St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27th APRIL 2022
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
09.30	1.	Employee of the Month Film - April 2022		Verbal	Assurance	Chair
09.40	2.	Apologies for Absence		Verbal	Assurance	Chair
09.45	3.	Declaration of Interests		Verbal		
09.50	4.	Minutes of the Board Meeting held on 30th March 2022		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.00	5.	Integrated Performance Report		NHST(22) 027	Assurance	Gareth Lawrence
		6.1	Quality Indicators			Sue Redfern
		6.2	Operational Indicators			Rob Cooper
		6.3	Financial Indicators			Gareth Lawrence
		6.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
10.20	6.	Committee Report – Executive		NHST(22) 028	Assurance	Ann Marr
10.30	7.	Committee Report – Quality		NHST(22) 029	Assurance	Rani Thind
10.40	8.	Committee Report – Finance & Performance		NHST(22) 030	Assurance	Jeff Kozer
10.50	9.	Committee Report – Audit		NHST(22) 031	Assurance	Ian Clayton

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.00	10.	Corporate Risk Register	NHST(22) 032	Assurance	Nicola Bunce
11.10	11.	Board Assurance Framework	NHST(22) 033	Approval	Nicola Bunce
11.20	12.	Learning from deaths quarterly report	NHST(22) 034	Assurance	Rowan Pritchard-Jones
11.30	13.	2021 Staff Survey Report and Trust action plan	NHST(22) 035	Assurance	Anne-Marie Stretch
Closing Business					
11.55	14.	Effectiveness of Meeting	Verbal	Assurance	Chair
	15.	Any Other Business		Information	
	16.	Date of Next Meeting – Wednesday 25th May 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

DRAFT
Minutes of the St Helens & Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 30th March 2022 via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chair
Members:	Ms A Marr	(AM)	Chief Executive
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs L Knight	(LK)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	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
	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

In Attendance:	Ms M Szpakowska	(MS)	Deputy Director of Human Resources (Observer)
	Ms L Codling	(LC)	Assistant Director of Workforce Development & Resourcing (Observer)
	Mr Gareth Lawrence	(GL)	Deputy Director of Finance
	Ms L Ford	(LF)	Quality Nurse Specialist (Item 2)
	Ms Y Mahambrey	(YM)	Quality Matron Patient Experience (Item 2)
	Ms A Finney	(AF)	Member of the public (Observer)
	Mr R Purewal	(RP)	Director – Healthcare (Observer)
	Mrs C Duffy	(CD)	Executive Office Manager *(Minute Taker)*

Apologies:	Mrs L Knight	(LK)	Partial apologies
	Mr G Appleton	(GA)	Partial apologies
	Dr R Thind	(RT)	Partial apologies

1 Employee of the Month (EoTM) Awards

1.1 The March EoTM award was presented to Dr Kalani Mortimer, Consultant Medical Microbiologist. Dr Mortimer was nominated by Oonagh McGugan, IPC Lead Nurse and the medical microbiology team.

1.2 Members watched the award film where RC made the EoTM presentation to Dr Mortimer.

1.3 RF commented that the award was very well deserved.

2 Patient Story

2.1 Matron Yvonne Mahambrey (YM) introduced the story which detailed how the Trust had supported a patient who was subject to a Deprivation of Liberty Order (DoLs). The story had been pre-recorded and was relayed by the ward manager.

2.2 The wife of the patient had been admitted to hospital and whilst an in-patient had deteriorated and died. The traumatic experience caused the patient to become extremely confused and the sudden and unexpected death precipitated an acute decline in the patient's own physical health. It was necessary for him to be admitted to hospital and was assessed as not having capacity.

2.3 The story focussed on the partnerships between the family, safeguarding and ward teams to ensure that mitigations were put in place to enable the patient to attend his wife's funeral whilst remaining an in-patient.

2.4 The lessons learned were outlined, and the medical and nursing teams highlighted the positive impact on both patient and family. 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.

2.5 RF thanked YM and commented that it was an emotional story and that everyone is affected by bereavement at some point in their lives. He noted the lessons learned and thanked all the staff involved.

2.6 LK also thanked YM and remarked on the complexities of the case due to the patient's vulnerability. YM confirmed that the lessons learned had been disseminated to all other ward managers and matrons.

3 Apologies for Absence / Welcome and Introductions

3.1 It was noted that a number of members would not be able to attend for the whole meeting and partial apologies for absence due to required attendance at other meetings were received as noted above.

4 Declarations of Interest

4.1 None, other than those already recorded.

5 Minutes of the Board Meeting held on 23rd February 2022

The minutes were approved.

5.1 There were no matters arising.

5.2 Action Log - RF confirmed both actions 30 and 36 remained **DEFERRED** due to COVID-19.

6 Integrated Performance Report - NHST(22)015

6.1 **Quality Indicators**

SR presented the report.

There had been 1 MRSA case in February 2022. SR reported that the RCA had shown that the case was unavoidable and that there were no lapses in care. A high level of care and commitment had been demonstrated by staff. SR explained that this had been a very complex patient.

VD asked what sort of input is provided to the Trust for patients with mental health needs. SR confirmed that patients are reviewed on a daily basis by the in reach mental health team and psychologist. The importance of ongoing care is recognised by all.

There had been 2 C.Diff cases in February (both hospital onset). Year to date (YTD), there had been a total of 49 cases, 28 hospital onset and 21 community onset against the Trust tolerance level for 2022/23 of 54. It was noted that 12 RCAs were currently outstanding.

There had been no never events reported in February

Safer Staffing fill rate (combined day and night) for February 2022 was 92.3%, YTD 92.2%.

There had been no validated grade 3 hospital acquired pressure ulcers in February. YTD there had been 2 grade 3 pressure ulcers, previously reported to Board.

During January there had been 4 falls resulting in severe harm or death and year to date 19 had been reported.

GB asked for an update on progress in implementing the falls strategy. SR reported that the enhanced risk assessment processes on eVitals was in place and additional support in ED from the falls team. The perfect ward (Tendable) app allows for audits of patient risk assessments, and immediate actions are taken to address anything identified. SR stated that in the last audit of 168 patients, only 2 had needed action where the risk assessment plans had not been fully implemented. Work is also ongoing with AQuA on patient safety culture, focusing on wards 5A, 5B and Bevan Court 2 initially to develop a roll out plan for the whole Trust. Dr Worthington, Assistant Medical Director and Consultant in Emergency Medicine is meeting each week with the falls team to identify immediate lessons from any incidents and issue a safety bulletin across all the wards.

GB was assured by the enormous amount of work that was being undertaken to reduce the risk of falls. GB asked if the planned digital alert for review of the risk assessments was now operational. SR reported that there was work in progress to develop this functionality with Care Flow but in the meantime handover documentation had been amended to include a reminder to review the falls risk assessment.

RF enquired whether benchmarking information with other similar Trusts about the rate of fall per 1000 bed days was available. SR explained there was no single national standard for reporting but would review the information that was available for inclusion in future reports.

VTE assessment remained suspended nationally.

HMSR (April to November) for 2021/22 was 97.7.

6.2 **Operational Indicators**
RC presented the report.

RC noted the Trust is still the top performing Trust in Cheshire & Merseyside and some way ahead of the national position in relation to the cancer targets.

Performance against the 62-day cancer standard was not achieved at 83.4% in January against the target of 85%, YTD performance was 85.03%.

The 31-day target was achieved with 98.0% performance in January, against a target of 96%. YTD performance was 98.2%.

The 2-week rule target was not achieved in January at 73.5% against the target of 93%. YTD performance was 85.2%. RC noted that this was due to the continued significant increase in referrals, resulting in capacity challenges for the service.

Accident and Emergency all types mapped performance for February was 73.7% (year to date 77.5%). The average daily attendances in February were 319.

The ambulance 30-minute turnaround time was not achieved in January 2022 with the average being 57 minutes. There had been 2,058 ambulance conveyances in the month. RC explained that if a GP requests an ambulance for a patient they must be brought to the ED, this means that some patients who could be managed in the community are presenting. This is being discussed with system partners.

The average number of super stranded patients in February was 138 compared with 132 in January, 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 renewed impact of COVID on care home capacity was a factor.

The 18-week referral to treatment target (RTT) was not achieved in January with 70.1% against the target of 92%. There were now 1,389 52+ week waiters as a result of the backlog from the pandemic. The 6-week diagnostic target was not achieved in February at 87.3% against the 99% target. Performance in January was 73.7%, and it was expected this improvement would continue.

Community nursing referrals had decreased slightly from last month; however, were still within the average range at 562 in January. The community matron caseload had also decreased in January to 138 from 143 the previous month.

RF reported that at the National Chairs' meeting, David Sloman, NHSE/I Chief Operating Officer, had asked that Trust Boards monitor Ambulance category 2 performance. RF asked if the Board could receive information about the local NWAS performance for category 2 calls and RC agreed to circulate this information to Board members.
ACTION: RC

RF also reported that David Sloman has reported on initiatives at other Trusts to release ambulance crews. RC responded that he was aware of these initiatives, and stated that the ED does not delay handovers if there are staff available to accept the patient safely.

6.3 **Financial Indicators**

NK 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 confirmation of Elective Restoration Funding (ERF), expenditure slippage and £3m additional system resources, along with inclusion of a further £1.1m ERF income allocated based on system performance, the Trust is forecasting a breakeven outturn position at Month 11 with £480.1m income and expenditure year to date.

The 2021/22 CIP target of £10m has been achieved recurrently. 2022/23 CIP schemes were being developed and NK felt the Trust would be in a good position to deliver recurrent savings. NK commended the hard work undertaken by operational and finance colleagues to achieve this strong position.

At the end of month 11, the cash balance was £75.4m.

The capital programme of £10.97m (excluding PFI lifecycle expenditure) would be achieved by the end of the year.

RF congratulated NK on the fantastic team effort, and on getting the Trust to such a strong position after all the uncertainty during 2021/22.

6.4 **Workforce indicators**

AMS presented the report. 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, it remains above the Trust's target of 4.5%, and absence had significantly increased again during March as infection rates had risen.

Long term sickness accounts for most absences at 69.08% with stress and anxiety remaining as the highest reasons for absence at 29.70%. The reported figures do not include other reasons for absence, such as self-isolation.

Mandatory Training compliance remains below the target of 85% of the available workforce at 74.2%. The Appraisal compliance is at 67.89%. A small improvement has been seen in February, and AM noted the improvement plans are being monitored by the Executive Committee.

RF recognised the impact of COVID and the pressures this has brought on business as usual activities

7 Committee Report – Executive - NHST(22)016

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

7.2 There had been three investment decisions, firstly, to approve the business case to appoint a substantive Paediatric GP with an Extended Remit (GPwER) to support the community paediatric service. AM noted that this was a very important role and would hopefully have a positive impact on paediatric attendances to ED; this is good for patient experience and managing activity in the most appropriate setting.

7.3 The second investment was to extend the contracts for the St Helens Shared Care Record and CIPHA Public Health Management System, on behalf of St Helens and the Cheshire and Merseyside ICS.

7.4 The third investment was in mitigations to manage the cyber security risk. The need to protect the Trust was recognised. IC confirmed that he had been assured of the actions the Trust was taking from reports given at the recent Mid Mersey Digital Alliance Board meeting.

7.5 AM also drew attention to the Health Inequalities Review and noted that a correlation between level of deprivation and referral rates had been expected. However, the analysis had shown some other unexpected findings which required further investigation. Work is ongoing and a presentation will be given to future Strategy Board when finalised.

IC asked if more information on survival rates could be reported. AM agreed the importance of this and RC confirmed that information can be provided from the data available from the cancer network. **ACTION: RC**

VD was pleased that this piece of work had been initiated and asked if the information would be shared with the local Place Based Partnerships. AM confirmed that she had asked Wayne Longshaw to present the information to St Helens Partnership Board, and as soon as the detail is ready it will also be shared with Knowsley and Halton. NK confirmed that the Trust's business intelligence team is fully integrated with the CCG and Local Authority teams, so they work very closely together.

GA stated that as interim Chair for the St Helens Place Based Partnership, he had been speaking to Graham Urwin who had noted the level of maturity of St Helens in this type of joint working to identify and address health inequalities. GA also commented on the renewed interest for Mid Mersey to work together on this with the Trust.

RPJ commented that the Cheshire and Merseyside ICS did appear to be aware of the importance for system working of having a shared care record across all 9 Places. CW confirmed that the intention is to move forward with the shared care record for all of Cheshire & Merseyside in the new financial year, using the St Helens Cares model.

7.6 AM reported that the Executive Committee had considered the Quality Account improvement priorities, following wide consultation with internal and external stakeholders and that these had also been included in the draft 2022/23Trust objectives.

7.7 AM highlighted that following a review of the Trust maternity data full assurance had been received that previously reported CRAB data was incorrect and that the Trust was not an outlier.

Board members noted the remainder of the report.

8 Committee Report – Quality - NHST(22)017

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

8.2 The guardian of safe working report had 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. Doctors receive a good training experience and provision of continual education.

8.3 The patient experience council had heard that the Trust scored in the top 20% for 63% of the questions in the children and young people's survey.

8.4 A very detailed report had been received on the deteriorating patients' project.

8.5 The medicines storage and security audit had shown improvement.

8.6 Safer staffing for December 2021 was reported with benchmarking. RT commented that it was important to note the impact of patients that require supplementary care and

the challenges that this brings to staffing. The resultant impact on cancellation of study leave, management tasks, mandatory training, and RCAs etc. was acknowledged.

The remainder of the report was noted.

9 Committee Report – Finance & Performance - NHST(22)018

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

9.2 It was noted that urgent care attendances remained high.

9.3 JK observed that the delivery of the 2021/22 Cost Improvement Plans (CIPs) had already been mentioned but felt it was important to note again as part of the formal feedback from the Finance and Performance Committee.

RF agreed that the Trusts performance in this area and joint approach to the delivery of CIPs was really outstanding.

9.4 JK reported that a very interesting presentation had been received on the six new ED performance metrics for 2022/23. The complexities of the system changes were acknowledged.

RF commented that many other trusts will be experiencing the same impact. He expressed his admiration for the ED staff.

9.5 An update on the draft financial plan for 2022/23 had been received, and JK asked members to note the risks associated with this and the income allocations from the ICS.

The Committee had recommended that Trust Board approved the 2022/23 expenditure budget; a paper would follow later in the meeting.

9.6 RF commented that there was a good level of assurance from this report.

The report was noted.

10 Approval of 2022/23 Budget - NHST(22)019

10.1 NK presented the report on the draft financial plan for 2022/23, noting that the income position may vary dependent upon ongoing discussion with the Cheshire and Merseyside Integrated Care System (ICS) about funding flows.

Financial arrangements are still being agreed and discussed with the ICS and mechanisms for all partners to breakeven have yet to be agreed.

10.2 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%).

10.3 The 2022/23 financial plan includes fixed planned income available for elective activity via a block contract mechanism. NK noted that 104% of baseline activity based on value is required to achieve this level of income.

10.4 The Trust has an indicative capital expenditure plan of £5.0m (excluding PFI), following a reduction in capital allocations across the ICS. This excluded any successful capital bids against national allocations, e.g. the elective recovery capital

10.5 NK explained that systems had been asked to develop fully triangulated plans across activity, workforce, and finances for 2022/23. The Trust's final organisational plan must be submitted to NHSE/I on 28th April.

10.6 VD asked whether the income shortfall this year was because of the COVID income withdrawal. NK confirmed that the reduction resulted from a 57% reduction in COVID income (-£13.8m) and a further reduction for the Cheshire and Merseyside convergence factor (- £4.7m).

VD asked if it would be possible to reduce the £7.6m for operational plan delivery, but NK explained that without the planned expenditure and delivering 104% of activity the Trust could not earn the ERF income. Although there remained a risk because ERF was to be allocated on the basis of system wide performance.

10.7 AS commented that the report demonstrated a good control of costs and CIP, which was important and impressive.

10.8 NK noted the scrutiny applied in the Finance and Performance Committee meetings, and robust effort given to the generation of the ideas to achieve the CIP by the Care Groups and Services.

JK confirmed that he was comfortable that the schemes to deliver the CIP had been identified on a recurrent basis.

10.8 The Board noted the current financial plan for 2022/23, accepting that the income position may vary depending on discussions with the ICS around funding flows.

The Board approved the 2022/23 expenditure budget.

11 Trust Objectives 2022/23 – NHST(22)020

11.1 AM presented the proposed 2022/23 Trust Objectives for approval. The new objectives will be launched at the Start of the Year Conference in May following Board approval, and will be displayed across the organisation

11.2 AM stated that the formal review of the 2021/22 objectives would come to the May Board, however via constant monitoring it was already clear that because of the disruption throughout 2021/23 some would need to the rolled over into the forthcoming year. Where this was the case the measures of success had been updated.

11.3 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.

11.4 The 2022/23 quality improvement objectives to be included in this year's Quality Account are incorporated into the proposed Trust objectives. These had received overwhelming support following the recent consultation exercise with staff and stakeholders.

11.5 LK commented that they seem to be really rounded and ambitious set of objectives.

GB stated that the report was excellent and contained everything that she would have expected to see. She congratulated the team on the amount of work that had gone into the report and confirmed that she was fully supportive.

GA noted that the terminology in point 9.2 needed amending from Integrated Care Partnerships to Place Based Partnership Boards. It was agreed the wording would be amended.

AS noted the focus on hydration and reflecting on the recent experience of some of his relatives who had been in hospital asked whether patient food was being looked at also. AM confirmed that hydration was an objective as it prevents acute kidney injury (AKI); this is for patient safety, not patient experience. She reported that the AKI project is ongoing across the organisation.

AM clarified that each Executive would have a set of personal objectives in addition to the Trust objectives they were leading.

11.6 AM confirmed that the objectives reflected the 2022/23 contribution to taking forward the Trusts strategic plans, which for Southport and Ormskirk Hospital NHST meant putting forward a plan for the optimum configuration of services to meet the needs of the population. The plan must then be shared with stakeholders by the end of the financial year.

11.7 PG noted that the report is excellent. It was inspiring for the community to know that the Trust has ambitions to continuously improve services and is honest and transparent about where improvements are needed.

IC commented that he was very happy with the report, and for the Trust to continue delivering five-star patient care strategy. He noted that achievement of the 62-day cancer standard of 85% was a remarkable performance in the current climate, against the local and national standards. However, from a patient point of view, he would like to see the Trust performing even better than the national standard.

JK commented that the report was excellent; it is inspiring that the Trust constantly strives to achieve.

RF confirmed that the report was ambitious, pragmatic, and realistic.

The Board approved the objectives for 2022/23.

12 Care Quality Commission (CQC) compliance and registration - NHST(22)021

12.1 SR presented the report, which provided a summary of policies, process and practices across the Trust to demonstrate how ongoing compliance is maintained with the fundamental standards required by the CQC, to remain registered..

The self-assessment concluded that there was assurance that the Trust remained compliant with all of the fundamental standards.

12.2 The report noted that the Trust was last inspected by the CQC in 2018, with a final inspection report published in March 2019 and the overall Trust rating of outstanding. This rating remains in place.

The inspection report had identified three breaches of the CQC regulations in relation to Marshalls Cross Medical Centre. Actions had been taken to address these and they had been independently reviewed by Mersey Internal Audit Agency and assessed as fully compliant.

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

The Board noted the report and was assured.

13 Elimination of Mixed Sex Accommodation - Declaration - NHST(22)022

13.1 SR presented the report to provide assurance to the Board that the Trust has complied with the national guidance to eliminate mixed sex accommodation.

SR noted that during the pandemic, some adjustments had to be made within ICU, but the Trust remained fully compliant, with no breaches during 2021/22.

13.2 RF noted that this was excellent. There were no questions from members, and the declaration of compliance was approved.

14 Gender Pay Gap 2021/22 Annual Declaration - NHST(22)023

14.1 AMS presented the report to update members on the 2021/2022 Gender Pay Reporting Submission which must be published by 30th March 2022 following approval at Trust Board.

14.2 AMS outlined the legislation and explained that 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.

AMS highlighted that the gender pay gap and equal pay are two 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 based on their sex.

AMS noted that the annual requirement to publish data by the 30th March each year was temporarily deferred by six months in 2021 due to the Covid-19 Pandemic. The deadline has been reinstated for 2022, meaning this is the second gender pay report published by StHK within five months. Ordinarily the Gender Pay Report is published in the July following the March 31st snapshot date, to ensure the data is timely and any actions remain relevant. As such, AMS explained that this report will be followed by a third Gender Pay Report, for 2022-23, in July. This will bring the Trust's gender pay reporting back into synch.

AMS clarified the table for the mean hourly rate of pay, noting that a low percentage represents a good performance by the Trust. The Trust's pay gap had increased by 4.78% from the 2020/21 position. The gap will be heavily influenced by smaller numbers of higher paid staff. AMS noted the median hourly rate of pay, which demonstrated a 0.04% decrease in from the 2020/21 position, was thought to be the more realistic comparator.

