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)016
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 February 2022. There were four Executive Committee meetings held during this period. The investment decisions made were: 1. To approve the business case to appoint a substantive Paediatric GP with an Extended Remit (GPwER) to extend the community paediatric service 2. To extend the contracts for the St Helens Shared Care Record and CIPHA Public Health Management System 3. To invest in mitigations to reduce the impact of the cyber security risk The Executive Committee discussed the COVID-19 pandemic and its impact on the Trust. At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration. The Committee also considered regular assurance reports covering; Risk Management Council and corporate risk register, mandatory training and appraisal performance, safer staffing and the Integrated Performance Report.
Trust objectives met or risks addressed: All Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 30th March 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in February 2022.

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

2. 3rd February 2022

2.1 Health Inequalities Review

The Director of Finance and Information presented the initial work that had been undertaken to understand health inequalities for patients in five areas; ED attendances, elective activity, outpatient first attendances, outpatient DNA rates and vaccination uptake. Inequality had been assessed in respect of ethnicity and deprivation index. The analysis had been undertaken against a pre-COVID baseline (January 2019 to December 2019) in comparison to a rolling 4 month average up to November 2021. It was acknowledged that 92% of the local population identifies as white British and the numbers of patients attending the Trust from other ethnic backgrounds are relatively small.

It was agreed that this analysis was an excellent piece of work undertaken by the Business Intelligence Team, and would now need to be developed into an ongoing reporting cycle. Some of the results were as intuitively expected and others were more difficult to explain, raising more questions for the team to explore.

It was agreed that the work should continue and a presentation would be given at a future Strategy Board session.

2.2 Quality Account priorities

The Director of Nursing, Midwifery and Governance presented an update on the delivery of the Quality Account improvement priorities for 2021/22. It was acknowledged that the ongoing effects of the pandemic on normal business had impacted on the achievement of the priorities and following discussion it was agreed that four should be proposed to continue in 2022/23 and be included as part of the Trust objectives for the year. The results of the consultation with stakeholders would be presented in March with final recommendations for the 2022/23 improvement priorities.

2.3 Vaccination as a condition of deployment (VCOD)

The Deputy CEO/Director of HR reported that the government had announced the VCOD legislation was to be reviewed and preparations by NHS providers to implement the regulation were to be paused during a period of consultation.

2.4 Trust Board Agendas

The Director of Corporate Services presented the draft Trust Board agendas for the February meetings.

2.5 Maternity Data

The Director of Nursing, Midwifery and Governance had reviewed the CRAB maternity information that had previously been reported at the committee. The review had found that between 2017 and 2021 there had been 14 stillbirths, 11 extremely premature births and two further cases had been categorised in error in the original report. This review provided assurance that the Trust maternity service did not have excessive rates of still birth or neonatal deaths. When sadly these events did occur, the care was reviewed and reported externally as required.

2.6 Urgent COVID Issues

The Director of Integration reported that there had been a significant reduction in the reported cases of COVID, with the rates in Merseyside now lower than Cheshire. It was agreed that as long as the trend continued the weekly prevalence reports could be discontinued.

Gold Command had escalated a review of the visiting restrictions. However the Director of Nursing, Midwifery and Governance requested that the restrictions remained in place whilst nosocomial infections continued to be high. It was reported that there had been a spike in nosocomial infections in the previous seven days with a number of ongoing outbreaks across the Trust. The cumulative nosocomial infection rate for the Trust since April 2021 was 8.4% and had fluctuated in line with the peaks of community prevalence throughout the pandemic. The challenges of enforcing COVID IPC rules at the Trust, especially in public areas when the rules in other settings had been relaxed for the general public, were acknowledged.

The committee discussed the implications of the removal of COVID funding, including on the suspension of car parking charges for staff and the steps that would need to be taken for these to be reintroduced after two years.

2.7 Southport and Ormskirk Hospital Update

The Deputy CEO/Director of HR reported that NHS Estates had been asked to undertake a review of the backlog maintenance risks at both hospital sites and this was being arranged as quickly as possible.

3. 10th February 2022

3.1 Sterile Services Contract

The Director of Corporate Services presented a paper which set out the options for the Sterile Services when the contract with the current provider ended in 2025. The committee agreed with the recommendation that the Trust should not seek to bring the service back in house as provision is complex and technically challenging. It was

therefore agreed that a re-procurement exercise should be undertaken using one of the existing NHS Frameworks.

3.2 Annual Leave Carry Over

The Deputy CEO/Director of HR presented a proposal that would allow agenda for change staff to carry forward 5 days annual leave into the 2022/23 leave year and be paid for up to 5 further days if they had been unable to take these during 2021/22. This proposal mirrored the arrangements that had been agreed at the end of 2020/21 and recognised the ongoing impact of the pandemic and operational pressures which had resulted in leave being cancelled. It was acknowledged that this was an exceptional provision with the expectation that staff should be encouraged and supported to take their leave entitlement during the next financial year. The Director of Finance confirmed that provisions had been made in 2021/22 for the payment of untaken leave, as proposed in the paper.

3.3 Risk Management Council and Corporate Risk Register Report

The Director of Corporate Services presented the Chair's assurance report from the Risk Management Council. The Trust risk register contained 772 risks, of which 25 had been escalated to the Corporate Risk Register. This was a reduction from the previous month with five high/extreme risks being closed or de-escalated since January. There was one new approved high risk relating to the capacity of the Breast Cancer service to respond to the increase in two week wait referrals being experienced. The report provided a summary of the assurance reports from the CIP Council, Claims Governance Group and Major Incident Planning Group. There was also a report on the Freedom of Information response improvement plan. The Risk Management Council had approved the revised Trust Fire Policy.

3.4 Robotic Process Automation (RPA)

The Director of Informatics presented a paper that set out the funding that had been received to implement RPA across Cheshire and Merseyside Trusts. The ICS had selected Blue Prism to support the development of "bots" to undertake repetitive administrative tasks thereby improving productivity and efficiency and releasing staff time. The proposal was that STHK and Southport and Ormskirk Hospital would work together on the RPA development. The committee welcomed the funding that had been allocated by the ICS but requested that a business case be prepared that would detail the benefit realisation plans and the costs of implementation.

3.5 Technology Awards

The Director of Informatics presented a paper that detailed the funding awards that the trust had received from the national technology funds to support the delivery of the Trusts Digital Strategy. Capital funding had been received from the elective recovery tech fund and the digital maturity fund, which also came with an allocation of non-recurrent revenue. A number of digital developments were proposed as a result of this funding; Speech recognition software, replacement of the theatre management system, eConsent, printing solutions, and digital maternity developments. The informatics team were congratulated on the successful bids for national funding and the committee

agreed that more detailed information about the revenue costs and benefits realisation plans for each of these projects was needed to understand the implications for other services and budget setting.

3.6 Integrated Performance Report (IPR)

The Director of Finance and Information presented the January IPR and members reviewed the metrics where performance was not on target and agreed changes to the narrative.

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

The Deputy CEO/Director of HR reported the NHS Estates visit to the Trust had now been arranged for 21st February. The Lancashire Fire service had inspected Ormskirk Hospital.

A time out session with the S&O Executive Directors was planned for 18th February and would focus on the operational plan and Trust objectives for 2022/23.

There were plans for meetings with key stakeholders including the local MPs.

3.8 COVID Issues

The Director Nursing, Midwifery and Governance reported that the Nosocomial infection rate remained high at 8.9% and continued to be a cause for concern. Each incidence was investigated and staff and patients reminded of the importance of maintaining the IPC precautions that were still required in healthcare settings.

It was reported that the Cheshire and Merseyside Directors of Nursing were due to discuss visiting restrictions at their next meeting.

4. 17th February 2022

4.1 Safer Staffing Report

The Director of Nursing, Midwifery and Governance presented the detailed safer staffing report for December and the fill rates for January. In December the registered nurse/midwife overall fill rate had been 93.02% and in January it was 91.55% reflecting the increase in staff absence as a result of Omicron. Wards with a fill rate of less than 90% had been scrutinised and any patient safety incidents had been reviewed to see if there were links with staffing levels on the ward at the time. There was no evidence of a direct link between the staffing levels and these incidents. The demand for supplementary care for patients who required close supervision had continued to be very high, reflecting the acuity of patients admitted to the Trust. The efforts of the nursing team, in maintaining safe staffing levels in the very difficult circumstances experienced during January were acknowledged.

4.2 Nurse establishment review

The Director of Nursing, Midwifery and Governance presented the draft nursing establishment paper which presented the results of the review of the staffing levels for

each ward reflecting any changes in practice, service demand or acuity of patients. It was noted that the last review had been undertaken in 2019/20 before the pandemic. This review had found that for 29 of the 33 wards at the Trust the nursing establishment remained appropriate to provide high quality care for the patients. On four wards the assessment indicated additional staffing may be required. It was agreed that detailed discussion was required with the finance team to provide a clear understanding of any additional funding being requested. As a result it was proposed that the review be reconsidered by the committee following these discussions.

4.3 Mandatory Training and Appraisal Compliance

The Deputy CEO/Director of HR presented the mandatory training and appraisal compliance figures for each Director and also by staff group. The impact of the extreme operational pressures and high staff absence due to Omicron in January were acknowledged, however work continued to support staff to access and complete the mandatory training at a time that was convenient for them.

4.4 Paediatric GP with an Extended Remit (GPwER) Business Case

The Director of Operations and Performance presented the business case, seeking funding to recruit 0.7WTE GPwER. This post had been created as a pilot at Lowe House Health Centre which had been funded by St Helens CCG for an initial 12 months. The service had been very successful and the proposal was now to make it permanent, with the contacts counted as Trust activity going forward. The business case was approved.

4.5 Shared Care Record and CIPHA Public Health Management System

The Director of Integration presented the paper which explained that Cheshire and Merseyside were not yet in a position to develop a system wide shared care record and as a result it was recommended the current contract for the St Helens shared care record be extended for a further 3 years with an annual break clause.

The CIPHA Public Health Management system is currently hosted by STHK and the current contract ends on 31st March. As the ICB is not yet a statutory body it is proposed that this contract is also extended for a further 12 months and expanded to include Cheshire. At the end of 2022/23 it is proposed that St Helens and then the trusts in Cheshire would be the first to migrate to the new Cheshire and Merseyside solution.

Both contract extensions were approved.

4.6 COVID Issues

The Director of Nursing, Midwifery and Governance reported that although remaining high the nosocomial rate had plateaued and the number of outbreaks were reducing as wards had reported no new cases for 28 days.

Gold Command reported that the number of COVID positive inpatients had continued to decease with the majority now admitted with COVID rather than because of COVID.

There continued to be a high level of PALs contacts and complaints relating to the difficulties experienced by relatives trying to contact the wards. This issue had been exacerbated by the COVID visiting restrictions but would still be an area for improvement when these were lifted.

4.7 Southport and Ormskirk Hospital NHS Trust

The Deputy CEO/Director of HR reported on the first Quarterly Joint Meeting between STHK, S&O and NHS England, which formed part of the governance of the Agreement for Long Term Collaboration.

5. 24th February 2022

5.1 Southport and Ormskirk Hospital NHS Trust

The Deputy CEO/Director of HR reported that the future of the laundry service was being considered and it was agreed that a paper should be presented at the next Strategy and Operations Committee to approve the proposed direction of travel.

It was also reported that senior staff from the two Trust finance teams had held a joint away day to consider opportunities for collaboration.

5.2 Cyber Security Business Case

The Director of Informatics presented a business case for investment to further mitigate cyber risks. The proposals were to increase the frequency of penetration testing, increase the capacity to restore systems if there was an attack and investments in alternative MiFi devices as an alternative mode of communication if systems had to be taken down. The proposals were approved.

5.3 New Acute Services Contract Minimum Data Set

The Director of Informatics reported that the new data set had to be implemented in 2022/23 and would require a system upgrade to Care Flow. The Trust upgrade had been scheduled for August.

5.4 COVID Issues

The Director of Corporate Services reported that the recent government announcements and move to “living with COVID” were not reflected in any updated guidance from the UKHSA about the Infection Prevention Control guidelines for healthcare settings and NHSE guidance had been issued confirming that all current restrictions, staff testing and self-isolation and individual and work place COVID risk assessments were to remain in place.

Committee approved an extension to free TV access for patients until 31st March.

There was a discussion about the future of the Mass Vaccination Centre at St Helens Saints Rugby Ground and the alternative models for delivering the ongoing vaccine programme. Cheshire and Merseyside had started the planning process with each Place

being asked to model the demand for vaccines across each cohort and the capacity needed to deliver this.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)017

Reporting from: Quality Committee

Date of Committee Meeting: 22nd March 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
Jacqui Scott, Head of Nursing & Quality, Community and Primary Care
Stephen Beckett, Head of Quality, Clinical Support Service Care Group

In Attendance:

Teresa Keyes, Deputy Director of Nursing and Quality
Rajesh Karimbath, Assistant Director of Patient Safety
Anne Rosbotham-Williams, Deputy Director of Governance
Sue Orchard, Head of Midwifery
Lynn Ashurst, Matron, Surgical Care Group - observing
Lisa Sams, Matron, Quality and Risk – observing
Su Hobbs, Associate Head of Nursing and Quality Urgent Care

Matters Discussed:

The process for managing radiological discrepancies was discussed, noting that there were robust procedures in place to ensure lessons learned were identified and that cases are managed through the serious incident process where this was indicated.

Plans are in place to increase compliance with level 3 safeguarding training in Maternity, noting that this should be achieved by the end of May.

Integrated Performance Report (IPR) highlighted:

- No new Never Events, but one new MRSA bacteraemia reported in February; this was fully reviewed and it was confirmed that exemplary care was provided, with no lapses in care contributing to the infection
- 49 cases of C difficile reported year-to-date; 24 have been successfully appealed,

with 13 attributed to the Trust and 12 root cause analysis (RCA) reviews in progress
- Registered nurse/midwife safer staffing fill rate for combined days and nights was 92.3% in February and 92.2% year-to-date
- 4 falls resulting in severe harm or above in January, with 19 year-to-date
- HSMR was 97.7 year-to-date (April – November)
- 31 day target was achieved in January, however 62 day and 2 week targets were not achieved
- Continued challenges in meeting emergency care access targets, although 99% of patients were seen and treated within 4 hours at the Urgent Treatment Centre. The Committee noted the actions being taken to improve performance in ED and the actions taken to maintain patient safety
- Average daily number of super stranded patients (patients with length of stay over 21 days) increased from 132 in January to 138 in February and work remains ongoing with system partners to address this
- 18 week referral to treatment and 6 week diagnostic targets were not achieved
- Slight decrease in District Nursing referrals and in Community Matron caseloads
- The Committee Chair requested additional assurance for the next meeting that there were plans in place to improve the percentage of cancer patients with completed staging data
- The Committee noted that a review of neonatal unit closure was underway to identify what mitigating actions were required going forward
- Noted that sickness absence was above the Trust target and mandatory training and appraisals were below target, with measures being taken to improve this position within the context of the ongoing impact of the COVID pandemic

Guardian of Safe Working

The report provided assurance that there are effective procedures in place to ensure junior medical staff are supported with their training and that the Trust is compliant with safe working hours. This also included monitoring locum hours to ensure staff are not working excessive hours leading to a detrimental impact on patient care. Any concerns raised are dealt with appropriately and the Committee noted that the doctors receive a good training experience.

Clinical Effectiveness Council Report

The Council received presentations from the Haematology Department, Paediatrics, Acute Medical Unit and Resuscitation Services. A number of reports were reviewed including the IPR, mortality, maternity performance indicators, Drugs and Therapeutics Group and National Emergency Laparotomy Audit. It was noted in particular that the Resuscitation Team are working hard to increase compliance with life support mandatory training and that, following the implementation of a new service via the COVID Medicines Delivery Unit, 110 patients had received neutralising monoclonal antibodies (nMABs) in the community.

2021-22 Draft Quality Account

The Committee received the latest draft of the Quality Account which will be subject to external consultation and then final approval by the Quality Committee and Trust Board in May.

Patient Experience Council report

The Council reviewed a number of reports, including Friends and Family Test,

learning disabilities and autism survey, discharge effectiveness, use of interpreters, progress in achieving the Trust's equality objectives, End of Life Steering Group and results of both the inpatient and children and young people's national surveys, noting that the Trust scored in the top 20% for 63% of the questions in the children and young people's survey. In addition, the Committee heard that changes were being made as a result of the Nutritional Steering Group effectiveness review and that actions were being taken to improve the number of advance care plans in place.

Deteriorating Patients Project

The Committee received a detailed report on the progress in the Deteriorating Patient Project, noting in particular that a business case for a Quality Assurance Lead is being considered. Work is ongoing to identify deteriorating patients at an earlier stage and intervening in more effective ways, including updated documentation, engagement with Healthcare Assistants and piloting of helicopter view of national early warning score (NEWS) compliance. This will be included as one of the Trust's objectives for 2022-23. The Committee commended the work that had already taken place and recognised the scale of the project.

Patient Safety Council report

A number of reports were receive, including an update from the Patient Safety Team, report relating to compliance with safety alerts, work of the Tissue Viability Team to support ongoing reduction in pressure ulcers due to lapses in care, input of pharmacy technician in ED with focus on ensuring medicines reconciliation is undertaken and confirmation that the Trust is still achieving the targets set in the retired CQuIN for sepsis.

Tendable

Presentation provided an update on the implementation of the Tendable audit app to capture and report on the wide range of audits, outlining recent improvements to the system and changes made as a result of audit findings. It was noted that all inpatient areas are now using the app and that a pilot of the revised Quality Care Accreditation Tool (QCAT) had taken place. Each Care Group lead provided assurance on how the results from the audits are shared via their governance groups to maintain focus on improvement actions and maintaining high standards.

Falls Care Plan Review

The Committee received a report on the implementation of personalised care plans following the identification of a patient's risk of falling. There was generally good compliance overall, though falling leaf symbol and green wrist band had lower levels. The Falls Strategic Plan for 2022-23 to drive further improvement was noted.

Medicines Storage and Security Audit

The latest audit was conducted using Tendable by the Pharmacy/Medicines Safety Team and highlighted an improved level of compliance, as well as alignment with the wards' own audits undertaken via the nursing care indicators, providing assurance that the self-assessments are accurate. The audit results were shared with the relevant teams to ensure corrective actions are taken on weaker areas, with communication and engagement to increase fridge/room temperature recording.

Safer Staffing December 2021

The overall registered nurse/midwife fill rate for January was 91.5% and 101.81% for HCAs, with an increase in the number of wards with less than 90% and 85%

nurse/midwife fill rates compared to the previous month.

The report reviewed any incidents that had occurred on the wards with less than 85% fill rate, noting staffing levels compared to funded establishment and where additional staff were requested to provide supplementary care, including 1-1 care for patients at risk of falling.

The Committee commented positively on the additional information now included in the report, including the requirements for supplementary care and cancellation of study leave/management days to maintain safe staffing levels, noting that this provided the relevant context to be able to understand the bigger picture. The importance of recording any staffing shortfalls on Datix was also noted.

Assurance Provided:

- No overdue safety alerts (CAS)
- Increased compliance with medicines safety
- Effective procedures in place to maintain safe working conditions for junior medical staff
- Ongoing achievement of over 90% sepsis screening and administration of antibiotics within 1 hour for patients with sepsis in ED
- Actions taken to ensure safe levels of nursing staff across the Trust

Decisions Taken:

Approval of Patient Experience Council Terms of Reference

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

- Ongoing support for the Deteriorating Patient Project
- Addition of supplementary care to the Strategic Falls Action plan for 2022-23

Matters for escalation:

- Proactive use of Tendable App to assess the quality of care provided and address areas for improvement
- Ongoing commitment of staff to delivering high standards of care

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: 30th March 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)018

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 24th March 2022

Summary

Meeting attended by:

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

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was below the 85% target in January, at 83.4%.
- Target 31 day performance was met in January, at 98.0% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in January, at 73.5% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 49.7% in February and 56.5% year to date. All type mapped STHK Trust footprint performance was 73.7% in February and is 77.5% year to date. The Trust saw average daily attendances of 319, which is an increase compared to January at 298. Total attendances for February were 8,932.
- The ambulance turnaround time target was not achieved in February, at 57 minutes on average. The Trust was the third busiest in C&M and fifth busiest across the North West.
- In February, overall sickness had decreased to 7%, from 9.6% in January.

B) Finance Report Month 11

- At Month 11, the Trust is reporting a breakeven position year to date and a breakeven forecast outturn.
- The 21/22 HCP CIP target of £10m has been met recurrently and focus is now on progressing 22/23 schemes.
- The Trust's full capital allocation is expected to be utilised by the end of the 21/22 financial year.

- At Month 11, the Trust has a cash balance of £75m and is achieving the Better Payment Practice Code (BPPC) requirement for non-NHS invoices by value at 98.7% against a target of 95%.

C) Update on ED Metrics

- The committee received an update on the six new ED performance metrics.
- Ability to report against some of the metrics will be dependent on updates to the ECDS system and process changes to ensure required information is recorded by staff.
- The committee noted the update and the requirement for more granular patient level data than that which was provided previously.

D) 21/22 CIP Programme Update

- The committee received the report on the Trust's 21/22 CIP programme.
- The £10m system CIP requirement has been met in 21/22 and recurrently.
- The committee noted that the focus is therefore now on identifying and progressing schemes for the 22/23 financial year.

For Approval

E) 22/23 Draft Financial Plan

- The committee received an update on the 22/23 draft financial plan.
- The draft plan gives a deficit of £34.1m, assuming expenditure of £527.6m and income of £493.5m.
- The committee reviewed the planning assumptions:
    - CIP at 3.5% (£18.5m)
    - ERF income of £13.3m (excluding any national ERF funding for activity exceeding 104% of 19/20 value)
    - Removal of non-recurrent system funding available in 21/22
    - Excludes Covid out of envelope (mass vaccinations), CDC and CIPHA costs
- The £34.1m deficit includes:
    - Income pressures £16.7m
    - National pressures (inflation including PFI inflation and depreciation) £19.4m
    - System pressures (operational plan delivery and escalation ward) £11.4m
    - Local pressures (Exec contingency, full year effect of 21/22 schemes and DAP increases) £5.1m – funded via CIP target
    - The above pressures are partly offset by CIP of £18.5m (3.5%)
- The 22/23 CIP target of 3.5% (£18.5m) consists of:
    - National CIP 2%
    - Local pressures 0.9%
    - Covid 0.6%
    - **Total 3.5%**
- 22/23 CIP schemes of £19.9m have been identified to date
- Initial Capital Resource Limit (CRL) of c£5m against internal depreciation of c£10m. £13m of capital bids being put forward by the system against the elective recovery and diagnostic allocations.
- Risks associated with deficit draft plan include failure to comply with breakeven duty in 22/23, with 3 years to recover breakeven cumulative position.

- The committee noted that discussions regarding the basis of final 22/23 income allocations are ongoing with the C&M HCP/ICS and therefore the income plan is likely to change prior to submission of the final plan on 28th April.
- The committee noted the 22/23 draft financial plan and recommended Board approval of the 22/23 draft expenditure budget but noted the challenges on the income allocations that are currently out of the Trust's control.

For Information

CIP Council Update – Update noted by the committee
Procurement Steering Council Update – Update noted by the committee

Risks noted/items to be raised at Board

- Risks associated with 22/23 draft financial plan and income flows within the newly formed ICS
- The committee recommend Board approval of the 22/23 expenditure budget

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 and approve the 22/23 draft expenditure plan
Presenting officer: J Kozer, Non-Executive Director
Date of meeting: 24th March 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)019

Title of paper: Draft Financial Plan 2022/23

Purpose: To provide an update on the draft financial plan for 2022/23

Summary:

The following paper outlines the current draft plans for 2022/23.

The plans include the following:

- CIP of 3.5% (£18.5m)
- Activity plans to deliver national guidance
- Net expenditure increase year on year of £1.6m
- Income allocations issued by the ICS/CCG based on historical allocations (including Covid top ups and other non-recurrent allocations in 21/22)

The current draft plans deliver a deficit of £34.1m. The breakdown of the deficit is described in the table below:

	£m
21/22 Forecast Surplus/(Deficit)	**0.0**
Income	
Covid income	-13.8
Income allocations	-9.6
Net ERF income	5.6
Convergence adjustment to income	-4.7
Regional CIPHA income	2.7
NCAs/LVAs income	2.0
Other income	1.1
Total income pressures	**-16.7**
National pressures	
Inflation	-14.7
PFI inflation	-2.5
Additional depreciation charges	-2.0
Energy inflation	-1.0
Car parking	0.8
Total national pressures	**-19.4**
System pressures	
Operational plan delivery	-7.6
FYE escalation ward	-3.8
Total system pressures	**-11.4**
Local pressures	
Exec Contingency (0.5%)	-2.6
DAP increases	-1.6
FYE of 21/22 schemes	-0.9
Total local pressures	**-5.1**
CIP	
National (2%)	10.5
Local pressures (0.9%)	5.0
Covid (0.6%)	3.0
Total CIP	**18.5**
22/23 Draft Plan Surplus/(Deficit)	**-34.1**

The ICS are currently reviewing the income allocations due to their historic nature and the reduced transparency/complications of adjustments that have occurred over the past two years.
Corporate objectives met or risks addressed: Financial, Performance, Efficiency and Productivity
Financial implications: None as a direct result of this paper
Stakeholders: Trust Board
Recommendation(s): Approval of the draft 2022/23 financial plan
Presenting officer: N Khashu (Director of Finance & Information)
Date of meeting: 30th March 2022

1. Executive Summary

1.1 The purpose of this paper is to provide an update on financial plans for the 2022/23 financial year.

1.2 Financial arrangements are still being agreed and discussed with the Health & Care Partnership (HCP). Mechanisms for all partners to breakeven have yet to be agreed.

1.3 The Trust's draft financial plan for 2022/23 gives a deficit of £34.1m. Of this, c.£16.7m relates to income shortfalls, £19.4m relates to national pressures, £11.4m relates to system pressures and £5.1m relates to local pressures. These pressures are partly offset by assumed CIP of £18.5m (3.5%).

1.4 The 2022/23 financial plan includes fixed planned income available for elective activity via a block mechanism.

1.5 The Trust has an indicative capital expenditure plan of £11.1m. Re-prioritisation is expected, due to the C&M ICS approval process.

1.6 Systems are asked to develop fully triangulated plans across activity, workforce and finances for the 2022/23 financial year. The Trust's final organisational plan will be submitted to NHSEI on 28th April.

