St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 25th MAY 2022
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
10.00	1.	Employee of the Month Film - May 2022		Verbal	Assurance	Chair
10.15	2.	Patient Story		Film	Assurance	Sue Redfern
10.30	3.	Apologies for Absence		Verbal	Assurance	Chair
10.35	4.	Declaration of Interests		Verbal		
10.40	5.	Minutes of the Board Meeting held on 27th April 2022		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.50	6.	Integrated Performance Report		NHST(22) 036	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
		6.5	Informatics			Christine Walters
Committee Assurance Reports						
11.15	7.	Committee Report – Executive		NHST (22) 037	Assurance	Ann Marr
11.25	8.	Committee Report – Quality		NHST (22) 038	Assurance	Rani Thind
11.35	9.	Committee Report – Finance & Performance		NHST (22) 039	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.45	10.	Aggregated Incidents, Complaints and Claims Report	NHST (22) 040	Assurance	Sue Redfern
11.55	11.	Approval of the 2021/22 Quality Account	NHST (22) 041	Approval	Sue Redfern
12.05	12.	2021/22 Trust objectives - review	NHST (22) 042	Assurance	Ann Marr
12.15	13.	Ockenden 2 – self assessment	NHST (22) 043	Assurance	Sue Redfern
Closing Business					
12.30	14.	Effectiveness of Meeting	Verbal	Assurance	Chair
	15.	Any Other Business		Information	
	16.	Date of Next Meeting – Wednesday 29th June 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 27th April 2022 via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chair
Members:	Ms A Marr	(AM)	Chief Executive
	Mr J Kozer	(JK)	Non-Executive Director
	Dr R Thind	(RT)	Associate Non-Executive Director
	Mrs L Knight	(LK)	Associate Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters	(CW)	Director of Informatics
	Prof R Pritchard-Jones	(RPJ)	Medical Director
	Mr G Lawrence	(GL)	Director of Finance and Information
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr G Appleton	(GA)	Board Adviser
	Mr A Sharples	(AS)	Board Adviser
In Attendance:	Mr R Purewal	(RP)	Director – Healthcare (Observer)
	Mrs K Pryde	(KP)	Directorate PA (minute taker)
Apologies:	Mr P Growney	(PG)	Non-Executive Director
	Mr R Cooper	(RC)	Director of Operations and Performance

1. **Employee of the Month (EoTM) Award**

1.1. Employee of the Month for April was Sam Langley, Practice Nurse Development Lead.

1.2. Board members watched a video where RC presented the award to SL.

2. **Apologies for Absence/Welcome and Introductions**

2.1. As noted above. RF advised that PG was missing the Board meeting due to attending his MBA graduation ceremony. RC had sent apologies as a result of the Trust declaring an OPEL 4 critical incident, as a result of increased ED attendances and bed occupancy levels.

2.2. RF also welcomed GL to his first Board meeting as the Director of Finance and Information.

3. **Declarations of Interest**

3.1. No new declarations were made.

4. **Minutes of the Board meeting held on 30th March 2022**

4.1. The minutes were approved with the following amendment.
4.1.1. Para 10.4 should have read £5m rather than £11.1m.

4.2. There were no matters arising.

4.3. Actions were discussed. It was agreed to close action 36 recognising that the CCGs would cease to exist at the end of June.

5. **Integrated Performance Report – NHST(22)027**

5.1. **Quality Indicators**

5.1.1. SR presented the report.
5.1.2. There had been no Never Events in March 2022 and in 2021/22 there had been one.
5.1.3. No MRSA in March 2022 and 2 during 2021/22.
5.1.4. There were 2 C.Diff positive cases reported in March 2022 (1 hospital onset and 1 community). For 2021/22 there had been 32 cases (20 hospital onset and 12 community onset). 22 further cases have been successfully appealed. The 2021/22 annual tolerance for CDI was 54.
5.1.5. The overall registered nurse/midwife Safer Staffing fill rate for March 2022 was 91.5%. 2021/22 average rate was 92.1%.
5.1.6. There were no falls in February resulting in severe harm. There had been 19 YTD.
5.1.7. There were no validated Grade 3 hospital acquired pressure ulcers with lapse in care in February 2022. There have been 2 validated incidents YTD.

5.1.8. Community services reported a total of 76 incidents in February; 6 were low harm, with no moderate harm reported and the remainder were no harm.

5.1.9. VTE reporting remains suspended nationally.

5.2 **Operational Indicators**

5.2.1 GL presented the report in the absence of RC.

5.2.2 The 62-day cancer 85% standard was achieved in February at 85.4% YTD 85.1%. The 31-day target of 96% was achieved in February with performance of 98.5%. The 2-week rule target of 93% was not achieved in February with performance of 79.1%, this was as a result of a significant increase in referrals.

5.2.3 ED 4-hour access performance for March was 72.9% and YTD 77.1% (all types mapped). The Trust saw a 6% daily increase in attendances during March compared to February with 337 attendances as the daily average. Ambulance turnaround was not achieved with an average handover time of 70 minutes. There had been 2,249 ambulance conveyances which was the most of any Trust in Cheshire and Merseyside.

5.2.4 The average daily number of super stranded patients in March 2022 was 125, compared with 138 in February. This excludes Duffy and Newton Intermediate Care.

5.2.5 The 18-week referral to treatment target (RTT) was not achieved in February with 68.6% compliance and YTD 68.6% (target 92%). The six-week diagnostic was not met in February with 87.3% compliance against the 99% target. There were 1,426 patients who had been on the waiting list for over 52 weeks.

5.2.6 AM informed the Board that over the weekend, ambulance turnround times had increased to over 2 hours. This was a direct result of the number of attendances and extremely high bed occupancy which meant that patients could not be moved from the ED. The previous day a major incident had been declared as result of the pressures the Trust was under. This had resulted in a system response to try and alleviate the immediate pressures. However, short, medium and longer-term solutions were required, and the Trust was working with partners to review all options. AM felt that there needed to be more community options for patients who need care but no longer require medical intervention, so they do not block hospital beds.

5.2.7 RF reflected on a recent regional Chairs where an initiative at Lancashire Teaching Hospital to release ambulances in 15 minutes had been promoted. RF agreed that to be safe for all patients at every stage of their NHS care, there needed to be more bed capacity to respond to the increases in demand and complexity.