AMS urged caution in trying to benchmark the Trusts position, because of the differences in the reporting methods of local trusts, and the high number of external factors.

14.3 AMS asked the Board to note the actions that were being undertaken to address the issues raised by the report which were detailed in section 4 of the report.

14.4 RF noted the complexities of this report and stated that the clarity on the difference with equal pay was useful.

VD enquired about the position of the Trust in the national table; she asked if this depended on the size of the organisation, and if specialist trusts were included.

AMS confirmed that every NHS organisation is included, for example CCGs are incorporated. The 24/7 nature of an acute hospital is very different to that of a CCG. AMS verified that there is no other comparator or benchmarking data available at the moment but that nationally and societally, this matter is being taken more seriously now and more information and analysis are expected. The Trust needs to ensure that everything possible is done to remove barriers for staff.

The Board approved the report for publication.

15 Workforce Indicators Report - NHST(22)024

15.1 AMS presented the report which provided the Board with details of achievement of the delivery of the Trust's Workforce Strategy over the last eight months July 2021 – February 2022.

The report provided 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.

AMS felt the report illustrated the Trusts commitment to developing the organisational culture and supporting the workforce in line with the Trust objectives, and in particular the commitments the Trust has made in terms of the NHS People Plan.

The four priorities (or pillars) were noted as:

- 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 staff 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.

15.2 AMS highlighted some key points from the report;

15.2.1 Pre-pandemic the Trust had been top of the national league for the annual flu campaign; however, due to the pressures and attitudes to vaccination, it had fallen to 72% in 2021/22. This change in attitude had been reflected across the NHS and the Trusts performance remained one of the highest.

15.2.2 Equality and diversity are areas of focus. There had been some issues with a disciplinary gap for BAME colleagues and for disabled staff. The staff survey had highlighted that they were feeling pressured. A lot of support is being offered and reasonable adjustments put in place following recent employment tribunals which had focused on the themes of flexible working and reasonable adjustments.

15.3 LK commended the amount of work that had been undertaken, particularly on the DES innovation fund project and wellbeing. She asked that her thanks are passed on to the team.

15.4 GB also thanked AMS for the comprehensive and interesting report, which reinforced the amount of work being undertaken to look after the Trust staff.

GB asked if there were concerns about the recruitment and retention of staff.

AMS explained that the turnover of staff during the pandemic was not representative because of the number of temporary staff that had been taken on for specific COVID related roles. However there are some "hotspots" across the Trust where staff turnover is a cause for concern and in these areas deep dives are being undertaken and listening events with the staff to try and understand the underlying causes.

15.5 RF noted the amount of information in the report and thanked the HR team for their all their efforts in the previous 24 months which had been even more complex and unique than usual as a result of the pandemic.

The Board noted the report.

16 Workforce Safeguards NHST(22)025 part 1

16.1 SR presented the report which provided assurance that the Trust is compliant with the Workforce Safeguards Standards introduced by NHS Improvement (2019/20).

16.2 The Trust had completed an initial self-assessment in 2019 against these standards and this had now been repeated. The self-assessment identified:

- Nursing: 13 of the 14 standards remain fully compliant, with the remaining 1 requiring further work.
- Medical & Dental were compliant with 8 of the standards with 6 requiring further work that was planned for 2022-23.
- Allied Health Professionals are compliant with 8 of the recommendations, with 6 requiring further work that was planned for 2022-23.

16.3 Although work on the action plans had been paused during the pandemic, this had now been restarted.

16.4 LK commented that many of the actions are reliant on the functionality of the Allocate system. SR agreed and noted that there was a lack of national guidance in relation to optimum staffing requirements for many of the professions which made assurance more challenging.

RPJ agreed and noted that the professional bodies for medics/surgeons did not have the rich set of metrics on staffing levels that nursing has, and therefore professional judgement has to be used. The role of the guardian of safe working is especially important in this and as a route for junior Doctors to raise any concerns, which then have an escalation route via the Trusts governance framework.

16.5 SR explained that staffing issues are managed pro-actively in real time but it was also important that have a strategic improvement plan as well as the operational response.

The Board noted the report and the action plan to achieve compliance with all the standards.

Nursing Establishment Review NHST(22)025 part 2

16.6 SR presented the second part of the report on the latest findings of the nursing workforce inpatient ward establishment review undertaken in September 2021 (data collection completed prior to the reviews).

Nurse establishment reviews are recommended to be undertaken twice a year and reported to Boards annually, to meet the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) recommendations and the RCN nursing workforce standards. SR confirmed that due to the COVID -19 pandemic and the impact on both activity and staffing the reviews had not been undertaken in 2020-21.

16.7 The findings of the review had been discussed at Executive Committee meetings on 17th February and 24th March 2022. The review confirmed that the funded establishment, the nurse staffing budgets, and financial ledger were all aligned.

16.8 The comprehensive review and triangulation of data indicated that there were three ward areas: 2D, 3A, and Bevan Court 2 where the Registered Nurse staffing levels were not at the recommended nurse to patient ratio as a result of service changes WTE.

SR clarified that usually there is a 60/40 RN/HCA split for the ward staffing, with 1:8 patient ratio for days and 1:11 ratio for nights.

16.9 The Executive Committee had identified funding to adjust the nursing establishment in these three areas.

16.10 In September 2021, there had been 58.05 WTE RN vacancies and 33.34 WTE HCA vacancies. This included staff who had been appointed substantively and international OSCE nurses who had not yet commenced. Nurse vacancies are monitored each month.

16.11 VD asked about the Birthrate Plus data, and enquired if these recommendations were in addition and also whether the new maternity triage system, BSOTS (Birmingham Symptom-specific Obstetric Triage System), would require extra staffing.

SR confirmed that the Birthrate Plus review was a separate specialist review of midwifery staffing and the report was expected very soon and would then be the subject of the business case to the Executive Committee, if additional staff were recommended.

16.12 GB thanked SR for work undertaken and enquired if the review included the requirements for supplementary care.

SR explained that the requirements for supplementary care were not part of the ward establishment because the need was unpredictable. During the winter months, approval had been given to over recruit to create a pool of HCAs for the wards that needed them for supplementary care, in addition to bank and agency staff to try and create a flexible resource.

16.13 RF confirmed that he was assured that the review demonstrated that the nursing budget was correct while still recognising that staff remained under enormous pressure due to other factors, such as 100% medical bed occupancy, delayed discharges and staff absence levels..

The report and the additional investment in the 3 wards identified, was noted.

17 Ockenden – one year on NHST(22)026

17.1 SR presented an update on the first Ockenden review of Maternity, one year on from publication in December 2020, using the Maternity Services Assessment and Assurance Tool.

17.2 T the assessment identified the Trust was compliant with 11/12 of the clinical priorities, with one priority being partially compliant. This related to the twice daily consultant led ward rounds.

There was also the evidence to demonstrate Trust compliance with 117 out of the 122 Immediate and Essential Actions criteria. There are five amber actions in progress, with three of these relating to the completion of case note audits, which were underway.

17.3 The Maternity workforce is continually assessed, including the provision of bi-annual workforce papers and an ongoing proactive rolling recruitment programme to minimise vacancy gaps as much as possible. SR confirmed approval had been given to over recruit by 6 WTE midwives to cover maternity leave gaps in the establishment.

The Maternity service had 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 NHSFT.

17.4 The preliminary Birthrate Plus workforce assessment report had been received in March 2022. The final report is now expected.

17.5 RT asked case notes were randomly selected for audit and SR confirmed that random selections were made from the cases that met the audit criteria.

17.6 AMS recalled the reason for the Ockenden review in the first instance, and the big concerns about culture in the Trust concerned and asked if there was any further actions the Trust needed to take in relation to the culture in the department.

SR reported that in response to the Ockenden 1 findings listening events had been undertaken with staff to identify any areas of concern and actions taken as a result. RT as the Board maternity champion had a important role in these events and could escalate any issues of concern if not assured that the appropriate actions were being taken.

17.7 RF reflected on the importance of the actions that SR had reported given the heart-breaking reports of what had happened to mothers and their babies at Shrewsbury and Telford Hospitals.

The Board noted the report and confirmed that it was assured by the progress that was being made to deliver the action plan.

18 Effectiveness of Meeting

18.1 RF asked LC, observer, for her views of the meeting. LC noted that it had been insightful to hear the breadth of the information discussed at Board. She was impressed by the Directors depth of understanding and challenging questions to one another and had found it very useful from a workforce perspective.

RF confirmed that although the NEDs understood the challenges being faced by the workforce, it was part of their role to question and constructively challenge. RF thanked LC for her comments.

Raj Purewal (RP), observer, commented that he was very proud of the great work being undertaken by the Trust.

19 Any Other Business

19.1 RF fed back from the Knowsley Freedom of the Borough event. It was a huge honour for the Trust to receive this accolade; there had only been 10 recipients since Knowsley was formed as a Borough.

19.2 RF noted that it was the last Trust Board meeting for NK and VD, who were both moving on to new posts, and for CD (minute taker) who was retiring.

RF commended NK on his expertise in his role as Director of Finance, noting that his proficiency was as expert as any he had seen previously. RF particularly thanked NK for his ability to simplify complex issues and noted his excellent sense of humour that would be missed by all his Board colleagues.

RF thanked VD for her support to the Trust and for him personally, especially her patience. RF was pleased to have been able to support VD through the Aspiring Chairs Programme see her development into her taking up the new Chairmanship of LHCH.

RF thanked CD for her 13 years at the Trust and commended her expertise and professionalism in her role as Executive Office Manager. He thanked her for her support personally with his own role, and for the support she offered the whole team.

20 Date of Next Meeting

Wednesday 27th April 2022.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 27th APRIL 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
41	30.03.22 (6.2)	Provide additional information about category 2 ambulance performance	RC	27.04.22
42	30.03.22 (7.5)	Include information about cancer survival rates in future reports on the impact of health inequalities	RC	TBC

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)027
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no Never Events in March 2022. (YTD = 1).

There were no MRSA cases in March 2022. (YTD = 2). The RCA findings indicated that one case was unavoidable due to no lapses in care.

There were 2 C.Difficile (CDI) positive cases reported in March 2022 (1 hospital onset and 1 community onset). YTD there have been 32 cases (20 hospital onset and 12 community onset). 22 further cases have been successfully appealed. The annual tolerance for CDI for 2021-22 has been set at 54.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for March 2022 was 91.5%. 2021-22 YTD rate is 92.1%.

During the month of February 2022 there were no 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 ulcers with lapse in care in February 2022. (YTD (validated incidents) 2021-22 = 2).

Community services reported a total of 76 incidents in the month of February; 6 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 - December) for 2021-22 is 98.0

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: G Lawrence
Date of Meeting: 27th April 2022

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (February 2022) at 85.4%. YTD 85.1%. The 31 day target was achieved in February 2022 with 98.5% performance in month against a target of 96%, YTD 98.2%. The 2 week rule target was not achieved in February 2022 with 79.1% in month and 84.6% 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 March 2022 was 47.9% and YTD 55.8%. The all type mapped STHK Trust footprint performance for March 22 was 72.9% and YTD 77.1%**.** The Trust saw average daily attendances of 337, which is up compared to February, at 319. Total attendances for March 2022 was 10,451.

Total ambulance turnaround time was not achieved in March 2022 with 70 mins on average. There were 2,249 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,058 in February 22.

The UTC had 4,381 attendances in February 2022, which is a decrease of 4% (161) compared to the previous month. Overall 98% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in March 2022 was 125 compared with 138 in February. 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 February 2022 with 68.6% compliance and YTD 68.6% (Target 92%). Performance in January 2022 was 70.1%. There were (1426) 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 February; however the levels are still within average range (532 in February in comparison with 562 in January). Caseload size is within normal range (1230 in February compared to 1243 in January). Community matron caseloads have seen a further decrease in the month of February to 111 compared to 138 in January. 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 is currently in the process of preparing the annual accounts ready for the draft submission of the 21/22 position to NHSEI on the 26th April. The figures given below are provisional subject to finalisation of the position. Full details of the final 2021/22 position will be confirmed following finalisation and approval by the Audit Committee.

Surplus/Deficit - For the financial year 2021/22, the Trust is expecting to breakeven, in line with the forecast presented in March 2021.

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 12, the cash balance was £51.2m.

Capital - Capital expenditure (CDEL) was in line with forecasts at £18.9m. This was higher than the initial plan submitted at the beginning of the year as a result of additional PDC funding secured.

Human Resources

In March 2022, all staff sickness was 7.16% which was a slight increase from February (7.0%). All Nursing & Midwifery ward areas was 8.8% which is an increase of 0.2% in February.
N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include COVID absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.

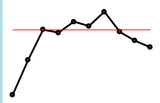
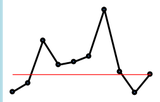
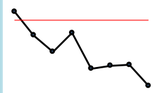
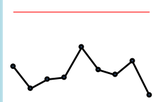
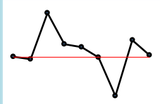
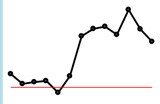
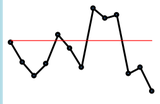
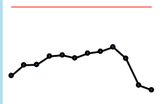
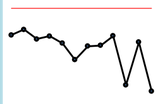
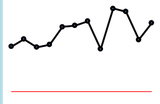
Mandatory Training Compliance remains below the target at 74.72%. The Appraisal compliance is at 65.88%.

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

Mar-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

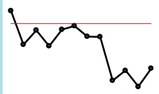
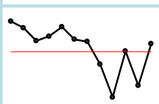
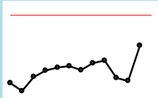
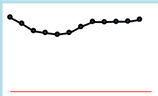
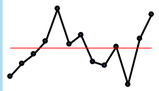
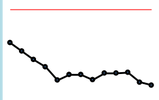
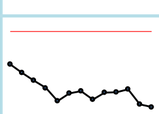
	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Mar-22	2.7%	2.6%	No Target	3.1%		Post wave 3 of COVID, performance 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	▲	Nov-21	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Dec-21	92.3	98.0	100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Dec-21	100.1	106.0	100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Nov-21	89.5	94.2	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	Dec-21	87.9	88.0	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	Dec-21	103.3	102.3	100.0	104.7					
% Medical Outliers	F&P	T	Mar-22	2.4%	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	Mar-22	26.3%	46.8%	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	▲	Feb-22	67.7%	75.2%	90.0%	74.8%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team has been involved to find a sustainable solution particularly in A&E. This has now gone live and reporting will reflect it subsequently 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 have worked with CCG colleagues to confirm the change in policy and now gone-live with action plan in place to monitor impact and quality of summary being sent out. Dip in reporting reflects the changeover of process and current reporting evidences 83% (April 1st).	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Feb-22	43.8%	69.4%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Feb-22	97.5%	97.2%	95.0%	96.8%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	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	▲ £	Mar-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	Mar-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	▲ £	Mar-22	0	2	0	2		There were no MRSA cases in March 2022. (YTD = 2). The RCA findings indicated that one case was unavoidable due to no lapses in care.	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	▲ £	Mar-22	2	32	54	28		There were 2 positive C Diff samples in March 2022. YTD there have been 54 cases of which the Trust has successfully appealed 22 cases, leaving 32 cases. 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		Mar-22	5	49	No Target	29		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Feb-22	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	▲	Feb-22	0	19	No Contract target	31		No falls resulting in severe harm category or death in February 2022.	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 March 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		Mar-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	Mar-22	91.5%	92.1%	No Target	92.2%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Mar-22	2	30	No Target	49					

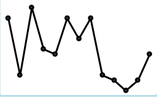
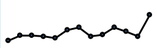
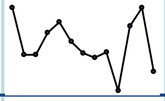
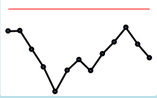
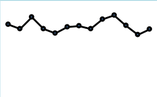
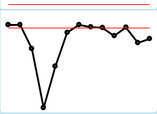
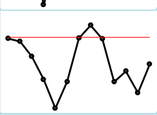
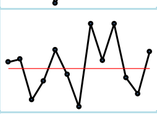
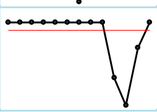
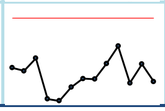
Mar-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

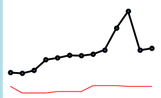
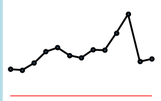
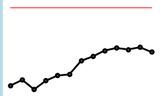
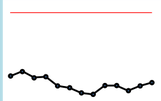
	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Feb-22	79.1%	84.6%	93.0%	94.3%		2WW referrals remain high. This has been accepted as the new norm. Capacity remains a challenge due to increased demand coupled with staff sickness and vacancies.	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	▲ £	Feb-22	98.5%	98.2%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Feb-22	85.4%	85.1%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-22	68.6%	68.6%	92.0%	70.6%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. Recovery plans are in place.	COVID restrictions had stopped elective programme and therefore the ability to achieve RTT is not possible.	RTT continues to be monitored and patients tracked. Long waiters tracked and discussed in depth at weekly PTL meetings. activity recommenced but at reduced rate due to social distancing requirements, PPE, patient willingness to attend and this has begun to be impacted upon as Covid activity increases again. urgent, cancers and long waiters remain the priority patients for surgery at Whiston with application of P- codes effectively implemented. 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	▲	Feb-22	1,426	1,426	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Mar-22	1.2%	0.82%	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	▲ £	Feb-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	▲	Mar-22	47.9%	55.8%	95.0%	78.0%		Accident and Emergency Type 1 performance for March 2022 was 47.9% and YTD 55.8%. The all type mapped STHK Trust footprint performance for March 22 was 72.9% and YTD 77.1%. The Trust saw average daily attendances of 337, which is up compared to February, at 319. Total attendances for March 2022 was 10,451. Total ambulance turnaround time was not achieved in March 2022 with 70 mins on average. There were 2,249 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,058 in February 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	▲	Mar-22	72.9%	77.1%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Mar-22	0	0	0	0					

Mar-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
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Mar-22	0	0	0			Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Mar-22	21	254	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, but dipped in March due to closure of a number of overdue complaints.	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	Mar-22	43	268	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Mar-22	69.8%	79.5%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to March 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	Mar-22	342	317		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Mar-22	125	108		72					
Friends and Family Test: % recommended - A&E	Q	▲	Mar-22	78.5%	79.0%	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 dipped in February and March 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	▲	Mar-22	95.5%	95.7%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Mar-22	91.7%	95.6%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-22	93.6%	93.3%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Mar-22	97.0%	95.4%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Mar-22	100.0%	97.7%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-22	93.7%	93.8%	95.0%	94.2%					

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	▲	Mar-22	7.2%	7.0%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In March 2022, all staff sickness was 7.16% which was a slight increase from February (7.0%). All Nursing & Midwifery ward areas was 8.8% which is an increase of 0.2% in February. N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include COVID absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.	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	Mar-22	8.8%	9.6%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Mar-22	65.9%	65.9%	85.0%	51.3%		The Appraisal compliance has reduced by 2.0% since February and is at 65.9%. Below target by 19.1%. Mandatory training compliance continues to improve and has risen by 0.5%. Below the target of 85% at 74.7%.	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	Mar-22	74.7%	74.7%	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	Mar-22	1.3%	13.97%	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							Finance indicators in the IPR are greyed out subject to final accounts being completed.	Delivery of Control Total		GL
Progress on delivery of CIP savings (000's)	F&P	T										
Reported surplus/(deficit) to plan (000's)	F&P UOR	T										
Cash balances - Number of days to cover operating expenses	F&P	T										
Capital spend £ YTD (000's)	F&P	T										
Financial forecast outturn & performance against plan	F&P	T										
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T										

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-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	▲ £	100.0%	97.4%	100.0%	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	95.5%	85.0%		91.1%		
	Total > 62 days		0.0	0.5	0.0	1.0	1.0	1.0	0.0	0.5	0.5	0.0	1.0	1.0	0.0	6.0			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5			0.0		
Lower GI	% Within 62 days	▲ £	58.6%	87.5%	61.1%	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	79.2%	85.0%		78.7%		
	Total > 62 days		6.0	1.0	3.5	3.5	0.0	1.0	2.5	0.0	3.0	4.0	3.0	2.0	1.0	23.5			22.0		
	Total > 104 days		2.0	1.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	1.5	1.0	0.0	0.0	4.0			6.0		
Upper GI	% Within 62 days	▲ £	100.0%	66.7%	100.0%	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	88.2%	85.0%		83.1%		
	Total > 62 days		0.0	3.5	0.0	0.0	0.0	1.0	3.0	1.0	0.0	0.0	1.0	0.0	0.0	6.0			11.5		
	Total > 104 days		0.0	0.5	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0			4.0		
Urological	% Within 62 days	▲ £	92.3%	79.2%	80.0%	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	79.1%	85.0%		85.6%		
	Total > 62 days		1.0	2.5	2.0	2.0	4.5	1.5	4.5	2.0	1.0	3.5	0.5	8.5	1.5	31.5			21.0		
	Total > 104 days		0.0	0.5					0.5	2.0		0.5	0.5		0.5	4.0			6.0		
Head & Neck	% Within 62 days	▲ £	57.1%	50.0%	0.0%	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	21.6%	85.0%		51.4%		
	Total > 62 days		1.5	1.0	1.0	3.0	1.0	2.0	1.0	1.0	2.0	0.5	2.0	0.0	1.0	14.5			9.0		
	Total > 104 days		0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	2.0			0.0		
Sarcoma	% Within 62 days	▲ £	100.0%		100.0%	100.0%		100.0%								100.0%	85.0%		83.3%		
	Total > 62 days		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		
Gynaecological	% Within 62 days	▲ £	60.0%	57.1%	83.3%	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	68.1%	85.0%		66.3%		
	Total > 62 days		1.0	3.0	0.5	0.0	0.5	0.0	2.5	2.0	1.0	0.5	3.0	0.0	5.0	15.0			17.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.5			2.0		
Lung	% Within 62 days	▲ £	80.0%	100.0%	100.0%	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	78.5%	85.0%		83.9%		RC
	Total > 62 days		1.0	0.0	0.0	2.0	0.0	2.0	0.0	2.5	3.0	1.5	1.0	2.5	1.5	16.0			10.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	1.5			1.0		
Haematological	% Within 62 days	▲ £		75.0%	57.1%	100.0%	37.5%	37.5%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	63.4%	85.0%		77.9%		
	Total > 62 days			1.0	3.0	0.0	5.0	5.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	15.0			8.0		
	Total > 104 days			0.0	1.0	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0			1.0		
Skin	% Within 62 days	▲ £	86.0%	94.6%	92.9%	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	92.8%	85.0%		93.6%		
	Total > 62 days		4.0	2.5	2.5	3.0	3.0	0.0	1.0	3.5	4.0	4.5	3.0	3.0	2.0	29.5			25.5		
	Total > 104 days		1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	1.5			3.0		
Unknown	% Within 62 days	▲ £	100.0%	80.0%			50.0%		100.0%		100.0%	100.0%		100.0%	100.0%	88.2%	85.0%		92.3%		
	Total > 62 days		0.0	0.5			1.0		0.0		0.0	0.0		0.0	0.0	1.0			1.0		
	Total > 104 days		0.0	0.5			0.0		0.0		0.0	0.0		0.0	0.0	0.0			0.5		
All Tumour Sites	% Within 62 days	▲ £	82.0%	86.4%	86.1%	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	85.1%	85.0%		86.7%		
	Total > 62 days		14.5	15.5	12.5	14.5	16.0	13.5	14.5	12.5	14.5	15.5	15.5	17.0	12.0	158.0			137.5		
	Total > 104 days		3.0	3.0	2.0	1.0	1.0	4.0	3.0	2.5	1.5	2.0	1.5	0.5	2.0	21.0			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%	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		
	Total > 104 days		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)028

Title of paper: Executive Committee Chair's Report

Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.