2. 2022/23 Financial arrangements

2.1 System envelopes will include a 2.8% uplift for inflation, including 3% pay inflation. This is assumed to cover the 22/23 increase in employer NICs. It is assumed that any pay award impact above this 3% will be funded in addition to current envelopes.

2.2 System envelopes will include a deduction in funding based on a national efficiency assumption of 1.1%.

2.3 System funding will be reduced by a 'convergence adjustment' to move towards fair share allocations, replacing the Financial Improvement Trajectories in place pre-Covid to bring Trusts with underlying deficits back to balance. For C&M this equates to a reduction of 0.9%.

2.4 System level Covid funding allocations will also be reduced by 57%.

2.5 Signed contracts between NHS providers and NHS commissioners will be required before 31st March.

2.6 The following services will continue to be funded outside of system funding envelopes:

- Specialised high-cost drugs and devices
- Specific COVID-19 services
- Elective services recovery funding
- Non-clinical services contracted by NHSI/E
- National service development funding (SDF)

2.7 Systems will have access to the following additional funding:

- National ERF if system/Trust exceeds 104% of the value of 19/20 activity
- Additional funding for Community Diagnostic Centres
- Additional funding for rollout of virtual wards

2.8 Systems will need to plan collaboratively to determine the distribution of the system resources and all systems are expected to report a balanced position.

3. Contracting arrangements

3.1 Signed contracts between NHS providers and NHS commissioners will be required for 2022/23.

3.2 Details of 2022/23 CQUIN schemes have now been confirmed. The fixed element of elective funding will be set to include CQUIN funding of 1.25% of the contract value, with payment of this element to be deducted from providers if not delivered.

3.3 2021/22 CCG block payments values will be used as the baseline for 2022/23 contract values, adjusted for national assumptions of 2.8% inflation and 1.1% efficiency requirement (net increase of 1.7%).

4. Other Income

4.1 During 2021/22, NHS England and NHS Improvement provided additional income support to NHS providers to recognise the impact of COVID-19 on non-NHS income streams. In 2022/23, NHS providers are required to recover their positions – either through recovery of non-NHS income streams, utilisation of capacity for NHS activity to be funded through the Elective Recovery Fund or decommissioning of costs associated with these income streams.

4.2 Car Parking income will revert back to pre COVID-19 arrangements (i.e. patient and staff charges will come back into force). This is in line with National guidance

4.3 Wales contract arrangements have yet to be concluded. The basis under local discussion being in line with that of CCGs (i.e. H2 2021/22 block contracts with inflationary increases).

4.4 Local authority income will be based on local negotiations. The outcomes of pay reviews are yet to be concluded.

4.5 Divisional income will be based on local negotiations. The outcome of pay and none pay inflationary reviews yet to be concluded.

5. Expenditure plan

5.1 As at Month 9 2021/22, the Trust's forecast outturn expenditure for 2021/22 was £526.0m. The table overleaf shows the movements from this 2021/22 forecast outturn position to the current draft expenditure plan for 2022/23 of £527.6m.

	£m
Forecast Outturn 2021/22 as at M9	**526.0**
National pressures	
Inflation @ 2.8%	14.7
Net PFI inflation	2.5
Additional depreciation charges	2.0
Additional energy inflation	1.0
System pressures	
Operational plan delivery	7.6
FYE 1A escalation ward	3.8
Local pressures	
Exec contingency (0.5%)	2.6
DAP increases	1.6
FYE of 21/22 Schemes	0.9
Other	
Community Investments	2.0
FYE Bridgewater transfers	2.0
Less Mass Vaccination	-7.7
Less Community Diagnostic Centre (CDC)	-3.1
Less National CIPHA	-9.9
Less CIP @ 3.5%	-18.5
Draft 22/23 Expenditure Budget	**527.6**

5.2 The 2022/23 plan shown above includes an assumed Trust CIP target of 3.5% (£18.5m).

5.3 The expenditure plan above includes Exec contingency of £2.6m.

6. Cost Improvement Plans (CIP)

6.1 The expenditure budget shown above includes an assumed 2022/23 CIP target of 3.5% (£18.5m).

6.2 The Trust's assumed CIP target of 3.5% consists of:

- 1.1% national efficiency assumption
- 0.9% C&M convergence adjustment (replaces pre-Covid Financial Improvement Trajectory regime to bring Trusts with underlying deficits back to balance)
- 0.9% to fund internal pressures (£5.1m, consisting of the full year effect of 21/22 schemes, growth/development reserve and cost increases relating to the Digital Aspirant Programme)
- 0.6% relating to the reduction in Covid funding. This relates to a 57% reduction in the Trust's actual Covid costs during 21/22.

6.3 22/23 CIP schemes are in development:

- c£20m schemes identified (see table), of which £7,6m RAG rated green as low risk
- Further schemes to be explored via CIP council, Care Group F&P meetings

	£m
Non-recurrent	6.0
Productivity	3.5
Covid reduction schemes	3.0
Reduce premium pay	2.5
Medicines optimisation	1.0
Consumables/other non pay	0.9
Procurement	0.7
Estates and Premises transformation	0.6
Admin review	0.6
Skill mix reviews	0.5
CNST rebate	0.4
Digital transformation	0.2
	19.9

6.4 As in previous years, schemes are identified by the respective Care Groups and back-office functions will be assessed to ensure that there are no patient safety or quality concerns via the quality impact assessment (QIA) process.

6.5 The cost improvement plans and associated target will be included within the Trust's final income and expenditure plans. Therefore, any underachievement against the CIP target will impact the overall I&E performance of the Trust.

6.6 To support the delivery of the CIP programme, the Trust will utilise the skills and expertise from the Care Group based Business Partners/Service Transformation team and the continued roll out and adaptation of the Model Hospital. This will be supplemented by the Getting it Right First Time (GIRFT) reports in year as well as any system-wide initiatives. There is an expectation that some of this information will need to be historic because of the COVID-19 pandemic and that costs and activity returns will be significantly impacted for comparison purposes.

6.7 Potential schemes identified in 2021/22 but not yet delivered will be reassessed in the context of the 2022/23 planning and financial guidance to ensure they remain deliverable or are replaced with alternative schemes in order to meet the CIP target.

7. Income Plan

7.1 Income of £493m is included in the draft plan. A £34m deficit position is currently being reported within this submission based on the expenditure plan above.

7.2 The draft income plan includes the following values provided by the C&M HCP:

- £13.3m Elective Recovery Funding (ERF) to support delivery of 104% elective activity restoration. This envelope is currently being validated and will require delivery against elective recovery targets before it is confirmed. Performance above planning guidance requirements will be funded over and above this if delivered.

- £12.2m System COVID support based on H2 2021/22 multiplied by 2, adjusted by a 57% reduction in recognition of the reduced COVID activity within healthcare settings.

- £28.5m Up Front Top Up support based on H2 2021/22 multiplied by 2, adjusted by C&M HCP 0.9% convergence, to support managing resource allocations back to within target at a C&M HCP level. Convergence will be in a staged approach over time with 0.9% being stage one commencing 1st April 2022.

- £1m for low volume CCG activity.
- £9m income from CCGs outside the C&M HCP.
- The 2021/22 central funding arrangement for other income streams such as car parking will no longer be in place for 2022/23.

7.3 Guidance is still being updated and yet to be concluded associated with ERF and Aligned Payment Incentive Rules to support restoration of elective activity.

8. Statement of Financial Position (SOFP / Balance Sheet) including liquidity

8.1 The planned deficit will need to be supported by DHSC funding, either in the form of PDC or a loan, in order to maintain Trust liquidity. It is expected that PDC would be offered rather than a loan, but this has not been confirmed.

8.2 The Trust currently has no treasury borrowings such as DHSC loans. The Trust will continue to repay capital debt relating to the PFI scheme (through the PFI unitary payment) and will also make capital repayments relating to IFRS16 leases.

8.3 The impact of the new lease standard (IFRS16) is included within the 22/23 plan. This brings additional assets onto the SOFP, with corresponding adjustments that increase depreciation and lease borrowing.

8.4 The Trust also continues to repay its Salix loan. The Salix loan was used to fund the Trust's Combined Heat and Power capital scheme. It is interest free and will be repaid over 5 years from October 2019, in equal twice-yearly instalments (payable in October and April) of £0.211m.

8.5 The Trust is assuming no deterioration or improvement in the aged debt relating to Lead Employer contracts. This will continue to be managed separately in order to understand and respond to any changes within the working capital.

8.6 The Trust's land and buildings are valued using the alternative single site methodology and VAT is excluded from PFI valuations. The Trust currently has no surplus estate and therefore does not anticipate any sales of surplus assets.

8.7 The Trust's forecast cumulative breakeven position is £4.4m at 31 Mar 2022, but the planned deficit will exceed this and turn this measure negative within Q1. That is, a YTD deficit greater than £4.4m will trigger the three year requirement to ensure a cumulative breakeven position.

9. Interest, tax, depreciation and amortisation (ITDA)

9.1 Planned depreciation has been calculated on a prudent profile based on the Trust's assets.

9.2 Due to the repayment of loans in 20/21, no treasury loan interest is payable. Only the Trust's finance leases and PFI give rise to interest repayments.

9.3 The Trust is currently assuming no PDC dividend payments within plan. However, the Trust is approaching the threshold for payments, and this will continue to be monitored.

10. Capital

10.1 The capital plan is funded from internally generated depreciation, which has increased due to the impact of IFRS16. Within the capital programme, increased leased asset depreciation is offset by increased lease borrowing repayments.

10.2 The capital plan includes PFI lifecycle replacement costs paid for via the PFI unitary payment. It also supports the Informatics 5 year capital programme. An amount is set aside for other expenditure including new and replacement equipment and essential developments. PFI lifecycle costs are recognised as the actual replacement costs at the time of delivery; the figures below are PFI-modelled costs, and are expected to change.

10.3 The Trust's capital budget must be agreed within the C&M ICS, and the overall ICS capital plan must be deemed affordable and approved, before the Trust's allocation of the capital budget is approved by NHSE/I. Due to the impact of PFI accounting, the Trust should run a surplus to cover part of the PFI deficit in the capital programme. This matter is subject to ongoing discussion with NHSE/I.

10.4 The indicative capital allocations are below.

Capital loan repayments	
CHP (Salix)	£0.4m
PFI	£12.1m
Draft IFRS16 lease impact	£10.2m

Capital expenditure	
PFI lifecycle maintenance	£6.6m *funded from 22/23 PFI UP*
Capital budget	£4.5m

Due to C&M ICS's late reduction in the value of the draft capital plan, a process of re-prioritisation will need to take place and be reviewed by Executive Committee.

10.5 The approach for capital planning will be managed via Capital Planning Council, which will report back to F&P Committee and the Executive Committee.

11. Risks

12.1 The most significant risks to delivery of the draft financial plan for 2022/23 are as overleaf:

Risk	Description	Mitigation
Shortfall in funding allocation	Deficit due to removal of non-recurrent funding plus unfunded cost pressures e.g. PFI inflation, energy inflation	ICS to review block allocations and incentive payments for final plan
CQUIN (£6m) & Best Practice Tariffs	Income dependant on delivery of targets	Delivery reviewed at Exec Committee and Quality Committee
ERF income (£13m)	Income dependant on delivery of target within system and locally	To be reviewed at F&P Committee
CIP	CIP target of 3.5% (£18.5m)	22/23 schemes in work up (see previous slide) - opportunities of £20m identified to be progressed via CIP Council/Care Group F&P meetings
Cash	Deficit will reduce cash balances	Ongoing monitoring of cash position
PFI income	Currently included in system top ups but will need to be separated out	Engage with HCP/ICS to remove from top up values
Capital	Capital spend lower than internal plan	Monitor of capital spend and project progress against planned timescales. Additional bids submitted for strategic schemes.
Hospital Discharge Programme	To cease from 22/23 - impact to funding and deliverability of operational targets	Continuation of escalation ward
Potential cost pressures due to Covid-19	Reduced Covid-19 funding allocation may be insufficient	Continue to engage with HCP/ICS for appropriate funding allocation based on costs
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
Breakeven duty	Draft plan deficit will cause the Trust to fail the breakeven duty in 22/23	Trust has 3 years to recover breakeven duty cumulative position

12. Recommendation

12.1 The Board are asked to note the current financial plan for 2022/23, noting that the income position may vary depending on discussions with the ICS around funding flows.

12.2 The Board are asked to approve the 2022/23 expenditure budget.

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)020

Title of paper: Proposed Trust Objectives 2022/23

Purpose: To approve the proposed 2022/23 Trust Objectives.

Summary:

1. The Trust Board agreed thirty three objectives for 2021/22. The final appraisal of whether these objectives have been achieved is due to be presented to the Trust Board in May 2022.

2. The Executive Committee has now drafted Trust Objectives for 2022/23 for approval by the Trust Board in March, so they can be launched to Trust staff at the Start of the Year Conference which is scheduled for early May.

3. As usual the objectives will be split into 9 categories; 5 representing the Trust's Five Star Patient Care criteria of care, safety, pathways, communication, and systems. There are then 4 categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency and productivity; and strategic plans.

4. The 2022/23 quality improvement objectives to be included in this year's Quality Account are incorporated in to the proposed Trust objectives. These were agreed following a consultation exercise with staff and stakeholders where there was overwhelming support for the four proposed quality improvement priorities:

    i. Continue to ensure the timely and effective assessment and care of patients in the Emergency Department
    ii. Reduce avoidable harm by preventing falls
    iii. Ensure patients in hospital remain hydrated
    iv. Improve the effectiveness of the discharge process for patients and carers

5. Due to the ongoing disruption and operational pressures caused by the COVID 19 pandemic there are a number of the proposed objectives that the executive are proposing should be carried forward from 2021/22. Where this is the case the measures of success have been reviewed and updated.

Trust objective met or risk addressed: provides assurance to the Board that the Trust is making sufficient progress in delivering its strategic objectives and annual plans.

Financial implications: None directly from this report.
Stakeholders: The Trust, its staff, patients and all stakeholders.
Recommendation(s): The Board approves the Trust objectives for 2022/23
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 30th March 2022.

Proposed 2022/23 Trust Objectives

Objective	Lead Director	Measurement	Governance Route	Comments
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of hospital-acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee	Quality Account improvement objective
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	DoOp	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24 hour period • Implement the new national ED standards to; see and treat 98% of patients within 12 hours and "clinically ready to proceed" • Implement revised safety checklist documentation which includes National Early Warning Score (NEWS) and sepsis screening and undertake regular audits to demonstrate effective monitoring and appropriate escalation	Quality Committee	Quality Account improvement objective
1.3. Increase capacity at the Trust and improve clinical adjacencies to optimise patient flow	DoOp/ DoCS	• Continue to progress the strategic site development plans for the Trust and the capital schemes planned for 2022/23 to improve patient facilities and increase capacity; • Paediatric Emergency Department and Children's Observation Ward	Executive Committee	Governance route changed to Executive Committee as business cases for current schemes approved

Objective	Lead Director	Measurement	Governance Route	Comments
		• Additional Theatre capacity at Whiston Hospital • Implement the accommodation strategy to create space in the main hospital buildings for clinical services • Deliver increased diagnostic capacity in support of the elective recovery plans		
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Reduce avoidable harm by preventing falls (QA)	DoN	• Reduction in the number of inpatient falls per 1000 bed days by at least 10% compared to 2021/22 (stretch target remains less than 7.2 inpatient falls per 1000 bed days) • 95% of patients to have a documented falls risk assessment within 6 hours of admission measured through quarterly audit of sample of patients • When falls do occur the subsequent investigation will identify the root cause so these can be monitored and analysed • Audit demonstrating that patients at risk of falling have a completed falls prevention care plan in place that has been reviewed as per hospital policy	Quality Committee	Quality Account improvement objective
2.2 Evaluate best practice and develop proposals for improving the Trust wide safety culture	DoN	• Commission an independent diagnostic and cultural survey to inform the development of the "Safe and Sound" strategy and action plan • Launch and publicise the agreed strategy and the ways that staff can contribute • Celebrate achievements and successes with regular bulletins and dissemination across all clinical and patient facing staff	Executive Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
2.3 Implement the recommendations of the Ockenden Report into the safety of Maternity Services	DoN	• Delivery of the year two action plan to implement the recommendations of the Ockenden Report • Achievement of the CNST maternity safety bundle for 2022/23	Quality Committee	
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)	DoOp	• Continue to improve inpatient survey satisfaction rates for receiving discharge information • In regular audits achieve a minimum 75% of patients who receive the discharge from hospital booklet • Achievement of the 20% target for patients to be discharged before noon during the week and 85% by 5.00pm, consistently across all wards • Achievement of 85% of the weekday average discharges to be achieved at the weekends, consistently across all wards • Implementation of standardised patient equipment ordering process for aides required at home.	Quality Committee	Quality Account improvement objective
3.2 Implement the multidisciplinary Community Crisis Response Service for St Helens	DoOp	• Respond to 80% of calls within 2 hours by Quarter 3, increasing to 90% by April 2023 • Reduce ambulance conveyances to the ED • Reduce unnecessary emergency admissions to hospital	Finance and Performance Committee	New
3.3 Improve acute care pathways to ensure optimal configuration of services	DoOp	Agree the optimal configuration of surgery, medical specialities and paediatrics within the Trust to; • Reduced number of patient ward moves • Reduced number of FCEs	Executive Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
		• Implement direct to specialty pathways • Improve patient satisfaction and experience ratings		
3.4 Continue to redesign outpatient pathways through transformation and modernisation	DoI/DoOp	• Introduce an electronic room-booking service, so that the capacity in the outpatient departments are optimised to accommodate additional clinics • Reduce DNAs by enabling patients to choose their preferred method of communication for appointments and appointment reminders • Implement electronic requesting for clinicians in outpatient settings e.g. prescribing, request for follow up appointments, diagnostic tests • Reduce the number of cancelled and rearranged appointments by 20% by revising the current clinic structures and piloting shortened booking horizons	Executive Committee	
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Improve communications for relatives who need to contact our wards	DoN/DoI	• Develop innovative solutions to enable relatives to be able to contact the clinical team on each ward and be regularly up dated about their loved one • Reduce PALs contacts and complaints relating to communication with wards • Reduce the number of abandoned calls to wards	Quality Committee	New
4.2 Introduction of digital letters and “real time chat” alongside telehealth appointments to support patients in having a	DoI	• Digital letters that meet the accessibility standards and can easily be shared with other carers or relatives • Improved digital information supported by “messaging” to	Executive Committee	New

Objective	Lead Director	Measurement	Governance Route	Comments
choice about how they communicate with the Trust		enable patients to ask questions about their care or condition directly and easily with the clinical team looking after them		
4.3 Improve internal processes and communication systems with patients and relatives about patient property	DoN	• Reduction in incidents relating to lost patient property • Reduction in PALs contacts and formal complaints received about patient property	Quality Committee	New
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Deliver the 2022/23 Digital Strategy Objectives and achieve HIMSS Level 5 or greater by Autumn 2023	DoI	• Reduce the amount of paper in nursing and therapies documentation produced, as part of the paper based medical record by 90% • Reduce the amount of paper in medical documentation by 50%, aided by in-built clinical decision support • During Careflow downtime ensure clinicians have access to patient allergies, problem/diagnostic lists, medications and lab results	Executive Committee	
5.2 Implement and electronic bed management and discharge planning system across inpatient wards at Whiston Hospital.	DoI	• Help ensure that the sickest patients are seen soonest by the use of Early Warning Scores (EWS). These are available via the clinical modules within Careflow EPR, specifically Vitals on desktops and handheld devices, Careflow Connect, and Patient Flow, which displays the EWS in a colour coded format. • Roll out electronic whiteboards across Whiston Hospital wards • Improve access to patient information by the implementation and roll out of Workspace and Narrative digital clinical documentation Reduction in patient LOS by supporting achievement of the national discharge targets	Executive Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
		• Patient information to be entered electronically only once and used many times.		
5.3 Implement new Community EPR solution	DoI/DoOp	• To improve the management of patients in the community • Reducing the amount of paper that clinicians have to complete , releasing more time to care • Improving the ability to share information in real time with primary and secondary care colleagues. Supporting joined up care.	Executive Committee	New
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				
People Plan Pillars – Looking After our People				
6.1 Enhance health and wellbeing support services for staff and promote attendance	DoHR	• Comply with NICE guidance and the NHS People Plan and provide an extended range of support services to improve the health, well-being, and resilience of our staff , including supporting staff who have been impacted by the COVID-19 pandemic • Implement a new person-centred well-being and attendance management policy framework that supports staff to return to work • Develop a leadership development training programme that supports managers deliver the new approach	Strategic People Committee	
People Plan Pillars - Belonging to the NHS				
6.2 Continue to listen to our staff to ensure we remain an employer of choice	DoHR	• Agree the priority actions from the 2021 staff survey and deliver them in 2022/23	Executive Committee	
6.3. Improve the methods of delivery and ease of access of	DoHR	• Achieve the COVID-19 recovery improvement trajectory of 85% compliance with mandatory training across all staff	Strategic People	

mandatory training to increase compliance rate recovery		groups • Continue to innovate with the subject matter experts to create alternative delivery methods to support staff access to mandatory training	Committee	
6.4 Respond to feedback from staff to improve appraisals and appraisal compliance to support staff to deliver high quality patient care.	DoHR	• Continue to embed the new Trust appraisals process and evaluate the impact with staff • Achieve the COVID-19 recovery improvement trajectory of 85% compliance with staff appraisals across all staff groups	Strategic People Committee	
People Plan Pillar – New Ways of Working				
6.5 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimal design of the workforce and the right number and skill mix of staff	DoHR	• Undertake a benefits realisation review for e-rostering and e–job planning to improve levels of compliance • Improve the management and governance processes that support e-rostering and reduce errors • Restart the specialist nursing job planning project with the aim of having 50% of this staff group with refreshed job descriptions • With the Director of Nursing review opportunities for the development and deployment of the band 2-6 nursing workforce to ensure effective use of resources aligned to patient acuity and the delivery of safe and effective care.	Executive Committee	
People Plan Pillar – Growing for the Future				
6.6 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Recruit 180 additional new permanent nurses • Recruit 80 of the new nurses and 20 medical and dental staff via international recruitment programmes • In partnership with the Medical Director and Director of Nursing, Midwifery & Governance develop workforce development plans to achieve a strong pipeline of new clinical roles including 15 TNAs, 6 ACPs and 6 PAs	Strategic People Committee	

		• Support registered nurses to adopt a flexible approach to working, offering all those eligible retire and return conversation • Increase the Healthcare Support Worker use of the internal transfer scheme by 10% and improve staff retention rates for this group of staff by 15% through meeting career aspirations and development opportunities within the Trust • Create opportunities for people who are "new to care" offering the care certificate and apprenticeship programmes • Support more staff to undertake further training in Advanced Clinical Practice and Leadership Development, utilising the apprenticeship levy		
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Deliver the elective recovery activity targets to reduce waiting lists	DoOp	• Deliver at least 104% of 2019/20 elective activity levels • By July 2022 no one to have waited longer than two years • Eliminate waits of over 18 months by April 2023 • Provide mutual aid in specific specialities to support the delivery of system recovery targets	Finance and Performance Committee	New
7.2 Implement recovery plans to consistently achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including the new 12 hour see and treat targets • 62-day cancer treatment standard • Diagnostic tests completed within 6 weeks • Ambulance handover times (under 30 minutes) • Working with system partners reduce the % of medically	Finance and Performance Committee	

		optimised patients with delayed discharges		
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g. GiRFT to ensure that all services meet best practice standards	DoOp	• Continued participation in national programme of GiRFT and other reviews and delivery of the resulting action plans • Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery and sustainability of the changes	Finance and Performance Committee	
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaboration at scale to increase efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration at scale with system partners	Executive Committee	
8.2 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2022/23 • Delivery of the agreed Cost Improvement Programme • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.	Finance and Performance Committee	
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve	DoCS	• Meet statutory and regulatory responsibilities • Implement the new performance and accountability frameworks when the ICBs are created in July 2022.	Trust Board	

system success				
9.2 Working with health and care system partners implement Place based Integrated Care Partnerships to improve the health of the local population	DoInt	• Support our local boroughs to establish Integrated Care Partnerships (ICPs) • Position the Trust as a key partner and anchor institution in each Place ICP	Trust Board	
9.3 Provide leadership and direction as part of the C&M ICB to achieve clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations • Support the development of effective Provider Collaboratives that enhance collaboration and integration of acute services and coordinates the delivery of the elective recovery plans to maximise the capacity available to the system	Trust Board	
9.4 Progress the Agreement for Long Term Collaboration (ALTC) with Southport and Ormskirk Hospital NHS Trust	All	• Continue to provide management support to S&O • Continue to develop plans to address the fragile clinical services working with clinicians across both Trusts and other providers as necessary • Develop a plan, with the Shaping Care Together programme that will deliver sustainable clinical services	Trust Board	New

END

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)021

Title of paper: Care Quality Commission (CQC) compliance and registration

Purpose:

This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to provide assurance to the Board.

Summary:

The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The Trust's last inspection took place in July/August 2018 and covered the following areas:

- Use of resources
- Surgery
- Urgent and emergency care
- Maternity
- Community services
- Marshalls Cross Primary Care Service
- Well-led domain

The final report was published on 20th March 2019 and the overall Trust rating was outstanding. This rating remains in place.

The report identified three breaches of the CQC regulations in relation to Marshalls Cross Medical Centre. Actions have previously been taken to address the three issues internally, which have been assessed by Mersey Internal Audit Agency and found to be compliant.

The CQC's transitional regulatory approach to monitoring implemented in 2020-21 was maintained during 2021-22, which included an in-depth review of Maternity Services in April 2021. There were no concerns raised as a result of this review.

Appendix 1 provides an updated summary of compliance against each of the relevant standards.

Corporate objectives met or risks addressed:

Care, safety and communication

Financial implications:

The CQC charges all providers an annual registration fee to cover its regulatory activities based on a % of the patient care income from the most recent annual accounts.

2019-20 fee = £238,394

2020-21 fee = £249,293

2021-22 fee = £281,838

Stakeholders: Trust Board, patients, carers, staff, regulators, including the CQC and commissioners

Recommendation(s):

For the Trust Board to:

- Review the information provided to confirm compliance with the fundamental standards and on-going CQC registration requirements and to determine if further information or evidence is required.