5.2.8 RPJ reported that he was working with NWAS to identify ways to improve handover protocols so that everyone was proactive, and crews could be released as quickly as possible.

5.2.9 GA felt that capacity in domiciliary care was a concern and that if the Trust could work with care homes to utilise capacity that was currently not open or utilised this might provide an economically viable solution for the system.

5.2.10 GB asked if there was any indication that the increase in urgent cancer referrals was going to plateau. RPJ responded that there is a genuine increase in the number of patients who are found to have cancer, but there is also evidence that GP behaviour has changed, and they have a different threshold for making 2-week urgent referrals because of the increased waiting times via other routes. A deep dive into the changes is being undertaken by the Business Intelligence Team to give the executive a better understanding of how much of the increase is driven by demand and how much is changes in behaviour. This would examine the issue at PCN and practice level.

5.2.11 IC was concerned that Head & Neck and Gynae cancer performance had not improved. He understood that there were the most complex pathways involving several different Trusts but was concerned that despite there being a Cheshire and Merseyside Cancer Alliance improvement plan, this did not appear to have yet had any impact. AM responded that there were entrenched issues with these pathways and disappointingly they remained dysfunctional. Thankfully this was only a very small number of patients. RT confirmed that a deep dive had been undertaken at the request of the Quality Committee, which had confirmed that all patients were individually tracked but the delays were often that the MDTs did not meet every week or that the condition was complex e.g. there were multiple lesions.

5.2.12 AS asked what steps the Trust was planning to alleviate the operational pressures, recognising that there were; political, financial, practical (finding accommodation and staffing it) issues to be addressed. AM responded that some opportunities had already been identified to provide additional beds in the community (care home settings) and these were being pursued with partner. The critical issue was to be able to recruit and retain staff. Other plans to reconfigure internally to create more bed capacity were also being developed, but these were longer term options requiring capital investment.

5.2.13 GB asked what would change on the 1st April that would make a difference to the e-discharge performance. This was mentioned in the commentary, but the significance was not clear. RPJ clarified that the new e-discharge system would be operational from 1st April meaning that in ED the discharge summary would only need to be completed once. Already this had made a difference and performance had increased to 83% in the first few weeks of April.

5.3 **Financial Indicators**

5.3.1 GL presented the report.
5.3.2 The trust was now expecting to finish the year with a small operating surplus, but this would be confirmed once the audited accounts were posted.
5.3.3 The 2021/22 system required CIP target of £10m has been achieved recurrently.
5.3.4 At the end of Month 12, the cash balance was £51.2m.
5.3.5 Capital expenditure 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.
5.3.6 RF commented that the regional position was also that the system would break even for 2021/22. There were however, expected to be increased financial challenges in 2022/23.

5.4 **Workforce Indicators**

5.4.1 AMS presented the report.
5.4.2 AMS commented that the operational performance and pressures were reflected in the key workforce metrics
5.4.3 In March 2022, all staff sickness was 7.16%, this includes normal sickness and COVID sickness reasons only. These figures do not include COVID absence reasons for staff who had to self-isolate.
5.4.4 Appraisal compliance is at 65.88%. Staff are still under pressure. There is additional training for line managers to support the quality of appraisals so that it is a positive experience for staff.
5.4.5 Mandatory training compliance in March was 74.72%. Clinical staff are having to prioritise patient care over training.
5.4.6 AMS confirmed that the Executive Committee receives a detailed report on compliance each month and is working with their areas of responsibility to create an improvement trajectory.
5.4.7 LK asked if wellbeing conversations are part of the appraisal process, and AMS confirmed that it was and that where appraisals could not go-ahead managers were being encouraged to continue to have these wellbeing conversations with staff.
5.4.8 GB asked what was being done to support the staff in ED, who were working under sustained and extreme pressure. AMS responded that there is a cohesive team in ED with good support for one another. In additional there is food and treats available for staff which are re-stocked regularly. SR acknowledged that the staff were tired and there had been some challenges but overall, the team had coped very well with such sustained pressure.
5.4.9 JK asked about staff turnover. AMS reported that overall, this remains stable, which is an indicator that staff are recognising the Trust is doing all it can to manage the pressures. There are, however, some hot

spots where turnover rates have increased, and these are receiving additional support from the HR and OD teams to understand and respond to the underlying causes.

5.4.10 AM confirmed that any NEDs who were not yet 85% compliant with their mandatory training had been contacted as a reminder.

5.4.11 The IPR was noted.

6 Committee Report (Executive) – NHST(22)028

6.2 AM presented the report and highlighted key issues of note.

6.3 There had been three investment decisions approved in February:

- Medical equipment tracking business case.
- 2022/23 indicative IT capital programme.
- Extensions to selected Winter Plan capacity schemes into Q1 of 2022/23

6.4 Proposals were presented to the committee 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 had been seen a crucial and this had subsequently been discussed at both ICS and regional level. The proposals and communication plans were agreed. AM reported that following discussion with the CMAST Chief Executives only one acute Trust was not re-introducing staff car parking charges.

6.5 The committee had reviewed the progress in delivering the essential and immediate actions form the first Ockenden Report.

6.6 The Executive had reviewed mandatory training compliance in detail and identified staff groups who would not be as impacted by the operational pressures on urgent and urgent care and could be targeted for improvement.

6.7 The initial review of the winter incentive pay scheme had found that it had increased the number of bank hours, but further analysis was required to determine if this was additionality.

6.8 In relation to item 4.5 IC confirmed that he was keen to be a NED tester for the new IPR.

6.9 AMS confirmed that in relation to item 2.1 S&O had one contract that was impacted by the NHSE guidance.

6.10 The report was noted.

7 Committee Report (Quality) – NHST(22)029

7.2 RT presented the report.

7.3 There were three actions which had been discussed, two of which related to cancer performance and had been discussed earlier in the meeting.

7.4 The Quality Committee had identified increased DNA rates as an issue of concern from the IPR, and a report had been requested on the actions being taken to address this.

7.5 Assurance had been provided that all 4th and 5th degree tears occurring during labour were subject to a full investigation and review of the care provided. There was also assurance that the Trust is not an outlier when this indicator was benchmarked.

7.6 The Patient Experience and Inclusion Strategy had been revised by the Patient Experience Council and was approved by committee.