Summary:

The paper provides a summary of the issues considered by the Executive Committee at the meetings held during March 2022.

There were five Executive Committee meetings held during this period. The investment decisions made were:

1. Medical Equipment Tracking Business Case
2. 2022/23 indicative IT capital programme
3. Extensions to selected Winter Plan capacity schemes into Q1 of 2022/23

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: 27th April 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were five Executive Committee meetings in March 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 March 2022

2.1 Southport and Ormskirk NHST Update

The Deputy CEO/Director of HR led a reflection on the Strategy and Operations Committee meeting on 2nd March and confirmed the arrangements for covering the duties of the Associate Director of Corporate Governance who had now taken up a 12 month secondment with another Trust in Greater Manchester.

Committee also discussed S&O's exposure to contracts with Russian linked companies following the recent NHSE guidance and the actions that could be taken.

2.2 Medical Equipment Tracking Business Case

The Director of Corporate Services presented the business case, which requested investment to be able to track essential medical equipment. This would allow the Electrical and Biomedical Engineering (EBME) Department to track the circa 1000 pieces of life critical equipment so that they could be located easily when needed for patients and for routine maintenance. This would release nursing and EBME staff time (from tracking down equipment) and also address the risk of this critical equipment missing planned servicing and maintenance if it could not be located. The software would alert if equipment was taken off site, which would also help reduce losses and replacement costs. A successful trial had been undertaken in the ED and there was potential to roll out the technology to all medical equipment currently stored in the equipment library. The business case was approved.

2.3 2022/23 Commissioning for Quality and Innovation (CQUIN)

The Medical Director presented the paper which detailed that CQUINs were being reintroduced for 2022/23 and would represent 1.25% of contract value. For the Trust this was circa £5m of the total contractual income. The Trust was currently in discussion with the CCGs to agree which of the CQUINS (9 acute, 4 community and 1 specialist) would be used to calculate the CQUIN payments. Five of the 9 acute CQUINS needed to be agreed and all of the community and specialist CQUINs would apply.

2.4 COVID-19 Issues

The Director of Operations and Performance reported issues escalated from Gold Command, which included further discussion on visiting, staff testing and risk assessments and expected changes to the national Infection Prevention Control guidance post the government's recent announcements about "living with COVID". The committee agreed to

wait until definitive national guidance was issued rather than change local practices and risk having to change them again.

There was also an update from the vaccination team which was working with St Helens CCG and the Cheshire and Merseyside Vaccination Gold Command to plan the delivery of the future COVID vaccination programme as this became business as usual for the NHS.

The Deputy Director of Finance reported that guidance was expected imminently that would confirm that funding for free car parking for NHS staff would end on 31st March 2022. This will be extremely unpopular with staff, and so it was emphasised that all trusts would need to take a collaborative stance on this issue.

3. 10th March 2022

3.1 Risk Management Council and Corporate Risk Register Report

The Director of Corporate Services presented the Chair's assurance report from the March Risk Management Council (RMC) meeting. In total there were 744 risks reported of which 28 were escalated to the Corporate Risk Register (CRR) including 3 new risks escalated during February. The new high risks related to; the number of nursing vacancies in ED; the increase in 2 week rule cancer referrals to the Dermatology department and the risk to the Trust outpatient letter printing solution which was no longer supported by the supplier.

The report also summarised feedback from the Cost Improvement Council, the Claims Governance Group and an update on the Freedom of Information Request improvement plan. The Council had approved the revised terms of reference for the Emergency Planning, Preparedness and Resilience Group and the revised policy for the Control of Aspergillus during Construction.

3.2 Trust Board Agenda – March 2022

The Director of Corporate Services presented the draft Trust Board agenda for review. It was noted that the 2021 national staff survey results were now not due to be released until 30th March and therefore the Board report would need to be deferred to the April meeting.

3.3 Local Clinical Excellence Awards (LCEA) Process 2021/22

The usual competitive LCEA process had been suspended during COVID and the funds distributed equally to all eligible consultants. National negotiations were on-going with the BMA about the future of the LCEAs but for 2021/22 no agreement had been reached. The committee therefore approved the distribution of the LCEA fund on the same bases as 2019/20 and 2020/21.

3.4 COVID Issues

The Director of Operations and Performance reported that the national guidance on easing visiting restrictions had been received and the Trust visiting working group had made a recommendation to reintroduce controlled visiting for up to 2 people at set times of the day. The communications and guidance for staff was being updated to enable the new processes to be introduced. It was agreed that the balance of risk appeared to have

shifted and the psychological benefits of visitors for most patients outweighed the risks of infection.

The Medical Director reported that in the previous 7 days there had been 2 definite and 2 probable nosocomial infections. The national increase in infection rates and the new sub variant of Omicron were noted as potential risks for nosocomial infection.

3.5 IT Capital Programme 2022/23

The Director of Informatics presented the proposed capital programme for IT in 2022/23 as part of the five year rolling investment programme. These were the specific schemes against the nominal ring fenced capital allocation agreed each year as part of the Trust's capital programme. There were some changes from the original five year plan as a result of successful bids for national funding which had allowed some items to be brought forward. The portfolio continued to cover the 3 areas of; IT assurance, EPR digital maturity and improving clinical and business systems. The Trust has commissioned an independent HIMSS assurance review to confirm the progress that has been made to date. The 2022/23 programme was approved in principle but each individual investment will be subject to business case approval.

3.6 Perioperative Wellbeing Project Pilot

The Medical Director reported that the Trust was part of a pilot project to support patients awaiting surgery and provide them with pre-habilitation coaching. The selected patients with increased risk factors would be encouraged to reduce these before their planned surgery and it was hoped this would improve recovery time and outcomes. This was an exciting initiative which had attracted national funding and the committee looked forward to the evaluation of the pilot phase.

3.7 Strategic Issues

The Chief Executive reported on the proposed allocation of the £76m Cheshire and Merseyside allocation of the elective recovery capital over 3 years to increase capacity to meet the elective recovery improvement targets.

Proposals to change the configuration of services at LUHFT had also been discussed at the recent System Oversight Meeting.

4. 17th March 2022

4.1 Skin preparation in Theatre

The Director of Nursing, Midwifery and Governance introduced a paper which detailed how a change in the manufacture of certain products was necessitating a move to a more expensive product to continue to meet the NICE guidance for using 2% Chlorhexidine in alcohol. This was an unavoidable cost pressure of c£50k per annum, but did provide an opportunity to eliminate some risks that had been identified with the previous product. The change was approved.

4.2 Mixed Sex Accommodation – Annual Declaration

The Director of Nursing, Midwifery and Governance presented the annual declaration on mixed sex accommodation ahead of the March Board meeting. There had been no

reported breaches of the mixed sex accommodation guidelines during 2021/22 and the policy for accommodating patients remained current.

4.3 Draft Trust Objectives 2022/23

The Director of Corporate Services presented the draft objectives that had been developed with each of the Directors. A small number of amendments and additions were suggested to be incorporated into the final version that would be presented to the March Trust Board.

4.4 Reintroduction of staff car parking charges

The Director of Corporate Services presented proposals to reintroduce staff car parking charges from 1st April 2022, taking into account the exemptions required to meet the government mandate in relation to staff working nights and those who were disabled. The unpopularity of the end of free parking which had been funded centrally during the pandemic was acknowledged as was the complexity of implementing the mandate exceptions. The importance of all Trusts acting together was emphasised and this had been discussed at both ICS and regional level. The proposals and communication plan was agreed.

4.5 Integrated Performance Report (IPR)

The Director of Finance and Information presented the February IPR for review and agreement of the supporting narrative. It was noted that reporting of the 18 week referral to treatment time had now resumed nationally and was once again included in the IPR. It was also acknowledged that the MRSA case reported in February had been classified as unavoidable following the RCA. The committee was disappointed to see that there had been no improvement in mandatory training compliance and it was agreed that a detailed report on compliance was required and an action plan to support an improvement trajectory.

4.6 COVID Issues

The Director of Operations and Performance provided feedback from the Gold Command meeting. The revised testing guidance stated that staff would continue to be tested beyond 1st April when the national testing programme ended and it was therefore agreed that the self-isolation hub would need to remain operational for a further 3 months.

There had been positive feedback from staff and patients about the reintroduction of visiting; however the impact on car parking at busy times and the increase in nosocomial infections was noted.

In the previous 7 days the nosocomial rate had increased to 12.2% with 10 definite and 3 probable infections.

5. 24th March 2022

5.1 Safer Staffing Report - February

The Director of Nursing, Midwifery and Governance presented the figures for February and the detailed staffing report for January.

In February the overall Registered Nurse/Midwife fill rate had been 92.34% and the HCA fill rate 112.17%.

The committee recognised the hard work that had gone into maintaining these staffing levels during an incredibly difficult period and complimented the senior nurse management team for all their efforts.

There had been a higher number of health care acquired infections during the month, but this was partly driven by seven cases of VRE detected on ward 3D. An outbreak had been declared, and ward practices and the environment were being reviewed with support from the IPC team.

5.2 Nurse establishment review

The Director of Nursing, Midwifery and Governance presented the paper which detailed the review of the nurse establishment that had been conducted. There were three areas where the current establishment of posts had been judged not to be sufficient as a result of service changes and proposals to address these gaps were included. The proposals were agreed subject to approval at the March Trust Board.

5.3 Workforce Safeguards Assessment

The Director of Nursing, Midwifery and Governance presented the workforce safeguards self-assessment.

The Workforce Safeguard standards had been introduced by NHS Improvement in 2018 and the Trust had completed its first self-assessment in 2019, but this had been suspended during the pandemic and the paper represented the Trusts second review of its workforce practices against the standards. The self-assessments for Nursing and Midwifery, Medical and Dental and Allied Health Professions had been reviewed and the actions plans revised.

The committee noted that the processes to support these standards, including national guidance and benchmarks were more developed for Nursing and Midwifery staffing.

The paper was approved for presentation at the March Board meeting.

5.4 Ockenden – one year on

The Director of Nursing, Midwifery and Governance presented an update on the action plan developed in response to the immediate and essential recommendations from the first Ockenden report which had been published in December 2020. It was noted that the final Ockenden report was due to be published and all maternity units had been asked to present a position statement on Ockenden 1 to their Boards before the end of March 2022.

The report noted that the Trust was compliant with 11 or the 12 recommendations and had completed 117 or the 122 actions, with 5 actions still in progress and waiting to be evidenced when the required case note audits were completed.

5.5 Winter Schemes Review Part I

The review had been undertaken to evaluate the impact of the Winter Plan schemes and also to assess which would need to continue in light of the ongoing extreme operational pressures in urgent and emergency care.

Committee agreed the recommendations to continue funding ward 1A, additional ED nursing posts and the additional frailty matron for a further period of three months.

Committee agreed that options for increasing bed capacity were needed if the level of demand remained at “winter” levels.

5.6 COVID Issues

The Director of Corporate Services reported on the issues escalated from Gold Command. There had been a sharp increase in patients being admitted with COVID in the previous 7 days. However the majority were patients admitted with COVID rather than because of COVID and their greatest clinical need was for speciality care. In response, patients were being cohorted in bays, rather than on dedicated COVID wards, to remain compliant with the IPC guidance. This was putting additional pressure on beds and patient flow. In addition staff absence had increased, again reflecting community infection rates.

There had been 18 definitive and 18 probable nosocomial infections in the previous week and there were 16 outbreak wards. Committee reflected on the relaxation of COVID government guidelines for the general public, the re-introduction of visiting and the increased community prevalence which made any IPC restrictions in healthcare settings less effective.

5.7 Gender Pay Gap Report 2021/22

The Deputy CEO/Director of HR presented the Gender Pay Gap report. The report was to be presented to the Trust Board in March and there was then a legal obligation to publish the Trust’s results by the end of March 2022. The gender pay gap calculations are based on a snap shot of pay information taken at 31st March 2021. The gender pay gap is the difference between the average hourly rate of pay for men and women employed in an organisation.

Committee approved the report to be presented to the Trust Board.

5.8 Mandatory Training and Appraisal Compliance

The Deputy CEO/Director of HR presented the compliance figures for February and members discussed the pressures on staff and further options to increase compliance. A more detailed breakdown of compliance within care groups confirmed that staff in patient-facing roles had the lowest compliance rates, reflecting the operational pressures at the Trust.

5.9 Southport and Ormskirk NHST

The Deputy CEO/Director of HR reported that the S&O Executive Directors were developing Trust objectives for 2022/23 which would be approved at the next Strategy and Operations meeting.

It was noted that the S&O quarterly Trust Board meeting was taking place on 31st March.

The NHS Estates report on backlog maintenance at S&O had now been received and a response was being developed.

Meetings had taken place with LUHFT in relation to the service level agreements, and funding for the Shaping Care Together programme for 2022/23 had been secured.

6. 31st March 2022

6.1 Mandatory Training Dashboard

The Deputy CEO/Director of HR presented the new mandatory training dashboard designed to give directors and managers a more detailed picture of which teams or subjects needed additional focus to improve their compliance rates. This development was welcomed by the Executive Committee as an additional tool to help improve mandatory training compliance.

6.2 Queens Jubilee Additional Bank Holiday

The Deputy CEO/Director of HR presented a report which recommended that the extra bank holiday in 2022 be treated the same as all other bank holidays for the purpose of calculating pay and leave entitlements for staff who worked on the day. This approach had been proposed by the Cheshire and Merseyside Trust HR Directors in the absence of national guidance, so that all staff in the ICS were treated the same. The recommendation was agreed.

6.3 Development of the new Integrated Performance Report (IPR)

The Director of Finance and Information introduced the item and explained the process that had been undertaken to agree the 30 key indicators that would form the first section of the new IPR, working with the company which had been selected to support the process, Cloud9. Members discussed the appropriate use of statistical process control (SPC) and the importance of setting control limits and using visual prompts to avoid false assurance. It was agreed that SPC was potentially useful for some indicators but not all.

Many of the metrics were derived from standalone systems which could not provide an automatic feed into the IPR. Automation of the reporting from these systems was the next phase of development.

It was agreed that it would be better to keep working on the IPR rather than rush its development and then have problems. It was suggested that some of the Non-Executive

Directors should be asked to “test” the proposals and provide feedback to help the development process.

The Business Intelligence team were thanked for their work to date in developing the new IPR.

6.4 Impact of the winter pay incentive scheme

The Director of Nursing, Midwifery and Governance presented the initial evaluation of the 3 x 5 week cycles of winter pay incentives that had taken place between November and February, where enhanced pay rates had been offered to staff undertaking additional bank shifts.

The analysis indicated that the Trust has secured 7,777 additional bank hours across the three cycles, however further work was required to compare this to a pre pandemic baseline period. It was also noted that the first cycle had the greatest impact, but this may have been because it was not over the Christmas or February half term school holiday periods.

It was agreed that further work would be undertaken and a final report brought back to the committee.

6.5 Winter Plan Schemes Extension - Part II

The Director of Operations and Performance presented the 2nd part of the evaluation of the winter plan schemes and assessment of what needed to continue to respond to the ongoing operational pressures. The report detailed the evaluation of each scheme and which had brought the most benefits. It was agreed that a number could be stood down but that others, in addition to those approved the previous week, would need to be retained. These included; AMU outreach capacity; dedicated ED pharmacists; discharge coordinators and the ED Quality Matron. Three month extensions were approved and it was agreed that during this period work would be undertaken to review the model and create a plan for more medical beds.

6.6 COVID Issues

The Director of Operations and Performance reported on the issues discussed at Gold Command and commented on the revised testing guidance that had been issued by NHSE. This had been reviewed and proposals for implementation locally were being developed. However without changes to the national IPC guidance for COVID the impact on the Trust’s processes would be minimal.

It was acknowledged that the number of nosocomial infections remained high and a number of outbreak wards had been closed to visitors.

COVID expenditure extensions were agreed for COVID cleaning and free TV for patients.

6.7 Southport and Ormskirk Hospitals NHST

The Deputy CEO/Director of HR provided feedback on the S&O assurance committees and the Shaping Care Together programme board meeting.

6.8 Director of Finance and Information

This was the last Executive Committee meeting for Nik Khashu and members thanked him for all his work at the Trust and wished him well for his new role at NHSE North West.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22) 029
Reporting from: Quality Committee
Date of Committee Meeting: 19th April 2022
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery & Governance Rob Cooper, Director of Operations Gareth Lawrence, Director of Finance Debbie Stanway, Head of Nursing & Quality, Medical Care Group Tracy Greenwood, Head of Nursing & Quality, Surgical 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 Su Hobbs, Associate Head of Nursing and Quality Urgent Care Peter Williams, Deputy Medical Director Anne Monteith, Assistant Director of Safeguarding for safeguarding report Janet Sumner, Directorate Manager for supplementary care presentation Lauren Hanson, Dementia and Delirium Nurse Specialist for supplementary care presentation
Matters Discussed **Action log** Noted that a review of cancer staging data presented in the IPR is to be undertaken. The Chair has reviewed a number of cases where 62-day referral to treatment target was not met within gastroenterology and gynaecology noting that no consistent themes were identified that need to be addressed internally. The Executive Committee are looking at plans to improve patient flow and reduce congestion within the Emergency Department (ED), which will be brought to the Board in due course. These will include effective use of pathways already in place and increased use of community capacity, as well as consideration of new models of care.

COVID update
Update on latest COVID-19 infections was provided and changes to the categorisation/management of outbreaks were discussed, as well as ongoing work to ensure the most recent guidance is followed.