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

Date of meeting: 30th March 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 14th March 2022
	Full assurance in place in STHK
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Remuneration	DoHR		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard, which is applied to all new appointments and renewed annually. All records available for review by CQC if required.
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive	DoNMG		Director of Nursing, Midwifery and Governance is the Accountable Person registered with the CQC. Director of Nursing registered with the CQC as responsible officer and confirmed in the latest certificate received dated 02/12/2019.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	Quality	DoNMG		See information below for compliance
1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	Quality	DoNMG		All patients are assessed on admission/commence on caseload and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, promotion of John's Campaign to support carers who wish to stay with patients/carer beds (which has remained in place during the pandemic as a valid exemption to the visiting restrictions) hearing loops & communication aids. In outpatients, double, early and late appointments are used along with desensitising visits to clinics. Specialities have developed their own pathway supporting people with additional needs and include imaging, endoscopy and pre-operative assessment. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. Mental Capacity Act included in mandatory training. Up-to-date Consent Policy in place and available on the Trust's intranet with quarterly consent training provided by the clinical lead for consent. Compliance with nursing care indicators is regularly audited and reported to each ward using the audit app, Tendable. The Trust received an overall rating of outstanding for the caring domain, with examples of compliance sited in the CQC inspection report, including the fact there were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were met appropriately and promptly. The CQC observed positive interactions when staff were seeking consent. Positive comments continue to be received via NHS website and Friends and Family Test feedback, including via the newly introduced Trust website feedback form. These are shared with the relevant teams to boost morale and to continue to support high quality care.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, including when sleeping, toileting and conversing.	Safe, **Caring,** Responsive	Quality	DoNMG		The Trust's values include respectful and considerate and these are reiterated at interview, on induction and during appraisals. Values based recruitment is in place for all staff. Privacy and dignity is assessed as part of the CQC inspection, external PLACE assessments (which were paused during the pandemic) and internal audits (which have continued during 2021-22). The Trust was rated best nationally in last PLACE assessment for third year running (2019). 2020 inpatient survey (reported 2021) results state 97% of patients reported that they were given enough privacy when being examined or treated, compared to the average score of 95%. Privacy and dignity consistently score highly in the Nursing Care Indicators. Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. Provision of Single Sex Accommodation Policy in place, which requires any breaches to be reported via the Datix system. Annual mixed sex declaration submitted to the Board each March with no unjustified breaches reported in 2021-22 and 2020-21, with two breaches reported in 2019-20 for step down patients in Critical Care and none for over two years prior to this.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe,** Responsive	Quality	MD		Up-to-date Consent Policy in place and patients are consented using standard Trust forms for all procedures. Annual consent audit undertaken as part of the clinical audit programme which is reported to the Clinical Effectiveness Council. CQC observed positive interactions when staff were seeking consent. Consent training provided quarterly. Any incidents where consent issues are identified, including through claims and complaints, are investigated and actions taken to deliver improvements.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	Quality; Workforce Council; Executive	DoHR, DoNMG, DoCS,		H&S risk assessments in place and outlined in H&S Policy & supporting documents. Workplace inspections reported to Health and Safety Committee which reports to Workforce Council and programme of environmental checks in place, with actions taken to address any issues identified. All staff are risk assessed as part of the pandemic response, with appropriate redeployment put in place depending on the outcome of the risk assessment. Staff reported positively on the availability of personal protective equipment during the pandemic and Health and Safety Executive review in December 2020 found no cause for concern. Relevant checks against job description/person specification undertaken as part of recruitment process for all staff. Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. Missed doses of medication are recorded in electronic prescribing and medicines administration (ePMA). Pharmacy staff undertake audits of missed doses and medicines security, providing feedback to individual wards for improvement. Improvements noted in the latest medicines security audits reported to the Quality Committee in October 2021. Programme of medical device maintenance in place. Compliance with infection prevention is regularly audited and root cause analysis undertaken on any serious incidents, including CDiff/MRSA cases. Two MRSA bacteraemia reported year to date in 2021-22 and CDiff cases remain below threshold set in 2021-22. In relation to Marshalls Cross Medical Centre actions were taken to strengthen the processes for the following, which were reviewed by MIAA and confirmed as completed: • Follow up of uncollected prescriptions • Monitoring of NICE guidelines • Managing patients on high risk medicines • Undertaking risk assessments

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	Quality, Workforce Council	DoNMG, DoHR		The Trust has a zero tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's values and ACE behavioural standards. Each clinical area has a Safeguarding file with key information to ensure all suspicions are reported appropriately. Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, ie those working with children and young people and those in decision-making roles respectively. Compliance with training is reported to the Quality Committee. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training, with increase in referrals maintained in 2021-22. The Trust provides training in conflict resolution. CQC inspection report highlighted that the relevant policies and procedures were in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	Quality	DoNMG		Trust rolled out the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance in 2015 which is now included in the electronic risk assessments. Patients identified as at risk of malnutrition have food charts in place. There is a red tray and red jug system in place for patients who require additional support with eating and drinking. All general wards are required to operate protected mealtimes, which was reviewed and relaunched in 2021-22. Patients are regularly assessed to note any changes in nutrition and hydration status. Regular audits are conducted to maintain focus on high standards of hydration and nutrition throughout the Trust. In addition, electronic fluid balance charts to support appropriate recording of hydration are now in place and moved to Careflow vitals in March 2021, which will further aid compliance due to reduction in need to use different systems/devices. An action plan to continue to improve hydration is in place. The volunteer service had increased the number of trained dining companions to further support patients during meal times, which were reintroduced in 2021-22 following suspension due to volunteers not attending wards in the pandemic.
7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	Quality	DoCS		The Trust was rated best acute Trust for Patient Led Assessments of the Care Environment (PLACE) programme in 2017, 2018 and 2019 (the latest inspection). The Trust achieved 100% for; • cleanliness • condition, appearance and maintenance of the hospital buildings A comprehensive internal environmental audit is undertaken to maintain these exceptionally high standards. Workplace inspections and COSHH risk assessments in place. Waste Management Policy in place with regular awareness raising and training provided for staff. Security service provided 24 hours per day and Lone Worker Policy in place.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	Quality	DoNMG		Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of PALS. Improvements to the management of complaints remain ongoing, with effective system in place via Datix for recording and monitoring each complaint. Themes and actions taken identified and reported to Patient Experience Council, the Quality Committee and the Board, to support Trust-wide lessons learned. Mersey Internal Audit Agency provided a significant assurance rating on the process for learning lessons from complaints and incidents in 2020-21, with evidence provided in 2021-22 to close outstanding recommendations.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
9	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	**Well-led,** Responsive	Board	CEO		An annual Board effectiveness review is undertaken, including a review of the Board Committees and the outcomes are considered by the whole Board. Progress in delivering the Trust's objectives is reported to the Board annually and these are then refreshed for the next year. The Board and its committees review key performance indicators via the integrated performance report (IPR) monthly, identifying areas where compliance could be improved to target actions appropriately. MIAA review the governance arrangements within the Trust, including compliance with the CQC processes. External Audit review the annual governance statement. The Trust complies with the NHS Publication scheme, with an internal team briefing system in place to ensure staff are aware of the results of external reviews. Ward accreditation scheme in place (Quality Care Assessment Tool – QCAT) that is aligned to CQC standards, which was relaunched in 2021-22 following temporary suspension due to the pandemic. CQC noted that there was effective staff engagement in the development of the Trust's vision and values, which were widely understood across the organisation. The comprehensive ward to Board review of each clinical area through the annual Quality Ward Round will be relaunched in 2022.-22. In relation to Marshalls Cross Medical Centre actions were taken to put in place; • Audit programmes to monitor quality and identify areas for improvement • Undertake risk assessments

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce Council	DoHR		Comprehensive workforce strategy in place supported by Recruitment and Retention Strategy, including targeting workforce hotspots and proactive international recruitment for both medical and nursing staff. The Trust has an ongoing collaboration with Masaryk University, Brno, Czech Republic to recruit newly qualified doctors who trained using the English syllabus. There is an active recruitment programme for the nursing and midwifery workforce, on-going throughout the year. The Trust continues to explore all possible opportunities to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals: • An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally. This includes the reintroduction of both face to face and virtual open events • Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and ODP apprenticeships • Implementation of the nursing associate role with 15 trainees completing their training in March 2022 and further trainees commencing training in Autumn 2022 • Implementation of e-rostering, which has been implemented in 98% of the organisation, with the remaining 2% being introduced in the early part of the 2022-23 financial year. E-job planning is being taken forward for other staff groups to include medics • Launch of a new online appraisal and personal development plan system which includes an enhanced focus on health, wellbeing and staff support • Equality, Diversity & Inclusion champions appointed to lead new staff networks created: Carers, Building a Multi-Cultural Environment, Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+), Menopause, Armed Forces and supporting a healthy workforce There is a comprehensive workforce performance dashboard, which enables detailed monitoring/oversight. A safer staffing report is presented to the Quality Committee, with detailed staffing review reported to the Board twice yearly including nurse establishment and patient acuity. In relation to Marshalls Cross Medical Centre action was taken to ensure sufficient numbers of suitably qualified, competent, skilled and experienced people to provide formal clinical leadership, including increased GP lead sessions.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
11	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	**Well-led**	Workforce Council	DoHR		Effective procedures in place for pre-employment and on-going revalidation of relevant staff. The Trust has range of HR policies and procedures in place. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties. MIAA review recruitment as part of ongoing audit cycle to provide external assurance on compliance with policy and procedure.
No FS maps to this regulation	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying and harassment is tackled in relation to duty of candour.	**Safe**	Quality Committee	DoNMG		Electronic reporting system, Datix, includes mandatory field to confirm compliance with Duty of Candour Compliance included in serious incident Board report Training is provided to staff within the following training programmes: • Trust's induction. • Mandatory training • Root cause analysis training There are a number of routes for raising concerns across the Trust, including speak in confidence electronic system launched in 2016-17 as a route for staff to report concerns anonymously. Assistant Director of Patient Safety appointed as Freedom to Speak Up Guardian, with 4 additional guardians to ensure staff have wide access. CQC confirmed in their inspection report that the Trust has good systems in place to fulfil its obligations in relation to the Duty of Candour Regulations.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	**Responsive,** Well-led	Executive	DoCS		Ratings available on internet with links to the full reports using the CQC widget. Full list of clinics and sites where services provided collated for staff to display ratings in individual clinics.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)022
Title of paper: Elimination of Mixed Sex Accommodation - Declaration
Purpose: To provide assurance to the Trust Board that the Trust has complied with the national guidance to eliminate mixed sex accommodation.
Summary: All trusts are required to make an annual declaration confirming compliance with the guidance in relation to elimination of mixed sex accommodation and the provision of appropriate single-sex facilities. Failure to comply with the guidance could result in significant financial penalties for breach of contractual standards, unless it would be in the overall best interests of the patient or is their personal choice. The annual declaration must be published on the Trust website. No breaches were declared in 2020-22 and the Trust continues to implement the Provision of Same Sex Accommodation Policy in order to prevent any breaches.
Corporate objectives met or risks addressed: Safe and effective care
Financial implications: Financial penalties can apply if breaches occur
Stakeholders: All staff and external partners
Recommendation(s): The Board approves the declaration in relation to the elimination of mixed sex accommodation
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 17th March 2022

Exec Committee: Annual Mixed Sex Accommodation declaration.

Eliminating Mixed Sex Accommodation Declaration

1. Background

1.1 In November 2010, the Chief Nursing Officer (CNO) and Deputy NHS Chief Executive wrote to all NHS Trusts. The letter (PL/CNO/2010/3) set out the expectations that all NHS organisations 'are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, or their personal choice'. The CNO letter included detailed guidance on what was meant by 'overall best interests', including situations, for example, when a patient is admitted in a life threatening emergency.

1.2 This was followed by another letter from the Chief Nursing Officer and Deputy NHS Chief Executive in February 2011 (Gateway ref 15552) setting out expectations regarding annual declarations of compliance.

1.3 Further guidance, ‘Delivering same-sex accommodation’ was issued by NHS England and NHS Improvement in September 2019 which provided clarification about what constitutes a breach.

1.4 Covid-19 Response, a letter dated 28 March 2020 from NHSE/I provided the trust with guidance relating to reducing burden and releasing capacity for staff so that emergency planning can be undertaken as part of the local NHS response to the Covid-19 pandemic. The letter stipulated that MSA breaches did not need to be returned to NHS Digital from 1 April 2020 to 30 June 2020.

1.5 Trust Boards are required to declare compliance annually and if they are not able to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance.

2. Declaration of Compliance

2.1 The Trust Board of St Helens and Knowsley Teaching Hospitals NHS Trust confirms that mixed sex accommodation has been virtually eliminated within all its hospitals, except where it is in the overall best interest of the patient, or reflects their personal choice.

2.2 We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen by exception based on clinical need, for example, where patients need specialist equipment such as in critical care areas.

2.3 Sleeping accommodation does not include areas where patients have not been admitted, such as cubicles in the Emergency Department or assessment areas.

2.4 If our care should fall short of the required standard, the Trust will report it. St Helens and Knowsley Teaching Hospitals NHS Trust have assurance

mechanisms in place to monitor compliance, the management structure to manage any breaches and the desire to ensure we are communicating to patients and the public that we are continuing to meet our commitment to providing same-sex accommodation.

2.5 The Trust board monitors compliance with mixed sex accommodation compliance monthly as reported in the integrated performance report (IPR).

3. Data collection and performance

3.1 There were no reportable breaches in 2021-22.

4. Current Situation

4.1 Gender mixing only occurs within critical care units and the emergency department. This is in line with the overall best interests criteria stated by the CNO.

4.2 All adult in-patient wards are either single sex, or where they are mixed sex, areas within the ward are designated as male or female, with separate designated toilets and bathrooms. Where admissions and transfers may potentially cause a mixed sex breach ward teams are able to move patients to prevent this.

4.3 Children, young people and their parents will be asked at time of admission if they wish to be cared for with others of a similar age in a single sex bay or in a single room. This preference is used to determine where to place a child or young person in our children's wards.

4.4 Any changes proposed to the ward environment include a risk assessment to ensure that the requirements for single sex accommodation can continue to be met.

4.5 The Trust's Provision of Same Sex Accommodation Policy was updated in 2020 and is available for staff on the Trust's intranet.

5. Patient experience

5.1 Year-to-date there has been no PALS or formals concerns raised regarding privacy and dignity in relation to mixed sex accommodation.

6. Recommendation

6.1 The Trust Board are asked to approve the he annual statement of compliance This will then be published on Trust website and submitted to NHS England.

Ends

Exec Committee: Annual Mixed Sex Accommodation declaration.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)023
Title of paper: Gender Pay Gap Report 2021/2022
Purpose: To update the Trust Board on the 2021/2022 Gender Pay Reporting Submission for 2022 to be published on the 30th March 2022 following approval at Trust Board.
Summary: All organisations are required by law to report on Gender Pay in line with the Equality Act (Gender Pay Gap Information) Regulations 2017 as part of the Public Sector Equality Duty. The Government have provided specific guidance on the calculation of the data and what is required and this report adheres to the guidance provided.
Corporate objective met or risk addressed: Compliance with Trust's Public Sector Equality Duty under the Equality Act 2010.
Financial implications: Potential fine if not reported on the government portal and published in accordance with the law.
Stakeholders: Trust Board, Management, Staff, Patients, NHS England, Commissioners, Staff-Side
Recommendation(s): The Trust Board are requested to approve the Gender Pay Gap Report 2021/22 to comply with the statutory requirement to publish the report on the 30th March 2022 following presentation to the Trust Board.
Presenting officer: Anne-Marie Stretch, Deputy Chief Executive and Director of HR
Meeting date: Thursday 30th March 2022

Gender Pay Gap Report 2021/2022

1. Introduction

1.1 Legislation

Organisations are required by law to report on Gender Pay in line with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 as part of the Public Sector Equality Duty.

Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The results must be published on the employer's public-facing website and the government's website. There are six calculations that we must publish:

- mean gender pay gap
- median gender pay gap
- mean bonus gender pay gap
- median bonus gender pay gap
- proportion of males and females receiving a bonus payment
- proportion of males and females in each pay quartile

Alongside the calculations if the organisation is a business or charity it must also publish a "written statement" that confirms that the published information is accurate. This statement must be signed by an "appropriate person" as follows:

- for any corporate body other than a limited liability partnership, this will be a director (or equivalent)
- for a limited liability partnership, this will be a designated member
- for a limited partnership, this will be a general partner
- for any other kind of partnership, this will be a partner
- for an unincorporated body of persons other than a partnership, this will be a member of the governing body or a senior officer
- for any other type of body, this will be the most senior employee

The data and written statement must be published within a year of the "snapshot date" (31st March) and must be published by 30th March each year.

1.2 What does Gender Pay Gap refer to?

Gender pay gap shows the difference in the average pay between men and women within an organisation. In many cases the average pay of women is lower than that of men, because there tend to be fewer women than men in very senior high earning positions. Even in organisations that have a majority female workforce (such as the NHS), if the most senior or most highly compensated positions are occupied disproportionately by men, the average pay of women in the organisation will remain significantly lower.

If a workforce has a particularly high gender pay gap, this can indicate there may be multiple issues to address, and the aim is that organisations take steps to tackle them. As such, gender pay audits are an effective tool to highlight continued systemic gender inequality within an organisation.

Gender pay gap and equal pay are two very different subject areas and should not be conflated. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is direct discrimination and unlawful to pay people unequally on the basis of their sex.

1.3 Adjustments to Gender Pay Reporting due to Covid-19 Pandemic

The annual requirement to publish data by the 30th March of each year was temporarily deferred by six months in 2021 due to the Covid-19 Pandemic. The March 30th deadline has been reinstated for 2022, meaning this is the second Gender pay report published by StHK within five months.

In addition, we ordinarily publish our Gender Pay Report in the July following the March 31st Snapshot date, well in advance of the following March 30th deadline, in order to ensure our data is timely and any actions remain relevant. As such this report will be quickly followed by a third Gender Pay Report, for 2022-23, due in July, thus bringing the Trust's equality reporting back into synch.

Sep-21	Deferred 2020/2021 Gender Pay Report Published
Mar-22	2021/2022 Gender Pay Report Published
Jul-22	2022/23 Gender Pay Report to be Published

For this reason we have recognised and noted the progress against actions from the recent September 2021 Gender Pay report, and will review and redraft timely and appropriate actions on the next iteration.

This is also the first Gender Pay Report covering the staffing changes that occurred in response to the pandemic. Its snapshot date of 31st March 2021 clearly will not reflect an ordinary point with regard to staffing profiles. With this in mind the current data will be most accurately reviewed in context of the previous and forthcoming years' reports.

2. Overview of St Helens & Knowsley Teaching Hospitals NHS Trust

On 30th March 2022, the Trust will submit Gender Pay Gap (GPG) information for the year 2021-2022. As of 31st March 2021 a total of 7,027 individuals were employed by the Trust, up from 6,227 on 31st March 2020. The Trusts headcount is slightly higher than in previous years due to additional temporary resources recruited to support the covid pandemic. This is expected to reduce again in 2022/23.

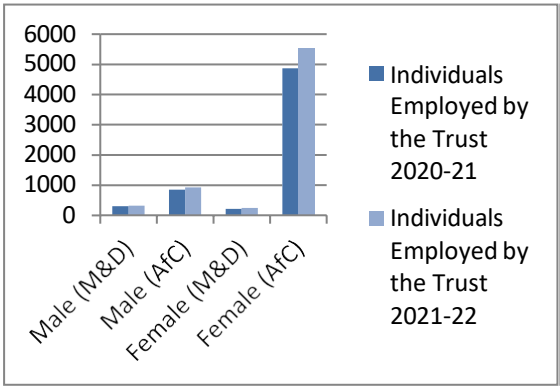
The GPG figures are based upon figures drawn on 31st March 2021, referred to as the 'snapshot date' and includes anything that is paid or invoiced up to for the period of March 2021.

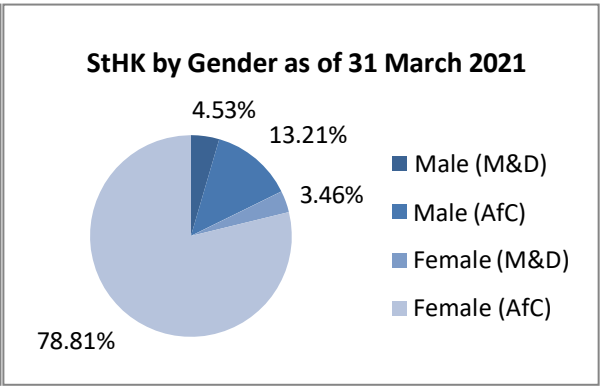
For the purposes of GPG reporting 'employee' is defined as:

- people who have a contract of employment within the organisation
- workers and agency workers (those with a contract to do work or provide services)

- some self-employed people (where they must personally perform the work)

Results should be considered in relation to the Trust's overall gender demographics, which are shown below for context.





2.1. Mean Hourly Rate of Pay

Table 2.1 Mean Hourly Rate of Pay

Gender	Mean Hourly Rate 2020/21	Mean Hourly Rate 2021/22
Male	£21.42	£22.56
Female	£15.34	£15.08
Difference	£6.08	£7.48
% Pay Gap	28.38%	33.16%

A low percentage represents a good performance by the Trust. The Trust's mean hourly gender pay gap has increased by 4.78% from our 2020/21 position, following a decline of 0.59% in the previous year. Mean Pay Gap will be influenced more heavily by smaller numbers of higher paid staff, so the median pay gap is generally accepted as the better indicator.

Table 2.1.2 Mean Hourly Rate of Pay (Medical & Dental and Agenda for Change (AfC)

Table 2.1 details the Mean Hourly Rates of Pay for both Male and Female staff categorised as Medical and Dental (M&D - N=561) and Agenda for Change (AfC – N=6,276).

Gender	Mean Hourly Rate 2020/21 (M&D)	Mean Hourly Rate 2021/22 (AfC)	Mean Hourly Rate 2021/22 (M&D)	Mean Hourly Rate 2021/22 (AfC)
Male	£39.02	£15.28	£41.97 (+£2.95)	£15.91 (+0.63)
Female	£35.25	£14.46	£37.98 (+£2.73)	£14.83 (0.37)
Difference	£3.77	£0.82	£3.99	£1.08
% Pay Gap	9.66%	5.37%	9.49%	6.78%

Table 2.1.3 Overall Mean Hourly Rate of Pay

	Mean Hourly Rate	Number of Staff	Total (Mean Hourly Rate x Number of Staff)	
Male (M&D)	£41.97	318	£13,346.46	
Male (AfC)	£15.91	928	£14,764.48	28,110.94/1,246 Total = £22.56
Female (M&D)	£37.98	243	£9,229.14	
Female (AfC)	£14.83	5,538	£82,128.54	£91,357.68/5.781 Total = £15.08

2.2 Median Hourly Pay Rates

Table 2.2 Median Hourly Rate of Pay

Gender	Median Hourly Pay Rate 2020/21	Median Hourly Pay Rate 2021/22
Male	£15.68	£16.34
Female	£13.15	£13.63
Difference	£2.53	£2.71
% Pay Gap	16.13%	16.09%

A low percentage represents good performance by the Trust. There is been a 0.04% decrease in the Trust's median rate of pay gap from our 2020/21 position.

Table 2.2.1 Median Hourly Rate of Pay
(Medical & Dental and Agenda for Change (AfC))

Table 2.2.1 details the Median Hourly Rates of Pay for both Male and Female staff categorised as Medical and Dental (M&D - N=561) and Agenda for Change (AfC – N=6,466).

Gender	Median Hourly Rate 2020/21 (M&D)	Median Hourly Rate 2020/21 (AfC)	Median Hourly Rate 2021/22 (M&D)	Median Hourly Rate 2021/22 (AfC)
Male	£42.89	£13.10	£45.21	£13.50 (+£0.40)
Female	£40.68	£12.80	£41.81	£13.19 (+£0.39)
Difference	£2.21	£0.30	£3.40	£0.31
% Pay Gap	5.15%	2.29%	7.52%	2.30%

2.3 Mean and Median Bonus Pay

The mean bonus gender pay gap was as follows:

Gender	Avg. Pay	Median Pay
Male	£0.00	£0.00
Female	£0.00	£0.00
Difference	£0.00	£0.00
Pay Gap %	0%	0%

1.1. Proportion of males and females receiving bonus payment

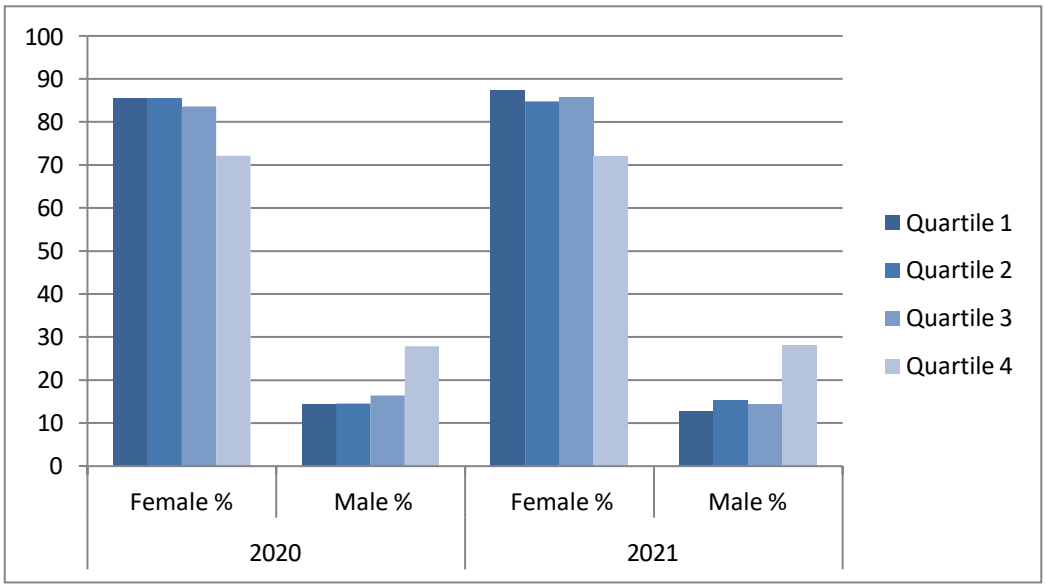
The proportion of males and females receiving bonus payments was as follows:

Gender	Employees Paid Bonus	Total Employees	%
Female	0	5781	0%
Male	0	1246	0%

2.4 Proportion of Females and Males in each Pay Quartile

Table 2.4 Comparison of the Proportion of Females and Males in each Pay Quartile 2020-2021/2021-2022

	2020/21				2021/22			
Quartile								
	Female	**Male**	**Female %**	**Male %**	**Female**	**Male**	**Female %**	**Male %**
1	1,331	225	85.54	14.46	1,518	220	87.34	12.66
2	1,330	227	85.42	14.58	1,488	267	84.79	15.21
3	1,302	255	83.62	16.38	1,450	244	85.60	14.40
4	1,123	434	72.13	27.87	1,325	515	72.01	27.99
Overall	**5,086**	**1,141**	**81.68**	**18.32**	**5,781**	**1,246**	**82.43**	**17.57**



In this element of the reporting, male and female staff are divided equally into four quartiles based on their hourly earnings, range from the lower quartile (1) to the upper quartile (4).