7.7 The quarter 4 complaints report had shown that the number of first stage complaints had reduced in the period, but there had been an increase in 2nd stage complaints.

7.8 The Patient Safety Council had reviewed and revised its Terms of Reference as part of the annual effectiveness review, and these were approved.

7.9 The Q4 Safeguarding reports had provided excellent assurance and highlighted two issues; staff training compliance and timescales for completing health assessments for looked after children. It was reported that the Paediatric service had now secured additional capacity to try and reduce these timescales.

7.10 The Quality committee had also discussed the one year on Ockenden progress report and it was reported that the Trust was compliant with 11 or the 12 initial actions and progress was being made in relation to the final action which related to the number of consultant ward rounds.

7.11 The report was noted.

8 Committee Report (Finance & Performance) – NHST(22)030

8.2 JK presented the report.

8.3 The committee had noted cancer and ED performance as areas of concern from the IPR.

8.4 The month 12 finance report had been received.

8.5 The committee had also reviewed the draft 2022/23 financial plan and the improved position compared to the March reports as a result of securing additional income. It had been noted that discussions with the ICS were continuing.

8.6 Committee noted that £23m of potential CIP schemes had been identified for 2022/23.

8.7 The committee workplan for the year had been reviewed.

8.8 There were no risks or items to be escalated to Board.

8.9 The report was noted.

9 Committee Report (Audit) – NHST(22)031

9.2 IC presented the report.

9.3 IC noted that it had been a very successful meeting with high levels of assurance received.
9.4 The committee had been pleased to note the progress being made in delivering the internal audit plan and agreed management actions.
9.5 The Head of Internal Audit opinion for 2021/22 was substantial assurance.
9.6 The Anti-Fraud Services 2021/22 Annual Report was rated as green against the Government functional standards for counter fraud.
9.7 The committee approved the internal audit plan for 2022/23 and the anti-fraud plan for 2022/23
9.8 The committee approved the external audit plan and audit fee for 2022/23.
9.9 The Board noted the report.

10 Corporate Risk Register (CRR) – NHST(22)032

10.2 NB presented the report.
10.3 NB reported that the trusts risk management process had been reviewed as part of the internal audit programme and had received substantial assurance.
10.4 The paper provided a quarterly overview of the CRR and the full trust risk register to provide assurance that the Trust was operating an effective risk management process. There continued to be a high number of risks escalated to the CRR which reflected the operational pressures the trust was experiencing, with most risks relating to the potential impact on patient care.
10.5 The report was noted.

11 Board Assurance Framework (BAF) – NHST(22)033

11.2 NB presented the report.
11.3 The paper detailed the proposed changes to the BAF since the last quarterly review in January 2022.
11.4 In January the Board had requested that the score of strategic risk 1 be reviewed. This had been done but as a result of the operational pressures the executive recommended that the score should remain at 20.
11.5 The executive had also considered if the score of strategic risk 2 should be increased as the financial plan approved by the Board would mean the trust was likely to breach the break-even duty during 2022/23. However, as discussions about the financial plan were ongoing with the ICS the recommendation was for this risk score to remain at 16 and be reviewed again in July when the final plan would be known.
11.6 GB asked if there were plans for Quality Ward Rounds to be reinstated now that many of the COVID-19 restrictions had been relaxed. SR confirmed that a proposal for re-starting the Quality Ward Rounds was being developed and would be brought to the Quality Committee. **ACTION: SR**
11.7 GB commented that she felt risk 5 should include more detail about the agreement for long term collaboration with S&O.

11.8 The changes to the BAF were approved.

12 Learning from Deaths – NHST(22)034

12.2 RPJ presented the report, which covered the period July – December 2021.
12.3 In the period a total of 245 reviews had been requested and 133 completed today. The results of the completed reviews were summarised and showed there were no concerns in 92% of the completed reviews and 4(n) which had been referred for further investigation.
12.4 Operational pressures were impacting on the capacity to complete the expected number of reviews but it was hoped that this backlog would be cleared by the end of the next quarter. The CRAB system is also now being used to identify patients with risk triggers as an additional check that the right patient notes are being reviewed.
12.5 The key learning points were in relation to checking alerts in the patient electronic record and taking great care in communicating messages to families/carers. RPJ noted that there had been fewer issues relating to DNACPR decisions which provided assurance that previous learning points had made an impact.
12.6 GB commended the medical management team on the report, which was concise but provided significant assurance.
12.7 RT asked if post operative deaths are reviewed and RPJ confirmed that this was the case as part of the learning from deaths process and via a number of other national audits.
12.8 The report was noted

13 2021 Staff Survey Report and Trust Action Plan – NHST(22)035

13.2 AMS presented the result of the 2021 staff survey.
13.3 The 2021 survey was conducted in October and November 2021and the national results had been published on 30th March 2022.
13.4 280 NHS organisations in England took part in the NHS Staff Survey. Over 500,000 staff responses were received.
13.5 The Trust response rate was 37% (2,500 staff). The highest response rate had been for corporate services. This was the first year that the Trust had surveyed every member of staff instead of a representative sample. The results provided more data and allowed this to be analysed in more detail than had previously been possible. An interactive dashboard had been developed for managers to help them understand the issues in their area and as a result develop targeted action plans.
13.6 There have been significant changes to the national survey since 2020 which made comparisons of performance more difficult; there were 38 new questions in 2021 and a further 8 had been modified. These questions are aligned to the 8 NHS people plan pillars and for 7 of the pillars the Trust performance was better than the national average for acute and community trusts.

13.7 The Trust results are in the top 20th centile of all acute and community hospitals.

13.8 AMS summarised the departments /services which had flagged as performing lower than the Trust average and were being followed up to identify the root cause of the concerns.

13.9 JK was concerned that Medirest staff were flagging in a number of the categories. AMS clarified that only Retention of Employment (ROE) Medirest staff had been included in the survey. NB confirmed that the Estates and FM team were working with the Medirest management locally and regionally to share the results and agree actions to improve staff engagement. It was acknowledged that some services provided by Medirest had been particularly hard hit by COVID and this had an impact on management and supervisor capacity as well as for the frontline staff. Staff turnover had also been very high as once furlough ended there were less onerous jobs in other parts of the economy that offered higher pay.

13.10 LK commented that she had attended a national Well-being guardian event and across the whole NHS the impact of the pandemic had been seen in the staff survey results.