Integrated Performance Report (IPR) highlighted:

- No new Never Events, MRSA bacteraemia, falls resulting in severe harm or above and no category 3 or 4 hospital acquired pressure ulcers reported in March
- 54 cases of C difficile reported year-to-date of which 22 have been successfully appealed, noting the high quality of the root cause analysis investigations
- Registered nurse/midwife safer staffing fill rate for combined days and nights was 91.5% in March and 92.1% year-to-date
- Hospital Standardised Mortality Ratio (HSMR) was 98 (April – December 2021)
- 62-day and 31-day targets were achieved in February and are above target year-to-date
- 2-week rule target was not achieved due to significant increase in referrals
- Continued challenges in meeting emergency care access targets, however 98% of patients were seen and treated within 4 hours at the Urgent Treatment Centre
- Average daily number of super stranded patients (length of stay over 21 days) decreased from 138 in February to 125 in March; reducing this further to below 100 remains a priority to reduce congestion in the ED
- 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 commended the delivery of financial metrics, including year-end surplus, achievement of recurrent cost improvement plans and full delivery of the capital programme for 2021-22
- The Committee requested further information on the work being undertaken to reduce the number of do not attends (DNAs) particularly in outpatients to be brought to a future meeting
- It was noted that the Trust's Maternity Service is not an outlier compared to other trusts in the region for 3rd and 4th degree tears during labour, which are all subject to a detailed review
- Noted that the CQC had been present in the ED in the previous week as part of their inspection of North West Ambulance Service

Patient Experience Council report
The Council reviewed a number of reports, including Volunteers, Cancer Patient Experience and Assurance Group, Friends and Family Test, complaints and PALS and patient experience within the Medical Care Group. An update on the actions being taken to address areas highlighted by the primary care patient survey at Marshalls Cross was provided. The Council heard that changes were being made following the End-of-Life Steering Group effectiveness review, including revisions to the membership and standing agenda items. In addition, the Quality Committee sought assurance that the Trust has sufficient resources to deliver the Accessible Information Standards and approved the Patient Experience and Inclusion Strategy.

Complaints, Concerns, Claims and Friends and Family Test Quarter 4 report
The Committee noted that the number of first stage complaints received reduced in Q4, although there was a slight increase in second stage complaints. Work remains ongoing to reduce the number of open complaints and the time taken to respond to

achieve the 90% target of responses sent within the timescale agreed with the complainant. March 2022 saw the highest number of responses issued.

The Committee noted the reduction in claims received, however there was an increase in the number of notified inquests. Lessons learned and actions taken for complaints and claims were detailed within the report.

There was a slight increase in PALS contacts in Q4, although the conversion rate to formal complaints remained lower than 4%. Friends and Family Test results showed the recommendation rate for inpatients remaining above target, but below target for other areas, with waiting times adversely affecting the rate in the ED.

Patient Safety Council report
A number of reports were received, including an update from the Patient Safety Team, serious incident quarterly reports for Q3 and 4, compliance with safety alerts, medical devices, medicines safety (noting the increase in patients receiving medicines reconciliation) and infection prevention. Actions taken following incidents were noted by the Council. The Council approved a number of policies and procedures and presented the revised Terms of Reference to the Quality Committee for approval.

Safeguarding Quarter 4
The Committee received a detailed report noting the Trust received significant assurance from the CCG relating to activity, other than amber ratings for training and for compliance with completion of health assessments within 20 days for looked after children. The delay in completing health assessments is due to staffing challenges within the Trust's paediatric community team, with posts currently out to recruitment and use of locum to improve this position. Training remains a priority for improvement, however, the CCG is assured that staff are making appropriate referrals and ensuring our patients are safe.

The report noted the high levels of activity and the complexity of cases referred to the Team, as well as the Paediatric Liaison Team who work with a number of other professionals to ensure the correct information is shared to safeguard children. In addition, the significant increase in patients detained under the Mental Health Act was reported, although it is unclear what the reason for this is. Quarter 4 had 42 patients compared to 18 in the previous quarter, however there was a reduction in Child and Adolescent Mental Health Service (CAMHS) referrals.

The number of Deprivation of Liberty Safeguard (DoLS) applications has stabilised, following a substantial increase from quarter 1 onwards.

Infection Control Quarter 4
The report noted the rise in COVID-19 cases, wherein January saw the highest number of positive patients in the Trust, the majority of whom were asymptomatic. The Trust is reviewing the latest guidance published by NHS England and how this can be implemented.

The Trust's overall nosocomial infection rate for 2021-22 was 10.2% compared to 9.7% at 31st March 2021. The report highlighted the changes to the criteria for declaring and managing an outbreak.

The report detailed figures for a number of alert organisms and infections, noting that cases had reduced from last year for E coli bacteraemia and pseudomonas aeruginosa with no cases of Carbapenemase-Producing Enterobacteriaceae (CPE). The Committee sought assurance that the Trust is compliant with the 2021 cleaning standards requirement, which will be included in future reports.

Ockenden compliance
The Committee received an update on compliance with the Ockenden recommendations, noting that there was full compliance with 11/12 of the clinical priorities and that there would need to be additional investment to increase consultant cover to achieve compliance with the requirement for twice daily consultant led ward rounds, with one taking place on the night shift; currently whilst there are twice daily ward rounds, 5/10 are in the evening rather than the night shift. In addition, the Trust is compliant with all but 4 of the immediate and essential criteria, with plans in place to complete these.

A further Ockenden report was published at the end of March 2022 with 60 actions required. Maternity Services are producing a report which will be submitted to the Executive Committee to outline the current position.

The final report from the Birthrate Plus® review is due this week, which will inform future staffing requirements. The Head of Midwifery provided assurance that staff are well-supported, in response to a question from the Committee.

Supplementary Care presentation
The findings from a recent audit on supplementary care was provided, which noted the number of patients who required supplementary care, the reasons for this and the high number of patients who do not meet the criteria to reside who need supplementary care. The results led to several recommendations including a repeat audit (with some refinements), increased levels of training in both supplementary care and dementia/delirium and the need to secure recurrent funding to meet ongoing demand.

Safer Staffing January 2022
The overall registered nurse/midwife (RN/M) fill rate for February was 92.34% and 112.17% for HCAs, with 13 wards below the 90% fill rate for RN/M and 11 wards below 85% fill rate for RN/M and HCA.

The report indicated the process for supporting safer staffing during January, including postponing of training and cancellation of management time. Details were included for staff moves, supplementary care and reported incidents relating to staffing, with an analysis of reported harms.

Clinical Effectiveness Council report
The Council received the following reports, IPR, HSMR, maternity indicators, mortality surveillance group, national emergency laparotomy audit and overdue procedural documents. In addition, the terms of reference were considered, with further changes to be made and two documents for approval, both of which require further work prior to being approved. The Consent Policy required additional detail relating to delegated consent, as well as enhanced procedures at Care Group level and bespoke training.

Assurance Provided:

- Reduction in the number of first stage patient complaints received, with 100% acknowledged within 3 days and an increase in the number of complaints closed.
- No overdue safety alerts (CAS)
- Rate of inpatient falls per 1000 bed days continues to decrease
- 99.8% compliance with MRSA screening

Decisions Taken:

Approval of Patient Experience and Inclusion Strategy 2022-25

Approval of Patient Safety Council Terms of Reference

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

- Presentation on the actions being taken to reduce the number of DNAs, particularly in outpatients
- Review of compliance with the national standards of healthcare cleanliness 2021 to be reported to future meeting

Matters for escalation:

- Ongoing work to achieve access targets, appraisals and mandatory training

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: 27th April 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)030
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 21st April 2022

Summary

Meeting attended by:

J Kozer – NED & Chair
P Growney – NED
A Sharples – Board Advisor
N Bunce – Director of Corporate Services
R Pritchard Jones – Medical Director
A Bassi – Divisional Medical Director
G Lawrence – Director of Finance & Information
A Matson – Assistant Director of Finance – Financial Management

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was above the 85% target in February, at 85.4%.
- Target 31 day performance was met in February, at 98.5% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in February, at 79.1% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 47.9% in March and 55.8% year to date. All type mapped STHK Trust footprint performance was 72.9% in March and is 77.1% year to date. The Trust saw average daily attendances of 337, which is an increase compared to February at 319. Total attendances for March were 10,451.
- The ambulance turnaround time target was not achieved in March, at 70 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- In March, overall sickness had slightly increased to 7.16%, from 7.00% in February.

B) Draft Finance Report Month 12

- Month 12 21/22 financial reporting is not yet finalised and therefore a verbal update on the draft position was given.
- The Trust is currently expecting to deliver a £0.7m surplus for the 21/22 finanical year.
- 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 21/22 CDEL capital allocation of £18.9m has been utilised.
- At Month 12, the Trust has a cash balance of £51.2m.
- A full financial report will be presented to the Committee once the accounts have been approved by the Audit Committee.

C) Update on 22/23 Financial Plan

- The draft plan reviewed at the previous meeting gave a deficit of £34.1m, assuming expenditure of £527.6m and income of £493.5m. This draft expenditure plan was approved by the Board.
- Since submission of the draft plan, conversations have continued at C&M system level and the plan has been adjusted to reflect:
    - Additonal system resources £1.0m
    - Non recurrent adjustments of £2.6m
    - National ERF (based on activity plans) £4.0m
    - National ERF (Advice & Guidance – St Helens) £2.0m
    - Giving a total improvement since the draft plan of **£9.6m**
- Following these changes, the 22/23 plan currently gives a revised deficit of £24.5m (£34.1m deficit in approved draft plan less £9.6m improvements covered above).
- 22/23 potential CIP schemes of c.£23m have been identified to date
- Discussions are ongoing with the HCP/ICS on assessment of provider plans under the Aligned Payment Incentive (API) rules and allocation of potential additional system funding
- The final 22/23 financial plan reflecting any further amendments will be submitted to the Board for approval on Weds 27th April, ahead of submission to NHSE/I on Thurs 28th April.

For Approval

D) Finance & Performance Committee 22/23 Workplan

- The proposed workplan for the 22/23 year was presented, including monthly performance reports and Council updates, and further regular updates including Care Group presentations on CIP progress.
- It was agreed by the committee that the CSS and Community Care Groups should be invited to present to the committee twice during the year, rather than once as proposed in the document.
- The workplan was approved by the committee, subject to the above amendment.

For Information

CIP Council Update – Update noted by the committee
Capital Council Update – Update noted by the committee

Risks noted/items to be raised at Board

N/A

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: J Kozer, Non-Executive Director
Date of meeting: 21st April 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)031

Reporting from: Audit Committee

Date of Committee/Council Meeting: 13 April 2022

Reporting to: Trust Board

Attendance: Ian Clayton (Chair), Jeff Kozer, Gill Brown.

Matters discussed

- **Losses and Special Payments** – report was discussed and accepted.
- **Management Responses – Questionnaire** – this is an annual exercise to inform the external auditor's risk assessment. Management's responses were considered and discussed.

Assurance provided

Internal audit

- **Follow Up Report** - the Committee was pleased to note that four reports' actions were now satisfactorily concluded, meaning that follow-ups were up-to-date.
- **Progress Report** – MIAA outlined delivery to date of the 2021/22 internal audit plan, including three finalised reports.
    - *Mandatory Training* [moderate assurance]
    - *ESR / HR Payroll* – [substantial assurance]
    - *Key Financial Controls* – [high assurance] (each system)
- **Head of Internal Audit Opinion** - the overall opinion provides **substantial assurance**. Along with other assessments and assurance, this will be incorporated into the Trust's Annual Governance Statement (AGS) within its Annual Report.

Anti-fraud

- **Anti-fraud Services 2021/22 Annual Report** – the Trust's Anti-Fraud Specialist presented the Report, which (self-)assesses the Trust against the *Government Functional Standard 013 for Counter Fraud*.
  The Trust's overall rating for 2021/22 is **Green.**

Standing/Finance items

- **Audit Log –** the Trust's internal summary of progress in implementing MIAA recommendations, including managers' progress reports, was discussed and accepted.
- **Aged Debt –** the Trust's M12 'over 90 day' debt balance has fallen to £5.99m. Recent progress with the individually largest invoices was noted, with Lead Employer

the largest area of 'slow payment' by theme.

- **Tender and Quotation Waivers** – the Head of Procurement's assurance paper was noted.

Decisions taken

External audit

- **Draft 2021/22 Audit Plan –** Grant Thornton UK LLP (GT) presented a plan for 2021/22 year-end, including a revised fee of £91,500 excluding VAT. The fee had been found to benchmark acceptably amongst NW providers, and the plan was accepted by the Committee.

Internal audit

- **Draft 2022/23 Audit Plan –** MIAA's plan was approved by the Committee.

Anti-fraud

- **Draft 2022/23 Anti-Fraud Plan –** MIAA's plan was approved by the Committee.

Risks identified and action taken

None.

Matters for escalation

None.

Recommendation

For the Board to note.

Committee Chair: Ian Clayton

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)032

Title of paper: Corporate Risk Register Report

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

Summary:

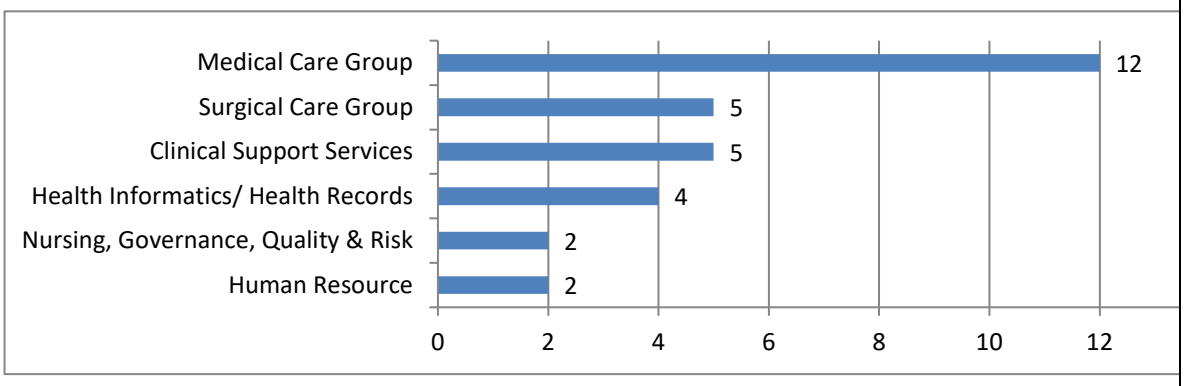
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

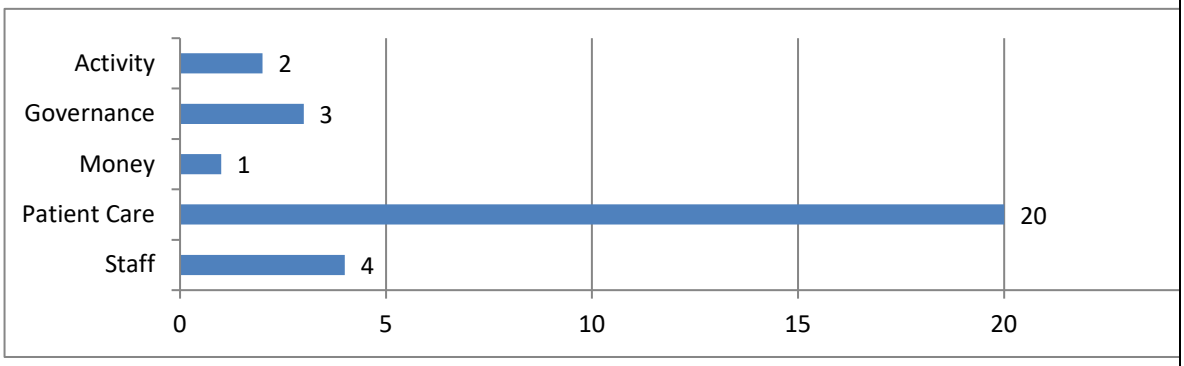
This report (appendix 1) is based on Datix information and covers the risks reported and reviewed during March 2022. The report shows;

- The total number of risks on the risk register was 806 compared to 772 in January. This includes a number of new 2022/23 CIP risks added to the risk register.
- 57.10% (450) of the Trusts reviewed risks are rated as moderate or high compared to 58.15% (442) in January.
- There are 30 high/extreme risks (appendix 2) that have been escalated to the CRR compared to 29 in January.

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



The risk categories of the CRR risks are;



The report also includes comparisons of the Trust risk profile with the previous quarterly report (January 2022) and against the same period last year – April 2021 (Appendix 3).

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

Financial implications: None directly from this report.

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

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 27th April 2022

Appendix 1

CORPORATE RISK REGISTER REPORT – APRIL 2022

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/04/2022	Previous Reporting Period 1/03/2022	Previous Reporting Period 1/02/2022
Number of new risks reported	39	25	20
Number of risks closed or removed	23	15	16
Number of increased risk scores	8	3	5
Number of decreased risk scores	15	15	12
Number of risks overdue for review	101*	28	14
Total Number of Datix risks	**806****	**774**	**772**

**reduced to 62 by the RMC meeting*
***includes risks that have been reported but not yet scored in DATIX as it is a live system*

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

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
38	**31**	**14**	**93**	**9**	**153**	**69**	**165**	**35**	**151**	**8**	**11**	**10**	**1**
83 = 10.53%			**255 = 32.36%**			**420 = 53.30%**				**30 = 3.81%**			

**Based on 788 scored risks*

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

2.1 Surgical Care Group – 167 risks reported 21.19% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
1	**5**	**1**	**15**	**3**	**36**	**21**	**35**	**11**	**34**	**2**	**2**	**1**	**0**
7 = 4.19%			**54 = 32.34%**			**101 = 60.48%**				**5 = 2.99**			

2.2 Medical Care Group – 131 risks reported 16.62% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
21	**7**	**1**	**10**	**1**	**23**	**6**	**20**	**13**	**17**	**2**	**2**	**7**	**1**
29 = 22.14%			**34 = 25.95%**			**56 = 42.75%**				**12 = 9.16%**			

2.3 Clinical Support Care Group – 116 risks reported 14.72% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**3**	**0**	**15**	**0**	**22**	**13**	**25**	**4**	**24**	**3**	**1**	**1**	**0**
8 = 6.90%			**37 = 31.90%**			**66 = 56.90%**				**5 = 4.31%**			

2.4 Primary Care and Community Services Care Group – 51 risks reported 6.47323% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**0**	**0**	**6**	**0**	**6**	**6**	**11**	**3**	**17**	**0**	**0**	**0**	**0**
2 = 3.92%			**12 = 23.53%**			**37 = 72.55%**				**0**			

2.5 Corporate – 323 risks reported 40.98% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**16**	**12**	**47**	**5**	**66**	**23**	**74**	**4**	**59**	**1**	**6**	**1**	**0**
37 = 11.45%			**118 = 36.53%**			**160 = 49.53%**				**8 = 2.47%**			

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

Department	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	4	18	21	4	**47**
Estates and Facilities Management	0	9	16	5	**30**
Nursing, Governance, Quality & Risk	2	17	10	4	**33**
Finance	0	10	17	8	**35**
Medicines Management	0	25	29	4	**58**
Human Resource	2	81	25	12	**120**
Total	**8**	**160**	**118**	**37**	**323**