The overall increase in number of employees between the last two Gender Pay Audit dates has moderately impacted the gender representation across pay quartiles. This is attributed to the increase in recruitment and higher staff turnover during the pandemic. The quartile with the most entrenched Gender Pay inequality, which impacts our overall Gender pay rating the most (quartile 4), is also the quartile that has changed the least.

3. NHS Comparators

All employers have until the 30th March 2022 to report their gender pay gap information. Reliable organisational benchmarking is therefore not available until after the reporting deadline. As of 21th March 2022, just 131 NHS of a possible 269 listed NHS organisations had submitted their 2021/22 information. Pre-deadline comparator reports tend to over-estimate the position of Trusts, as shown in this adjusted table of StHK's pre-deadline position (shown in brackets) and post deadline position for the past two years. As such we can currently only reliably report this retrospectively or on interim reports. The historical positions are as follows:

	Mean GPG	Median GPG
2019/20 StHK	28.9%	15.8%
2019/20 Ranking out of 269	**147 (15)**	**147 (11)**
2020/21 StHk	23.4%	16.1%
2020/21 Ranking out of 235	**134 (28)**	**177 (23)**
StHK 2021/22	33.2%	16.1%
2021/22 Ranking out of 131	**TBC (124)**	**TBC (102)**

Bold denotes final post-deadline ranking, brackets the early indicator ranking. For both Mean and Median a good performance is a low ranking.

4. Conclusion and Actions

The analysis of the 2021 data clearly shows that there remain some differences in pay between the genders at STHK. In light of the data detailed above and in the 2020-21 report, the following actions were identified and remain in progress:

Action 2020-21 Gender Pay Report	Progress
Analysis of flexible working requests to identify the working patterns of males and females (by department) and any barriers that females may face when pursuing career opportunities.	Review has taken place. New flexible working Policy launched March 2022
Educate and support employees to be aware of the inclusive people practices they can access and utilise including reasonable adjustments, flexible working, carers' passport and HWWB services.	New Reasonable Adjustments Policy has been developed (launching March/April 2022); NHSEI funding bid secured to support development of health and adjustments toolkit.
Ongoing work to identify flexible working options to be included on job adverts in order to promote the Trust as a supportive employer.	Workforce team reviewing approach to attraction and recruitment using outcomes from an external review and service user feedback with a focus on Refreshed Recruitment and Retention Strategy for March 2022
Review of how we welcome back and support staff that may have had a significant amount of time away from work (i.e. maternity or adoption leave) and analysis of what the barriers are to further career progression when returning to work.	
Undertake a review of recruitment processes to remove any gender bias. i.e. at the shortlisting stage or during interviews.	

Paper No: NHST(22)024

Subject: HR Indicators Report.

Purpose: This paper provides Trust Board with details of achievement of the delivery of the Trusts Workforce Strategy over the last eight months July 2021 – February 2022 and provides an update for, and assurance on, the management of workforce matters during the Covid-19 pandemic and subsequent Covid-19 recovery plans. This paper was deferred from the January Board due to operational pressures in the Trust and therefore covers a period of eight months as opposed to the usual six.

Summary: The Trust is committed to developing the organisational culture and supporting our workforce in line with our Trust objectives and in particular the commitments the Trust has made in terms of the NHS People Plan. This paper provides an update on workforce activity and achievements since Board received a HR Indicators Report in July 2021.

In particular the report focusses on how the Trust has ensured the importance of the People Plan agenda and the actions the Trust has taken to ensure supply of an appropriately skilled workforce whose health, safety and wellbeing has continued to be a priority during the pandemic. The paper is aligned with the four pillars:

1. Looking after our people – with quality health and wellbeing support for everyone;
2. Belonging in the NHS – with a particular focus on the discrimination that some staff face;
3. New ways of working and delivering care – capturing innovation, much of it led by our NHS people
4. Growing for the future – how we recruit, train and keep our people, and welcome back colleagues who want to return

Overall the paper summarises achievements/progress to date.

Corporate Objective met or risk addressed:

Developing organisation culture and supporting our workforce

Financial Implications: None at this time

Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues

Recommendation(s):

The Trust Board is requested to note the content of this paper and that actions are in place to ensure continued delivery of the Trusts Workforce Strategy

Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR

Trust Board: March 2022

This report format focusses on four key pillars from the National NHS People Plan Priorities:

Looking after our people	**with quality health and wellbeing support for everyone;**
Belonging in the NHS	**with a particular focus on the discrimination that some people face;**
New ways of working and delivering care	**capturing innovation, much of it led by our NHS people;**
Growing for the future	**how we recruit, train and keep our people, and welcome back colleagues who want to return;**

This report outlines workforce data, action plans and progress to date. Typically, Trust Board receives this information on a six monthly basis, however due to operational pressures in the Trust this report is now presented the March Board and thus covers the period **July 2021 to February 2022.**

Pillar 1 – Looking after our people

This pillar focusses on the action we will take to keep our people safe, health and well. The relevant HR Indicators for this pillar are:

- Wellbeing Hub Activity
- Vaccination Data, including flu and Covid-19
- Sickness absence
- Absence Improvement Programme

Pillar 1 – Looking after our people

Areas of focus

- **Supporting our people through Covid with their health and wellbeing** continues to be an area of significant activity – with the department carrying out high numbers of pre- employment checks (1800), HWWB appointments (7930) and management referrals (920) this period. Reducing DNA's in HWWB is a particular area of focus
- **Promoting wellbeing –** the Wellbeing Hub have delivered over 130 sessions/events with 1,063 people equating to an average of 8 staff per session. Our counsellors/MHN and Psychologists have seen 1,011 staff in supporting staff, the impact slide highlights some of the benefits to these sessions (see slide 5)
- **Improving attendance** - as expected sickness overall has increased particularly with the emergence of the Omicron variant, reaching 8.47% which is an increase overall 2.5% since the start of the pandemic. Stress (30%) remains the main cause of sickness absence with chest/respiratory related absence increasing at the height of the pandemic to 25%.
- Positive outcomes in staff being offered or accepted the chance to have a wellbeing conversation via the appraisal totalling 1,562, this is also being offered throughout the wellbeing network

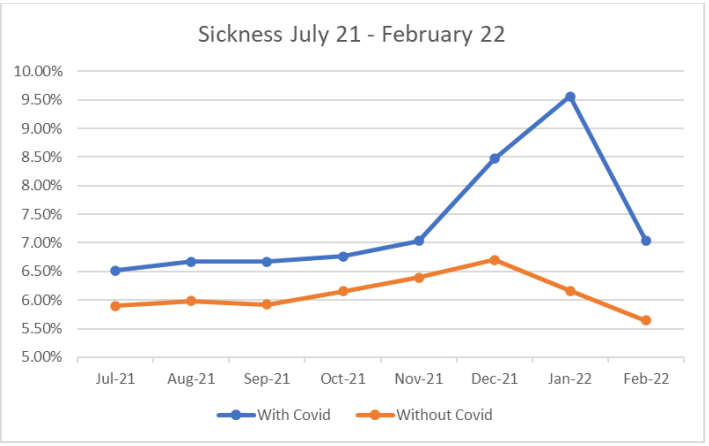
Progress To date

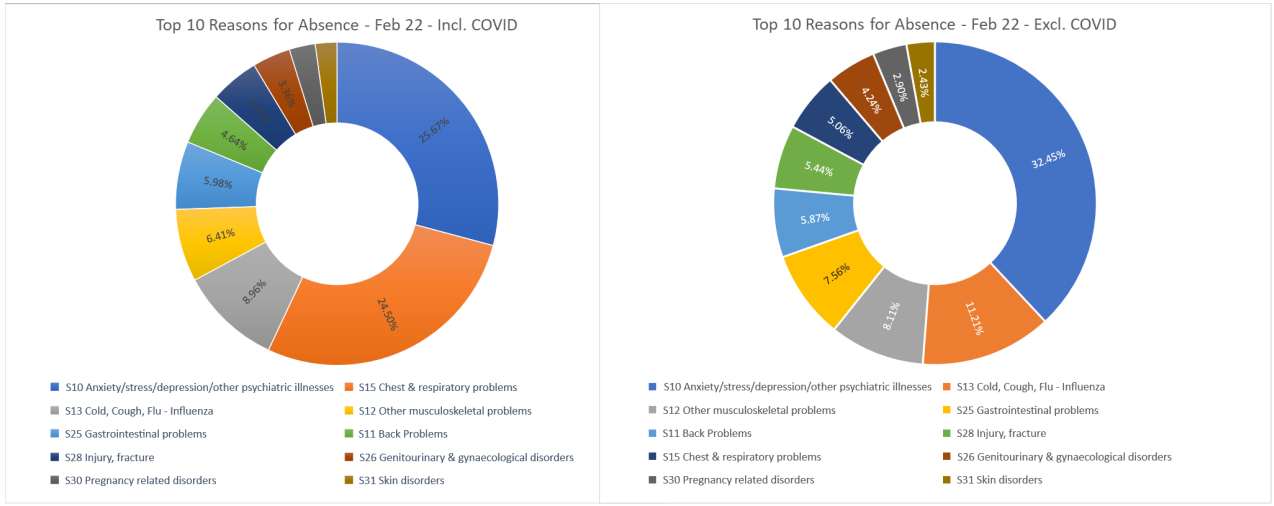
- **Covid-19 vaccination** status is high at 95% first dose, 93% second dose
- Flu vaccination campaign is still underway with the programme running up until the 31st March 2022.
- **Covid-19 Self isolation Hub** The Self-Isolation Hub had received a total of 3,749 staff referrals in this period with an average of approx. 30% positive rate.
- HWWB win **Occupational Health Team of the Year 2021** – from OHW+ Personnel Today.
- The **HWWB Strategy 22-25** has been approved at the March 22 Workforce council.
- Regular and ongoing engagement from the **Wellbeing Hub** across levels 1-5 at Whiston, ED, ICU, St Helens and Newton have been extremely positive, the collated feedback suggests staff are feeling primarily fatigued and stressed but after they attend an event or session staff feel in the round feel better equipped to deal with the challenges that lay ahead
- **Vaccination as a Condition of Deployment (VCOD)** programme was established with representation from staff side colleagues. working in collaboration with the Cheshire & Merseyside Deputy HR Directors network for consistency of approach and following national directives. VCOD has now been revoked from 15th Mar 22

Areas of risk and mitigation

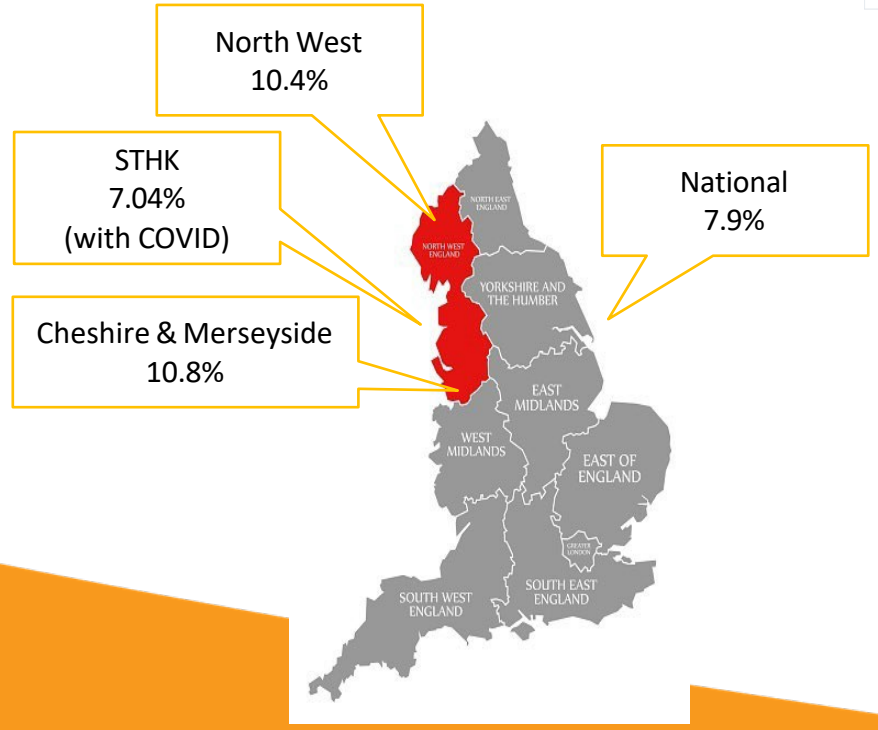
- **HWWB appointment attendance.** During this period approximately 40% of HWWB appointments have been negatively impacted by non-attendance. This has been on an upward trend during the pandemic but we are now seeing gradual improvement in March 2022 and year on year.
    - DNA's on the part of the individual - 20% - general feedback overall is sickness, on annual leave, childcare issues and forgetting the appointment details
    - Postponements, re-scheduled activity from both the individual and HHWB, and withdrawals (20%) – in particular the period Dec 21 – Jan 22 saw 17% of appointments re-scheduled due to Covid staff sickness in the department
    - Mitigation – In order to reduce DNAs HWWB are calling all appointments ahead of time, engaging directly with staff to understand why and escalating back to key stakeholders. In addition appointment bookings receive letters, and text message reminders.
- **Sickness.** Efforts continue to reduce levels of sickness absence across all areas, challenging times remain due to the impact of Covid-19. The Absence Improvement Programme (see slide 8) identifies our programme of mitigation.

Pillar 1 – Looking after our people – Metrics and Activity





Regional sickness Including Covid February 2022



Occupational Health Activity

1,804 Pre-Employment Assessments

7,930 Appointments e.g. blood tests, dermatology, MMR vaccination

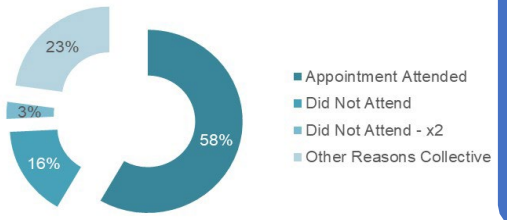
920 Management Referrals

78% OH Advisor

<10% OH Physician

16% Signposted to support

Appointment Perfromance (STHK)



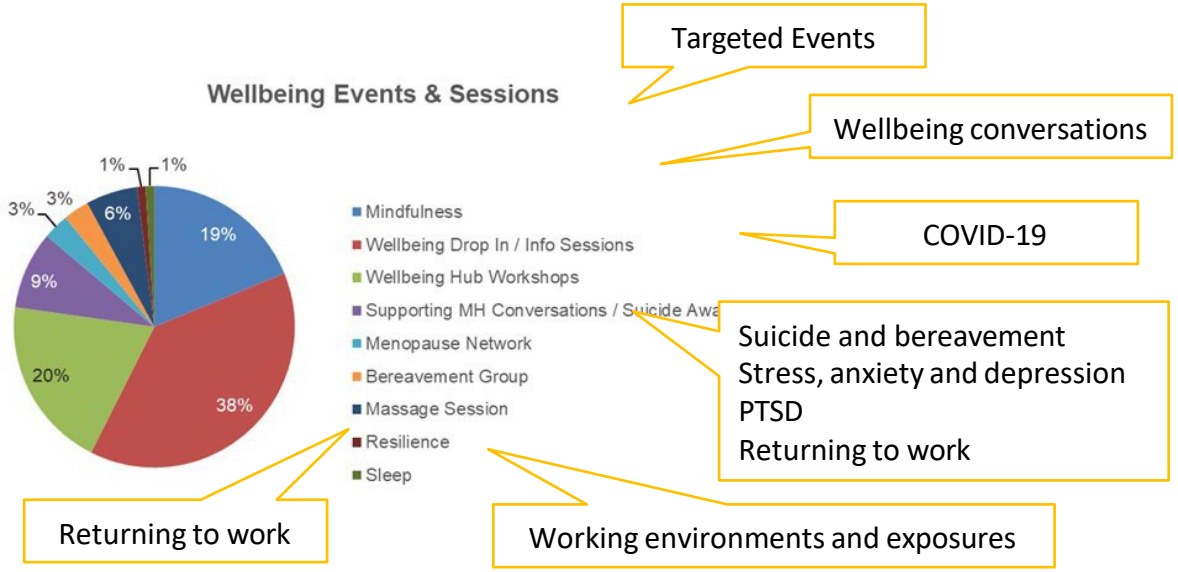
We are compassionate and inclusive
We are recognised and rewarded
We each have a voice that counts
We are safe and healthy
We are always learning
We work flexibly
We are a team

OUR NHS PEOPLE PROMISE

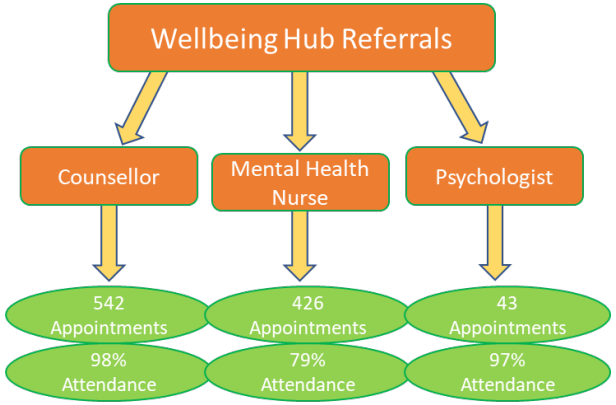
Pillar 1 – Looking after our people

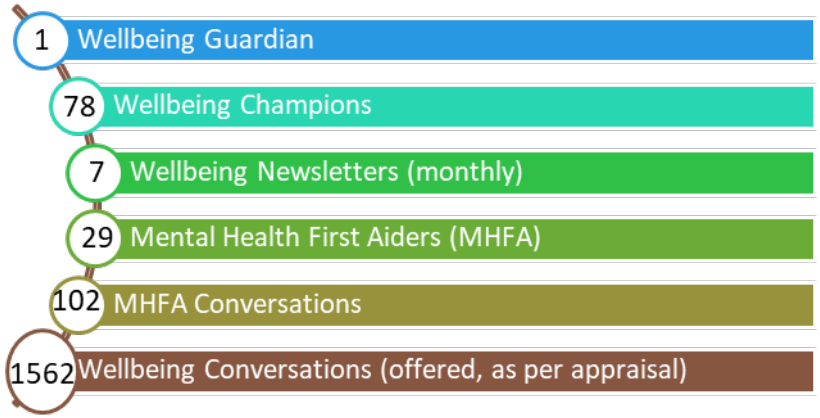
Target areas for HWWB include –

- Tackling absence through both HWWB services and the Absence Management Programme
- Managing stress, the highest reason for absence throughout 2020, 2021 and 2022 to date
- Managing the impact of Covid-19 on the workforce
- Tackling high rates of DNA in the HWWB service



On a scale of 1 (struggling) to 5 (fantastic) how did you feel	
Before the event/session	After the event/session
2.9	4.1





Vaccination Programme

Flu Campaign - Data as at end Feb 2022	StHK Total	HCW NHS Trusts England Sept 21-Jan 22	HCW North West Region Sept 21- Jan 22
Flu Vaccination (all)	68%		
Flu Vaccination (Patient Facing)	72%	59.6%	63.0%

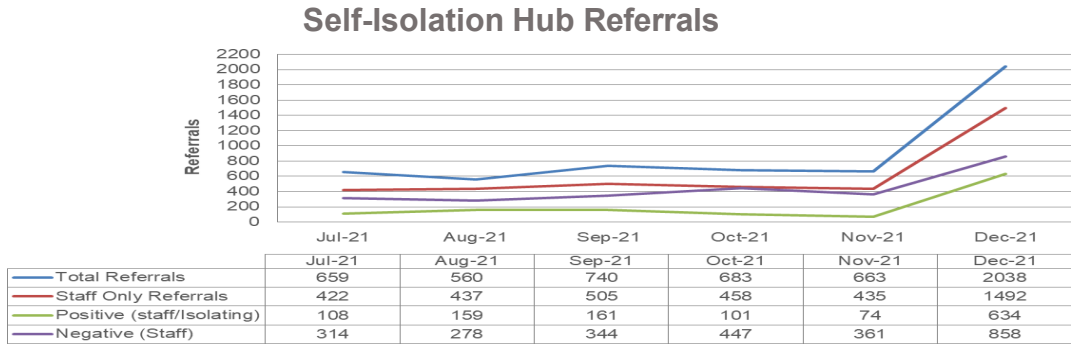
Covid Vaccination Campaign - Data as at end Feb 2022	First Dose	Second Dose
Covid-19 vaccination (all)	95%	93%
Covid-19 vaccination (Patient Facing)	95%	93%
Covid-19 vaccination (BME)	90.7%	90.7%
Covid-19 vaccination (BME Patient Facing)	91.5%	87.3%

PILLAR 1 IN ACTION…

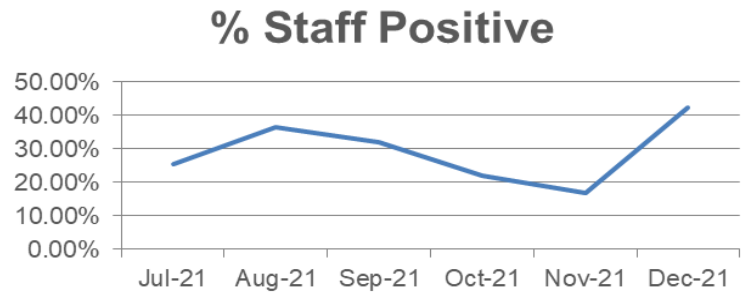
Covid-19 Self isolation Hub

Continuing to provide vital support for management and staff to deploy staff to support current operational demands with hub staff continuing to be proactive in supporting staff and managers in a prompt turnaround of testing and the issuing of advice

The Self-Isolation Hub had received a total of 3,749 staff referrals in this period with an average of approx. 30% positive rate.



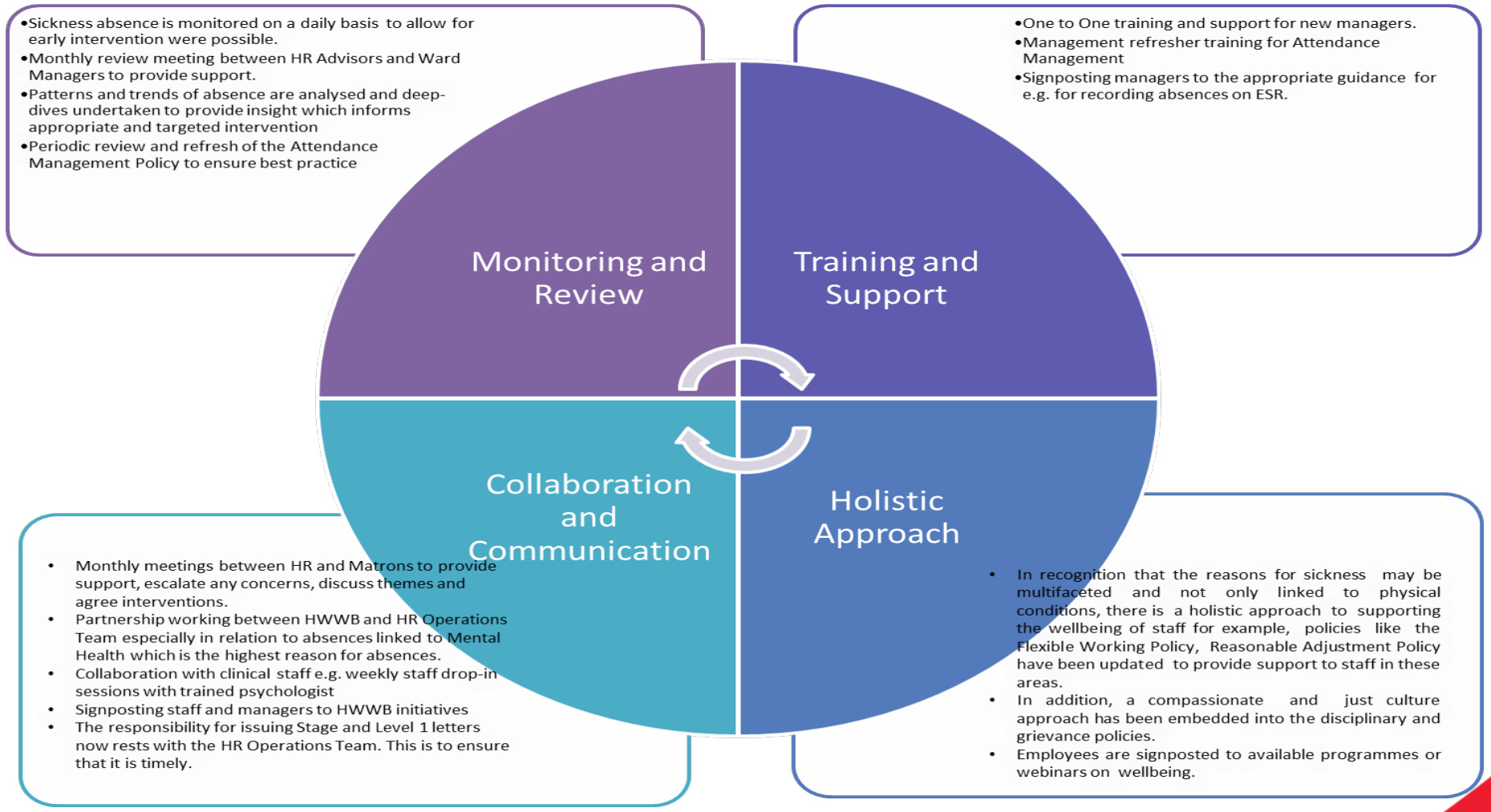
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total Referrals	659	560	740	683	663	2038
Staff Only Referrals	422	437	505	458	435	1492
Positive (staff/Isolating)	108	159	161	101	74	634
Negative (Staff)	314	278	344	447	361	858



Pillar 1 – Looking after our people

Absence Improvement Programme

- Non-Covid sickness in February 2022 at 5.64% indicates that the Trust is almost back to pre-pandemic levels when compared to February 2020 at 5.56%. Including Covid sickness at February sits at 7%
- The Trust has a lower % sickness absence than the ICS, Regional and National reported figures



Pillar 2 – Belonging in the NHS

Belonging in the NHS highlights our delivery of actions to create an organisation culture where our people feel they belong. The relevant HR Indicators for this pillar are:

- Trust Workforce Profile
- Data on Employee Relations Cases including the rise in the number of Employment Tribunal cases
- Leadership and People development to support staff
- WRES and WDES data specifically in relation to the formal disciplinary process and staff feeling pressure from their manager to come to work despite not feeling well enough to perform their duties

Pillar 2 – Belonging in the NHS

Areas of Focus

- **Tackling the disciplinary gap** – The Trust's WRES report for 2020 – 2021 shows an increase in the ratio of BAME colleagues referred into the disciplinary process from 1.14 in 19/20 to 1.44 in 20/21
- Adapting our values and standards to focus on more **compassionate and inclusive leadership**
- As well as reviewing HR policies and introducing the 72 hour pause process (Just Culture), work is underway to develop and deliver an **education programme** to managers and employees with the aim of reducing the number of cases referred for formal investigation.
- **WRES:** A higher percentage of disabled staff than non-disabled staff report feeling pressure to come to work despite not feeling well enough to perform their duties. Our response rate is 29.2% for disabled staff and 20% for non-disabled staff is below the national average, but remains a priority area. Staff Survey was undertaken during the Global Pandemic which could be a contributing factor however, focus is needed from the Trust to reduce this percentage

Areas of risk and mitigation

- **Employment tribunals** - a review of HR cases was undertaken particularly in relation to disability and reasonable adjustments A number of actions have been planned include training sessions for managers, review of relevant documents including the redeployment toolkit, recruitment policy, grievance process templates and reasonable adjustment templates.
- **Tackling the disciplinary gap**: a WDES Innovation Fund in-depth engagement project is underway to better understand the needs, adjustment and support our people require. This includes data cleansing, Disability Awareness Training for all line managers, staff side colleagues, mental health first aiders and well-being champions and the development of a toolkit to encourage staff to be open about how the Trust can do more to support them at work.