13.11 GB commended AMS on an excellent presentation which set out the issues very clearly, identifying the departments/services where focused attention was needed.

13.12 IC reflected that the results were a cause for concern but he was assured by the level of analysis and obvious concern of the executive to understand the issues and support staff. However, the national picture was that NHS staff were sending a message about the impact of the pandemic.

13.13 RF summarised that the priority for the Board was to work with staff to do everything we could to make them feel happy and satisfied with their work at the Trust. He was assured that the Executive were committed to having this dialogue.

13.14 The Board noted the 2021 staff survey results and approved the proposed actions.

14 Effectiveness of Meeting

14.2 RF commented that he felt there had been good levels of engagement and participation at the meeting.

15 Any Other Business

15.2 RF reported that he had attended the Long Service awards the previous week and had been humbled by the number of staff receiving awards for 25 and 40 years working at the Trust.

15.3 The Trust staff had been awarded the Freedom of St Helens at the Lord Mayors dinner the previous week. RF and AM had been accompanied by staff who had received the EOTM award during the year.

16 Date of next meeting

16.2 The next meeting will take place on Wednesday 25th May 2022.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 25th MAY 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	Next Board Time Out
41	30.03.22 (6.2)	Provide additional information about category 2 ambulance performance	RC	Revised to 25.05.22
42	30.03.22 (7.5)	Include information about cancer survival rates in future reports on the impact of health inequalities	RC	TBC
43	27.04.22 (11.6)	Develop plans for the reinstatement of Quality Ward Rounds for consideration at Quality Committee.	SR	QC action

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)036
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no Never Events in April 2022. (YTD = 0).

There were no MRSA cases in April 2022. (YTD = 0).

There were 5 C.Difficile (CDI) positive cases reported in April 2022 (4 hospital onset and 1 community onset). (YTD = 5). The annual tolerance for CDI for 2022-23 has not yet been published (the 2021-22 limit is being used in the absence of publication of the 2022-23 objectives).

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 March 2022 there were 3 falls resulting in severe harm or death category . (YTD severe harm or above category falls = 22)

There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in March 2022. (YTD 2021-22 validated incidents = 2).

Community incidents reported in March increased to 120 compared to 76 incidents in February. 12 were low harm, with no moderate harm reported and the remainder were no harm.

Performance for VTE assessment suspended by NHSE since March 2020.

YTD HSMR (April - January) for 2021-22 is 98.1

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 22/23 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: 25th May 2022

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (March 2022) at 86.3%. YTD 85.1%. The 31 day target was achieved in March 2022 with 98.4% performance in month against a target of 96%, YTD 98.2%. The 2 week rule target was not achieved in March 2022 with 84.3% 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 April 2022 was 50.7% and YTD 50.7%. The all type mapped STHK Trust footprint performance for April 22 was 74.4% and YTD 74.4%**.** The Trust saw average daily attendances of 321, which is down compared to March, at 337. Total attendances for April 2022 was 9,627.

Total ambulance turnaround time was not achieved in April 2022 with 55 mins on average. There were 2,142 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,249 in March 22.

The UTC had 5,319 attendances in March 2022, which is an increase of 18% (938) compared to the previous month. Overall, 97% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in April 2022 was 135 compared with 125 in March. 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 March 2022 with 68.2% compliance and YTD 68.2% (Target 92%). Performance in February 2022 was 68.6%. There were (1461) 52+ week waiters. The 6 week diagnostic target was not achieved in March 22 with 84.9% compliance. (Target 99%). Performance in February 2022 was 87.3%.

There was a slight increase in District Nursing Service referrals in March; however, the levels are still within average range (597 in March in comparison with 532 in February). Caseload size is within normal range (1233 in March compared to 1230 in February). Community matron caseloads have decreased in the month of March to 95 compared to 111 in February. 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's final 22/23 plan gives a deficit of £24.5m. At Month 1 we are in line with plan at a £2.3m deficit.

Surplus/Deficit - At the end of Month 1, the Trust is reporting a deficit position of £2.3m, with £41.3m of income and £43.6m of expenditure year to date.

CIP - The Trust's CIP target for 22/23 is £18.5m. As at Month 1, low risk schemes either delivered or at finalisation stage total £12.6m in year and £3.2m recurrently.

Cash - At the end of M1, the cash balance was £56.5m.

Capital - Capital expenditure for the year to date [including PFI lifecycle maintenance] totals £0.6m. Internally generated depreciation exceeds the 2022/23 capex plan. The plan has been agreed at ICS/ICB level, and includes PDC funding (£15.1m) which is not fully signed off nor drawn down from DHSC.

Human Resources

In April 2022, all staff sickness was 6.7% which was a reduction from March (7.1%). All Nursing & Midwifery ward areas was 9.0% which is an increase of 0.2% from March. N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include COVID absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.

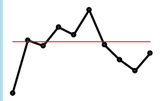
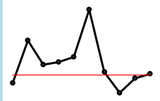
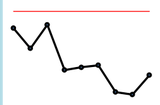
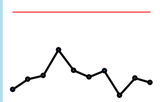
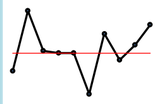
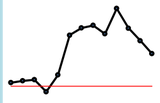
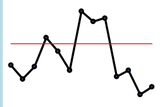
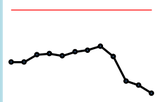
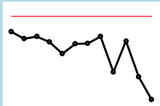
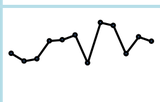
Mandatory Training Compliance continues to improves but remains below the target at 75.7%. The Appraisal compliance has reduced in month and is at 61.1%.