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

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

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

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	24/03/2022	4 x 2 = 8	Action plan in place	Strategic People Committee
2	Operational	767	**If** ED are unable to recruit to nursing vacancies and maintain nursing establishment **then** there is a risk to patient safety	4 x 5 = 20	4 x 5 =20	26/01/2022 Sue Redfern	23/03/2022	4 x 2 = 8	Action plan in place	Executive Committee
3	Patient Care	935	**If** the breast service experiences an increase in referrals that exceeds capacity **then** the two week cancer referral target may not be achieved	3 x 5 = 15	3 x 5 = 15	05/11/2021 Rob Cooper	23/03/2022	3x 3 = 9	Action plan in place	Finance and Performance Committee
4	Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 4 = 16	3 x 5 = 15	17/03/2020 Sue Redfern	23/03/2022	4 x 2 = 8	Action plan in place	Executive Committee
5	Money	1152	**If** there is an increase in bank and agency **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	24/03/2022	4 x 3 = 8	Action plan in place	Quality Committee
6	Patient Care	1492	**If** the number of dermatology referrals for the 2ww cancer access target continue **then** there is a risk to patient, safety, experience and clinical effectiveness	3 x 3 = 9	3 x 5 = 15	26/01/2022 Rob Cooper	31/01/2022	3 x 3 = 9	Action Plan in place	Finance and Performance Committee
7	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	10/03/2022	4 x 3 = 12	Action plan in place	Executive Committee
8	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	17/02/2022	4 x 2 = 8	Action plan in place	Finance and Performance Committee
9	Staff	1944	**If** the Trust cannot recruit sufficient dermatology consultants to meet the increasing demand **then** the service may have to close to new referrals.	4 x 3 = 12	4 x 5 = 20	18/11/2021 Rowan Pritchard Jones	25/03/2022	4 x 2 = 8	Action plan in place	Executive Committee
10	Patient Care	2080	**If** patients have to be cared for in the ED corridor **then** there is an increased risk of patient harm.	5 x 4 = 20	5 x 4 = 20	03/11/2021 Rob Cooper	24/03/2022	5 x 2 = 10	Action plan in place	Quality Committee
11	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	25/032022	2 x 2 = 4	Action plan in place	Executive Committee
12	Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 3 = 12	4 x 5 = 20	09/12/2021 Rob Cooper	23/03/2022	2 x 4 = 8	Action plan in place	Executive Committee
13	Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	5 x 5 = 25	30/03/2020 Rob Cooper	29/12/2021	3 x 2 = 6	Action plan in place	Strategic People Committee
14	Patient Care	2523	**If** delivery suite isn't adequately staffed, **then** there is a risk that patient safety will be compromised	3 x 4 = 12	3 x 5 = 15	23/03/2022 Sue Redfern	23/03/2022	3 x 2 = 6	Action plan in place	Quality Committee
15	Patient Care	2545	**If** the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, **then**	4 x 4 = 16	4 x 4 = 16	21/07/2021	23/03/2022	4 x 2 = 8	Action plan not recorded	Quality Committee

			there is a risk that compliance with this standard may not be maintained			Sue Redfern			in Datix	
16	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	25/03/2022	5 x 2 = 10	Action plan in place	Executive Committee
17	Patient Care	2767	**If** inpatient maternity staffing shortfalls persist **then** this could have a negative impact on patient safety. It will also have an impact on patient experience and Staff burnout	3 x 3 = 9	3 x 5 = 15	23/03/2022 Sue Redfern	23/03/2022	3 x 2 = 6	Action plan in place	Quality Committee
18	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.	5 x 4 = 20	5 x 4 = 20	21/10/2020 Rob Cooper	16/03/2022	5 x1= 5	Action plan in place	Executive Committee
19	Patient Care	2964	**If** there are not sufficient dieticians to meet the increased incidence of gastro-intestinal cancers **then** this could impact on their treatment outcomes	3 x 5 = 15	3 x 5 = 15	13/10/2020 Sue Redfern	15/03/2022	3 x 1 = 3	Action plan in place	Executive Committee
20	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	01/03/2022	3 x 2 = 6	Action plan in place	Executive Committee
21	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	29/10/2020 Sue Redfern	16/03/2022	3 x 2 = 6	Action plan in place	Executive Committee
22	Patient Care	3046	**If** Cardio-Respiratory is unable to provide sufficient staff to cover ECG provision throughout the whole of the Trust **then** here is a risk that ECG's are not undertaken in a timely manner.	4 x 5 = 20	4 x 4 = 16	21/04/2021 Rowan Pritchard Jones	25/03/2022	4 x 2 = 8	Action plan in place	Executive Committee
23	Patient Care	3057	**If** the stroke service does not have 8 consultants in post **then** there is a risk to the level of service provision based on predicted activity	4 x 5 = 20	4 x 5 = 20	25/05/2021 Rob Cooper	25/03/2022	2 x 3 = 6	Action plan in place	Executive Committee
24	Patient Care	3166	**If** Bevan Court 2 is unable to provide appropriate Registered Nurse & HCA levels for patient care **then** there is a risk to patient safety, quality of care and experience	4 x 5 = 20	4 x 5 = 20	23/09/2021 Sue Redfern	25/03/2022	2 x 4 = 8	Action plan in place	Executive Committee
25	Staff	3178	**If** there are not sufficient staff in post **then** there is a risk to service delivery	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	21/02/2022	4 x 2 = 8	Action plan recorded	Executive Committee
26	Patient Care	3180	**If** the Trust cannot secure sufficient staff to undertake supplementary care for the patients who need it, **then** there is a risk to the quality and safety of care	4 X 5 = 20	4 x 4 = 16	21/07/2021 Sue Redfern	17/01/2022	4 x 2 = 8	Action plan in place	Strategic People Committee
27	Patient Care	3199	**If** medical patients are to 'forward wait' on a medical ward **then** there is a risk to patient safety, dignity and experience	4 x 4 = 16	4 x 4 = 16	02/11/2021 Sue Redfern	24/03/2022	4 x 2= 8	Action plan in place	Executive Committee
28	Patient Care	3251	**If** the current outpatient letter system is not replaced **then** there could be incorrect patient information included	4 x 5 = 20	4 x 5 = 20	21/10/2021 Christine Walters	21/03/2022	4 x 1 = 4	Action plan in place	Executive Committee
29	Governance	3298	**If** the Trust IT systems are infiltrated by Apache Log4j **then** data will be vulnerable and systems may have to be shut down	4 x 4 = 16	4 x 4 = 16	14/12/2021 Christine Walters	21/02/2022	3 x 3 = 9	Action plan in place	Executive Committee
30	Governance	3302	**If** the Trust subject access request process is not standardised **then** there is increased risk of ICO Infringement Orders.	4 x 4 = 16	4 x 4 = `6	15/12/2021 Christine Walters	11/03/2022	2 x 2 = 4	Action plan in place	Executive Committee

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

Risks that have been de-escalated or closed from the CRR since January 2022 are;

Risk Category	Datix Reference	Risk Description
Patient Care	2932	**If** a patient's fluid balance is not recorded, **then** there is a risk that the patient could become dehydrated or fluid overloaded.
Activity	3238	**If** the STHK sonographer staffing cannot be increased to provide the service at Widnes HCRC **then** there is a risk that there will be delays in providing non-obstetric ultrasound.
Patient Care	3060	**If** the Trust is unable to deliver its contribution to the COVID vaccine booster programme **then** the incidence of COVID infections and hospitalisations could increase
Patient Care	3162	**If** there are not sufficient staff to meet the demand for vaccination, **then** the Mass Vaccination site will not be able to deliver the planned activity

Appendix 3

Trust Risk Profile – January 2022

Comparison of the Trust risk profile in the last Board Report

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

Trust Risk Profile – April 2021

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

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
14	**23**	**18**	**70**	**9**	**116**	**57**	**138**	**32**	**124**	**8**	**5**	**5**	**0**
55 = 8.89%			**195 = 31.50%**			**351 = 56.70%**				**18 = 2.91%**			

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)033
Title of paper: Review of the Board Assurance Framework (BAF) – April 2022
Purpose: For the Executive Committee to review and agree any changes to the BAF to be presented to the Trust Board.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in January 2022. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** In January the Board requested that the score of risk 1 be reviewed and potentially reduced. However given the continued operational challenges resulting in poor patient experience, delays in urgent care and cancellations of elective procedures it is proposed that at this time the score should remain at 20. The Executive Committee also reviewed the risk score of risk 2 in light of the 2022/23 plan which is likely to breach the breakeven duty; however it is recommended that as there are potential mitigations and a degree of uncertainty about the income assumptions this should remain at 16 for this quarter.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE/I, CQC, Commissioners.
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 27th April 2022

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2022/23 Objectives and Long Term Strategic Aims

2022/23 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSE/I Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20		Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, claims, inquests and mortality reviews Development of the Nursing Strategy – currently subject to consultation (Now planned for May 2022) ~~Reduce hospital acquired AKI (March 2022)~~ ~~Winter Staffing Assurance Framework (January 2022)~~	~~Review of patient information to improve accessibility and understanding (March 2022)~~ Delivery of never event improvement plans and human factors training (May 2022) ~~Complete and provide assurance of compliance with all Ockenden actions – March 2022~~ Deteriorating patient improvement project (revised to September 2022) Birth Rate Plus review of maternity staffing (report delayed now scheduled for May 2022) Undertake self-assessment against the recommendations of Ockenden 2 and develop the Trust action plan (May 2022) Improve mandatory and core skills training compliance (July 2022)	5 x 1 = 5	R P-J/ SR

Risk 2 – Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports (Inc. GIRFT) • Annual audit programme • CQUIN monitoring Other; • NHSE/I monthly reporting • Contract Monitoring Board • NHSE/I Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Place Based Partnership Board • ICS Reporting • Financial sustainability self-assessment • ~~COVID-19 exceptional expenditure financial governance process~~	4 x 4= 16	Continue collaboration across C&M to deliver transformational CIP contribution	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances	Seek all possible sources of capital funding including national bids to support capacity planning (Ongoing) ~~Deliver the financial and activity plan agreed with C&M ICS for the second 6 months of 2021/22 (April 2022)~~ ~~Develop financial plans for 2022/23 based on the NHS Operational Planning Guidance (April 2022)~~ ~~Assess impact of Omicron COVID-19 surge on ability to deliver H2 financial and activity plans (March 2022)~~ Continue to monitor impact of COVID-19 on elective recovery plans and achievement of planned ERF income (July 2022) Delivery of the agreed 2022/23 financial plan (March 2023)	4 x 2= 8	GL

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

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

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

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career and leadership development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management Strategy	To Board; • Strategic Workforce Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES , WDES and Gender Pay Gap reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Group Other • Annual workforce plans • HR benchmarking • Nurse & Midwifery staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment	5 x 4 = 20	Equality Delivery System 2 – action plan	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3 Capacity to deliver the recovery and restoration plans for activities suspended due to COVID-19 Attendance management COVID-19 recovery plan Establish collaborative staff bank for C&M ICS for other services e.g. Radiology, Endoscopy, vaccination programme Mandatory training and appraisal compliance 85% recovery plans and detailed dashboards for managers	Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going) ~~Delivery of the NHS People Plan local action plans for 2021/22 (March 2022)~~ C&M Lead Provider role for the COVID vaccination programme – including planned winter booster programme for staff and the school aged Children's vaccination programme (On going) ~~Restoration of appraisal and mandatory training compliance with the 85% target (March 2022)~~ Refresh the ED&I Strategy and Action Plan (Revised to May 2022) ~~Implementation of the new regulations for mandatory COVID vaccination of NHS staff (April 2022)~~ Deliver the staff survey action plan (March 2023)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning and social distancing (COVID-19) • Compliance with NHS Estates HTMs	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Premises Assurance Model benchmarking • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Maintain 10 year strategic estates development plan to support the Trusts service development and integration strategies.	Implementation of new National Standards of Cleaning (May 2022) Implementation of the national Hospital Food Review recommendations and mandatory standards (once published) Test compliance against HTM/HBN guidance revised as a result of COVID learning. Compliance with the new Protect legislation for premises security – Consultation closed in July and draft legislation not yet published	3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2023) ~~Delivery of approved 2021/22 capital schemes~~ Delivery of the Whiston Additional Theatres Scheme (2023) Delivery of the 2022/23 approved capital schemes	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Careflow/DAP benefits realisation programme monitoring	4 x 4= 16	Annual Corporate Governance Structure review Technical Development	ISO27001 Service Improvement Plans IT Communications Strategy Digital Maturity Assessment	ISO27001 (revised to September 2022 due to COVID) ~~Careflow/ DAP benefits realisation programme delivery (revised to September 2022)~~ Achieve HIMMS Level 5 (November 2023) Migration from end-of-life operating systems – 85% complete. Extended support in place for the remaining 15%, which will be migrated (October 2022) ~~Delivery of the Digital Aspirant Programme (2020 - 2023)~~ Delivery of the EPR Digital Maturity Programme (March 2023) Delivery of Community EPR (Revised to December 2022) Respond to cyber threat alerts (including Log4J and the war in the Ukraine) and update systems as required (on going)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)034

Title of paper: Learning from Deaths Quarterly Report Q2 & Q3 2021-2022

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

Summary:

	No. of reviews	Green	Green with Learning	Green with positive feedback	Amber	Red
July 2021	40	17	14	5	0	0
August 2021	47	18	8	2	0	0
September 2021	34	12	4	4	0	0
October 2021	37	10	2	5	2	0
November 2021	45	15	2	2	2	0
December 2021	42	12	0	1	0	0

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

Financial implications: None arising from this report

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

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

Presenting officer: Dr Elspeth Worthington – Assistant Medical Director

Date of meeting: 27th April 2022

1 EXECUTIVE SUMMARY

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

In Quarter 2 2021/22 a total of 121 SJR's were requested 69.42% (84n) of the reviews had an outcome of no concerns (Green, Green with learning/positive).

In Quarter 3 2021/22 a total of 124 SJR's were requested 39.51% (49n) of the reviews had an outcome of no concerns (Green, Green with learning/positive). 3.22% (4n) of the reviews had an amber outcome, 3 of which are under specialist review and 1 is due to come to the next Mortality Surveillance Group

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

1.1. Shared learning for Q2

Check Alerts	**Communication with families/carers**
 If alert the sign is visible in your patient's electronic notes, make sure you click to open it – there are current alerts for this patient. It is your responsibility to do this as they may be vital in directing a treatment / management plan. Do you know what's included in alerts?	At times of high emotion and distress, it may be that families and carers do not take in what is happening to their loved one and may not be able to comprehend a poor prognosis, even more challenging over the phone. Staff must remain aware of verbal or physical cues from families/carers suggesting key messages haven't been fully appreciated so the communication reinforced can be accordingly.

Previous learning can be found in the "Learning into Action" section of the Trust Intranet

1.2 Sharing and embedding learning

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

2. ANALYSIS

2.1 Total number of reviews completed for Q2 2021/22

	No. of reviews	Green	Green with Learning	*Green with positive feedback	Amber	Red
July 2021	40	17	14	5	0	0
August 2021	47	18	8	2	0	0
September 2021	34	12	4	4	0	0

2.1.1 Total number of reviews completed for Q3 2021/22

	No. of reviews	Green	Green with Learning	Green with positive feedback	Amber	Red
October 2021	37	10	2	5	2	0
November 2021	45	15	2	2	2	0
December 2021	42	12	0	1	0	0

2.2 Specified Groups breakdown for Q2 & Q3 2021/22 (See Appendix 1)

	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Total
Cardiac Arrest Death	2	2	6	4	2	7	23
Concern Death	9	3	1	1	0	0	14
CRAB Mortality Triggers	5	0	5	1	6	5	22
Diagnosis Group Death	6	3	5	9	0	4	27
Internal request (not included in any other category)	0	0	0	0	1	0	1
Learning Disabilities Death	0	4	2	2	3	2	13
Medical Examiner Referral	1	1	1	1	3	3	10
Post operative death	8	8	9	7	5	8	45
Random Selection Death	7	24	5	10	21	13	80
Severe Mental Illness Death	2	2	0	2	4	0	10
Total	40	47	34	37	45	42	245

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

2.3 CRAB (Copeland risk adjusted barometer)

We continue to use CRAB to influence our selections for SJR. This will be reported further when we have 12 months data to interrogate; however, until then we have been able to determine that the majority of cases have received a GREEN outcome

	AMBER	GREEN	GREEN - WITH LEARNING	Green with learning - positive feedback
Jan 2021	0	6	1	1
Feb 2021	0	4	5	2
Mar 2021	0	7	4	2
Apr 2021	0	9	0	3
May 2021	0	8	1	2
Jun 2021	0	8	5	0
Jul 2021	0	2	2	1
Aug 2021	0	0	0	0
Sep 2021	0	0	1	2

2.4 DNACPR

As we continue to feedback learning generated from SJRs, we are starting to see evidence of changes to practice, in particular with DNACPR. A project group has been working with clinicians to determine where problems lie. Training and support has been put in place and this continues to have an impact on the SJRs in that we are seeing less DNACPR concerns. This theme has also been recognised in complaints with a downturn in the number of complaints about DNACPR. As was highlighted in early COVID escalation

decisions, where appropriate, DNACPRs are now being issued for this current admission only, this a huge improvement to previous practice where patients who had recovered were sent home with a valid DNACPR still in place.

3 CONCLUSION AND RECOMMENDATIONS

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

- SJR process is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised. (Appendix 2)
- Where concerns have been identified these have received further peer review and escalated as appropriate.

Appendix 1

Total Deaths in Scope[1]

Check against NWB downloaded LD List[2] **'Learning Disability Death'**	LeDeR Death Review
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List'[5] **'Alert Death'**[5]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
Random Sample, include all low risk deaths[6] **'Sample Deaths'**	SJR
Cardiac Arrests that result in death[7] **'Cardiac Arrest Deaths'**	SJR

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

Appendix 2

Forum/Communication Channel	Chair	Support
Quality Committee	Gill Brown	Joanne Newton
Finance & Performance	Jeff Kozer	Laura Hart
Clinical Effectiveness Council	Rowan Pritchard-Jones	Helen Burton
Patient Safety Council	Rajesh Karimbath	Helen Burton
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Elspeth Worthington	Jane Bennett
MCG Integrated Governance & Quality Meetings	Ash Bassi/Debbie Stanway	Joy Woosey
MCG Directorate Meetings	Debbie Stanway	Joy Woosey
SCG Governance Meetings	Tracy Greenwood/Wendy Harris	Gina Friar
SCG Directorate Meetings	Phil Nee	Julie Rigby
CSS Directorate Meetings	Caroline Dawn (Interim)	Sam Barr
ED Teaching	Ragit Varia/Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Cynthia Foster	
Grand Rounds	Cynthia Foster	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(22)035
Title of paper: NHS Staff Survey 2021 performance and Response
Purpose: For Information.
Summary: To provide the Trust Board with an overview of the analysis of the outcomes of the Staff Survey for 2021 and areas highlighted as requiring further investigation and which will form the basis of the 2022 action plan.
Corporate objectives met or risks addressed: Developing Organisational Culture and supporting our workforce, Safety, Communication
Financial implications: No new financial requirements directly from this paper
Stakeholders: Staff, Staff Side colleagues, Service users, Line Managers, CCG, CQC.
Recommendation(s): Members are asked to note the outcomes and accept for progression into a detailed milestone plan with interventions to address the areas of concern.
Presenting officer: Anne-Marie Stretch, Director of HR & Deputy CEO
Date of meeting: 27th April 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

2021 NHS Staff Survey Report

1. INTRODUCTION

During October and November 2021, 280 NHS organisations in England took part in the NHS Staff Survey. Full-time and part-time staff directly employed by an NHS organisation, were invited to participate, with over 595,270 responses received. The data generated is used for the purposes of the Care Quality Commission (CQC) monitoring assessments and by other NHS bodies such as the Department of Health.

For the first time all staff employed at St Helens and Knowsley Teaching Hospitals NHS Trust (STHK/ the Trust) at the time of the survey were invited to take part, which was administered on our behalf by Quality Health (QH).

Staff were either invited to complete on-line or via postal questionnaires which were distributed to staff by hand through the Trusts' network of Staff Survey Champions. Those staff provided a postal questionnaire could respond either by post, using a pre-paid envelope provided by QH, or on-line using the web link included in the invite letter.

Two reminders were sent; a first reminder letter or email and a further mailing which included a repeat full questionnaire or electronic link to it.

The results were published nationally on 30th March 2022.

Detailed results are available on the Trust Intranet Staff Survey pages, with a breakdown of the responses to each question available from the following site:

http://www.nhsstaffsurveyresults.com/

2. QUESTIONNAIRE CONTENT

It is important to note that this year saw some significant changes to the questionnaire content through the amendment of many questions, their removal or replacement. The details of all question changes can be found in Appendix 1.

A further significant change for the 2021 survey onwards, is the amendment of the Themes to align to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

Results are reported both as a percentage for individual question responses and aggregated on a 0-to-10-point scale, a higher score indicating a better result, for the

Themes. The list of questions feeding into each theme is presented in Appendix 2.

Just 2 themes remain unchanged from previous years, namely.

- Staff Engagement
- Morale

Owing to the replacement of the previous themes by the Staff Promise this year, it is not possible to provide a retrospective comparison of performance for anything other than Engagement & Morale.

The Survey Coordination Centre have not yet released the free text data received as part of the survey and the release date is yet to be confirmed. Once we have received this analysis, any resultant actions will be linked into the action plan.

3. RESPONSE RATE

3.1 STHK

2,388 completed questionnaires were returned from a workforce of 6,534. A response rate of **37%.** While this is a reduction in percentage terms since last year, it represents a significantly larger number of overall responses.

3.2 National

The mean average national response rate for Acute and Acute & Community Trusts in England was 46% a reduction of 150,944 responses when compared to the 2020 survey.