Progress to date

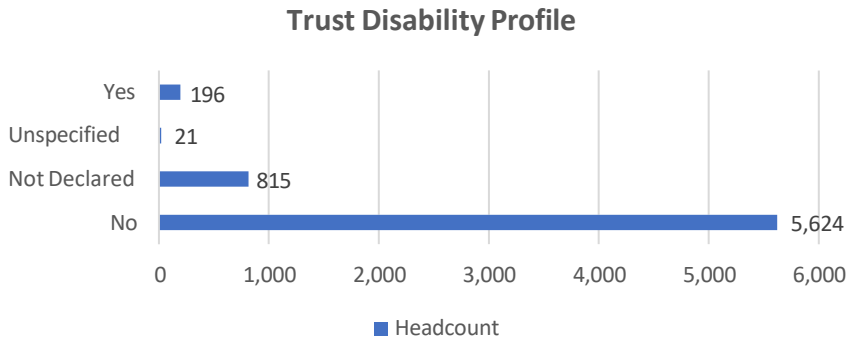
- The Trust has recognised the strategic focus and operational delivery required to ensure the Trust is well-led with regards to Equality, Diversity and Inclusion and as a result, has invested in a temporary role of **Assistant Director of HR & Inclusion.** This role is focusing on developing a robust 3 year strategy and action plan from 2022 for ED&I
- Health and Wellbeing conversations – to address the increase in the number of disabled people saying they have felt pressure to come to work whilst ill, a new **Reasonable Adjustments Policy** has been developed which includes guidance for managers to review staff wellbeing and adjustments, as well as consideration of leave as to support those with a disability.
- Successful in an NHSEI bid to secure funding to support adopting Reasonable Adjustment practices within the organisation
- **Governance –** the NHS People Plan sets out a requirement for Trust's to ensure networks within their organisations have a voice and are listened to. The Trust has well established Staff Networks who are now focused on aligning their vision and objectives to the new strategy and action plan, with the aim of increasing membership including allies.
- Due to a 66% increase **in Employment Tribunal (ET)** Cases when compared to the end of June 2021, a 'Lessons Learned' session was held in February 2022 with the Trust's solicitors to review some key cases.
- There has been a 60% decrease in the number **of Disciplinary cases** in this period compared to the period from October 2020 to June 2021. The reduction in formal cases is attributed in part to the revisions and implementation of disciplinary processes including Fast Tracks and 72-hour reviews which have helped to progress matters more quickly.
- Working in partnership with Care Groups and Corporate Services, the Learning & Organisational Development (L&OD) Team have contributed to meeting the Trust's objectives **by improving overall organisational performance and effectiveness**, in particular in relation to staff engagement, learning and organisational development programmes and initiatives.

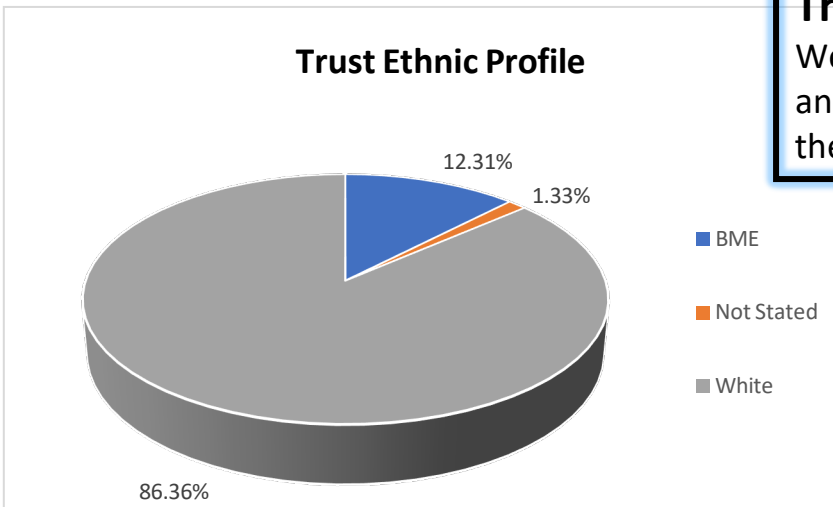
Pillar 2 – Belonging in the NHS – Trust Workforce Profile & Metrics

PILLAR 2 IN ACTION…

The NHS will be open and inclusive

We continue to apply principles of social justice and equity to the way we work towards closing the gap on health inequalities.





Gender	Headcount	%	FTE
Female	5,514	82.3	4744.42
Male	1,184	17.7	1119.96
Grand Total	6,698	100.0	5864.38

Workforce Race Equality Standard	2018 - 2019	2019 - 2020	2020 - 2021	National Average 2020 - 2021	Q1 – Q3 2021 - 2022
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	1.11	1.14	1.44	1.16	TBC

Workforce Disability Equality Standard (WDES)	2018 - 2019		2019 - 2020		2020 - 2021		2019 - 2020
	Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled	National Average
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties.	30.3%	19.3%	20.3%	14.1%	29.2%	20.0%	30.6%

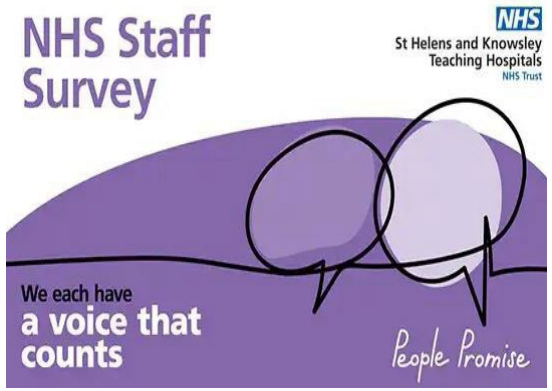
Pillar 2 – Belonging in the NHS

Current Cases at 28th February 2022						
Activity	**Medical Care Group**	**Surgical Care Group**	**C & PC**	**Corp, CSSG, Medirest**	**Medical**	**Total**
County Court	0	0	0	0	0	0
Disciplinary	0	4	0	0	0	4
ET	1	1	2	0	2	6
Fast Tracks	0	1	3	4	0	8
Grievances	2	0	1	4	3	10
Investigations	4	0	2	4	7	17
Overall Total	**7**	**6**	**8**	**12**	**12**	**45**

Closed Cases July 2021 to February 2022	
Activity	**Number**
County Court Cases	2
Disciplinary	28
Employment Tribunals	0
Fast Tracks	47
Grievances	20
Investigations	32
Long Term Sick Terminations	13
Total	142

- **Disciplinary activity** - an education programme to managers and employees to address for example micro aggressions, unconscious bias and bystander behaviour with the aim of reducing the number of cases referred for formal investigation
- The L&OD team have consulted widely across the Trust and have developed a draft **values and behaviours framework** that is helping to embed the principles of compassionate leadership.
- Working with managers to advise on **leadership and management development** for both teams and individuals.
- Guiding staff to appropriate **external learning** and have run numerous events at all levels and with many teams to support leadership development based on the Trust values.

Pillar 2 – Belonging in the NHS



- 2021 response rate of 37.1% - of 6,432 questionnaires 2,388 were responded to
- Report for the trust released under embargo to be shared with the Trust Board in April
- Reporting of the survey has been aligned to the **NHS People Promise**. and has moved away from the 'Themes' previously used
- For 2021 the survey moved away from the sample approach with questionnaires sent to 6,432 eligible staff and 2,388 questionnaires returned . a response rate of 37.1%.

Appraisals

- Language refreshed and consistent with the revised NHS Staff Survey 'Themes' and alignment to the NHS People Promise content
- Developed to support 'Wellbeing Conversations'.
- Simplified process to allow for both new starters and existing staff
- Deployment of new 'Virtual' appraisal training events x21
- Appraisal recovery - much work has been done to develop the Personal Development / Appraisal process and support the transition to an appraisal window that will continue through 2022 into 2023.

Developing our Leaders

STHK Foundation in Leadership

Cohort 2 completed their programme in September 2021 (10 attendees)
Cohort 3 started in October 2021. (8 Attendees)

STHK Making the Transition Development Programme

Cohort 1 completes Modules 2 to 4 during this period (16 Attendees) with delayed graduation planned for March 2022.

Leadership Coaching

Continued support for 16 Board and sub-Board level leaders though referral to the Trusts Senior Coaching provision.
One to one support for leaders at all levels where identified as part of a departmental or service cultural review.

NHS Leadership Academy/ HEE/ NHSE/I

Continued support for 16 Board and sub-Board level leaders though referral to the Trusts Senior Coaching provision.
One to one support for leaders at all levels where identified as part of a departmental or service cultural review.

Pillar 3 – New ways of working and delivering care – making the most of the skills we have

New ways of working include innovation, change and our ability to make effective use of our people's skills. The relevant HR Indicators for this pillar, whilst not data driven, focus on:

- Effective use of our workforce skills, learning and experiences, enabling us to work differently in the future
- Innovation and horizon scanning - planning for the future in our service areas
- Education and training our people for the future
- Mandatory training

Pillar 3 – New ways of working and delivering care

Areas of Focus

- Continued focus on making the most of **our workforce skills, learning and experiences**, developing new skill sets for staff to support them to work differently in the future
- **Educating and training our people for future** – including the cadets scheme and widening participation
- **Virtual Induction** –it has now been one year since the Trust began offering virtual inductions. In the last six months over 300 new staff have attended a virtual induction.
- NW Lead Employer **Collaborative Bank for Doctors in Training** continues to be the largest and most successful of its kind with 23 Trusts on board
- Supporting our staff in **financial management and planning**. The Wagestream project, which allows staff to draw down additional earnings and access financial wellbeing and support services, has been implemented for two pilot areas
- **Effective rostering** and improving the position from 95% to 100% of staff groups using e-rostering

Progress to date

- Working closely with Cheshire & Mersey in establishing, growing and learning from our achievements in **collaborative staff banks**, in Q3 we successfully bid for funding to expand our collaborative banks offer
- Partnership with Rugby League Cares for **psychological safety support** to provide targeted initiatives to support staff.
- Joint bid to C&M People Board with St Helens CCG, Council, Primary Care and St Helens Chamber to establish a **St Helens Health and Social Care 'Academy**' to attract local community to careers in health and social care that wouldn't normally have been able to access or chosen to do so, to provide the health and social care workforce of the future.
- **Apprenticeships activity** has resumed following the restrictions imposed by COVID and social distancing and lack of access to the organisation for providers. There is an increasing number of staff accessing higher level apprenticeships including Master Level development by both clinical and corporate areas. Levy is now being used to support development of Advanced Clinical Practitioners and Nursing Associates.

Risk and Mitigation

- There is a risk that the Trust may not meet **the roster publication** 8 week target. This has been affected by management days being cancelled to increase clinical capacity in the hospital. The Team have supported operational colleagues in creating their rosters and providing advice and training where required.
- Trust ability to take full advantage of the **apprenticeship levy** has been negatively impacted by Covid-19. Whilst activity has resumed, this will need to be sustained in order for the full levy to be utilised.

Pillar 3 – New ways of working

PILLAR 3 IN ACTION…

Support during Covid-19 so far

The HR Directorate continue to support the Trust-wide Covid-19 response efforts, making the most of the skills in our team–

- Mass Vaccination Programme including booster programme
- Redeployment activity and upskilling staff
- Fast tracking recruitment processes

- 98% of the organisation is now on the e-rostering system. The remaining 2% are being worked on to be compliant by end of March 2022.

- At the request of staff introduction of condensed working weeks, contributing to the home life balance of staff – pilot of six wards in January

- Continuing to increase communications across the Trust footprint on **apprenticeships**, including online events during National Apprenticeship week, promoting apprentices with managers and how this can be embedded within their workforce planning.
- L&OD are in the process of developing Administration and Clinical Career pathways supported by Apprenticeships.

- Between July 2021 and February 2022, **203** volunteers contributed over **13,800** hours across a variety of roles including pharmacy delivery, meet & greet and responders to support smooth discharge of patients to support smooth discharge of patients

- Extension of the Nursing Collaborative for 12 months

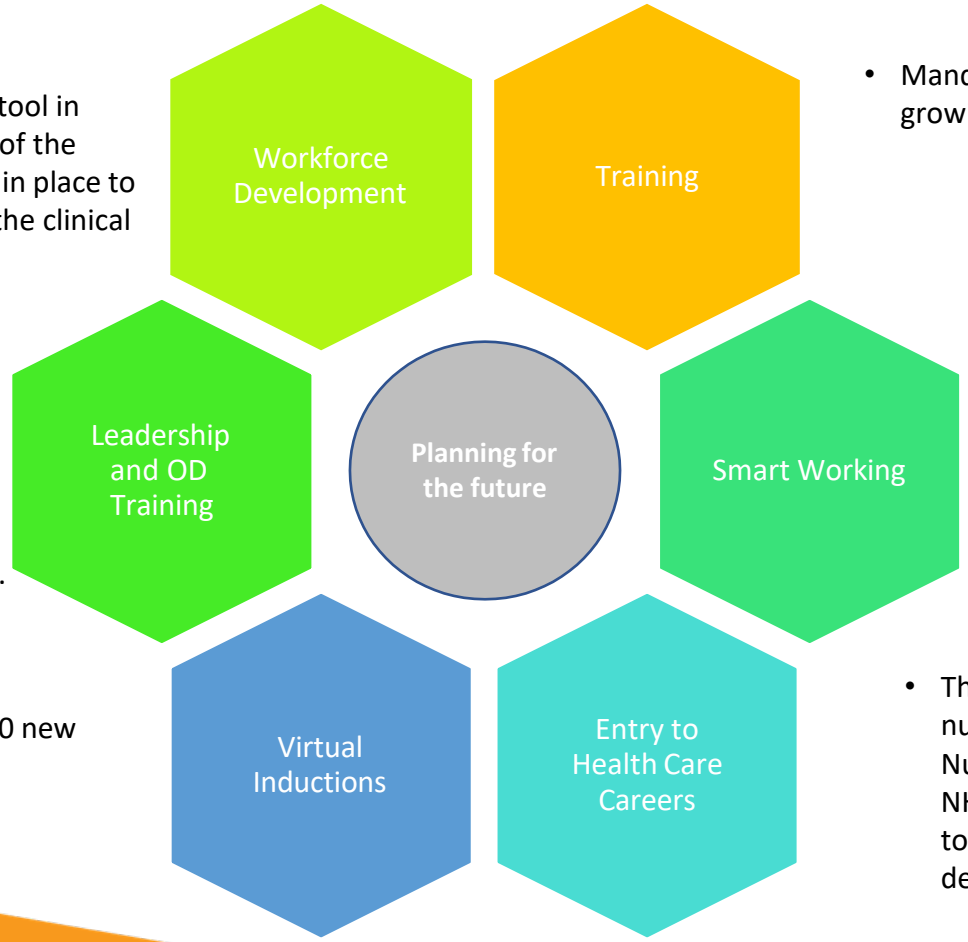
Pillar 3 – New ways of working

Innovation and horizon scanning and planning for the future in our service areas

- Workforce Planning is an important tool in understanding the workforce needs of the future and ensuring robust plans are in place to "grow our own" including changing the clinical workforce models if required.

- Mandatory training and e-learning which supports a growing and changing workforce

- Continued support for 16 Board and sub-Board level leaders though referral to the Trusts Senior Coaching provision.
- One to one support for leaders at all levels where identified as part of a departmental or service cultural review.



- Development of a policy to recognise the value in smart working and a consistent approach that works for our departments and teams

- In the last six months over 300 new staff have attended a virtual induction.

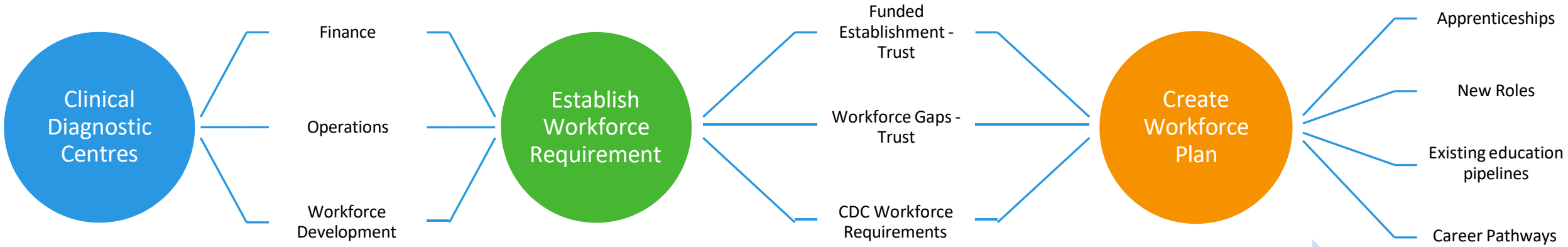
- The NHS Nationally continues to see a high number of vacancies especially for Registered Nurses and Health Care Assistants (HCAs). NHSEI have tasked Trusts with recruiting "New to Care" HCAs and undertaking work on development pathways.

Pillar 3 – New ways of working

Target areas for new ways of working include:

- Workforce Planning & innovation in clinical workforce models and recruitment
- Entry To Health Care Careers
- Use of Apprenticeships to support career pathways
- Leadership & OD
- Roster Publication

Workforce Planning & innovation in clinical workforce models and recruitment



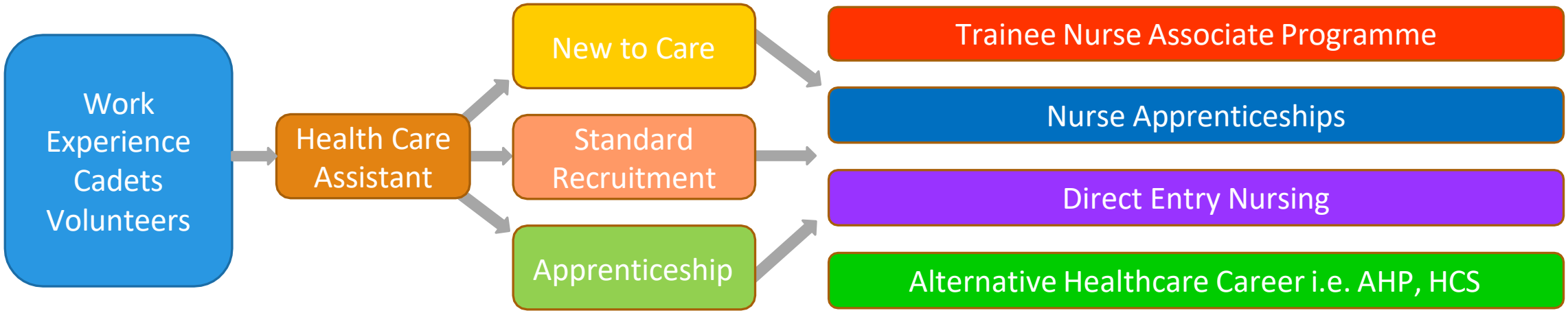
Ward Clinical Workforce Model Review

Pan Mersey International Nurse Recruitment – 2022/23

North West International Midwifery Recruitment 2022/23

North West International Radiography Recruitment 2022/23

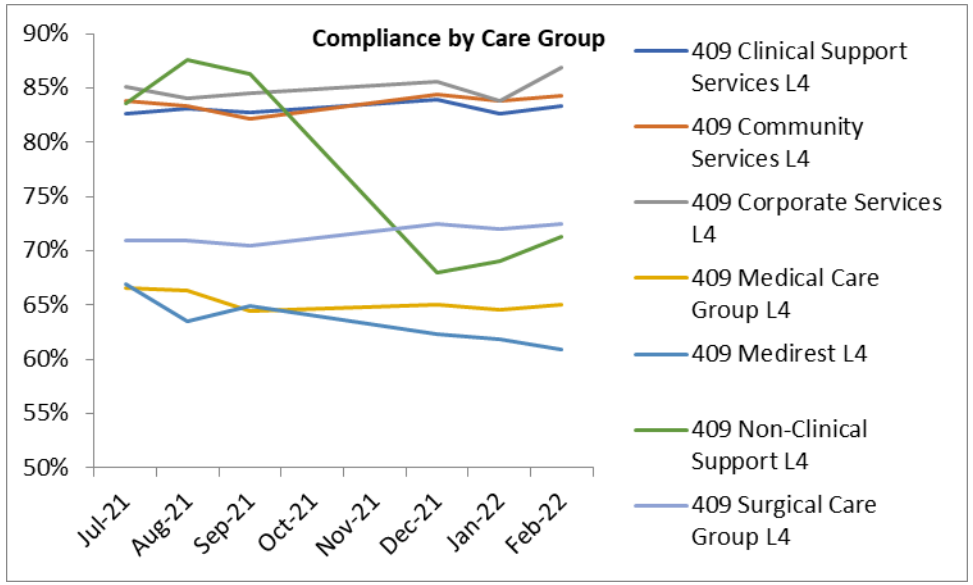
Entry to Health Care Careers

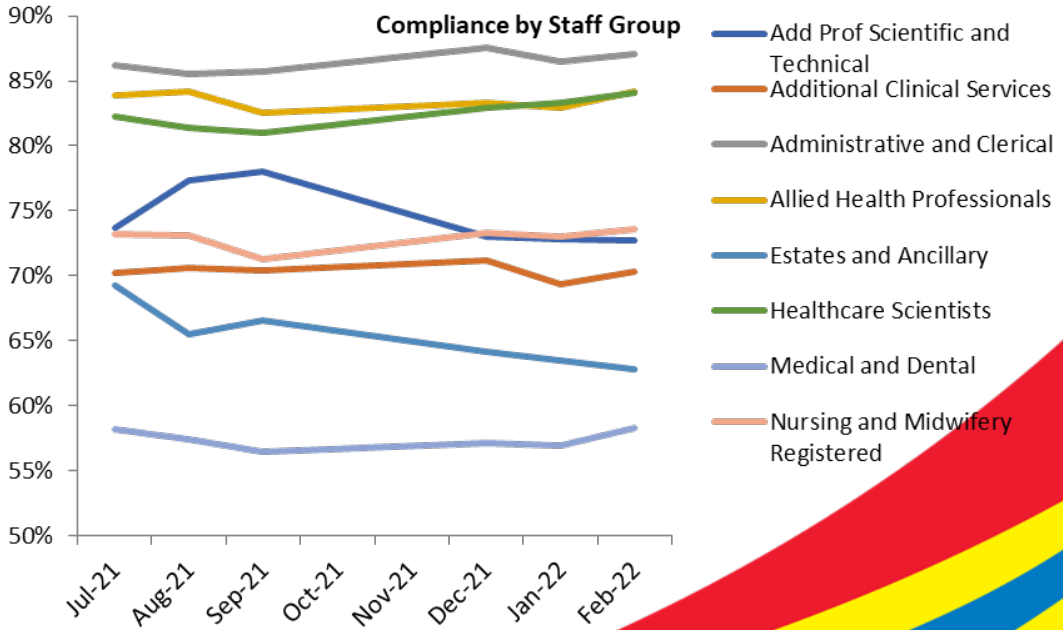


Pillar 3 – New ways of working and delivering care – making the most of the skills we have

Mandatory Training

- **Compliance** - Continued focus on supporting staff to complete their mandatory training in line with the NHS Core Skills Framework to meet the Trusts Statutory and regulatory obligations.
- Ongoing review of application of training requirements to roles to ensure only those that require the training for safe practice are required to undertake it.
- Development of additional e learning materials to increase flexibility of access for all staff groups.
- Robust monitoring and escalation processes in place to tackle areas and subjects of sub optimal performance in collaboration with Subject Matter Experts and service managers.
- **Streamlining Induction** – Staff joining the trust from another NHS organisation can now avoid the need to repeat training from the Core Skills Framework where this is in date at the time of transfer. This is reducing unnecessary duplication and thereby speeding access to the workplace.
- **STEP project** – Introduction of this programme allowing sharing of mandatory training compliance data for Trainee Doctors not directly employed by the Trust, is assisting in ensuring trainees both don't duplicate training and remain compliant as they rotate through the Trust.
- **Redesign of the Core Skills Framework** – The Assistant Director of OD is representing the Trust and Lead Employer on the National Steering group to ensure it's views are recognised as part of this review.





Risk and Mitigation

- There continues to be a risk around the number of additional subjects the Trust are asked to mandate and the impact this could have on the ability of staff to complete the Core Subjects. There is a process for approval which has been revisited to ensure only essential/ critical subjects are approved.
- Although in the last month compliance has improved in most areas, continued high levels of activity and absence, particularly in clinical areas , is impacting the ability of staff to be released to complete training.