The following key applies to the Integrated Performance Report:

▲ = 2022-23 Contract Indicator
▲£ = 2022-23 Contract Indicator with financial penalty
● = 2022-23 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Apr-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-22	2.6%	2.6%	No Target	2.6%		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	▲	Jan-22	97.0		100.0	98.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jan-22	100.6		100.0	105.5					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Dec-21	92.7		100.0	94.3		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	Jan-22	85.8		100.0	87.0		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. Increased discharges in recent months with improved integrations with system partners,	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jan-22	112.5		100.0	101.3					
% Medical Outliers	F&P	T	Apr-22	2.0%	2.0%	1.0%	2.1%		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	Apr-22	30.2%	30.2%	52.5%	46.8%		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	▲	Mar-22	65.3%		90.0%	74.3%		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. Audit confirms >90% urgent letters sent in 7 days.		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 82% (May 12th).	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Mar-22	24.6%		95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Mar-22	97.3%		95.0%	97.2%					

Apr-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q4	84.9%		83.0%	84.8%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement of required 80% of patients have spent 90% of their stay in the stroke unit	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲ £	Apr-22	0	0	0	1		No never events in April 2022	Quality and patient safety		SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20			98.9%			Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Apr-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	▲ £	Apr-22	0	0	0	2		There were no MRSA cases in April 2022. (YTD = 0).	Quality and patient safety		SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Apr-22	5	5	54	32		There were 5 positive C Diff samples in April 2022. YTD = 5. The annual tolerance for CDI for 2022-23 has not yet been published (the 2021-22 limit is being used in the absence of publication of the 2022-23 objectives).		The annual tolerance for CDI for 2021-22 has been set at 54. Improvement actions in place and completed based upon RCA .	
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Apr-22	2	2	No Target	49		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Mar-22	0		No Contract target	2		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	▲	Mar-22	3		No Contract target	22		3 falls resulting in severe harm category or death in March 2022. (Ward 1B, 3C and Other area)	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Feb-20			95.0%			**March 20 to April 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		No Target	40					
To achieve and maintain CQC registration	Q		Apr-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%		No Target	92.1%		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		No Target	30					

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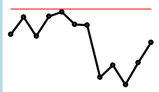
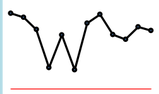
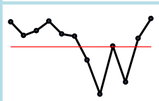
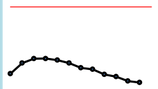
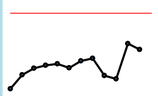
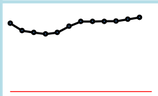
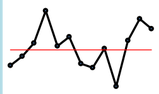
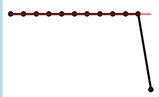
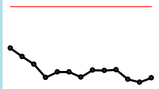
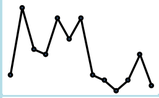
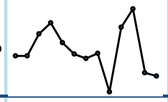
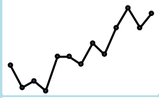
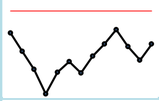
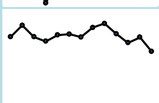
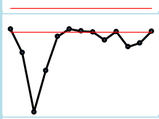
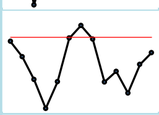
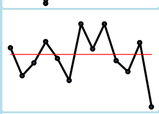
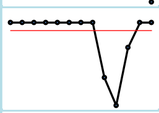
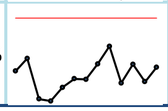
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Mar-22	84.3%		93.0%	84.6%		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	▲ £	Mar-22	98.4%		96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Mar-22	86.3%		85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Mar-22	68.2%		92.0%	68.2%		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	▲	Mar-22	84.9%		99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Mar-22	1,461		0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-22	1.0%	1.0%	0.8%	0.82%		Underperformance in cancelled ops has been due to staff sickness/absence and medical NEL pressures. 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	▲ £	Mar-22	98.1%		100.0%	99.8%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0						
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-22	50.7%	50.7%	95.0%	55.8%		Accident and Emergency Type 1 performance for April 2022 was 50.7% and YTD 50.7%. The all type mapped STHK Trust footprint performance for April 22 was 74.4% and YTD 74.4%. The Trust saw average daily attendances of 321, which is down compared to March, at 337. Total attendances for April 2022 was 9,627. Total ambulance turnaround time was not achieved in April 2022 with 55 mins on average. There were 2,142 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,249 in March 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	▲	Apr-22	74.4%	74.4%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Apr-22	0	0	0	0					

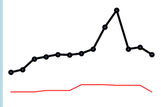
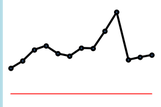
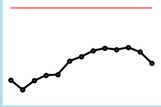
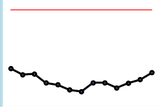
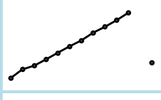
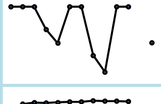
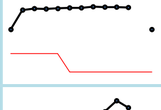
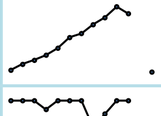
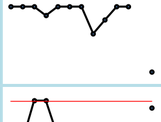
Apr-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Apr-22	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Apr-22	15	15	No Target	254		% new (Stage 1) complaints resolved within agreed timescales remains below the target, however more complaints are being closed than received, which is reducing the number of open 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	Apr-22	22	22	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Apr-22	68.2%	68.2%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to April 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	Apr-22	355	355		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Apr-22	135	135		108					
Friends and Family Test: % recommended - A&E	Q	▲	Apr-22	82.2%	82.2%	90.0%	79.0%		Recommendation rates are above target for inpatients, antenatal and postnatal community, but below target for the remaining areas. Recommendation rates for ED increased slightly in April.	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	▲	Apr-22	94.3%	94.3%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Apr-22	98.6%	98.6%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Apr-22	95.6%	95.6%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Apr-22	86.7%	86.7%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Apr-22	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Apr-22	94.0%	94.0%	95.0%	93.8%					

Apr-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Apr-22	6.7%	6.7%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In April 2022, all staff sickness was 6.7% which was a reduction from March (7.1%). All Nursing & Midwifery ward areas was 9.0% which is an increase of 0.2% from March. N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include COVID absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.	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	Apr-22	9.0%	9.0%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-22	61.1%	61.1%	85.0%	65.9%		The Appraisal compliance has reduced by 4.8% since March and is at 61.1%. This is below the appraisal target by 23.9%. Mandatory training compliance continues to improve and has risen by 1.0%.Compliance is now 9.3% below the target of 85%.	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 staff on AFC, the annual appraisal window opened on 1st April. 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	Apr-22	75.7%	75.7%	85.0%	74.7%					
NHS National Quarterly Pulse Survey : % recommended Care	Q	▲	Q3 2021-22	79.4%					Staff Friends and Family test superseded by the Quarterly staff survey in Q3.	Staff engagement, recruitment and retention.	Results published on the 30th March 2022 as part of the National Staff survey. The actions associated with the responses to these 2 questions form a key component of the Staff Survey action pan for 2022. This action plan will be to be monitored through the Executive Committee and People Council.	AMS
NHS National Quarterly Pulse Survey : % recommended Work	Q	▲	Q3 2021-22	68.5%								
Staffing: Turnover rate	Q F&P UOR	T	Apr-22	1.0%	1.0%	No Target	14.0%		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	Apr-22	Discontinued	Discontinued	N/A				Delivery of Control Total		GL
Progress on delivery of CIP savings (000's)	F&P	T	Apr-22	3,516	3,516	18,520						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Apr-22	(2,286)	(2,286)	(24,470)						
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-22	21	21	10						
Capital spend £ YTD (000's)	F&P	T	Apr-22	600	600	26,100						
Financial forecast outturn & performance against plan	F&P	T	Apr-22	(24,470)	(24,470)	(24,470)						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-22	93.1%	93.1%	95.0%						