3.3 Respondent Demographics

The 2,388 respondents comprised the following groups:

Gender	%
Male	17.3
Female	80.2
Non -binary	0.2
Prefer to self-describe	0.7
Prefer not to say	1.6

Age	%
66+	2.0
51-65	36.9
41-50	24.7
31-40	21.7
21-30	14.4
16-20	0.2

Ethnicity	%
White	90.0
Mixed/Multiple ethnic background	0.9
Arab	0.3
Asian/Asian British	7.1
Black/African/Caribbean/Black British	01.1
Other ethnic groups	0.6

Sexual orientation	%
Heterosexual or straight	92.8
Gay or lesbian	2.0
Bisexual	1.1
Other	0.6
Prefer not to say	3.3

Gender Identity	%
Same as the sex you were registered at birth	97.8
Not the same as the sex you were registered at birth	0.3
Prefer not to say	1.8

Religion	%
No religion	29.4.9
Christian	61.7
Buddhist	0.2
Hindu	1.8
Jewish	0.2
Muslim	1.5
Sikh	0.0
Other	1.4
Prefer not to say	3.7

Physical or mental health conditions	%
Yes	24.4
No	75.6

Occupational Group	%
AHP	9.8
Medical & Dental	8.6
Nurses & Midwives	27.7
Healthcare Assistants	10.4
Scientific and Technical	7.6
Social Care	0.1
Maintenance	4.2
Admin and Clerical	16.7
Central Functions /Corporate Services	7.5
General Management	1.9
Scientific and Technical /Healthcare Scientists	12.2
Public Health	0.3
Central Functions	8.2
Emergency Care Assistants	0.1
Other occupational group	1.6

When you joined this organisation, were you recruited from outside of the UK?	%
Yes	3.7
No	95.6
Prefer not to say	0.7

Care Group/ Directorate	Staff Headcount	Respondents	%
Clinical Support Services	1232	494	40
Community Services	531	1559	29
Corporate Services	881	510	57
Medical Care Group	1756	538	30
Medirest	351	108	30
Non-Clinical Support	34	16	47
Surgical Care Group	1758	563	32

4.0 RESULTS

To support benchmarking of performance, the results for all organisations are presented within one of the following 10 national benchmarking groups;

- Acute and Acute & Community
- Acute Specialist
- Mental Health & Learning Disability
- Learning disability & Community
- Community
- Ambulance

- CCG
- CSU's
- Social enterprises-mental Health
- Social enterprises-Community
- Community Surgical Services

Each group comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure.

STHK is placed in the group **'**Acute and Acute & Community' along with 125 other organisations**.**

4.1 Workforce Equality Standards

Results for the equality related questions in the survey contribute to a measure of how effective the Trust is in meeting both the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES).

4.2 Data analysis

When compared to the approach used in previous years where a random sample of 1250 staff were invited to participate, the increased effort to ensure over 6000 eligible staff were both aware and able to contribute survey has resulted in significantly greater volume of responses and allowed a more detailed and forensic analysis than was previously possible.

Using a newly developed interactive dashboard, developed in collaboration with the Trusts information team, we were able to drill down to see detailed performance at department and professional group level for both Themes and individual questions.

This new approach has allowed us to more accurately identify common and specific areas where the Trust, managers and staff need to focus any actions, and which are included later in this report

The dashboard has subsequently been made available to all staff and managers through the Staff Survey pages of the Trust Extranet, enabling them to easily see what colleagues in their Directorates and services are saying alongside the actions that will be taken.

Overall performance of the Trust against its benchmark group for all themes is shown in Appendix 3 from which, despite the challenges of the last 24 months, it is evident the Trust continues to perform significantly above the average across the majority of Themes.

The following section provides a more detailed analysis of the Trust against each theme, their sub themes, and questions.

4.2.1.1 Staff Engagement & Morale

Themes	2020 score	2020 respondents	2021 score	2021 respondents	Statistically significant change?
Staff Engagement	**7.6**	508	**7.1**	2381	↓
Morale	**6.6**	508	**6.1**	2383	↓

Staff Engagement is calculated as an average from the scores of the following three sub-themes:

Motivation Q2a, Q2b, Q2c	This year STHK performance has seen a reduction in line with the benchmark group however is still maintaining a better than average performance. Areas of the Trust returning the lowest scores are HR business partners, Theatres and Midwifery
Involvement Q3c, Q3d, Q3f	The general trend for all organisations in the group has been a reduction and STHK has followed this trend. The 'opportunity to show initiative' had the poorest score in Medirest and Biochemistry.
Advocacy Q21a, Q21c, Q21d	Whilst the general trend for scores across the group was a reduction, this was marginally greater for STHK against the best performing organisation, most notably in responses from Theatres.

Morale is calculated as an average from the scores of the following three sub-sections:

Thinking about leaving Q22a, Q22b, Q22c	2021 has seen scores fall across all organisations with STHK reflecting this change, but still performing positively above the average. Areas with the highest number of staff responding yes to this include SCBU, ICU and HR Business Partners
Work pressure Q3g, Q3h, Q3i	STHK is following the national group downward trend for this sub-score. This is most notable in staff saying 'there are sufficient staff in the organisation' from Midwifery, and St Helens Theatres.
Stressors Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a	The downwards trend is more significant in STHK, especially in relation to 'encouragement from manager' and 'consultation on changes to work', with the areas most affected being Theatres, ICU, Midwifery and Pathology

4.2.2 Promise element 1: We are compassionate and inclusive

Compassionate culture Q6a, Q21a, Q21b, Q21c, Q21d	STHK performance has seen a reduction in line with other organisations and is above the average but not the best in the benchmarking group and subsequent action will be required. Initial indications are performance is similar across all care groups for this sub theme.
Compassionate leadership Q9f, Q9g, Q9h, Q9i	This is a complete new set of questions and so no historical data is available for comparison. Scores indicate that STHK is performing just below the average for the benchmarking group, with the poorest feedback from staff in Medirest, Surgical Care and Clinical Support Services.
Diversity and equality Q15*, Q16a, Q16b, Q18	Although staff are reporting they have experienced less discrimination at work from service users, staff in Theatres and Midwifery are indicating an increase in discrimination at work that is greater than that for others within our benchmarking group.

Inclusion Q7h, Q7i, Q8b, Q8c	This subset comprises all new questions, so no historical data is available. STHK is performing significantly above the average across all questions in this subgroup.

4.2.3 Promise element 2: We are recognised and rewarded

Q4a, Q4b, Q4c, Q8d, Q9e	STHK has seen a marked reduction in its score for the questions in this theme in common with all other organisations, however for STHK this seems a particular issue in Medirest, Theatres and Midwifery.

4.2.4 Promise element 3: We each have a voice that counts

Autonomy and control Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b	Although STHK performance for this sub theme has followed the group trend for all these questions, we have seen a more obvious reduction in relation to an individual's ability to 'suggest and make improvements in their area of work' with staff from Medirest flagging this.
Raising concerns Q17a, Q17b, Q21e, Q21f	STHK scores are better than the group average and indicate that staff feel confident about raising concerns regarding unsafe clinical practice. This isn't the same for concerns of any other type or that the organisation will act on concerns they have raised, most notably in Theatres and SOHT Pathology.

4.2.5 Promise element 4: We are safe and healthy

Health and safety climate Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d	There is a common trend across the bench group of a reduction in scores for staffing, time, and resources. By comparison, for STHK the reduction was a more significant issue for staff in Theatres and Midwifery. When compared to the group, more STHK staff state they have not reported an incident of physical violence from patients at work when this has occurred, however are better at reporting bullying and harassment where this occurs. It should be noted that this isn't an indication that bullying and harassment has increased, more that staff are more likely to report when it occurs and remains an improvement on previous years feedback.
Burnout Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g	This sub theme comprises all new questions for this year. Scores show STHK to be performing in line with the group. Understandably, feedback is less positive in patient-facing areas of Medical Care and Surgical Care, and more specifically Midwifery, Theatres, ICU with Corporate areas and Medirest less impacted.

Negative experiences Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c	This group are personal health and wellbeing questions. In the main, STHK has seen a reduction in performance in line with that of the benchmarking group, except for staff suffering musculoskeletal (MSK) injury which has seen an increase, although this does remain better than the national average. MSK appears to be a concern for staff in Theatres, Bevan Court, and ICU. Stress was seen as a particular issue for staff in Newton, MET Team, Theatres, and Midwifery, Responses from AED nursing show a small increase in violence and aggression from patients/service users on staff.

4.3.3 Promise element 5: We are always learning

Development Q20a, Q20b, Q20c, Q20d, Q20e	A new question set with STHK performing positively when compared with the group and something we would hope to improve on. Areas with the least positive feedback are Medirest and Pathology.
Appraisals Q19a, Q19b, Q19c, Q19d	Results for this subgroup were significantly impacted by the positive action taken by the Trust and professional bodies to support staff during the pandemic and maintain a clinical service and it should be noted that during the reporting period, Appraisals were not mandated due to staffing pressures and COVID. Review of the data shows this to be associated with the responses of medical workforce which is significantly negatively impacting the score for this subset.

4.3.4 Promise element 6: We work flexibly

Support for work-life balance Q6b, Q6c, Q6d	All questions aligned to this sub-theme are new. STHK performance is in line with the benchmark group. Responses from Pathology SOHT, Midwifery and Theatres indicate this is a concern for staff in those areas.
Flexible working Q4d	Trust performance is at the average for the benchmark group, with responses regarding access to flexible working being least positive in predominantly clinical areas and for medical secretaries.

4.3.5 Promise element 7: We are a team

Team working Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a	Overall STHK is performing well in this sub theme. Positive feedback in relation to team dynamics has seen a reduction, especially for HR Business Partners, Medirest, Midwifery, and Pharmacy.
Line management Q9a, Q9b, Q9c, Q9d	The national trend for this subgroup has been to remain reasonably static. For STHK Positive responses have seen a reduction to or below the national average, most notably for staff in Medirest and Theatres.

5.0 CONCLUSIONS AND RECOMMENDATIONS

In what was and continues to be, an extremely challenging operational environment, it is good to see that the overall views of staff about their experiences of working at the Trust and of the standard of care given to our patients, remain better than the majority of our benchmark group partners and in some cases are better than like organisations across the Northwest and more locally within Cheshire & Merseyside.

However, it is disappointing that, although the Trust has worked hard over the last 12 months to engaging with, support and develop its workforce, we have seen a number of dips in performance and is apparent from the above analysis that there is work to be done to improve the experience and views of our staff.

In summary, this work falls into 3 areas of focus being;

1. **Corporate/ Strategic –** Addressing issues of safety including concerns raised over sufficient staffing, resources, acting on staff and patient feedback, visibility, and engagement with staff.
2. **Equality, Diversity & Inclusion –** Addressing concerns raised over discrimination, access to flexible working, career progression
3. **Service specific** – Delivery of focussed OD work with services/departments that have consistently flagged low scores across a range of themes/questions i.e., Maternity, Theatres, Medirest and ITU.

Further detail of the actions associated with each of these areas is given in Appendix 4

More specific detail of actions, ownership and timescales will be published following receipt of divisional plans on 30th June 2022. Those individuals owning specific actions will attend a bimonthly staff survey action group chaired by the Assistant Director of OD and progress will be monitored monthly through the Workforce Council.

6.0 Action required by the Committee

The Board are asked to note the content of this report and to approve and support the recommendations. Actions to address the areas of concern will be incorporated into the Staff 2021 Survey Action Plan for delivery in 2022, monitored by the Workforce Council and as part of the Board Governance Assurance Framework.

APPENDIX 1 - Changes made to the 2021 NHS Staff Survey questionnaire.

New questions for 2021:

Section	Question
YOUR JOB	
	6b. My organisation is committed to helping me balance my work and home life.
	6c. I achieve a good balance between my work life and my home life.
	6d. I can approach my immediate manager to talk openly about flexible working.
YOUR TEAM	
	7d. Team members understand each other's roles.
	7e. I enjoy working with the colleagues in my team.
	7f. My team has enough freedom in how to do its work.
	7g. In my team disagreements are dealt with constructively.
	7h. I feel valued by my team.
	7i. I feel a strong personal attachment to my team.
THE PEOPLE IN YOUR ORGANISATION	
	8a. Teams within this organisation work well together to achieve their objectives.
	8b. The people I work with are understanding and kind to one another.
	8c. The people I work with are polite and treat each other with respect.
	8d. The people I work with show appreciation to one another.
YOUR MANAGERS	
	9f. My immediate manager works together with me to come to an understanding of problems.
	9g. My immediate manager is interested in listening to me when I describe challenges I face.
	9h. My immediate manager cares about my concerns.
	9i. My immediate manager takes effective action to help me with any problems I face.
YOUR HEALTH, WELL-BEING, AND SAFETY AT WORK	
	12a. How often, if at all, do you find your work emotionally exhausting?
	12b. How often, if at all, do you feel burnt out because of your work?
	12c. How often, if at all, does your work frustrate you?
	12d. How often, if at all, are you exhausted at the thought of another day/shift at work?
	12e. How often, if at all, do you feel worn out at the end of your working day/shift?
	12f. How often, if at all, do you feel that every working hour is tiring for you?
	12g. How often, if at all, do you not have enough energy for family and friends during leisure time?
	18. I think that my organisation respects individual differences (e.g., cultures, working styles, backgrounds, ideas, etc.)
YOUR PERSONAL DEVELOPMENT	
	20a. This organisation offers me challenging work.
	20b. There are opportunities for me to develop my career in this organisation.
	20c. I have opportunities to improve my knowledge and skills.
	20d. I feel supported to develop my potential.
	20e. I am able to access the right learning and development opportunities when I need to.
YOUR ORGANISATION	
	21f. If I spoke up about something that concerned me, I am confident that my organisation would address my concern.
BACKGROUND INFORMATION	
	24b. Is your gender identity the same as the sex you were registered at birth?
	30b. When you joined this organisation, were you recruited from outside of the UK?

Questions that have been reintroduced from 2019

Section	Question (2021):
YOUR PERSONAL DEVELOPMENT	
	19a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?
	19b. Yes, it helped me to improve how I do my job
	19c. Yes, it helped me agree clear objectives for my work.
	19d. Yes, it left me feeling that my work is valued by my organisation.
BACKGROUND INFORMATION	
	30a. How many years have you worked for this organisation?

Questions that have been modified:

Section:	Question (2020):	Change made in 2021:
YOUR JOB		
	1. Do you have face-to-face contact with patients / service users as part of your job?	Wording updated. 1. Do you have face-to-face, video or telephone contact with patients / service users as part of your job?

YOUR HEALTH, WELL-BEING, AND SAFETY AT WORK		
	11a. Does your organisation take positive action on health and well-being?	Wording updated and response options changed to agree/disagree scale. 11a. My organisation takes positive action on health and well-being.
YOUR EXPERIENCE DURING THE COVID-19 PANDEMIC		
	20a. Have you worked on a Covid-19 specific ward or area at any time?	Wording updated. 23a. In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?
	20b. Have you been redeployed due to the Covid-19 pandemic at any time?	Wording updated. 23b. In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?
	20c. Have you been required to work remotely/ from home due to the Covid-19 pandemic?	Wording updated. 23c. In the past 12 months, have you been required to work remotely / from home due to the Covid-19 pandemic?
BACKGROUND INFORMATION		
	22a. About you…	Wording updated, order of 'male' and 'female' response options switched, and 'non-binary' response option added. 24. What of the following best describes you?
	23. What is your ethnic background?	Wording updated. 25. What is your ethnic group? (Choose one option that best describes your ethnic group or background).
	25. What is your religion?	Wording updated. 27. What is your religion? Are you…

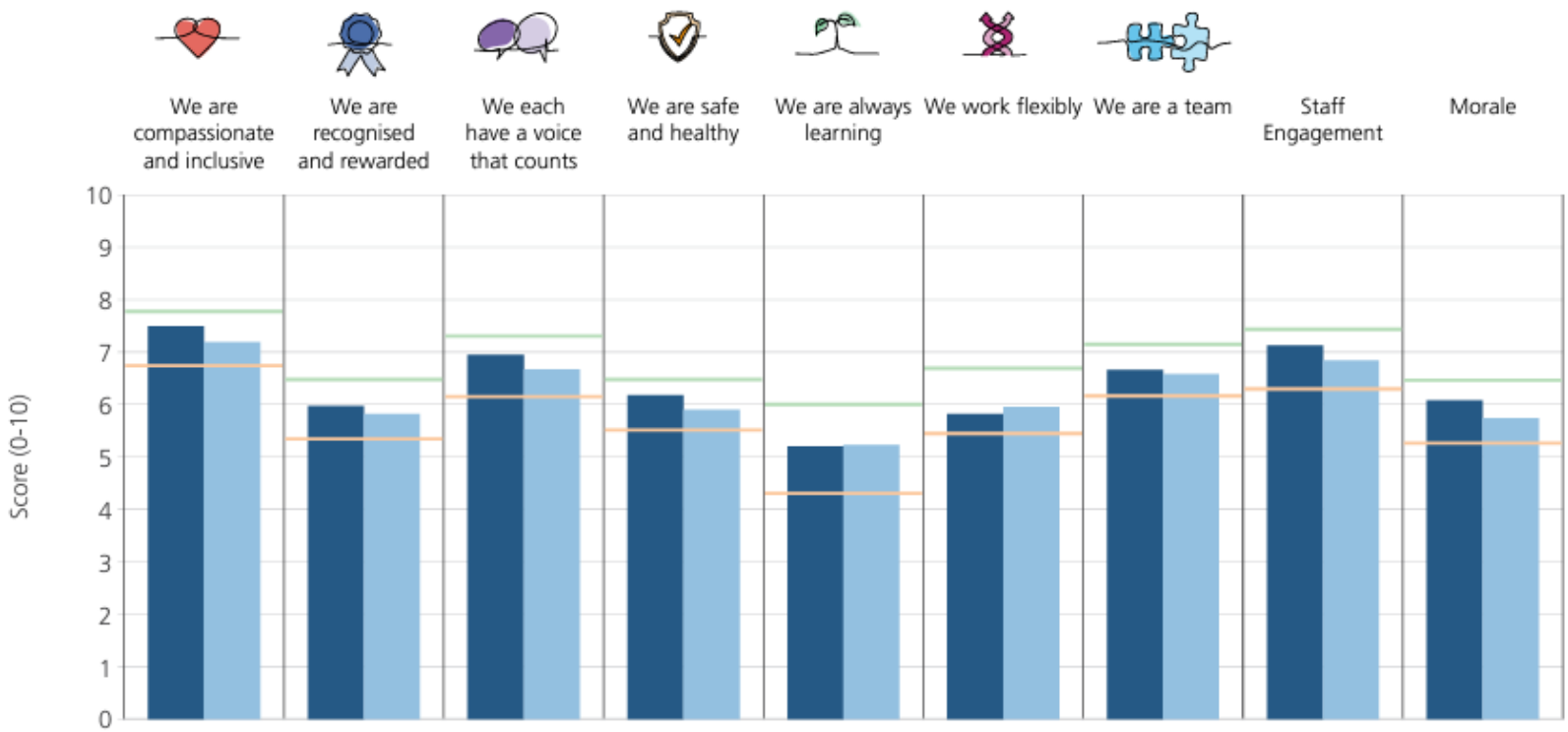
Questions that have been removed:

Section	Question (2020)
YOUR JOB	
	3c. I am able to do my job to a standard I am personally pleased with.
	5b. The support I get from my immediate manager.
	5c. The support I get from my work colleagues.
	5d. The amount of responsibility I am given.
	5e. The opportunities I have to use my skills.
	7a. I am satisfied with the quality of care I give to patients / service users.
	7c. I am able to deliver the care I aspire to.
YOUR MANAGERS	
	8b. My immediate manager can be counted on to help me with a difficult task at work.
	8e. My immediate manager is supportive in a personal crisis.
	9a. I know who the senior managers are here.
	9b. Communication between senior management and staff is effective.
	9c. Senior managers here try to involve staff in important decisions.
	9d. Senior managers act on staff feedback.
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	
	11f. Have you felt pressure from your colleagues to come to work?
	11g. Have you put yourself under pressure to come to work?
	16a. My organisation treats staff who are involved in an error, near miss or incident fairly.
	16b. My organisation encourages us to report errors, near misses or incidents.
	16c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.
	16d. We are given feedback about changes made in response to reported errors, near misses and incidents.
	17a. If you were concerned about unsafe clinical practice, would you know how to report it?
YOUR ORGANISATION	
	18e. I feel safe in my work.
YOUR EXPERIENCE DURING THE COVID-19 PANDEMIC	
	20d. Have you been shielding?
	21a. Thinking about your experience of working through the Covid-19 pandemic, what lessons should be learned from this time?
	21b. What worked well during Covid-19 and should be continued?