Pillar 4 – Growing for the future, recruiting, retaining and attracting people

The relevant HR Indicators for this pillar focus on:

- Staff retention – including turnover, workforce stability and leavers
- Staff movement – including the Internal Transfer Scheme (15 staff members have taken advantage of this between July 2021 and February 2022) and planning for potential retirements
- Temporary workforce – including recruitment of bank staff
- Recruitment Activity – including international recruitment

Pillar 4 – Growing for the future, recruiting, retaining and attracting people

Areas of Focus

- **Staff turnover** – turnover is on an upward trend, however information submitted via ESR suggests retirement and relocation are common reasons cited. ED is a particular area of concern, an MDT working group is being initiated and outcomes from this group will be evaluated for effectiveness to support roll out across other clinical areas. Turnover continues to be highest in Medical and Dental, although this is largely due to fixed term contracts.
- **Staff retention** – working collaboratively on development of forms and exit processes and delivering initiatives and projects (including support to managers) to improve retention.
- Implementation of **fast track pre-employment checks** using risk assessments where necessary to expedite time to hire. Time to hire is reducing – the percentage for overall employment check target met increased from 69% to 82% following introduction of the fast track checks.
- **Retirements** – the age profile of the workforce is such that there are 34% of our staff age 50 and over. This is highest in HCA and Registered Nurse staff groups. We are undertaking specific recruitment, on boarding and induction programmes for "new to care" HCAs in order to increase our available workforce and recruit to turnover. Plans are being developed to bring in 100 international nurses in 2022/23

Areas of risk and mitigation

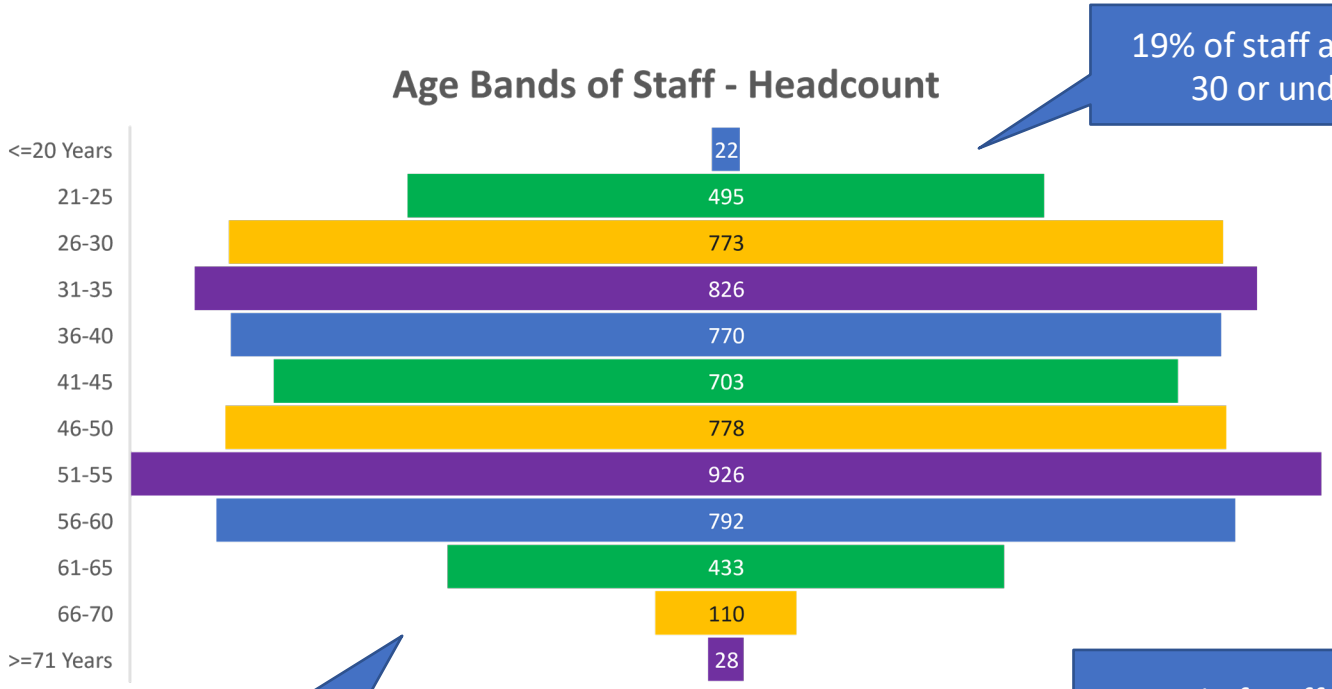
- The trust continues to use bank and agency to fill **temporary workforce**. Large scale vacancies are being worked on in a targeted way with areas like ED and Theatres being given focus, however in the short-term temporary workers will be required to bridge the gap. Targeted work for Theatres temporary workforce has proved successful, however for ED escalated rates continue to be utilised and reviewed on a weekly basis.
- The increase in international nurses for 2022/23 will require **additional resource** across recruitment, education and estates, in the meantime Pan Mersey funding has been secured to allow us to begin the recruitment process.
- **Exit interviews**. A review of the exit process is currently taking place to improve the process create a more effective way of collating leaver data using ESR and locally sourced intelligence. We are also looking at trends in leavers to identify hot spots

Progress to date

- Creating and maintaining robust **recruitment pipelines** across all staff groups to continue to feed in to our workforce and support the reduction in vacancies
  - International Nurse recruitment –77 newly appointed this period.
  - International Medic recruitment - 19 this period
  - HCA's – successful large scale recruitment underway. Framework developed to support HCA inductions
  - International AHP recruitment – inaugural C&M Action Plan
  - International Midwifery recruitment - action plan to be agreed
  - International Nursing recruitment – expression of interest has been submitted for 100 nurses to be onboarded in 2022/23
- Reviewing our approach to **attraction and recruitment** using outcomes from an external review and service user feedback with a focus on Refreshed Recruitment and Retention Strategy for March 2022
- **Rostering** - all ward areas have had their rosters reviewed and are being provided with support, advice and training on maximising the use of rosters.
- **Advanced Clinical Practitioners** – the Trust has submitted an expression of interest to HEE for funding to support two Trainee ACPs within the Trust to undertake their studies. This funding supplements the Trust using the Apprenticeship Levy where able and helps with extraction of staff for study and attendance at university.
- **The Nursing Clinical Workforce Review Project** is underway and a detailed Project Initiation Document (PID) is being drafted by the project lead.
- **Workforce Planning for the Clinical Diagnostic Hub** has started in collaboration with Finance Colleagues and the modality leads.

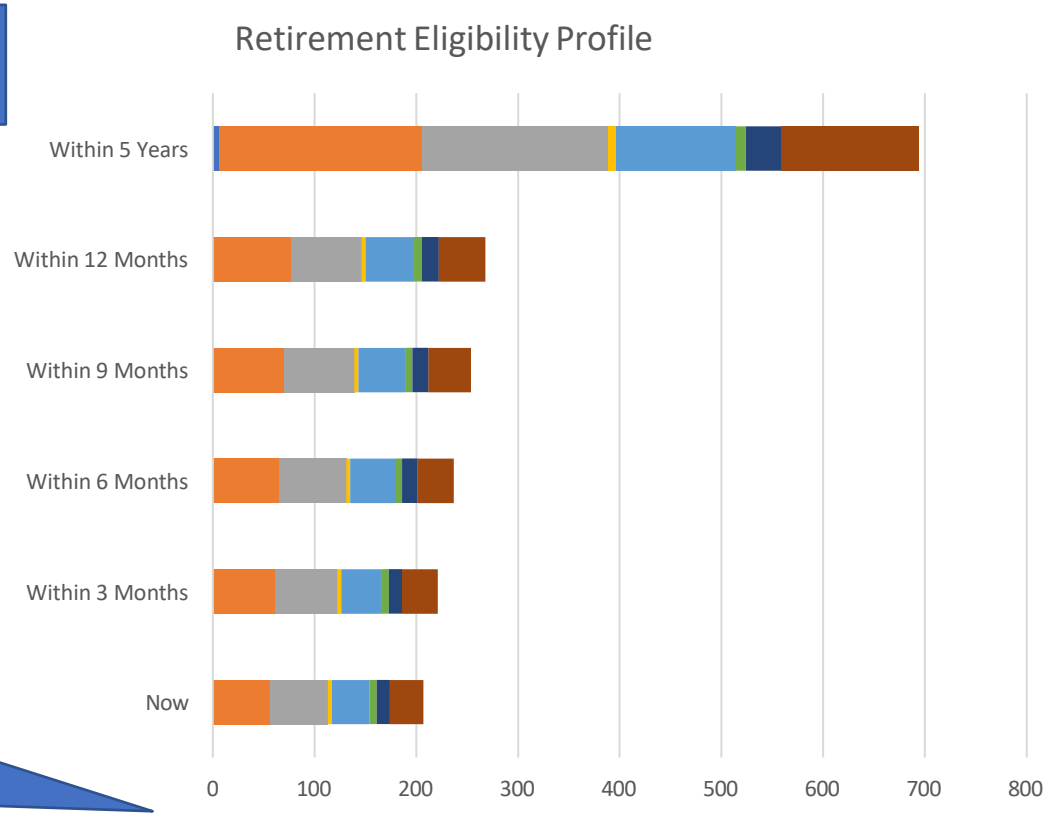
- Demand relating to **attraction and recruitment** have led to a reduced focus on analysis of retention data . This is being factored into a refreshed strategy and approach including providing a suite of retention tools to support managers in delivering retention initiatives at a local level.

Pillar 4 – Growing for the future, recruiting, retaining and attracting people



19% of staff are age 30 or under

34% of staff are aged over 50

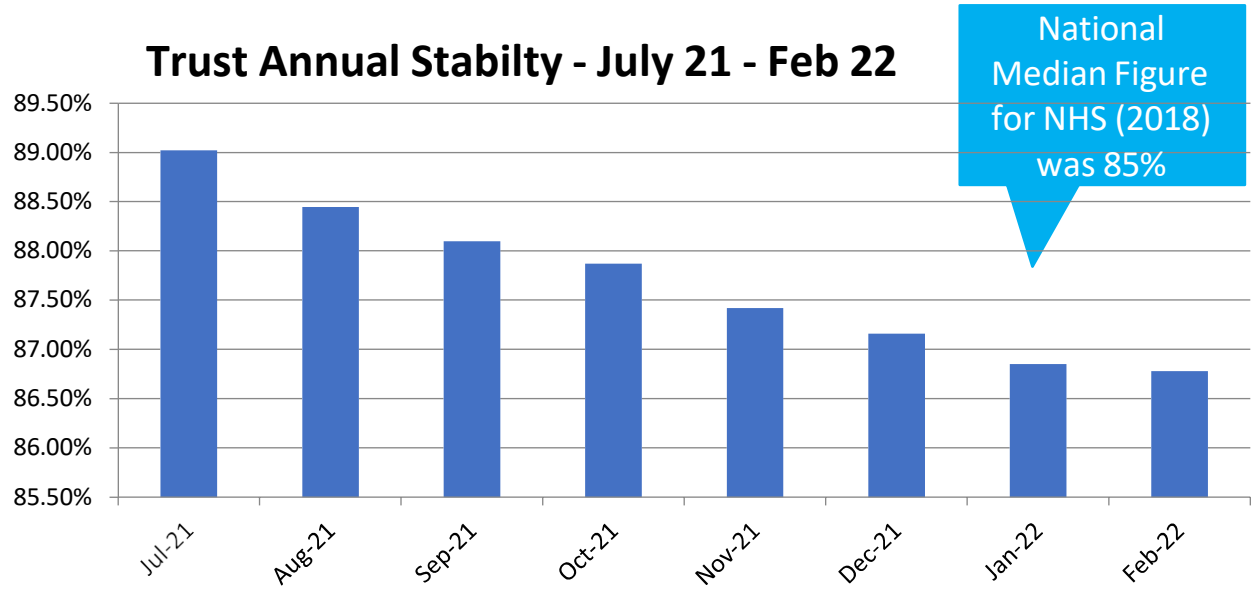


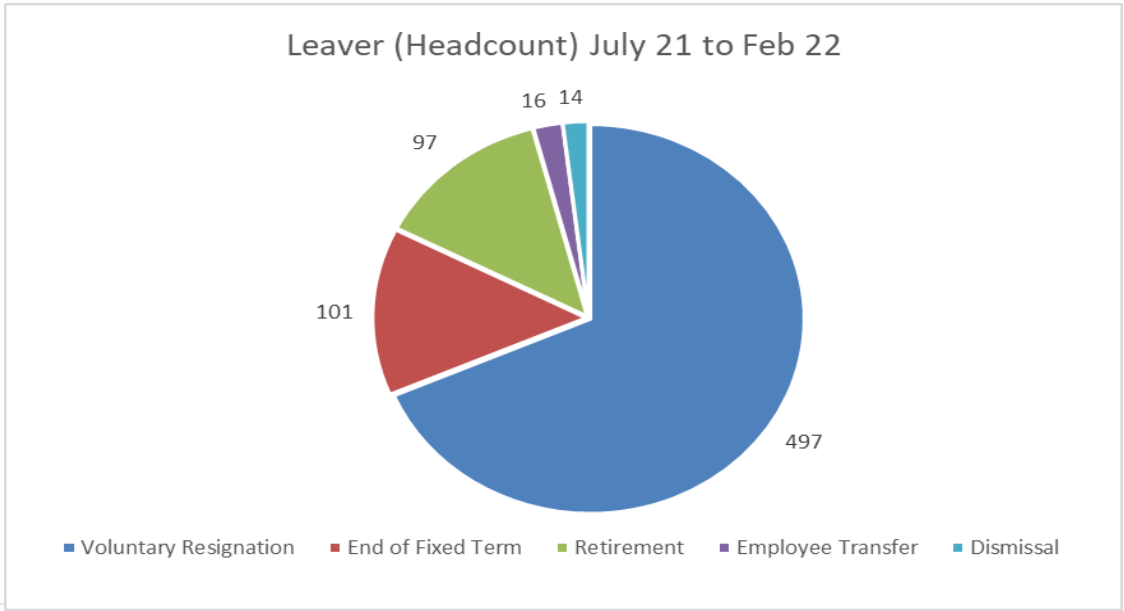
28% of staff are eligible to retire in the next 5 years

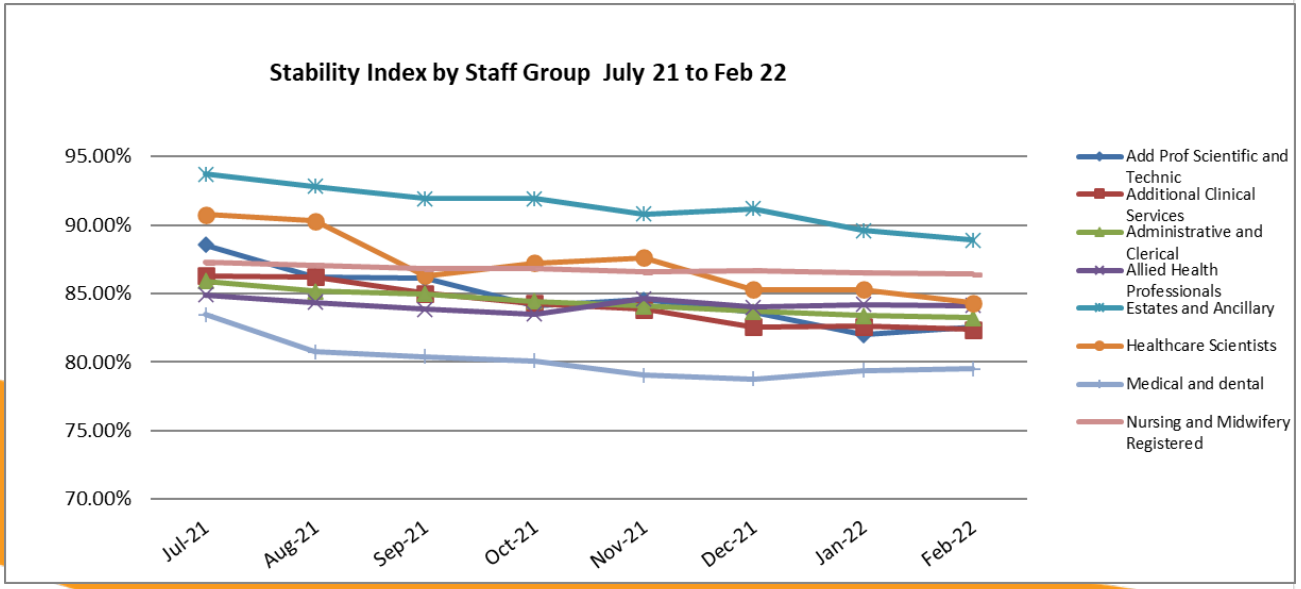
	Now	Within 3 Months	Within 6 Months	Within 9 Months	Within 12 Months	Within 5 Years
Add Prof Scientific and Technic	1	1	1	1	1	6
Additional Clinical Services	55	60	64	69	76	200
Administrative and Clerical	57	61	66	69	69	183
Allied Health Professionals	4	4	4	4	4	8
Estates and Ancillary	37	40	44	46	48	117
Healthcare Scientists	7	7	7	7	7	10
Medical and Dental	13	13	15	16	17	35
Nursing and Midwifery Registered	33	35	36	42	46	135

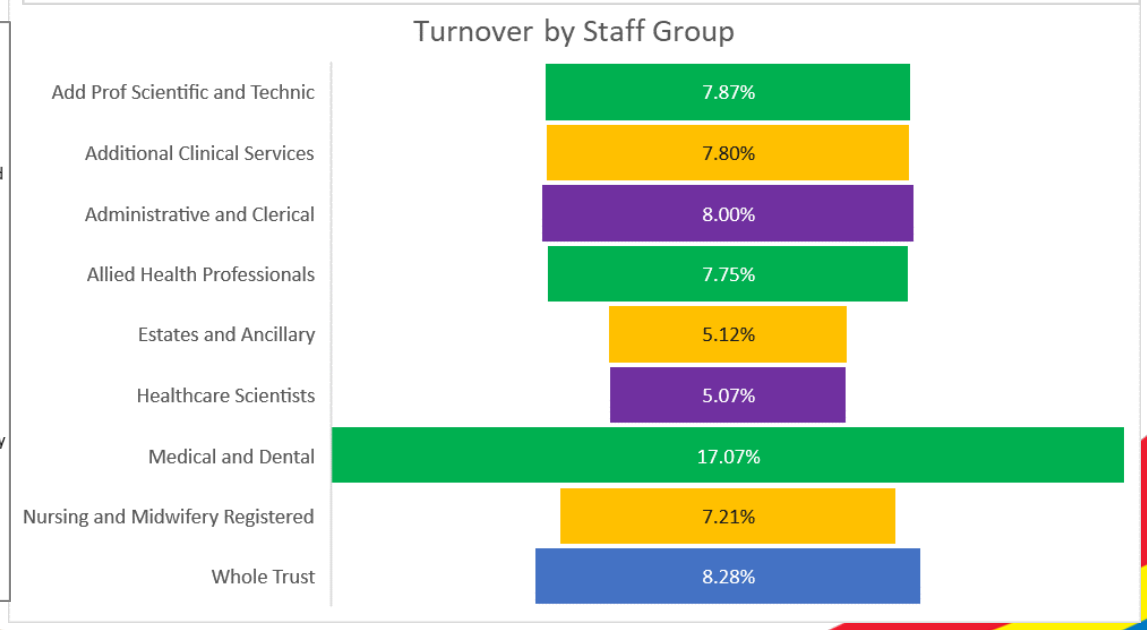
Data based on age 65 “norm” for retirement of all staff with the exception of RGN which is based on age 55.

Pillar 4 – Growing for the future, recruiting, retaining and attracting people





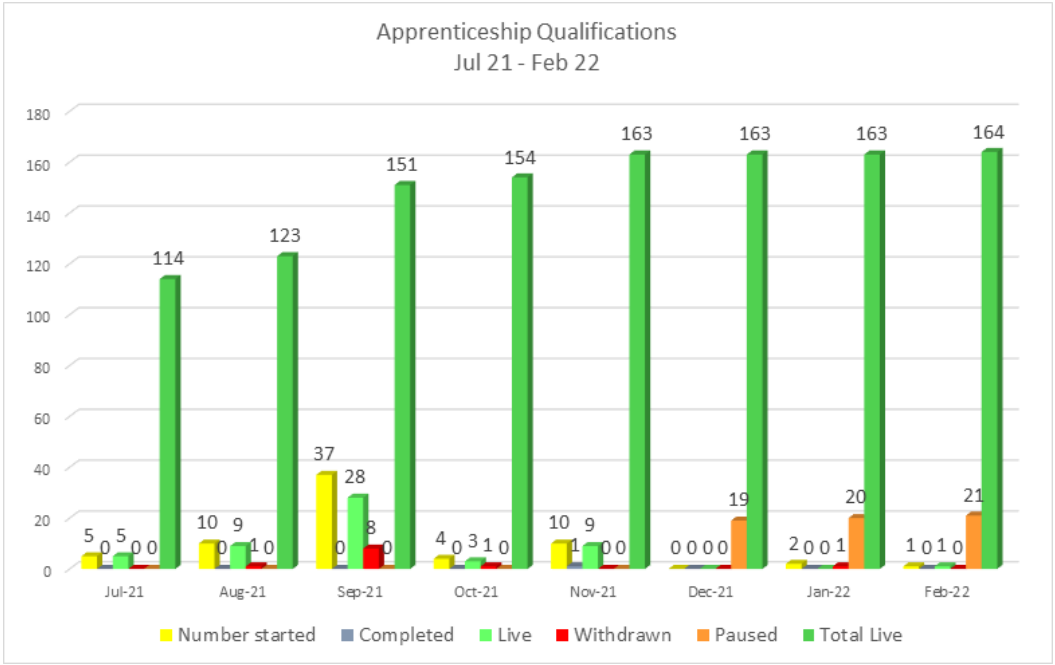




Pillar 4 – Growing for the future, recruiting, retaining and attracting people

Temporary workforce Average Figures per month July 21 – Feb 22

Month	Total Number of Requests	Total Filled	% Fill Rate	Filled By Bank	Filled By Agency	Unfilled
Jan-21	14,629	9,201	63%	7,016	2,185	5,428
Feb-21	14,154	9,064	64%	6,950	2,114	5,090
Mar-21	13,885	10,311	74%	8,071	2,240	3,574
Apr-21	11,648	8,448	73%	6,665	1,783	3,200
May-21	13,106	8,992	69%	7,160	1,832	4,114
Jun-21	14,168	9,667	68%	7,659	2,008	4,501
Jul-21	14,673	9,388	64%	7,455	1,933	5,285
Aug-21	15,323	9,332	61%	7,389	1,943	5,991
Sep-21	14,676	9,103	62%	6,948	2,155	5,573
Oct-21	14,253	9,291	65%	7,255	2,036	4,962
Nov-21	14,533	10,009	69%	7,847	2,162	4,524
Dec-21	15,106	8,772	58%	6,893	1,899	6,334
Jan-22	14,694	8,798	60%	6,872	1,926	5,896
Feb-22	13,039	8,394	64%	6,465	1,929	4,645
Overall total	**197,887**	**128,770**	**65%**	**100,645**	**28,145**	**69,117**



There has been a continued increase in the number of shift requests to be filled by Temporary Workforce. This is due to a variety of reasons including staff self-isolation and sickness, vacancies, increased bed occupancy and patient acuity as well as the requirement to open additional bed capacity. This has also been impacted by an increase in the number of shifts requested as well as worker availability due to self-isolation for COVID-19 as well as other sickness.

Pillar 4 – Growing for the future

Offers made by Staff Group	Substantive			Bank		
	Jan- Jun 2021	July-Dec 2021	Jan – Mar 22	Jan- Jun 2021	July-Dec 2021	Jan – Mar 22
Additional Clinical Services	224.95	331.02	37.51	167.00	163.00	18.00
Additional Prof Scientific & Tech	4.80	9.23	1.70	0	0	0
Administrative and Clerical	238.74	283.35	79.82	192.00	37.00	19.00
Allied Health Professionals	76.43	54.48	42.8	0	1.00	0
Estates and Ancillary	0	1.64	0	0	2.00	0
Healthcare Scientists	29.00	52.58	9.0	10.00	37.00	3.00
Medical and Dental	114.75	82.14	17.0	11.00	8.00	5.00
Nursing and Midwifery Registered	332.77	327.34	88.36	215.00	19.00	21.00
Grand Total	1021.44	1141.78	276.19	595.00	267.00	66.00
Internal v External offer split for July to Dec 47%:53% and Jan to June is 46.5%:53.5% and Man to Mar 52%:48%						

PILLAR 4 IN ACTION…

#teamSTHK: promoting recruitment through a targeted approach

Our Social media presence continues to grow through a variety of sources. We use Facebook, Twitter, LinkedIn and Instagram and vary the approach to advertising dependant on the role.

The recruitment team managed 1128 adverts between 1st July and 31st December; this is an increase of 133 (13.5%) compared to the period 1st January to 30th June. Offers made and start dates booked have also increased.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)025

Title of paper: Workforce Safeguards – safe and effective staffing

Purpose: To provide assurance that the Trust board that the trust is compliant with the Workforce Safeguards standards introduced by NHS Improvement (2019/20.)

Summary:

In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing*. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also setout guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. The paper included 14 recommendations to strengthen workforce safeguards and each Trust will be assessed against these recommendations.

The Trust completed a self assessment in 2019 against these recommendations and identified that for Nursing 12 of the 14 we are currently complaint but for the remaining 2 more work is required for the organisation to be fully compliant.

Due to the COVID-19 pandemic work on the specific actions contained within the attached action plan have been placed on hold. The Trust has continued to use a variety of processes to ensure that there is safe and effective staffing. This action plan refreshes the actions required to become fully compliant and provides an update on the existing practices that take place to ensure the organisation is safely staffed.

The Director of Nursing, Medical Director , AHP lead and Assistant Director of Workforce Development and Resourcing have completed a further self –assessment In February 2022 against the recommendations and freshed the action plan with realigned timeframes for achievement for 2022-23.

The self assessment identified that for:

- Nursing: 13 of the 14 remain fully compliant; the remaining 1 require further work for the organisation to be fully compliant. The actions to achieve full compliance are detailed in the action plan
- Medical & Dental are compliant with fully compliant with 8 of the recommendations with 6 requiring further work for the organisation to be fully compliant during 2022-23
- Allied Health Professionals are fully compliant with 8 of the recommendations with 6 requiring further work for the organisation to be fully compliant during 2022-23

The Workforce Safeguards self-assessment and progress against the action plan will be presented to Trust Board annually ,monitoring of delivery of the actions will by via the Executive Committee and Workforce Committee as mid- year review, with feedback via the chairs log to Trust board.