APPENDIX A

			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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	▲ £	97.4%	100.0%	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	100.0%	96.0%	85.0%		91.1%		
	Total > 62 days		0.5	0.0	1.0	1.0	1.0	0.0	0.5	0.5	0.0	1.0	1.0	0.0	0.0	6.0			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.5			0.0		
Lower GI	% Within 62 days	▲ £	87.5%	61.1%	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	86.7%	79.7%	85.0%		78.7%		
	Total > 62 days		1.0	3.5	3.5	0.0	1.0	2.5	0.0	3.0	4.0	3.0	2.0	1.0	1.0	24.5			22.0		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	1.5	1.0	0.0	0.0	0.0	4.0			6.0		
Upper GI	% Within 62 days	▲ £	66.7%	100.0%	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	36.4%	83.2%	85.0%		83.1%		
	Total > 62 days		3.5	0.0	0.0	0.0	1.0	3.0	1.0	0.0	0.0	1.0	0.0	0.0	3.5	9.5			11.5		
	Total > 104 days		0.5	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	3.0			4.0		
Urological	% Within 62 days	▲ £	79.2%	80.0%	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	93.9%	80.5%	85.0%		85.6%		
	Total > 62 days		2.5	2.0	2.0	4.5	1.5	4.5	2.0	1.0	3.5	0.5	8.5	1.5	1.0	32.5			21.0		
	Total > 104 days		0.5	0.0	0.0	0.0	0.0	0.5	2.0	0.0	0.5	0.5	0.0	0.5	0.0	4.0			6.0		
Head & Neck	% Within 62 days	▲ £	50.0%	0.0%	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	24.4%	85.0%		51.4%		
	Total > 62 days		1.0	1.0	3.0	1.0	2.0	1.0	1.0	2.0	0.5	2.0	0.0	1.0	1.0	15.5			9.0		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0			0.0		
Sarcoma	% Within 62 days	▲ £		100.0%	100.0%		100.0%									100.0%	85.0%		83.3%		
	Total > 62 days			0.0	0.0		0.0									0.0			1.0		
	Total > 104 days			0.0	0.0		0.0									0.0			0.0		
Gynaecological	% Within 62 days	▲ £	57.1%	83.3%	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	60.0%	67.3%	85.0%		66.3%		
	Total > 62 days		3.0	0.5	0.0	0.5	0.0	2.5	2.0	1.0	0.5	3.0	0.0	5.0	2.0	17.0			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	1.5	1.0	2.5			2.0		
Lung	% Within 62 days	▲ £	100.0%	100.0%	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	55.6%	77.2%	85.0%		83.9%		RC
	Total > 62 days		0.0	0.0	2.0	0.0	2.0	0.0	2.5	3.0	1.5	1.0	2.5	1.5	2.0	18.0			10.0		
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	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%	0.0%	60.5%	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	2.0	17.0			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	1.0	5.0			1.0		
Skin	% Within 62 days	▲ £	94.6%	92.9%	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	100.0%	93.3%	85.0%		93.6%		
	Total > 62 days		2.5	2.5	3.0	3.0	0.0	1.0	3.5	4.0	4.5	3.0	3.0	2.0	0.0	29.5			25.5		
	Total > 104 days		0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.5			3.0		
Unknown	% Within 62 days	▲ £	80.0%			50.0%		100.0%		100.0%	100.0%		100.0%	100.0%		88.2%	85.0%		92.3%		
	Total > 62 days		0.5			1.0		0.0		0.0	0.0		0.0	0.0		1.0			1.0		
	Total > 104 days		0.5			0.0		0.0		0.0	0.0		0.0	0.0		0.0			0.5		
All Tumour Sites	% Within 62 days	▲ £	86.4%	86.1%	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	86.3%	85.2%	85.0%		86.7%		
	Total > 62 days		15.5	12.5	14.5	16.0	13.5	14.5	12.5	14.5	15.5	15.5	17.0	12.0	12.5	170.5			137.5		
	Total > 104 days		3.0	2.0	1.0	1.0	4.0	3.0	2.5	1.5	2.0	1.5	0.5	2.0	3.0	24.0			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)037

Title of paper: Executive Committee Chair's Report

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

Summary:

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

There were three Executive Committee meetings held during this period due to the Easter break. The investment decisions made were:

1. Estates Strategy – approval to move to the next phase of the Whiston site development plan

2. Approval of the Patient Advice and Liaison (PALs) Business Case

3. Agreement to bid to retain the North West Lead Employer Contract

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.

Due to the cancellation of the meeting on 14th April the Risk Management Council and corporate risk register report and the Integrated Performance Report were circulated to committee members for information.

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: 25th May 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were three Executive Committee meetings in April 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. 7th April 2022

2.1 Estates Strategy – Site Development Plans

The Director of Corporate Services presented an update on the Estates Strategy and requests for approval to move some of the proposed schemes to the next stage of development. The Executive approved progressing to design and tender stage for the Whiston decontamination /endoscopy four storey extension scheme, and Whiston car park and drop off area improvements. Approval was also given to commence the design process for SDEC to be relocated to the current endoscopy department. It was noted that this would eventually release a 32-bed ward. The Executive also agreed to continue with the planning application for the 60-bed unit at the St Helens site, not going as far as to design stage at this time, pending a review of options for the location and scope of the elective surgery hub for North Mersey. The Committee also discussed the bed and flow pressures the Trust was experiencing and what could be done to alleviate these in the short term by working differently both internally and with system partners.