APPENDIX 2 - People Promise elements, themes and sub-themes

People Promise element	Sub-scores	Question
We are compassionate and inclusive	Compassionate culture Compassionate leadership Diversity and equality Inclusion	Q6a, Q21a, Q21b, Q21c, Q21d Q9f, Q9g, Q9h, Q9i Q15*, Q16a, Q16b, Q18 Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	[No sub-scores]	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control Raising concerns	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b Q17a, Q17b, Q21e, Q21f
We are safe and healthy	Health and safety climate Burnout Negative experiences	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
We are always learning	Development Appraisals	Q20a, Q20b, Q20c, Q20d, Q20e Q19a, Q19b, Q19c, Q19d
We work flexibly	Support for work-life balance Flexible working	Q6b, Q6c, Q6d Q4d
We are a team	Team working Line management	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a Q9a, Q9b, Q9c, Q9d
Theme	**Sub-scores**	**Question**
Staff Engagement	Motivation Involvement Advocacy	Q2a, Q2b, Q2c Q3c, Q3d, Q3f Q21a, Q21c, Q21d
Morale	Thinking about leaving Work pressure Stressors	Q22a, Q22b, Q22c Q3g, Q3h, Q3i Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q15 (historical calculation)* , Q16c, Q22d, Q28b		

APPENDIX 3 – National benchmarking of theme results



	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	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.5	6.0	6.9	6.2	5.2	5.8	6.7	7.1	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,379	2,363	2,352	2,347	2,201	2,340	2,374	2,381	2,383

APPENDIX 4 – Post Survey Actions

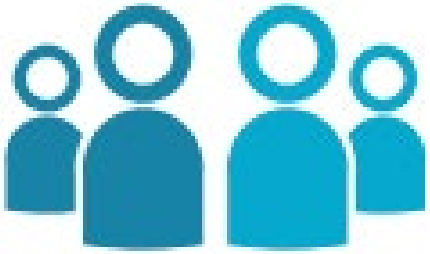
Action	By Whom	By When	Status/RAG/Comments
Publish and publicise survey results to staff • The management and full reports uploaded and available on the Intranet. • Launch Staff Survey dashboard to intranet • Summary of findings at Team Brief. • Copies to the local Staff Side representatives. • Circulation to the Valuing Our People Steering Group • Summary with links to full report on Global emails.	Assistant Director of Comms Assistant Director of OD	31/03/2022	Complete
Deep dive analysis of data	Assistant Director of OD	04/04/2022	Complete
Presentation of findings to: • Workforce Council • Strategic People Committee • Trust Board.	Assistant Director of OD	30/04/2022	In progress
1-2-1 meetings with senior leadership teams of each Care group/ Directorate to discuss the results relative to their staff/teams in a presentation form, to enable easy sharing with the whole directorate. Incorporating E&D data and identifying actions to be taken at a directorate/care group level.	Assistant Director of OD	20/05/2022	In progress
1-2-1 meeting with Maternity senior leadership team to establish initial actions	Assistant Director of OD	20/05/2022	In progress
1-2-1 meeting with Theatres senior leadership team to establish initial actions	Assistant Director of OD	03/05/2022	In progress
1-2-1 meeting with ICU senior leadership team to establish initial actions	Assistant Director of OD	20/05/2022	In progress
1-2-1 meeting with Medirest senior leadership team to establish initial actions	Assistant Director of OD	20/05/2022	In progress
Re-establishment of 'Quality Ward Rounds'	Deputy Director of Nursing	31/05/2022	
Re-establishment of face to face 'Teams Talks' to include additional members of the executive team. Frequency Bimonthly	Assistant Director of OD	31/05/2022	In progress
Open presentation of results to Trust by Quality Health	Assistant Director of OD	31/05/2022	In progress
Launch of ED&I training programme for managers to include understanding discrimination and reasonable adjustments	Deputy Director of HR	31/05/2022	
Review current recruitment and retention schemes to identify opportunities for expansion where appropriate.	Assistant Director of Workforce Development & Resourcing	31/05/2022	In progress
Review current ways to increase profile of senior managers and visibility to staff across the organisation	Assistant Director of Comms	30/06/2022	
Establishment of support programme for managers on the introduction and availability of flexible working options	Deputy Director of HR	30/06/2022	
Targeted focus groups facilitated by L&OD for each of Maternity,	Assistant Director of OD	31/05/2022	

Theatres, Medirest and ICU to validate staff feedback and determine specific actions			
Focus Group Feedback to Care group/ Directorate - Focus group themes, findings and action plan will be fed back to the DM/CD	Assistant Director of OD	30/06/2022	
Care Groups/ Directorates to agree and submit action plans to HR/L&OD Staff Engagement. Standardised templates will be used.	All ADOs and DMs	30/06/2022	
Review of processes to allow staff and patient feedback plus mechanisms to feedback on actions to staff particularly in relation to areas with low scores	Deputy Director of Nursing	31/05/2022	
Relaunch and promote Trust values aligned behaviours	Assistant Director of OD	30/06/2022	
Publication of full action plan	Assistant Director of OD	30/06/2022	
Establishment of a periodic programme of focus groups to provide a 'temperature check' and early indicator of potential issues.	Assistant Director of OD	30/06/2022	
Publication of 'you said, together we did'	Assistant Director of Comms Assistant Director of OD	31/08/2022	

END

St Helens and Knowsley Teaching Hospitals NHS Trust

2021 NHS Staff Survey



INTRODUCTION

During October and November 2021, 280 NHS organisations in England took part in the NHS Staff Survey. All full-time and part-time staff directly employed by an NHS organisation were invited to participate.

The results were published on 30th March 2022.

St Helens and Knowsley Teaching Hospitals NHS Trust

Survey mode	Mixed
Sample type	Census
Completed questionnaires	2,388
2021 response rate	37%

2021 benchmarking group details

Organisations in group: **126**

Median response rate: **46%**

No. of completed questionnaires: **444,326**

Acute and Acute & Community Trusts

Respondents

Care Group/ Directorate	Staff Headcount	Respondents	%
Clinical Support Services	1232	494	40
Community Services	531	1559	29
Corporate Services	881	510	57
Medical Care Group	1756	538	30
Medirest	351	108	30
Non-Clinical Support	34	16	47
Surgical Care Group	1758	563	32

Occupational Group	% respondents
AHP	9.8
Medical & Dental	8.6
Nurses & Midwives	27.7
Healthcare Assistants	10.4
Scientific and Technical	7.6
Social Care	0.1
Maintenance	4.2
Admin and Clerical	16.7
Central Functions /Corporate Services	7.5
General Management	1.9
Scientific and Technical /Healthcare Scientists	12.2
Public Health	0.3
Central Functions	8.2
Emergency Care Assistants	0.1
Other occupational group	1.6

Gender	%
Male	17.3
Female	80.2
Non -binary	0.2
Prefer to self-describe	0.7
Prefer not to say	1.6

Age	%
66+	2.0
51-65	36.9
41-50	24.7
31-40	21.7
21-30	14.4
16-20	0.2

Ethnicity	%
White	90.0
Mixed/Multiple ethnic background	0.9
Arab	0.3
Asian/Asian British	7.1
Black/African/Caribbean/Black British	01.1
Other ethnic groups	0.6

Sexual orientation	%
Heterosexual or straight	92.8
Gay or lesbian	2.0
Bisexual	1.1
Other	0.6
Prefer not to say	3.3

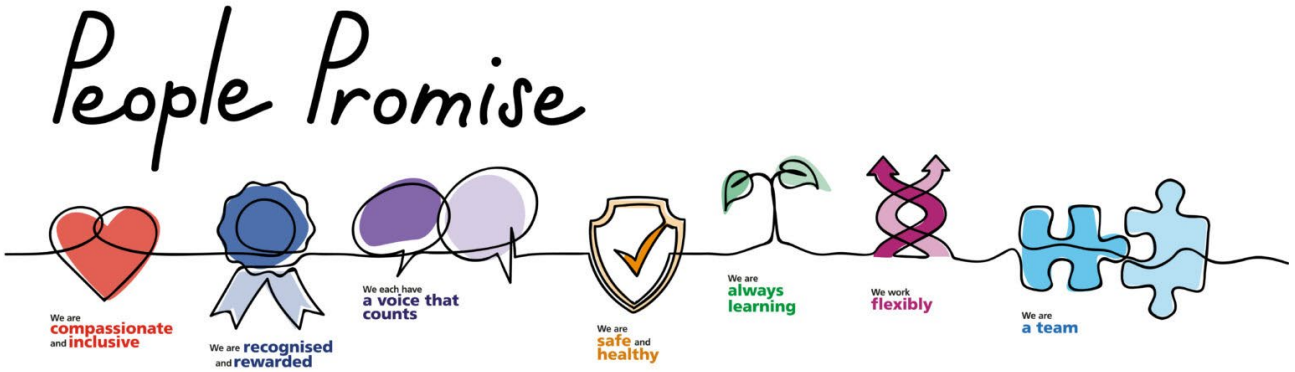
Significant changes to questionnaire content & Structure

Question changes

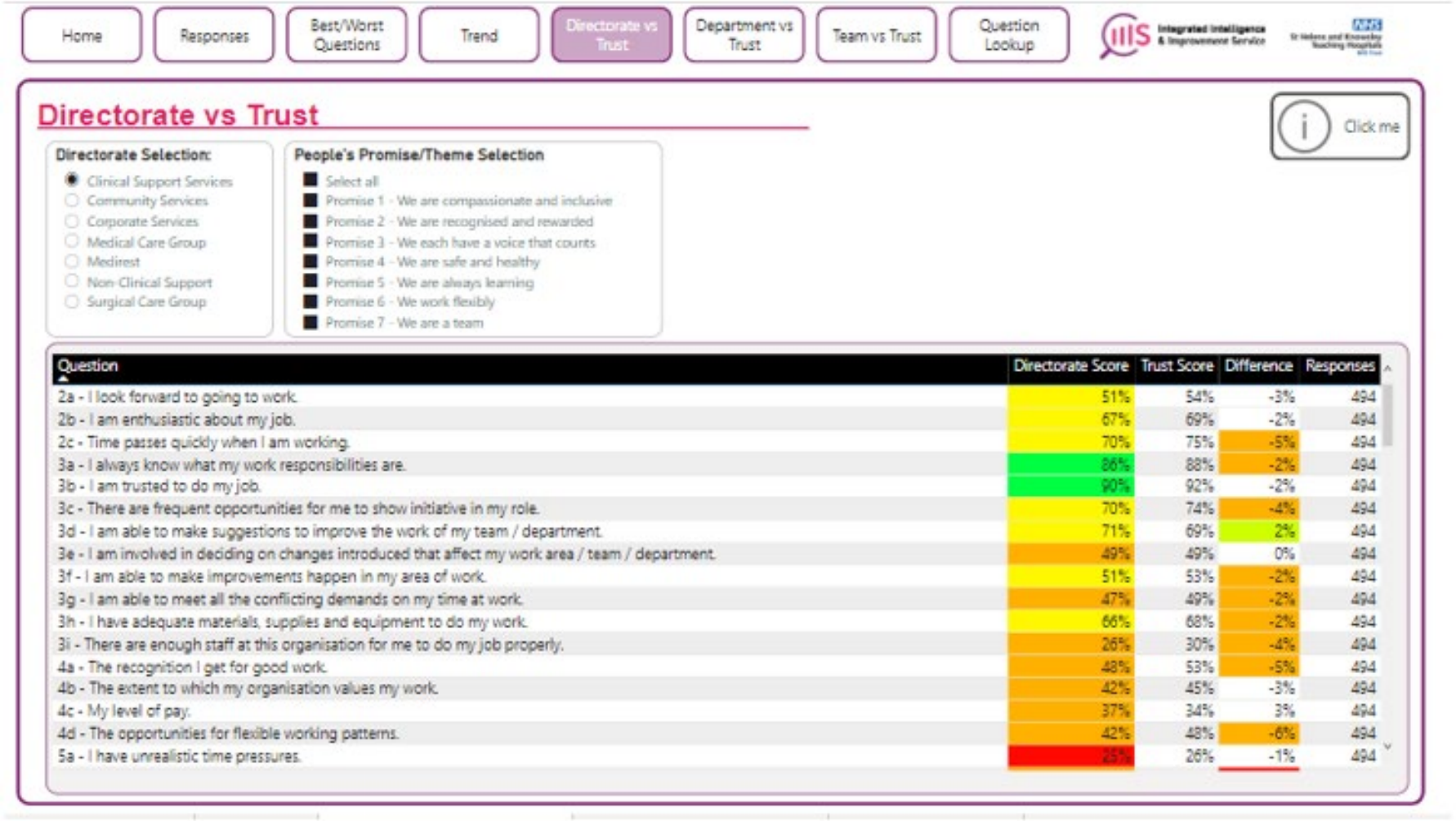
- 38 new questions
- 8 modified questions
- 24 questions removed

Theme changes

- Themes changed to align to the People Promise
- 2 themes remain unchanged from previous years;
    - ✓ Staff Engagement
    - ✓ Morale

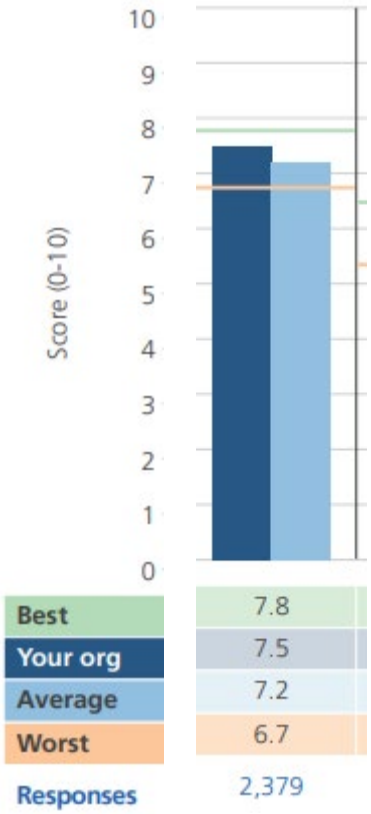


Data analysis and Interactive dashboard



Question	Directorate Score	Trust Score	Difference	Responses
2a - I look forward to going to work.	51%	54%	-3%	494
2b - I am enthusiastic about my job.	67%	69%	-2%	494
2c - Time passes quickly when I am working.	70%	75%	-5%	494
3a - I always know what my work responsibilities are.	86%	88%	-2%	494
3b - I am trusted to do my job.	90%	92%	-2%	494
3c - There are frequent opportunities for me to show initiative in my role.	70%	74%	-4%	494
3d - I am able to make suggestions to improve the work of my team / department.	71%	69%	2%	494
3e - I am involved in deciding on changes introduced that affect my work area / team / department.	49%	49%	0%	494
3f - I am able to make improvements happen in my area of work.	51%	53%	-2%	494
3g - I am able to meet all the conflicting demands on my time at work.	47%	49%	-2%	494
3h - I have adequate materials, supplies and equipment to do my work.	66%	68%	-2%	494
3i - There are enough staff at this organisation for me to do my job properly.	26%	30%	-4%	494
4a - The recognition I get for good work.	48%	53%	-5%	494
4b - The extent to which my organisation values my work.	42%	45%	-3%	494
4c - My level of pay.	37%	34%	3%	494
4d - The opportunities for flexible working patterns.	42%	48%	-6%	494
5a - I have unrealistic time pressures.	25%	26%	-1%	494

We are compassionate and inclusive



Areas exhibiting most positive scores

Compassionate Culture – Cancer Services, Urology Nursing

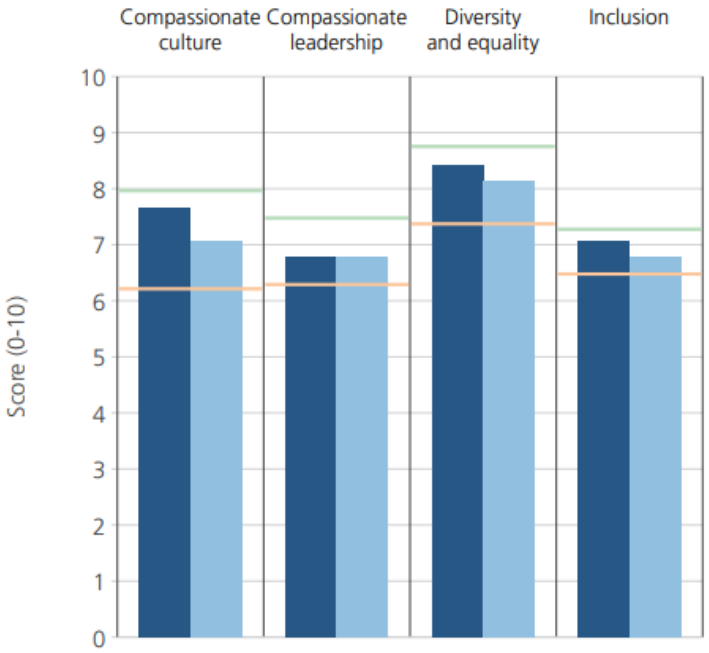
Compassionate Leadership – Community Paediatrics

Areas exhibiting less positive scores

Compassionate Leadership - Medirest, Surgical Care, Clinical Support Services

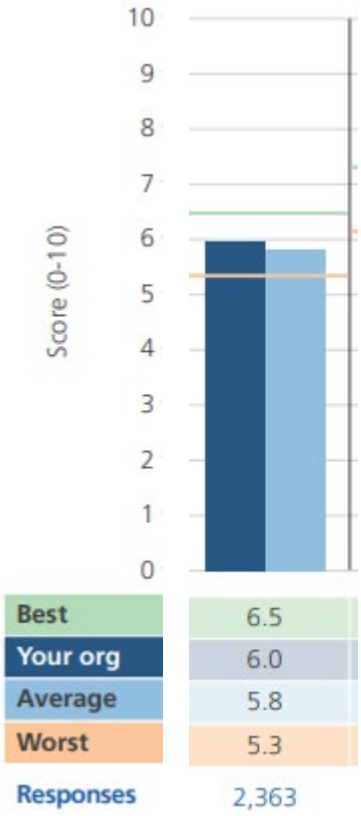
Diversity & Equality – Theatres, Midwifery

Sub- themes



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.7	6.8	8.4	7.1
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5

We are **recognised** and **rewarded**



No Sub- themes for this section

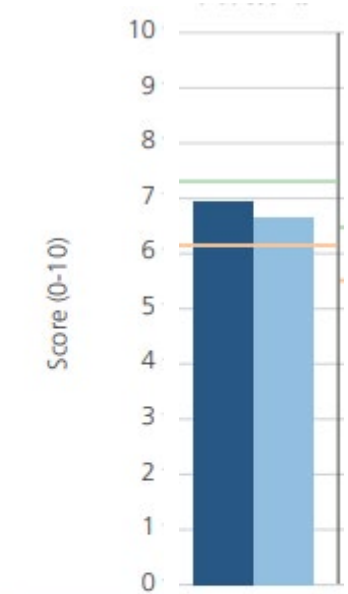
Areas exhibiting most positive scores

Urology Nursing, Diabetes Nursing, Supplies, Chief Exec Office

Areas exhibiting less positive scores

Medirest, Theatres, Midwifery

We each have
a voice that
counts



Best	7.3
Your org	6.9
Average	6.7
Worst	6.1
Responses	2,352

Areas exhibiting most positive scores

Autonomy and control – Urology Nursing, Cancer Services, Pathology Histology and Mortuary

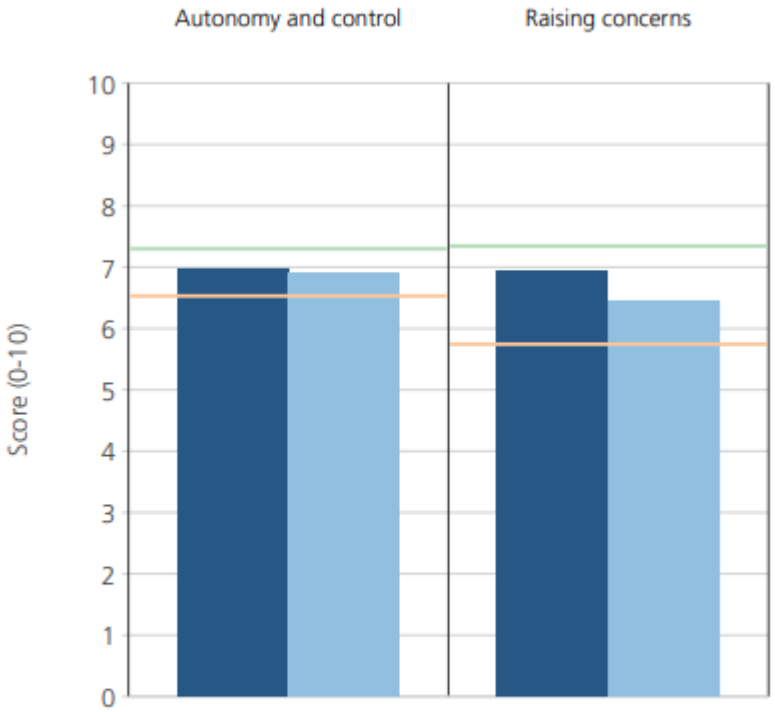
Raising Concerns – Urology Nursing, Gastrology Medical

Areas exhibiting less positive scores

Autonomy – Medirest

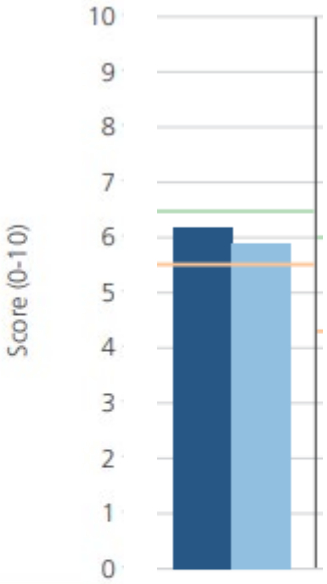
Acting on concerns – Theatres, Southport Pathology

Sub- themes



	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	7.0	6.9
Average	6.9	6.4
Worst	6.5	5.7