The details of the self assessment and actions to achieve full compliance are detailed

in the action plan (Appendix 1)
Corporate objective met or risk addressed: Provide high quality personalised care
Financial implications:
Stakeholders: Trust Board, Staff, NHSE/I, CQC, Commissioners, Patients, members of the public
Recommendation(s): The Trust Board are aksed to review the action plan to meet indentified actions the Workforce safeguards standards by March 2023
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Meeting date: 30th March 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Workforce Safeguards- Safe and Effective Staffing 2021/22 Review
Nursing & Midwifery / Medical & Dental / Allied Health Professionals

Overview

In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing*. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also set out guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. The guidance is applicable to all clinical staff The paper included 14 recommendations to strengthen workforce safeguards and each Trust will be assessed against these recommendations.

The 14 recommendations are included in the table below :

1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	
2	Trusts must ensure the three components are used in their safe staffing processes: • evidence-based tools (where they exist) • professional judgement • outcomes NHSI will check this in their yearly assessment.	
3	Assessment will be based on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.	
4	NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	
5	As part of this yearly assessment NHSI will also seek assurance through the Single Outcomes Framework (SoF), in which a provider's performance is monitored against five themes.	
6	As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their board that	

	they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.
7	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

The Trust completed a self –assessment against these recommendations in October 2019 for the following staff groups:

- Nursing & Midwifery
- Medical & Dental
- Allied Health Professional

Reports were created which identified areas of compliance and an action plan outlined in January 2020 for those areas requiring further work. This action plan includes updated information against each action

Update

Due to the COVID-19 pandemic work on the specific actions contained within the below action plan have been placed on hold. The Trust has continued to use a variety of processes to ensure that there is safe and effective staffing.

The Director of Nursing, Medical Director, AHP lead and Assistant Director of Workforce Development and Resourcing have completed a further self –assessment In February 2022 against the recommendations and have refreshed the action plan with realigned timeframes for achievement for 2022-23.

The self-assessment identified that for:

- Nursing: 13 of the 14 remain fully compliant; the remaining 1 require further work for the organisation to be fully compliant. The actions to achieve full compliance are detailed in the action plan
- Medical & Dental are compliant with fully compliant with 8 of the recommendations with 6 requiring further work for the organisation to be fully compliant during 2022-23
- Allied Health Professionals are fully compliant with 8 of the recommendations with 6 requiring further work for the organisation to be fully compliant during 2022-23

The Workforce Safeguards self-assessment and progress against the action plan will be presented to Trust Board annually, monitoring of delivery of the actions will by via the Executive Committee and Workforce Committee as mid- year review, with feedback via the chairs log to Trust board.

B (Blue)	Completed and Closed
R (Red)	Overdue
A (Amber)	At risk of missing deadline
G (Green)	On track

Nursing & Midwifery

Action No	Workforce Safeguards Recommendation & steps required to become fully compliant	Lead	Date Due	Update / Amended Actions	BRAG Status
1	**As part of the safe staffing review, the Director of Nursing and Medical Director <u>must</u> confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.** Previous Actions Outlined: The Trust will, moving forward, review and amend the safer staffing report to include other units and staff groups besides inpatient wards.	Director of Nursing	31 March 2023	The Nursing Safer Staffing report is completed on a monthly basis and covers all in-patient areas that are required to be reported on. Since the last report the Trust has expanded the inpatient bed base : Bevan Court 1 and 2 (August 2020) and as part of winter escalation plan Ward1A. QIA were completed As per CQC's NHSI Well-led framework guidance (2018) The Director of Nursing and Medical Director that they have reviewed the outcome of the assessment highlighting any recommendations The trust board are requested to approve the assessment findings Due to the Covid-19 pandemic work to create a formal oversight and reporting process for staffing in other areas was placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. **Update** Monthly safer staffing reports in 2022 include ED and Theatre staffing data Work will resume in 2022/23 and will continue in	

				line with the previous actions outlined. Monthly safer staffing reports are discussed with Executive committee and are reported to Trust board to provide assurance that staffing is effective and safe. The report includes any wards below 90% fill rate and analysis of ward staffing below 85%, vacancies, red flags and recruitment . Maternity workforce modelling is supported by Birthrate plus which is the accredited workforce tool for Maternity services The last Birthrate Plus Assessment for StHK was completed in 2016 and the current maternity funded establishment is compliant with the previous assessment A biannual maternity workforce paper is presented to Quality Committee providing assurance of safe staffing and highlighting any areas of concern and actions taken to ensure safe staffing A repeat BR+ full workforce assessment review funded by the LMS commenced in 2021. The data period that was required to be used was the financial year 2020/21 in order to have a full financial year of data. The final report is due April 2022 Paediatric and Neonatal nursing and medical staffing review was undertaken using ODN guidance in June 2021 and was included in the Trust's CNST submission evidence. A full review of specialist nurse job planning was conducted in 2020 further analysis of job roles to be completed The Senior Nursing team plan to review the Community, intermediate care and outpatient staffing establishment and skill mix using validated tools and methodologies. An outcome	

				paper detailing the findings and recommendations will be submitted to the Executive Committee for consideration when completed . The nurse staffing establishment review was conducted in September / October 2021 and is to be reported to Trust board March 2022. Next review is commencing April 2022 NHSE: Winter Preparedness 2021 preparedness: Nursing and midwifery safer staffing self-assessment was presented to Trust Board in January 2022 .The Trust can evidence compliance with all of the 29 indicators. There are 3 actions to be further implementation. Work will resume in 2022/23 and will continue in line with the previous actions outlined	
2	**Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.** Previous Actions Outlined: Model Hospital data is not reported in the IPR because of the time lag in the national data being reported. The Model Hospital Nursing workforce metrics such as care hours per patient day (CHPPD) e already used and included in the staffing report	Director of Nursing	31 March 2023	Due to the Covid-19 pandemic work on this action in relation to local quality dashboard was placed on hold. Update The nurse safer staffing data is collated and triangulated by using eroster , safe care allocate and finance to ensure consistency in reporting CHPPD performance is benchmarked against the Model Hospital CHPPD national figures on a monthly basis and is included in the Monthly Safe Staffing Report submitted to Executive Committee, Quality Committee and Trust Board. Work will resume in 2022/23 on a local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and	

				quality metrics Local dashboards to be scoped out with the Data Team.	

Medical & Dental

Action No	Workforce Safeguards Recommendation & steps required to become fully compliant	Lead	Date Due	Update / Amended Actions	BRAG Status
1	**Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.** Previous Steps Outlined: The Trust is currently six months into a two year project to implement activity based rostering in all specialties which takes service demand templates, job planning (for Medical & Dental, Allied Health Professionals and other groups as required) and rostering tools to build a service level oversight of staffing. This is built on the skills required to undertake the required work within the specialty. It is intended that this project will be completed by 31 March 2021.	Medical Director	TBC pending software discussions	At the point of creating this action plan the Trust was undertaking a project to implement activity based rostering in all specialties to build a service level oversight of staffing required to deliver services. Implementation of Allocate's activity based rostering system "Activity Manager" was stopped due to issues with the systems capability and this continues to be discussed with Allocate to understand what, if anything, can be done to resolve the concerns raised by operational teams. Further work as recommenced	
			31 March 2023	31 March 2020 As an interim measure work will be undertaken with specialties to triangulate budgeted establishment, gaps and clinical staffing levels needed for service delivery in order that a full assessment of safe staffing levels can take place. Update Due to the Covid-19 pandemic work to create a formal oversight and reporting process for staffing in other areas was placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue	

				in line with the previous actions outlined.	
	Previous Actions Outlined: As part of the above process bi-annual establishment reviews will be extended to all staff groups as they will be completed at a specialty level.		31 March 2023	30 June 2020 The above process will inform the establishment reviews which are required. These will subsequently be merged into whole specialty establishment reviews covering all staff groups. Update Due to the Covid-19 pandemic establishment reviews of all clinical groups reviews were placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue in line with the previous actions outlined.	
2	**Trusts must ensure the three components are used in their safe staffing processes:** • **evidence-based tools (where they exist)** • **professional judgement** • **outcomes** Previous Actions Outlined: A review of all staffing guidance published by Royal Colleges and other bodies will take place and, where appropriate, implemented within the Trust.	Medical Director	31 March 2020	Work has been completed regarding the changes to the junior doctor 2016 contract and the introduction of IMT roles.	
			31 March 2023	30 June 2020 Research will be undertaken regarding guidance that has been published by bodies such as Royal Colleges in order for the Trust to develop a Care Group / specialty level STHK staffing model. This will address patient safety in the first instance followed closely by safe working for Doctors which will look at safe staffing levels for both delivery of care and for the wellbeing and fatigue of Doctors.	

				Update Due to the Covid-19 pandemic work was placed on hold. We are aware that there are some Royal Colleges that have published guidance on staffing and work has begun to review this. This will resume in 2022/23 and will continue in line with the previous actions outlined.	
3	**As part of the safe staffing review, the Director of Nursing and Medical Director <u>must</u> confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.** Previous Actions Outlined: A review of all staffing guidance published by Royal Colleges and other bodies will take place and, where appropriate, implemented within the Trust.	Medical Director	31 March 2023	30 June 2020 Research will be undertaken regarding guidance that has been published by bodies such as Royal Colleges in order for the Trust to develop a Care Group / specialty level STHK staffing model. This will address patient safety in the first instance followed closely by safe working for Doctors which will look at safe staffing levels for both delivery of care and for the wellbeing and fatigue of Doctors. Update Due to the Covid-19 pandemic work was placed on hold. We are aware that there are some Royal Colleges that have published guidance on staffing and work has begun to review this. This will resume in 2022/23 and will continue in line with the previous actions outlined. Quarterly Reports on Guardian of Safe Working Hours: Doctors and Dentists in Training (1st October 2021 – 31st December 2021) – STHK trainees are presented by Medical Director	

4	**Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.** Previous Actions Outlined: Bi-annual establishment reviews will be extended to all staff groups once activity based rostering is implemented as they will be completed at a specialty level.	Medical Director		31 March 2020 As an interim measure work will be undertaken with specialties to triangulate budgeted establishment, gaps and clinical staffing levels needed for service delivery in order that a full assessment of safe staffing levels can take place. Update Due to the Covid-19 pandemic work to create a formal oversight and reporting process for staffing in other areas was placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue in line with the previous actions outlined. At the point of creating this action plan the Trust was undertaking a project to implement activity based rostering in all specialties to build a service level oversight of staffing required to deliver services. Implementation of Allocate's activity based rostering system "Activity Manager" was stopped due to issues with the systems capability and this continues to be discussed with Allocate to understand what, if anything, can be done to resolve the concerns raised by operational teams. Further work on this has been delayed due to the demands of COVID and the funding for the fixed term project resource ceasing on 31	

				March 2021.	
	Previous Actions Outlined: The establishment reviews will be undertaken in specialties and will encompass all staff groups including Medical & Dental and AHP.			30 June 2020 The above process will inform the establishment reviews which are required. These will subsequently be merged into whole specialty establishment reviews covering all staff groups. Update Due to the Covid-19 pandemic establishment reviews were placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue in line with the previous actions outlined.	
	Previous Actions Outlined: A suite of activity based rostering KPIs will be developed to enable the Trust to monitor the performance of specialties.			31 March 2020 Initial KPI suite will be created for the specialties that are live on activity based rostering and will be trialled and amended during the coming months. There may be a requirement to have differing KPIs by care group or specialty but this will not be known until the work is undertaken. Update: At the point of creating this action plan the Trust was undertaking a project to implement activity based rostering in all specialties to build a service level oversight of staffing required to deliver services.	

				Implementation of Allocate's activity based rostering system "Activity Manager" was stopped due to issues with the systems capability and this continues to be discussed with Allocate to understand what, if anything, can be done to resolve the concerns raised by operational teams. Further work on this has been delayed due to the demands of COVID and the funding for the fixed term project resource ceasing on 31 March 2021.	
5	**Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.** Previous Steps Outlined: Model Hospital data is not reported in the IPR because of the time lag in the national data being reported.	Medical Director	31 March 2023	Due to the Covid-19 pandemic work on this action was placed on hold. Work will resume in 2022/23 as follows: Local dashboards to be scoped out with the Data Team	
6	**Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.** Previous Actions Outlined: A standard operating procedure will be introduced to support the day to day staffing	Medical Director	31 March 2020	A SOP is being created to support the day to day staffing review process.	

	review process.				

Allied Health Professionals

Action No	Workforce Safeguards Recommendation & steps required to become fully compliant	Lead	Date Due	Update / Amended Actions	BRAG Status
1	**Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.** Previous Actions Outlined: The Trust is currently six months into a two year project to implement activity based rostering in all specialties which takes service demand templates, job planning (for Medical & Dental, Allied Health Professionals and other groups as required) and rostering tools to build a service level oversight of staffing. This is built on the skills required to undertake the required work within the specialty. It is intended that this project will be completed by 31 March 2021.	Director of Nursing	TBC pending software discussions	At the point of creating this action plan the Trust was undertaking a project to implement activity based rostering in all specialties to build a service level oversight of staffing required to deliver services. Implementation of Allocate's activity based rostering system "Activity Manager" was stopped due to issues with the systems capability and this continues to be discussed with Allocate to understand what, if anything, can be done to resolve the concerns raised by operational teams. Further work has recommenced.	
	Previous Actions Outlined: As part of the above process bi-annual establishment reviews will be extended to all staff groups as they will be completed at a specialty level.		31 March 2023	31 March 2020 As an interim measure work will be undertaken with specialties to triangulate budgeted establishment, gaps and clinical staffing levels needed for service delivery in order that a full assessment of safe staffing levels can take place. Update Job planning has been undertaken with Therapies and is required for the rest of the AHP workforce. All AHPs are on standard rostering to allow for oversight of staffing availability. Due to the Covid-19 pandemic work to create a	

				formal oversight and reporting process for staffing in other areas was placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue in line with the previous actions outlined.	
2	**Trusts must ensure the three components are used in their safe staffing processes:** • **evidence-based tools (where they exist)** • **professional judgement** • **outcomes** Previous Actions Outlined: The Trust has already completed Job Plans for the AHP workforce and we await the staffing tool guidance in order to progress this. A review of other available guidance will take place and, where appropriate, implemented within the Trust. A tool is currently in development nationally and will be implemented in due course.	Director of Nursing	31 March 2023	National AHP safer staffing work looking at the conversion of the Safer Nursing Care Tool has been formally ended due to the inability to transfer this to AHP specialism complexities. A new AHP proposal builds on this learning to look at a specific AHP operational workforce planning tool. Results were discussed at AHP “into action” programme board at the end of 2021 and a further update is awaited. As an interim measure professional judgement and outcomes are utilised to invoke business continuity plans where necessary. We are still awaiting staffing tool guidance.	
3	**As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.** Previous Actions Outlined:	Director of Nursing	31 March 2023	National AHP safer staffing work looking at the conversion of the Safer Nursing Care Tool has been formally ended due to the inability to transfer this to AHP specialism complexities. A new AHP proposal builds on this learning to look at a specific AHP operational workforce planning tool. Results were discussed at AHP “into action” programme board at the end of 2021 and a further	

	A tool is currently in development nationally and will be implemented in due course.			update is awaited.	
4	**Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.** Previous Actions Outlined: Bi-annual establishment reviews will be extended to all staff groups once activity based rostering is implemented as they will be completed at a specialty level. North west	Director of Nursing Medical Director	March 2023	31 March 2020 As an interim measure work will be undertaken with specialties to triangulate budgeted establishment, gaps and clinical staffing levels needed for service delivery in order that a full assessment of safe staffing levels can take place. Update Due to the Covid-19 pandemic work to create a formal oversight and reporting process for staffing in other areas was placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue in line with the previous actions outlined. At the point of creating this action plan the Trust was undertaking a project to implement activity based rostering in all specialties to build a service level oversight of staffing required to deliver services. Implementation of Allocate's activity based rostering system "Activity Manager" was stopped due to issues with the systems capability and this continues to be discussed with Allocate to understand what, if anything, can be done to resolve the concerns raised by operational teams. Further work on this has been delayed due to the demands of.	

				Update The AHP Workforce Project is underway in line with National work. STHK are leading C&M as the host of the C&M AHP Faculty and the AHP Workforce Lead. Work has begun on a Trust workforce project which includes workforce planning around elements such as return to practice, apprenticeships, preceptorships and support workers. North West AHP workforce growth underway in line with National work and StHK are leading the way with this work across Cheshire & Mersey hosting the Cheshire and Mersey AHP workforce lead alongside the Cheshire & Mersey faculty. The current Trust AHP workforce project plans will establish an AHP workforce plan alongside focus on; Return to Practice – currently underway in Radiology. Apprenticeships – Physiotherapy started in Sept 21/Occupational Therapy starts March 22, we have staff on both cohorts. Preceptorship – work underway to review and embed the framework, part of wider Cheshire and Mersey work group. Support Workers – work underway to review and embed the framework, part of wider Cheshire and Mersey work group.	

	Previous Actions Outlined: The establishment reviews will be undertaken in specialties and will encompass all staff groups including Medical & Dental and AHP.		31 March 2023	30 June 2020 The above process will inform the establishment reviews which are required. These will subsequently be merged into whole specialty establishment reviews covering all staff groups. Update Due to the Covid-19 pandemic establishment reviews were placed on hold. Staffing is reviewed at a local level by service leads and directorate managers and plans put in place to manage service gaps. Work will resume in 2022/23 and will continue in line with the previous actions outlined.	
	Previous Actions Outlined: A suite of activity based rostering KPIs will be developed to enable the Trust to monitor the performance of specialties.		31 March 2023	31 March 2020 Initial KPI suite will be created for the specialties that are live on activity based rostering and will be trialled and amended during the coming months. There may be a requirement to have differing KPIs by care group or specialty but this will not be known until the work is undertaken. Update: At the point of creating this action plan the Trust was undertaking a project to implement activity based rostering in all specialties to build a service level oversight of staffing required to deliver services. Implementation of Allocate's activity based rostering system "Activity Manager" was stopped due to issues with the systems capability and this continues to be discussed with Allocate to understand what, if anything, can be done to resolve the concerns raised by operational teams.	

				Further work has commenced on this	
5	**Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.** Previous Actions Outlined: Model Hospital data is not reported in the IPR because of the time lag in the national data being reported.	Director of Nursing	31 March 2023	Due to the Covid-19 pandemic work on this action was placed on hold. Work will resume in 2022/23 as follows: Local dashboards to be scoped out with the Data Team incorporating trust systems and National information from source such as Model Hospital. ESR data is currently incorrect regarding the coding of AHPs which impacts on the benchmarking data that is available in Model Hospital. A cleanse of this information is required. Action – some work is being undertaken as part of the Trusts AHP Workforce Support Worker Project. There is also work ongoing at a Trust Wide level within the ESR Team.	

6	**Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.** A standard operating procedure will be introduced to support the day to day staffing review process.	Director of Nursing	31 March 2023	SOP creation has been delayed due to the COVID-19 pandemic. In the interim day to day operational staffing is monitored and managed through daily huddles and sit-reps to inform staffing challenges and, where required, to invoke business continuity plans for escalation. There is a team / professional prioritisation matrix in place.	

END

TRUST BOARD

Paper No: NHST(22)025

Title of paper: Nurse Staffing Establishment Review paper

Purpose: To present to the Trust Board, the latest findings of the nursing workforce inpatient ward establishment review which was undertaken in September 2021 (data collection completed prior to the reviews).

Nurse establishment reviews must be undertaken by Trusts twice a year and reported to Board annually in order to comply with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and the RCN nursing workforce standards. Due to Covid -19 pandemic this was put on hold during 2020-21.

The findings and recommendations have been discussed and agreed at the Executive Committee on 17th February and 24 March 2022.

The review will provide the Trust Board with the assurance that the Trust has a nursing workforce with appropriately planned safe staffing resources to meet the patient care requirements.

Summary:

This nurse staffing establishment review paper will provide an overview of the key initiatives and work in progress to sustain the nursing workforce, this includes:

- Background to the nationally mandated review and latest staffing guidance for inpatient adult wards from NICE guidance, NHSi guidance (Developing Workforce Safeguards 2018) and the RCN nursing workforce standards (2021).
- Nursing and Midwifery financial budgets compared to workforce position
- Establishment and Shelford key findings summarised in Appendix 2
- The review confirmed that the funded establishment, the nurse staffing budgets and financial ledger were all aligned.
- The comprehensive review and triangulation of data indicated that there are 3 ward areas, 2D, 3A, and Bevan court 2 that indicated that additional RN is required to ensure the wards meets the recommended nurse to patient RN ratio. In additional there is ongoing requirement for 1.6 WTE HCA for Bevan court 2. This equates to 8.12 WTE RN and 1.68 WTE HCA. Total = 9.8 WTE.
- Wards 2D and Bevan court 2 have agreed uplift in their staffing budgets non-recurrent until March 2022, Ward 3A utilised the nurse bank for the additional shifts to cover additional activity.
- In September the RN vacancies were 58.05 WTE and HCA vacancies were 33.34 WTE. This included staff who had been appointed to post and OSCE nurses who had not yet commenced in post. this is monitored monthly .

- The recommendations to fund the 9.8 WTE were agreed by the Executive team, the funding will be released from the savings of 12 hour.

The staffing establishment reviews were undertaken in September 2021 and all data analysed to provide the assurance of the staffing levels in place meet the national recommendations.

Review key findings include:

- 29 of the 33 wards nursing establishments currently meet the nurse, patient, and skill mix requirements. This has been agreed by the review team and the ward matrons as part of the process

- 4 ward areas have been identified for further review:.

  *Ward 2D has a requirement for an additional RN at night to ensure the RN ratio of 1:11 is met.

  *Bevan court 2 were given a temporary uplift (non-recurrent funding) in August 2021 this was to provide an additional RN on Early shift ,1 RN on nights and 1 HCA on the early shift until 31st March 2022 and was included in part year finance run rate .

  *Ward 3A requirement is provide one to one nursing care for patients who have had a Diep procedure and require constant monitoring, this occurs 4 nights per week . The ward has seen increase in activity related to this procedure

  * Duffy unit: To undertake a contact care audit to review acuity and dependency to determine if staffing skill mix meets the requirements of intermediate care unit.

- Following the review Ward 1a winter escalation ward was opened initially to 16 beds then 32 as part of the winter plan. The staffing for this ward was a combination of newly appointed staff, international nurses and support from the other wards and specialist nurses. This is currently funded as part of winter pressures until end of June 2022. The ward was not part of the nurse establishment review in September as the ward did not open until November 2021.

- ED, ICU, Burns. Maternity and Paediatrics are also subject to separate emergent guidance either from NICE or NHS Improvement in relation to safe staffing levels

- Since the Covid -19 pandemic, it has been noted there has been a significant increase in the number of patients who have required supplementary care, this is

currently under review and data will be available to share at the next establishment review.

- The matrons as part of the daily/ twice daily staffing meetings review staffing across all wards and redeploy staff as required to address any shortfalls.

- As key action of the draft Nursing and Midwifery Strategy (2022- 2025) is development of the nursing workforce including expansion of roles e.g., Nurse associates who will support the work force development and skill mix. The Trust currently has 15 NA and 27 in training

- The trust continues with OCSE nurse programme

Corporate objectives met or risks addressed: Care, Safety, Systems

Financial implications: 8.12 WTE RN and 1.68 WTE HCA. Total = 9.8 WTE.
Funding to be realised from the savings from the implementation of 12 shift patterns

Stakeholders: Patients, public, staff, commissioners, Trust Board

Recommendation(s): The Trust board are asked to note the continued improvement in nursing workforce and the actions taken in relation to recruitment.
To approve the decision to support the increase by 8.12 WTE RN and 1.68 WTE HCA. Total = 9.8 WTE .across in the 3. wards areas identified

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

Date of meeting: 30 March 2022

Introduction

1.0 Background

It is a requirement that NHS providers continue to have the right people, with the right skills, in the right place at the right time to achieve safer nursing and midwifery staffing in line with the requirements of the National Quality Board (NQB, 2016) that states providers

- Must deploy sufficient suitable qualified, competent, skilled and experienced staff to meet treatment needs of patients safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required and keep them safe at all times
- Must use an approach that the reflects current legislation

The purpose of this nurse staff review paper is to provide the Board with assurance that the Trust has a clear validated process for monitoring and ensuring safe staffing levels. The Trusts' compliance will be assessed in the annual governance statement by confirming staffing governance processes are safe and sustainable.
This will be reviewed as part of any CQC inspections to demonstrate compliance with fundamental standards.
This compliance will be measured with a 'triangulated approach' including evidence-based tools and professional judgement and outcomes; this will ensure we have the right staff with the right skills are in the right place at the right time.

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

1.1 National context in relation to Nursing and Midwifery staffing

Nationally, nursing and midwifery workforce supply remains challenging with the shortfall in registered nurses being well documented as the biggest and most urgent need to address for all NHS providers. The NHS People Plan 2020-21 compliments the NHS

Long Term Plan (2019) identifying recruitment and retention as a key priority for nursing and midwifery workforce.

The NHS People Plan sets out practical actions that employers must focus on; these include.

1. **Looking after our people** – keeping people safe, healthy, and well
2. **Belonging to the NHS** – create an organisational culture where everyone feels they belong
3. **New ways of working** – effective use of people's skills and experience
4. **Growing for the future** – retaining colleagues for longer and renewed interest in NHS careers to expand workforce

Following the NQB (2016) expectations, implementation of NHSi Guidance 2018 (Developing Workforce Safeguards) and the System Oversight Framework (SOF) 2021 a full review is now undertaken annually (with a light touch review at 6 months) reporting to Executive Committee and Trust boards. This is to ensure ongoing quality with annual reporting to Trust Board. An establishment review was conducted in September 2021; the results from this review will be included in this paper for review.

NQB methodology 2016 / 2018

1.2 The Safer Nursing Care Tool (SNCT)

The SNCT is a NICE endorsed evidence based tool which uses acuity and dependency to support workforce planning. It is endorsed by the Shelford Group and the tool of choice by the NHSi. The tool uses a system of identifying patients according to acuity (how ill the patient is) or dependency (how dependent the patient is on nursing staff) and is detailed in appendix 1. This tool aide's development of future workforce requirements based on the results. It includes a staffing multiplier of 22% uplift for annual leave/study leave etc. and produces an average recommended WTE staffing figure based on the highest scoring days being applied right across the census period.