2.2 Trust Board agenda - April

The Director of Corporate Services presented the draft agendas for the planned Trust Board meetings for review and approval.

2.3 St Helens Festival

The Director of Integration presented a briefing on the St Helens Festival which was being arranged to celebrate the achievements of St Helens Cares. This was a five-day event (6th – 10th June) and awards were being made in a number of categories for which potential nominations from the Trust were identified. Several of the Executives had been asked to provide content for the event which was being held in person and online.

2.4 Workforce Disability Equality Scheme (WDES) – Innovation Projects

The Trust had received central funding to support projects that would improve the Trust's WDES ratings. The projects had four objectives; improve organisational policy, improve management competence in this area, improved information and resources for staff and an improved self-declaration rate. There were also plans to introduce an Adjustments Passport for staff. The Executive Committee endorsed the proposed objectives.

2.5 Urgent COVID Issues

The national testing protocols had been revised for both patients and staff and Gold Command had developed proposals for how these would be implemented, which were agreed.

The Committee also approved the recommendation to allow volunteers to return to ward areas, subject to vaccination status and completion of a COVID-19 risk assessment.

The nosocomial infection rate for the previous 7 days had been 9.2%. The changes to the testing protocol would mean that fewer hospital contacts would be detected in the future.

2.6 Southport and Ormskirk Hospitals NHST (S&O) update

The Deputy CEO/Director of HR reported that work was being undertaken to review the Shaping Care Together service option costs.

The Director of Informatics reported that she was working with the team at S&O to review the cyber security and network resilience risks as requested at the Strategy and Operations Committee.

3. 21st April 2022

3.1 Safer Staffing Report – Month 12

The Director of Nursing, Midwifery and Governance introduced the report. The overall RN/RM fill rate in March was 91.48% and the HCA overall fill rate was 106.7%. The report also contained a detailed analysis of staffing in months 10 and 11.

The Committee discussed the actions being taken to improve recruitment and retention and the listening events that had been undertaken with the Emergency Department, Theatres and with Matrons. The recent success of the latest group of international nurses in passing their OSCE tests was congratulated. The Committee discussed the opportunities for increasing international recruitment at a safe rate so that new staff could be appropriately supported and integrated into the workforce.

3.2 Patient Advice and Liaison (PALs) Business Case

The Director of Nursing, Midwifery and Governance presented the business case which sought approval to increase the size of the PALs team by 2 WTE staff to respond to the increased demand for PALs and increase the excellent work in resolving patients' and relatives' concerns as quickly as possible. The business case was approved.

3.3 Mandatory Training and Appraisal Compliance - March

The Deputy CEO/Director of HR presented the compliance rates which had not improved since February. Whilst acknowledging the pressures faced by many clinical and support staff responding to the emergency and urgent care pressures, it was felt that some other groups could be performing better, and it was agreed that these should be targeted.

3.4 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly review of the BAF, ahead of reporting to the April Trust Board.

3.5 North West Lead Employer Contract

The Deputy CEO/Director of HR briefed the Committee on the re-tendering of the North West Lead Employer contract that the Trust had provider since 2017. The Committee agreed that the Trust should bid to retain the contract and approved the draft bid which was to be submitted on 28th April.

3.6 Southport and Ormskirk NHS Trust update

The Deputy CEO/Director of HR provided feedback from the informal monthly meeting with NHSE and the ICS and the Shaping Care Together Programme Board. The S&O Executives were coordinating the re-introduction of car park charges with STHK, and this was planned to be effective in May. The Committee also discussed options to increase management support in specific areas to assist S&O.

4. 28th April 2022

4.1 Reference Costs

The Director of Finance and Information had been working with S&O to understand any differences in costing methodology and the impact this had on reference costs. There were some differences that had been found particularly in relation to the inclusion of zero day length of stay non-elective activity by S&O. This would be corrected for the 2021/22 submission which would result in an increase in the S&O reference costs.

4.2 Smoke Free

The Director of Nursing, Midwifery and Governance introduced the revised Trust policy and the proposals to implement the new tobacco dependency support programme for patients to fulfil the NHS Long Term Plan commitment to offer all patients support to stop smoking. Dedicated central funding had been allocated for 2 years to support the establishment of the service from Q3 of 2022/23. The policy and service proposals were approved.

4.3 Review of COVID Outcomes

The Director of Nursing, Midwifery and Governance presented a review of outcomes following nosocomial COVID-19 infections.

4.4 Ambulance Response Times

The Committee discussed the situation with ambulance delays and the impact on patient experience and safety. Many Trusts in Cheshire and Mersey were reporting bed occupancy of 99%. The CEO reflected that the situation was not sustainable. The recent UEC Getting it right First Time (GiRFT) meeting had concluded that the Trust had too few beds to meet demand. The Director of Corporate Services reported that the Trust had declared Opel level 4 due to the extreme pressures and outlined some of the system level responses

which had now begun to impact. The Committee reflected on what would be needed to achieve this level of response as business as usual.

4.5 Re-Introduction of Staff Car Park Charges

The Director of Corporate Services presented alternative proposals for the re-introduction of staff car parking charges that would reduce the costs for staff in the lowest pay bands. The cost to the Trust was acknowledged. It was agreed that a similar scheme would be introduced at S&O. The Committee recognised that any re-introduction would be unpopular but there was a national directive and the central funding for these costs had now ceased. The new charging scale would be re-introduced in May 2022.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)038
Reporting from: Quality Committee
Date of Committee Meeting: 17th May 2022
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery & Governance Rowan Pritchard-Jones, Medical Director Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance Debbie Stanway, Head of Nursing & Quality, Medical Care Group Stephen Beckett, Head of Quality, Clinical Support Services **In Attendance:** Peter Williams, Deputy Medical Director 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
Matters Discussed **Action log** All open actions reviewed and closed, noting the following in particular: • Increased engagement and ownership at Care Group level with infection prevention is having a positive effect on infection rates, with ongoing dissemination of information through the Clinical Directors forum and Matrons/Ward Managers' meetings, therefore the infection prevention summit has been put on hold • Improvements seen in specific mandatory training subjects • Presentation provided outlining the reasons patients do not attend (DNA) for appointments and the actions being taken to address these via the Outpatient Transformation Group, including patient initiated follow ups (PIFU) **Quality Account**