We are safe and healthy



Best	6.5
Your org	6.2
Average	5.9
Worst	5.5
Responses	2,347

Areas exhibiting most positive scores

Health and Safety climate – Diabetes Nursing, Supplies

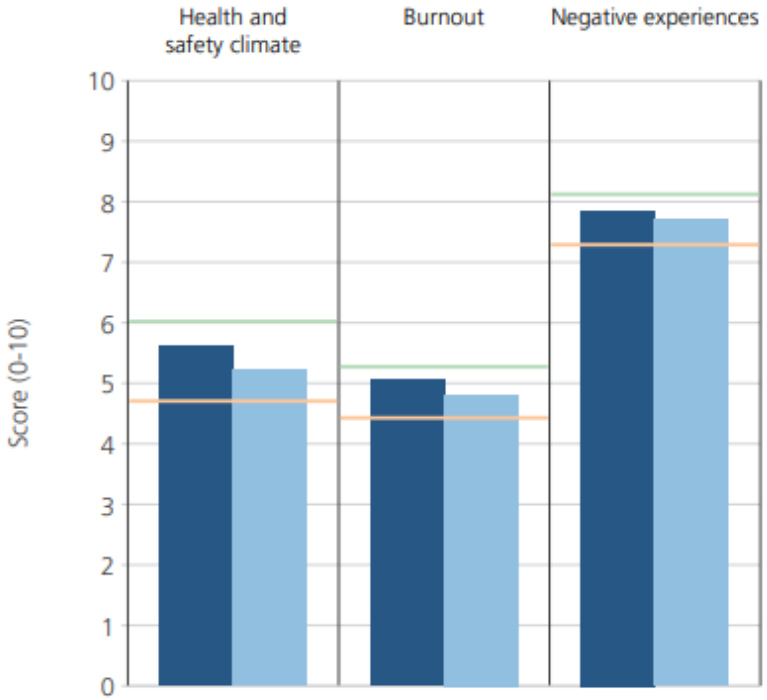
Burnout – Chief Exec Office, Community Paediatrics

Areas exhibiting less positive scores

Staffing & resources – Theatres, Midwifery

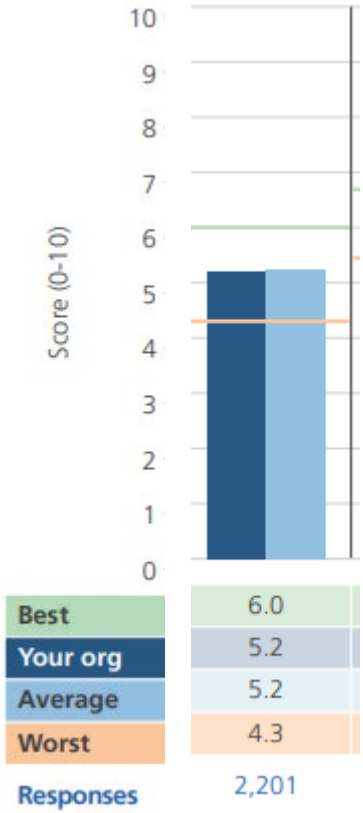
Burnout – Midwifery, Theatres, ICU

Sub- themes



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	5.6	5.1	7.9
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	2,380	2,372	2,361

We are always learning



Best	6.0
Your org	5.2
Average	5.2
Worst	4.3
Responses	2,201

Areas exhibiting most positive scores

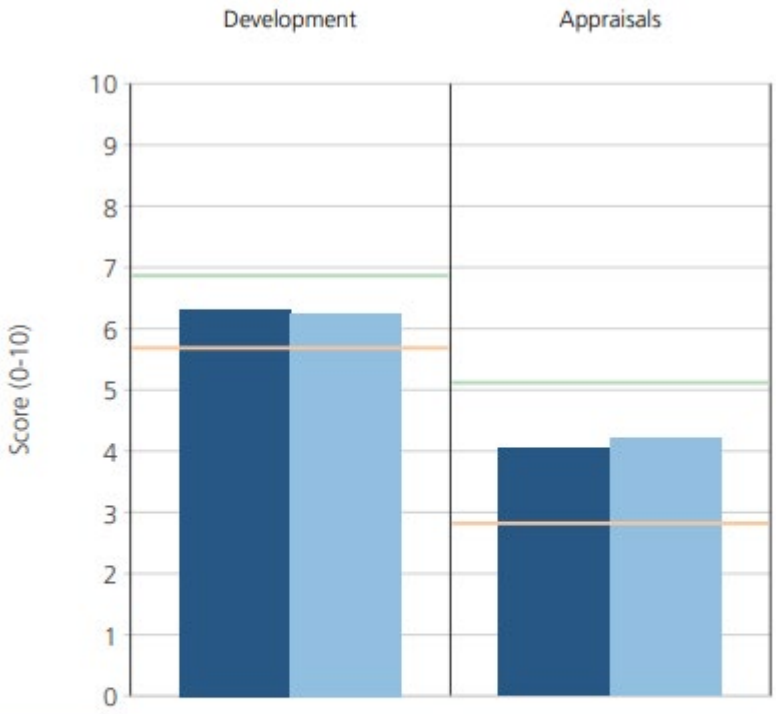
Development – Respiratory Medical, COE Medical

Appraisals – Community Paediatrics

Areas exhibiting less positive scores

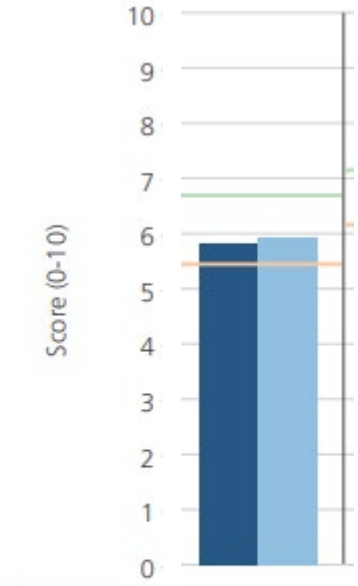
Appraisals – Medical Workforce

Sub- themes



	Development	Appraisals
Best	6.9	5.1
Your org	6.3	4.1
Average	6.3	4.2
Worst	5.7	2.8
Responses	2,364	2,211

We work flexibly



Best	6.7
Your org	5.8
Average	5.9
Worst	5.4
Responses	2,340

Areas exhibiting most positive scores

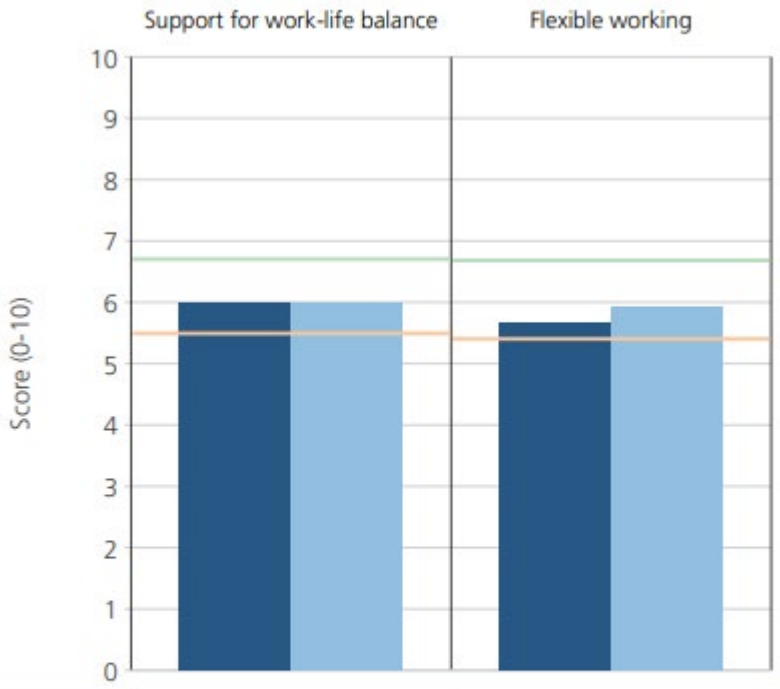
Support for work-life balance - Supplies

Flexible Working – Finance

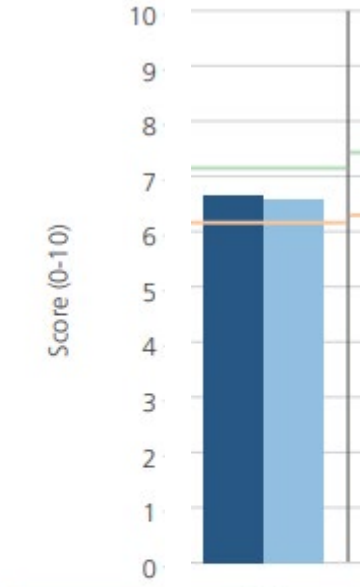
Areas exhibiting less positive scores

Flexible working - Southport Pathology, Midwifery, Theatres

Sub- themes



	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	6.0	5.7
Average	6.0	5.9
Worst	5.5	5.4
Responses	2,374	2,351



Best	7.1
Your org	6.7
Average	6.6
Worst	6.2
Responses	2,374

Areas exhibiting most positive scores

Team Working – Urology Nursing, Diabetes Nursing, B&P Medical

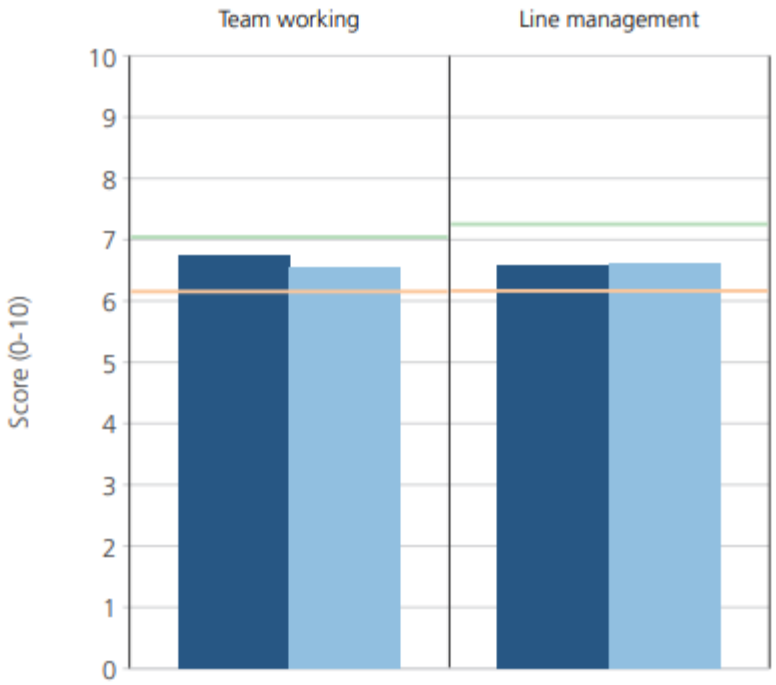
Line Management – Community Paediatrics

Areas exhibiting less positive scores

Team Working – Medirest, Midwifery, Pharmacy

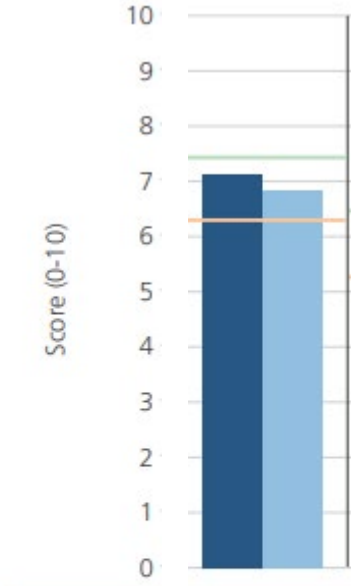
Line Management – Medirest, Theatres

Sub- themes



	Team working	Line management
Best	7.0	7.3
Your org	6.7	6.6
Average	6.5	6.6
Worst	6.2	6.2
Responses	2,374	2,384

Engagement



Best	7.4
Your org	7.1
Average	6.8
Worst	6.3
Responses	2,381

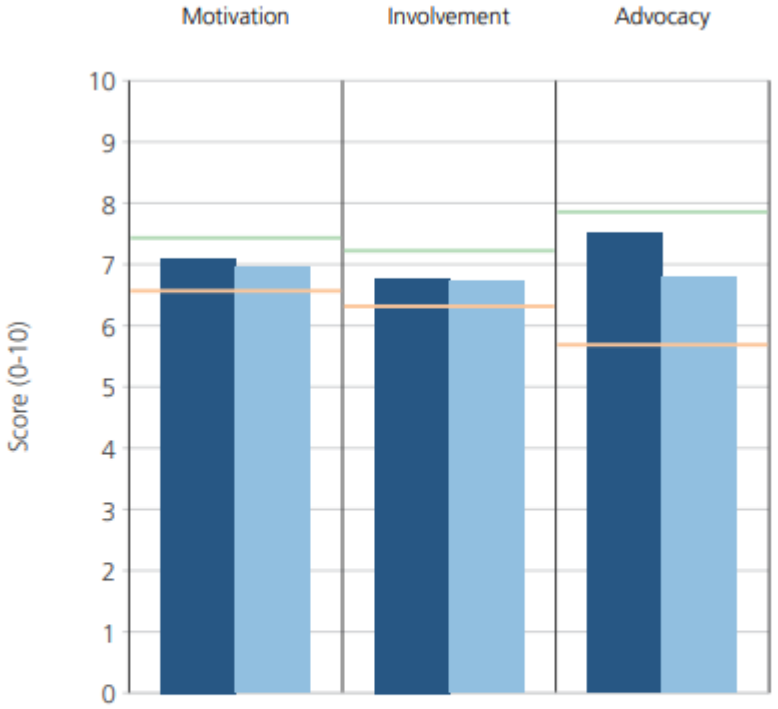
Areas exhibiting most positive scores

Motivation – Urology Nursing
Involvement – Chief Exec Office
Advocacy – Obs & Gynae Medical

Areas exhibiting less positive scores

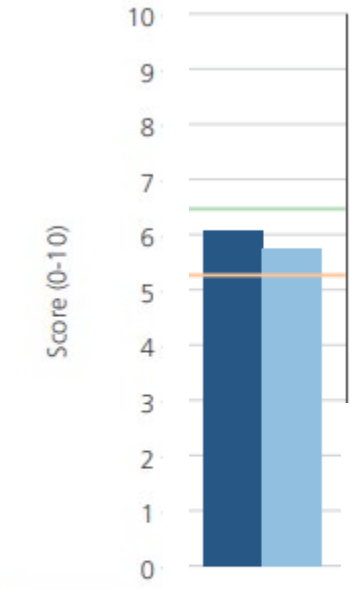
Motivation – Theatres, Midwifery
Involvement – Medirest, Biochemistry
Advocacy - Theatres

Sub- themes



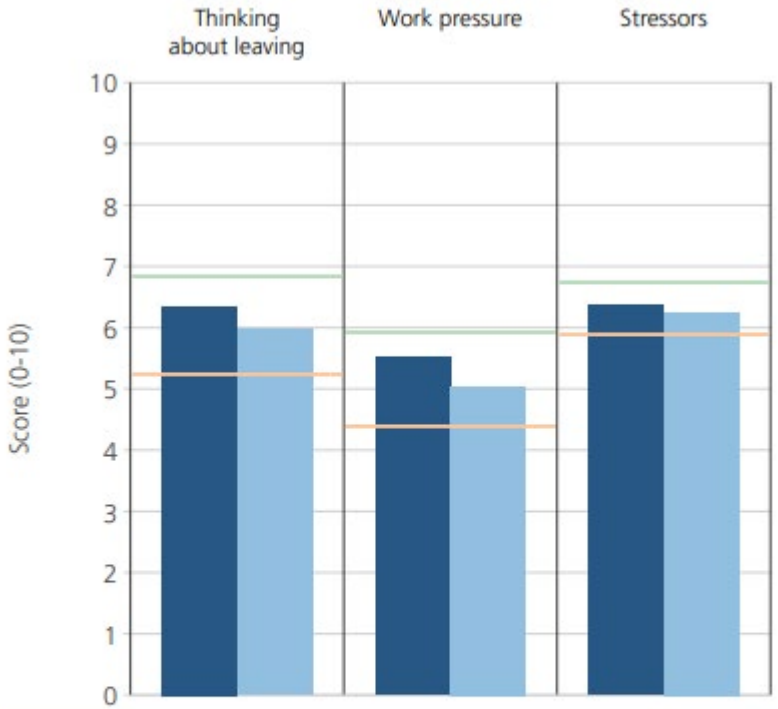
	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	7.1	6.8	7.5
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	2,349	2,380	2,367

Morale



Best	6.5
Your org	6.1
Average	5.7
Worst	5.3
Responses	2,383

Sub- themes



	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	6.3	5.5	6.4
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	2,372	2,377	2,369

Areas exhibiting most positive scores

Leaving – Supplies
Work Pressure – Diabetes Nursing
Stressors – Urology Nursing

Areas exhibiting less positive scores

Leaving – SCBU,ITU, HR Core Team
Staffing – Midwifery, St Helens Theatres
Encouragement from managers – ITU, Theatres, Midwifery, Pathology
Consultation on Changes - ITU, Theatres, Midwifery, Pathology

3 areas of focus for 2022 onward were identified from the 'deep dive' analysis;

1. **Corporate/ Strategic** – Addressing issues of safety including concerns raised over sufficient staffing, resources, acting on staff and patient feedback, visibility and engagement with staff

2. **Equality, Diversity & Inclusion** – Addressing concerns raised over discrimination, access to flexible working, career progression

3. **Service specific** – Delivery of focussed OD work with services/departments that have consistently flagged low scores across a range of themes/questions i.e. Maternity, Theatres, Medirest and ITU.

Next Steps

Action	By Whom	By When	Status/RAG/Comments
Publish and publicise survey results to staff • The management and full reports uploaded and available on the Intranet. • Launch Staff Survey dashboard to intranet • Summary of findings at Team Brief. • Copies to the local Staff Side representatives. • Circulation to the Valuing Our People Steering Group • Summary with links to full report on Global emails.	Assistant Director of Comms Assistant Director of OD	31/03/2022	Complete
Deep dive analysis of data	Assistant Director of OD	04/04/2022	Complete
Presentation of findings to: • Workforce Council • Strategic People Committee • Trust Board.	Assistant Director of OD	30/04/2022	In progress
1-2-1 meetings with senior leadership teams of each Care group/ Directorate to discuss the results relative to their staff/teams in a presentation form, to enable easy sharing with the whole directorate. Incorporating E&D data and identifying actions to be taken at a directorate/care group level.	Assistant Director of OD	20/05/2022	In progress
1-2-1 meeting with Maternity senior leadership team to establish initial actions	Assistant Director of OD	20/05/2022	In progress
1-2-1 meeting with Theatres senior leadership team to establish initial actions	Assistant Director of OD	03/05/2022	In progress
1-2-1 meeting with ICU senior leadership team to establish initial actions	Assistant Director of OD	20/05/2022	In progress
1-2-1 meeting with Medirest senior leadership team to establish initial actions	Assistant Director of OD	20/05/2022	In progress
Re establishment of 'Quality Ward Rounds'	Deputy Director of Nursing	31/05/2022	
Re establishment of face to face 'Teams Talks' to include additional members of the executive team. Frequency Bi monthly	Assistant Director of OD	31/05/2022	In progress
Open presentation of results to Trust by Quality Health	Assistant Director of OD	31/05/2022	In progress

Action	By Whom	By When	Status/RAG/Comments
Launch of ED&I training programme for managers to include understanding discrimination and reasonable adjustments	Deputy Director of HR	31/05/2022	
Review current recruitment and retention schemes to identify opportunities for expansion where appropriate.	Assistant Director of Workforce Development & Resourcing	31/05/2022	In progress
Review current ways to increase profile of senior managers and visibility to staff across the organisation	Assistant Director of Comms	30/06/2022	
Establishment of support programme for managers on the introduction and availability of flexible working options	Deputy Director of HR	30/06/2022	
Targeted focus groups facilitated by L&OD for each of Maternity, Theatres, Medirest and ICU to validate staff feedback and determine specific actions	Assistant Director of OD	31/05/2022	
Focus Group Feedback to Care group/ Directorate - Focus group themes, findings and action plan will be fed back to the DM/CD	Assistant Director of OD	30/06/2022	
Care Groups/ Directorates to agree and submit action plans to HR/L&OD Staff Engagement. Standardised templates will be used.	All ADOs and DMs	30/06/2022	
Review of processes to allow staff and patient feedback plus mechanisms to feedback on actions to staff particularly in relation to areas with low scores	Deputy Director of Nursing	31/05/2022	
Relaunch and promote Trust values aligned behaviours	Assistant Director of OD	30/06/2022	
Publication of full action plan	Assistant Director of OD	30/06/2022	
Establishment of a periodic programme of focus groups to provide a ‘temperature check’ and early indicator of potential issues.	Assistant Director of OD	30/06/2022	