1.3 Care Hours Per Patient Day (CHPPD) guidance

CHPPD data has been collected for acute and acute specialist providers since April 2016 and for community and mental health trusts since April 2018, following publication of Lord Carter's report on their productivity.
As a result of this:

- All trusts must submit CHPPD data via the Strategic Data Collection Service (SDCS).
- CHPPD is a measure of workforce deployment that can be used at ward level and service level or aggregated to trust level.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix.

Care hours per patient day =	Hours of registered nurses and midwives alongside hours of healthcare support workers
	Total number of inpatients

CHPPD metrics are compared monthly against national peers on a ward by ward basis; this is reflected within the monthly Safe Staffing Assurance Report.

The overall Trust CHPPD for the 6 month period before the review was 7.2 which is comparative with the national benchmark of 7.

1.4 Nursing/Midwifery skill mix / ratio guidance

The Royal College of Nursing, and NICE published guidance for safe staffing in general and elderly wards in 2021. The RCN guidance continues to recommend a 1:8 ratio of registered nursing staff to patients on days, 1:11 ratio of registered nursing staff to patients on nights, and a 60/40 skill mix for Registered Nurses (RN) and Health Care Assistants (HCA).

The Trust inpatient ward nurse establishments remain compliant with this. However, it is important to note different specialisms of nursing require differing bespoke skill sets to meet the core care needs of their patients.
This must, therefore, be reviewed and agreed when local templates for each ward staffing establishment is agreed and follows the recent advice from the CQC which suggest that when looking at staffing levels, there is no prescribed level and the correct staffing numbers for the ward consider the knowledge of the service you are providing focusing on the quality of care, patient safety and efficiency rather than just numbers and ratios of staff. The skill mix can be adjusted based on the levels of patient care, nursing intervention such as. Intermediate / rehabilitation care.

1.6 Safer Staffing Submission

It is a national requirement of all Trusts to publish their monthly nursing and midwifery staffing levels to the NHS website. Safer staffing levels are the total planned number of hours worked by registered and care staff measured against the total number of actual

hours worked to produce a monthly fill rate calculated as a percentage for nights and days on each ward. A deep dive is conducted monthly into wards below 85% compliant, this is reported to the Executive Committee and Quality Committee monthly and Trust board via the integrated performance report (IPR).

2.0 STHK Nursing and Midwifery establishment methodology

Completing the Trusts bi-annual establishment reviews has included the following tools to ensure compliance with national guidance is adhered to.

- Use of national SNCT
- SafeCare system (20 day audit extraction for acuity)
- Care Hours Per Patient Day
- Professional Judgement
- Peer group validation (Daily Staffing Meeting)
- Review of E-Rostering data
- Review of ward quality metrics: Nurse to bed ratio and red flag indicators including pressure ulcers, falls and medication errors.
- Reflections on the COVID 19 effect on staffing and the staff

3.0 Nursing/Midwifery establishment review process September 2021

As part of the review all wards across all hospital sites for adult and children inpatients were reviewed. The ward review group consisted of the Ward Manager, Matron, Deputy Director of Nursing and Midwifery, Heads of Nursing and Quality, Directorate Managers, Finance Business Partners and E-Resourcing Team.

Following the establishment review meeting the information from SafeCare (20 day audit), finance budgets, red flags and professional discussion information was collated into a detailed spreadsheet to evidence rationale for any uplift in budgets required. This has formed the basis of the recommendations

Separate corporate reviews have been undertaken in Intensive Care, Emergency Admission areas, Paediatrics and Maternity. Some of these are also subject to separate emergent guidance either from NICE or NHS Improvement in relation to safe staffing levels and any specific recommendations will be highlighted separately through the budget setting process.

It should be noted that as part of the establishment review this included a review of ward rostering templates to ensure compliance with the required key performance indicators. This is now being monitored via the Rostering Oversight Steering Group (ROSG).

It is noted anecdotally that there has been an increase in the complexity, acuity and dependency of the patients cared for in our general inpatient areas. Information on the acuity and dependency of our patients, including any enhanced care needs is available via the ‘Safe Care’ functionality in Health Roster. This information was used in this review as part of the professional judgment assessment.

4.0 Results of the Establishment review.

- 29 of the 33 wards nursing establishments currently meet the nurse, patient, and skill mix requirements. This has been agreed by the review team and the ward matrons as part of the process
- 3 ward areas have been identified as requiring additional Registered Nurses to meet the national requirements, 2 wards (2D and Bevan court 2) this requirement is for an additional RN at night to ensure the RN ratio of 1:11 is met.
- Bevan court 2 were given a temporary uplift (non recurrent funding) in August 2021 this was to provide an additional RN on Early shift ,1 RN on nights and 1 HCA on the early shift until 31st March 2022.
- Ward 3A requirement is provide one to one nursing care for patients who have had a Diep procedure and require constant monitoring, this occurs 4 nights per week The ward have seen an increase in activity for both DEIP and breast reconstruction procedures resulting in additional RN requirements .
- Duffy Unit further review of staffing is required using contact care time tool to determine acuity and dependency in the intermediate care ward; this is planned for April/ May 2022.

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Following the review Ward 1a winter escalation ward was opened initially to 16 beds then 32 as part of the winter plan. The staffing for this ward was a combination of newly appointed staff, international nurses and support from the other wards and specialist nurses. This is currently funded until end of June 2022 and will require further review.

Analysis of the 3 wards

- **Ward 2D – Recommended uplift 2.4 WTE RN**

This ward originally had 23 beds and staffed; accordingly, over time this has been increased to 25 then 28 beds for patient demand. The senior nursing team would propose if funding was available for an additional RN on night shift (2.4 WTE) this would allow the recommended night RN ratio of 1:11 can be met, it is currently 1 RN to 14 patients. During the winter period this has already been temporally approved and is funded non recurrently until end of June 2022.

- **Bevan 2 – Recommended 4.04 WTE RN.1.68 WTE HCA**

This ward was set up as an intermediate care ward however since the ward opened it has seen an increase in patient acuity / dependency. Nurse staffing is currently on the risk register rated as high risk this is being continuously reviewed and actions in place to mitigate the risk. To address the staffing pressures, it was agreed by the DON and Assistant Director of Finance (MCG) that following an outbreak and patients' safety red flags the unit were given a temporary uplift (non recurrent funding) to provide an additional RN on Early shift,1 RN on nights and 1 HCA on the early shift until 30 June 2022, this resulted in the staffing levels reflecting other 32 bedded DMOP wards and a RN/ patient

1.11 on nights. The demand for supplementary care is similar DMOP wards, in September 2021 the ward made an additional 167 supplementary care requests

- **Ward 3A Plastics recommended uplift 1.36 WTE RN**

Ward 3a is a plastic surgery ward which provided both inpatients and day case care. Patients are admitted for surgical DIEP (breast reconstruction including skin grafting) procedure is completed Monday-Friday. This patient cohort requires 1:1 RN ratio post-operatively, currently this is not factored into the RN WTE establishment. In addition to the DIEP procedures the ward completes a Free Flap procedure As part of the establishment reviews the proposal is for 1.36 WTE RN on 4 night shifts per week to support the DIEP patients.

3. Paediatrics and Special Care Baby Unit.

The neo natal unit preforms a workforce calculation using the Neonatal Clinical Reference group recommended Neonatal Nursing workforce staffing tool. This was undertaken in July 2021. Whilst STHK met the service specification for budgeted total nursing workforce (now +1.28WTE), there is a need to undertake a skill mix review to address the variances noted, e.g, a shortage of nurses Qualified in Speciality (QiS) and an over-establishment of non-qualified nursing staff, a skill mix was required which has been completed.

A review of the RCN and Bapen standards for paediatrics is in progress to undertake a gap analysis of the recommendations in the guidance, this includes the proposal that in addition to the full time supervisory ward manager there is a band 6 on each shift. We do not meet these standards; this is consistent across other paediatric units in DGH. The ODN advises there will potentially be funding allocated to all Trusts nationally from 22/23, from the Neonatal Critical Care Review (NCCR) allocation. It should also be noted that there is currently a national shortage of neonatal nurses.

4. Emergency Department Review.

The Shelford Acuity Tool is not suitable for use in the Emergency Department. A specific tool has been recently released by Shelford and will be used during future reviews following training on the use of the tool.
An accurate ED review requires staffing levels and designations, operational flow and consideration of additional corridor patients. There is currently a temporary agreement for an extra 1.0 WTE RN and 2.0 WTE HCA's due to corridor placed patients.
The corporate nursing and ED operational teams have reviewed the additional staffing requirements for the winter period.
This temporary funding which was approved by the Executive Committee until the end on 31st March 2022 and will need further Exective Committee discussion .

The uplift in staff included :

- 4 additional RN's for the corridor in ED
- Band 7 Nurse lead for SDEC
- Associate Head of Nursing and Quality band 8B

- Quality Nurse Specialist B7

ED Current staffing establishment, including vacancies (Sept 21)
September 2021 Staffing Vacancies

Staffing Establishment	Funded WTE	Contract WTE	Vacancy WTE
Nurse band 2	35.10	28.80	(6.30)
Nurse band 4	0.80	2.80	2.00
Nurse band 5	100.17	72.14	(28.03)
Nurse band 6	15.50	17.16	1.66
Nurse band 7	9.36	11.00	1.64
Trainee Nursing Associate	1.00	0.00	(1.00)
Grand Total	**161.93**	**131.90**	**(30.03)**

December 2021 update

Staffing Establishment	Funded WTE	Contract WTE	Vacancy WTE
Nurse band 2	44.47	40.00	4.00
Nurse band 4	0.80	0.80	0.00
Nurse band 5	100.59	76.00	24.00
Nurse band 6	15.50	19.16	0.00
Nurse band 7	10.36	10.40	0.04
Grand Total	**171.72**	**146.36**	**28**

Maternity staffing review.

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to the development of safe maternity staffing has been the overarching policy publications; ‘Safe Midwifery Staffing for Maternity Settings’ (NICE 2019) and ‘Better Births’ (NHS England 2016).

The Maternity service undertakes a 6 monthly staffing review or more regularly if required to calculate the midwifery staffing establishment and to ensure it meets CNST’s minimal evidential requirement relating to Safety Action 5 regarding effective midwifery workforce planning. A midwife to birth ratio is included and monitored monthly on the local and regional maternity dashboard monthly. This is a comparative ratio in its simplest form measuring midwifery staffing to the requirements of 1 midwife for every 28 births but does not reflect any acuity. The current mechanism of calculating this ratio is under review and the ratios will be reflected accordingly.

Birthrate Plus® has developed a method of assessing and analysing the required numbers of Midwives in relation to activity and acuity utilising a well-established workforce planning methodology and is the only nationally endorsed tool for calculating maternity staffing levels. The Birthrate Plus® methodology is based on an assessment of clinical risk, acuity and the needs of women and their babies during the antenatal period, labour, birth, the

immediate post-delivery period and the postpartum period within the hospital and in the community setting whilst utilising the accepted standard of 1 midwife to 1 woman in labour.

Currently the Maternity service is funded to the previous Birthrate+ assessment and is currently at 1:28 however, this predated the introduction of the Continuity of carer(CoC team, the Midwifery Led Unit (MLU) and the maternity triage alongside clinical changes that has increased the dependency of women including an increase in Inductions of labour in line with the National recommendations of, 'Saving babies lives'.
The maternity service has completed a full Birthrate plus assessment with all data submitted in 2021. The preliminary feedback meeting is scheduled for March 2022. The report will provide recommendations of the required staffing establishment across the entire maternity service and once finalised will be included in the next staffing report

Ongoing Developments

STHK are committed to providing safe, sustainable and productive staffing to meet the ever growing needs of our local population. In response to national guidance cited throughout the report there are a number of internal initiatives to support safer staffing, these include:

- Support for staff through health work and wellbeing services
- Development of an internal staff transfer process
- Flexible working/retire and return scheme
- Promoting listening events and engagement sessions to listen to and address staff concerns
- Increase availability of apprenticeship courses available to invest in and upskill existing workforce
- In house education and training programmes available for nursing and midwifery workforce to support succession planning into senior roles within the organisation
- Speciality specific preceptorship programmes for staff working in Maternity, ICU and the Emergency Department
- Trial of 12hr shift pattern working to meet staff request for home/work life balance
- Development of Ward Managers to manage the demands of daily staffing work pressures
- Staffing review to be undertaken for Band 2-6 to ensure staff are delivering care compliant with their job descriptions and competence
- Delivery of OSCE programme for International Nurses

Appendix 1

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (*Comprehensive Critical Care, DH 2000*). These classifications have been adapted to support measurement across a range of wards/specialties. The full SNCT is outlined below.

Safer Nursing Care Tool (SNCT)

Levels of Care	Descriptor- Care requirements may include the following
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	Elective medical or surgical admission May have underlying medical condition requiring on-going treatment Patients awaiting discharge Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly Regular observations 2 - 4 hourly Early Warning Score is within normal threshold. ECG monitoring Fluid management Oxygen therapy less than 35% Patient controlled analgesia Nerve block Single chest drain Confused patients not at risk Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or xperiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	Increased level of observations and therapeutic interventions Early Warning Score - trigger point reached and requiring escalation. Post-operative care following complex surgery Emergency admissions requiring immediate therapeutic intervention. Instability requiring continual observation/invasive monitoring Oxygen therapy greater than 35% +/- chest physiotherapy 2 - 6 hourly Arterial blood gas analysis - intermittent Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains Severe infection or sepsis

Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with spinal instability / spinal cord injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration / post-administration care) • Patient and / or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post-operative optimisation (pre-op invasive monitoring)/extended post-op care. • Patients requiring non-invasive ventilation/respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway and protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ / systems • Respiratory or CNS depression/compromise requires mechanical /invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia /haemorrhage/sepsis or neuro protection

Appendix 2 Establishment review template

Copy of Copy of
Copy of Nurse estab

September 2021 RN/M and HCA vacancies (excluding ED)

Ward	Ward	RN/M	HCA	ns	Complaints	Drug errors
1B	Duffy	0.90	-1.26	6	2	37
1C	Bevan Court 1	4.72	0.70	12	4	23
1D	Bevan Court 2	1.90	2.20	4	1	11
1E	1B	10.10	0.60	2	2	3
2A	1C	-0.29	-4.11	7	0	
2B	1D	-1.60	2.45	9	2	15
2C	1E	-0.27	2.38	5	5	7
2D	2A	5.71	2.21	3	3	8
3A	2B	3.98	0.79	1	0	4
3Alpha	2C	0.66	1.00	4	1	3
3B	2D	1.29	2.81	5	1	6
3C	2E	1.03	0.30	10	3	10
3D	3A	-0.40	0.00	31	2	9
3E Gy	3Alpha	0.37	1.13	2	2	6
3E Ort	3B	3.52	1.06	1	0	
4A	3C	2.87	2.62	7	4	12
4B	3D	3.93	-1.04	4	2	10
4C	3E Gynae	0.00	0.13	7	0	7
4D	3E Ortho	1.60	3.00	7	0	3
4E	3F	-1.35	-0.03	0	0	
5A	4A	-2.20	1.20	9	1	2
5B	4B	0.17	0.09	11	0	2
5C	4C	1.00	-0.60	2	0	7
5D	4D	0.25	1.09	3	0	3
Seddo	4E	9.61	0.00	0	0	3
Duffy	4F	2.05	1.53	0	1	9
Newto	5A	-3.14	0.99	3	0	18
Bevan	5B	-0.98	4.37	6	1	8
Bevan	5C	7.34	0.15	4	1	29
Sande	5D	1.01	2.83	0	0	
	SCBU	-0.02	1.61			
	Delivery Suite	3.30	1.40			
	Seddon	0.20	1.74			
	Newton Ward	0.82	0.00			
	Total	58.08	33.34			

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)026
Title of paper: Ockenden one year on
Purpose: To provide the Trust Board with an update and overview on the Ockenden review of Maternity, one year on from publication
Summary: The paper provides an update of the Trusts compliance to the Ockenden recommendations one year on following publication in December 2020 using the Maternity Services Assessment and Assurance Tool. The assessment tool identifies compliance to 11/12 of the clinical priorities with one priority being partially complaint relating to the twice daily consultant led ward rounds with one ward round being during the night handover and evidence to demonstrate compliance to 117 out of the 122 IEA criteria with 5 amber actions which are in progress with 3 of these relating to audit. Maternity workforce is continually assessed including the provision of bi-annual workforce papers with an ongoing proactive rolling recruitment programme to minimise vacancy gaps as much as possible alongside agreement to over recruit by 6 WTE midwives to cover maternity leave. The Maternity service has strengthened its leadership structure to include a Deputy Head of Midwifery role and Band 7 specialist midwifery roles following the TUPE transfer of Bridgewater community services. Preliminary Birthrate + workforce assessment report w asreceived in March 2022 and awaiting the final report which will be shared and discussed with the Executive team once received.
Corporate objectives met or risks addressed: Care; Safety; Pathways; Communication and Systems
Financial implications: Nil
Stakeholders: The Trust, Staff, Patients, Commissioners
Recommendation(s): The Trust Board are requested to note the contents of the paper
Presenting officer: Sue Redfern: Director of Nursing, Midwifery and Governance
Date of meeting: 30th March 2022

Introduction

On 10th December 2020 a report from Donna Ockenden was published following clinical review of the first 250 cases where concerns had been raised over the care that patients received from the maternity unit at The Shrewsbury and Telford Hospital NHS Trust. The report identified themes and recommendations and discussed immediate actions raised from these reviews and their associated actions for all Maternity Units in England.

NHS England requested that maternity services implement all 7 Immediate and Essential Actions (IEAs) described in the document alongside workforce and leadership recommendations. StHK completed the required standardised maternity assessment assurance tool and submitted evidence via the Future NHS Collaborative Platform in July 2021 demonstrating evidence of compliance to the required recommendations alongside an action plan that was developed for any areas of non or partial compliance.

On 25 January 2022, NHS England and Improvement sent a letter to Trusts thanking them for progress to date and to formally request that progress with implementation of the 7 Immediate and Essential Actions (IEAs) with plans to ensure full compliance to Ockenden one year on is discussed at public Board at the end of March 2022. Progress is also required to be shared and discussed with the Local maternity System (LMS) and additionally submitted to the regional maternity team by 15th April 2022.

Findings

The evidence submitted in July 2021 was reviewed at the request of the National team by the Midlands & Lancashire CSU (MLCSU). In December 2021, the maternity service received the findings of this assessment which confirmed full compliance to 9 out of 12 clinical priorities and partial compliance for two. Compliance was also achieved in 100 out of the 122 IEA criteria with 21 actions required.
7 of these actions were required to be undertaken by the Local Maternity System (LMS) or the Regional network with 15 actions required by StHK.

Over the last 12 months, the focus has been on embedding these essential actions with continued attention on the action plan thereby working towards full compliance with regular LMS meetings to discuss progress updates.

The Trust completed its self-declaration position against the Ockenden 7 IEAs, which include the 12 urgent clinical priorities to NHSE/I on 18/02/22 as requested. (Appendix 1)

The maternity service as requested by NHSE/I has undertook a further review of the 7 IEA's and 12 Clinical Priorities utilising the NHS Maternity Services Assessment and Assurance Tool (Appendix 2) which incorporates the recommendations from the Morecambe Bay investigation and the Ockenden

report. The assessment tool additionally includes a section relating to maternity workforce plans, maternity leadership and NICE compliance.

The Maternity service has evidence to demonstrate compliance to all IEA apart from 4 criteria which are rated as amber which include:

- Development of role descriptors for all key members who attend the Maternity safety champions meetings
- Completion and presentation of an audit of 1% of health records that personal care and support plans are in place to formally risk assess women at every antenatal contact in order that they have continued access to care by the most appropriate trained professional.
- Completion and presentation of an audit of 1% of health records that women are enabled to participate equally in all decision making processes.
- Completion and presentation of an audit of 5% of health records that women make choices following a shared and informed decision-making process including women who have specifically requested a care pathway which may differ from that recommended by a clinician across the maternity pathway.

All audits have all been registered and added to the annual plan and are currently in progress.

There is one outstanding clinical priority to which we are partial compliant. The action relates to the requirement to implement consultant labour ward rounds twice per day, 7 days per week with one review being during the night shift. Presently there is a resident consultant presence 5/10 and a ward round occurs at 20.30 hours. On the days that there is no resident consultant the 2nd ward round occurs at 17.30. An additional consultant has been appointed in March 2022 and once in post will increase the resident consultant availability and the night ward round will increase to 6/10. A business case to increase the Obstetric consultant establishment is in progress and if approved will enable full compliance to this Ockenden clinical priority.

There are 2 actions attributed to the regional network which in IEA 4: Managing complex pregnancy. Development of agreed maternal medicine pathways and criteria for referral to maternal medicine specialist centres which have not yet been finalised. StHK will implement once pathways and criteria referrals have been developed.

The LMS have completed their 5 outstanding actions in March 2022 which includes:

- The production of a Standard Operating Procedure (SOP) that outlines how Trusts report the Maternity dashboard internally and externally through the LMS
- Production of SOP that details the plan to implement the Perinatal Clinical Quality Surveillance Model and how this will be embedded in the ICS governance structure and signed off by the ICS.

- Provision of SOP including an organogram of organisations involved in the implementation of the Perinatal Clinical Quality Surveillance Model.
- Development of LMS reports showing regular review of training data and a training needs assessment externally validated by the LMS three times per year
- Validation of Multi professional training by the LMS

The LMS have produced a standardised Quarterly maternity board reporting template for all C+M maternity units to use as a guide to provide assurance to the Trust Board (Appendix 3) which covers the essential reporting requirements for Maternity Services to Board of:

1. Compliance with the Immediate and Essential Actions (IEAs) outlined in Part One of the Ockenden Report1
2. Maternity Incentive Scheme (MIS)
3. Perinatal Quality Surveillance Model (PQSM)
4. The Perinatal Clinical Surveillance Quality Assurance Report
5. The C&M Clinical Outcome / Outlier Report
6. Serious Incidents
7. Health Care Safety Investigation Branch (HSIB)
8. Care Quality Commission CQC Review
9. Safety Champion Report
10. Workforce: Maternity and Neonatal Staffing
11. Midwifery Continuity of Carer (MCoC)

The Maternity Services Assessment and Assurance Tool also factors in other considerations, taking the urgent actions further and triangulating with other standards, which include Maternity Workforce Planning and leadership.

The Trust has a duty to ensure that Midwifery staffing levels are adequate and that women are cared for safely by appropriately qualified and experienced staff and to provide assurance that the midwifery establishments are providing safe, high-quality services with an aim of right staff, right place, right time with the right skills.
A bi-annual maternity workforce paper is presented to Quality Committee providing assurance of safe staffing and highlighting any areas of concern and actions taken to ensure safe staffing.

Maternity workforce modelling is supported by Birthrate plus which is the accredited workforce tool for Maternity services The last Birthrate Plus Assessment for StHK was completed in 2016 and the current maternity funded establishment is compliant with the previous assessment however Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best and safest care to women, babies and families. For StHK this has been reflected in an increase in births and attendance within triage, complexity of women and the implementation of saving babies lives resulting in an increased CS

and IOL which have necessitated the need for a repeat BR+ full workforce assessment review.
This review was supported and funded by the LMS and commenced in 2021. The data period that was required to be used was the financial year 2020/21 in order to have a full financial year of data. A preliminary report has been received in March 2022 and a meeting with BR+ has been scheduled for Tuesday 29th to discuss some anomalies and clarification of some details. Once the final report has been received this will be presented to the Executive committee for consideration.

Staffing levels across the maternity service has remained a challenge throughout 2021/22 with sickness and absence improving.

All maternity units in Cheshire & Merseyside participate in regional gold command calls to provide a Sitrep and to look at how we can support each other via mutual aid. These meeting have reduced from daily to weekly in response to the improving picture regionally. Continued review of staffing and activity occurs ensuring movement of staff to the clinically required areas and redeployment of staff, senior management and specialist midwives as required including the utilisation of bank / agency and overtime as required.

There has been an ongoing rolling recruitment programme to address any deficits in vacancies as early as possible and to be proactive to cover prospective maternity leave and retirements with five successful recruitment sessions in the previous six months and currently out to advert. Recruitment of International Midwives is recognised as being crucial to support the future workforce and StHK are working collaboratively across the Northwest for the new programme.

The Trust has agreed to over establish by 6 WTE midwives to cover maternity leave due to the continued cover required and as filling fixed term contracts is proving difficult to attract midwives due to the number of midwifery vacancy positions both locally and nationally.
The Maternity service has strengthened its leadership structure to include a Deputy Head of Midwifery role following the TUPE transfer and expansion of the community midwifery service from Bridgewater alongside additional band 7 specialist midwifery roles and Community team leaders.

Conclusion

The Maternity Services Assessment and Assurance Tool has been utilised to assess its current position one year following the receipt of the Ockenden report by providing evidence and assurance to the Trust Board alongside key actions required to maintain current compliance and complete actions to achieve full compliance.
The assessment tool identifies compliance to 11/12 of the clinical priorities with one priority being partially complaint relating to the twice daily consultant led ward rounds with one ward round being during the night handover. One additional consultant has been appointed to increase compliance with a

business case in development for additional consultants which will enable full compliance.
There is evidence to support compliance to 118 out of the 122 IEA criteria with 4 amber actions which are in progress with 3 of these relating to audit. All of which are in progress .

Maternity workforce is continually assessed including the provision of Biannual workforce papers to Quality committee. There has been an ongoing proactive rolling recruitment programme over the past 6 months which continues alongside engaging in the new programme in the Northwest of recruitment of International Midwives and Trust agreement to over recruit to an over establishment of 6 WTE midwives to cover maternity leave.
The Maternity service has strengthened its leadership structure to include a Deputy Head of Midwifery role and Band 7 specialist midwifery roles following the TUPE transfer of Bridgewater community services.

A full Birthrate plus assessment has been completed in 2021 with a preliminary report being received in March 2022. Following receipt of the final assessment report, the findings will be presented to the Executive committee for consideration.

Recommendations

The Trust board members are requested to consider the findings of this paper and discuss the evidence provided in the maternity assurance and assessment tool alongside the required actions to ensure full compliance prior to submission to the Trust Board on 31st March 2022 and to the LMS and the regional maternity team by 15th April 2022.

Appendix 1: Maternity Ockenden self-declaration position. Feb 2022


StHK signed Ockenden self decla

Appendix 2: The Maternity services Assessment and assurance Tool


Assessment and assurance tool one