The Quality Account was reviewed, with discussion on the actions being taken to improve the percentage of patient deaths having palliative care coded

Integrated Performance Report (IPR) highlighted:

- No new Never Events or MRSA bacteraemia reported in April and no category 3 or 4 hospital acquired pressure ulcers reported in March
- 5 cases of C difficile and 3 falls resulting in severe harm reported in April
- Hospital Standardised Mortality Ratio (HSMR) was 98.1 (April 2021– January 2022)
- 62-day and 31-day targets were achieved in March and are above target year-to-date
- 2-week rule target was not achieved due to significant increase in referrals, but showed an improvement on the previous month
- Continued challenges in meeting emergency care access targets, however 97% of patients were seen and treated within 4 hours at the Urgent Treatment Centre, despite a significant increase in attendances. Ambulance turnaround times improved in April. There was an improved position in ED, with reduced congestion at the end of April, due to concerted actions taken system-wide in response to the Trust's escalation to Operational Pressures Escalation Level (OPEL) 4. Lessons learned as a result of this will be implemented ahead of the Jubilee bank holiday
- Average daily number of super stranded patients (length of stay over 21 days) increased to 135 in April compared to 125 in March
- 18-week referral to treatment and 6-week diagnostic targets were not achieved
- Slight increase in District Nursing referrals and decrease in Community Matron caseloads
- Decrease in sickness absence noted in April and the Committee sought assurance that the target is appropriate noting the current context of ongoing demands placed on staff. The Committee also noted the ongoing support provided to staff who are absent due to sickness

Clinical Effectiveness Council report

The Council received a detailed presentation from Radiology, which highlighted the actions being taken to meet demand and the improvements made in the previous year, including the provision of new equipment. The acute oncology ED fast track referral protocol and non-specific symptoms faster diagnostic pathway were approved, as well as the terms of reference for the Research, Development and Innovation Group. A number of reports were discussed including IPR, mortality, maternity indicators, CRAB data, Intensive Care national audit results and laboratory performance.

The following items were escalated to the Quality Committee: work to increase recruitment and retention within Radiology; slight delay in coding that could impact on HSMR/CRAB data; work to support cellular pathology reporting to meet demand and ensure urgent requests continue to be managed appropriately, noting the new equipment recently installed to increase productivity

NICE guidance compliance

The Committee received a detailed report for quarter 1&2 2021-22, noting high levels of compliance with COVID 19 rapid guidelines and the work being undertaken to ensure compliance with all applicable guidance.

Patient Safety Council report
A number of reports were received, including an update from the Patient Safety Team and a falls report which noted an overall reduction in total falls per 1000 bed days compared to last year, although rate of moderate/severe falls remains consistent with previous year. The Council received Infection Prevention and Safeguarding reports and received assurance that usage of controlled drugs was in line with other north west trusts. Each Care Group provided a detailed report and assurance of processes for sharing lessons learned from incidents. A number of procedures were approved. The Council noted the work ongoing to improve mandatory compliance training and security of controlled drugs.

The Falls Prevention Strategy was considered, with further amendments to be made prior to approval by the Quality Committee in June.

Quarter 4 Incidents, Never Events and Serious Incidents Thematic Review
The report noted that 22 new incidents had been reported to StEIS in the last quarter, with 16 reports submitted, all within the agreed timescales and 8 investigations were closed by the CCG. The majority of StEIS reported incidents related to falls or maternity diverts and the highest category of incidents related to pressure ulcers, including those that were not attributed to the Trust. The report noted a higher level of no harm and low harm incidents compared to national figures and a lower level of moderate and above harm incidents, indicating a positive safety culture. The report highlighted a number of actions identified as a result of StEIS incidents.

Ockenden 2
The Committee received a verbal update following a review of the 92 required actions, noting that there were seven red areas requiring a detailed plan to achieve the requirement. A full report will be provided to the Executive Committee in May and then the Quality Committee in June. The Committee were pleased to note the collaborative working taking place with Southport and Ormskirk Hospitals NHS Trust maternity service.

Patient Experience Council report
The Council noted the patient story, which featured a video outlining a patient's pre-operative experience, which will be widely shared across the Trust to reiterate the need for kind, compassionate care and effective communication. The Council reviewed a number of reports, including Patient Experience and Inclusion, noting the re-launch of the Patient Participation Group and the need to further improve patients' and carers' experience of discharge supported by the re-launch of the Discharge booklet. The Urgent and Emergency Care survey report highlighted that the Trust scored better than most trusts for three questions and about the same for the other questions, as well as the actions being taken to improve lower scoring areas. Improvements in attendance at the Nutritional Steering Group were noted following changes made as a result of the Group's effectiveness review. The Council requested further information on the reasons for lower levels of satisfaction within the Trauma and Orthopaedic Clinic at Whiston which will be reported to the next meeting.

National Cancer Patient Experience Survey
A detailed report was provided noting that the Trust had participated in the voluntary survey as one of 55 trusts. The Trust maintained an excellent overall score of 9.13

coming second nationally, with haematology scoring 10/10. Each area is reviewing the findings for their service and actions that are specific to them, however there are Trust-wide actions to further improve, which include ongoing support and resources for local teams to deliver a positive patient experience.

Assurance Provided:

- Patients who are on PIFU pathway are also tracked to ensure no patients who need to be seen are lost to follow up
- Quality Account noted to provide a good reflection on the work undertaken across the Trust in 2021-22
- Continued focus on the achievement of the cancer targets
- Dementia and Delirium Team continue to contact carers of patients flagged on Careflow as having dementia to provide an update on their care
- Results of the national Cancer Patient Experience Survey noted the Trust received the second best score of 9.13

Decisions Taken:

Approval of draft Quality Account prior to submission to the full Board

Approval of the Complaints and PALS Annual Report

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

- Clarification of rapid access chest pain clinic activity and 30 day elective readmissions noted in the IPR
- Presentation on new urgent care metrics
- Follow up on outstanding NICE guidance relating to cardiology and stroke
- Addition of supplementary care to the Falls Prevention Strategy
- Compliance with review of Datix incidents to be reported to Patient Safety Council

Matters for escalation:

- Continued challenge in meeting national targets

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: 25th May, 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)039

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 19th May 2022

Summary

Meeting attended by:

Jeff Kozer (Chair & NED)
Ian Clayton (NED)
Paul Growney (NED)
Gareth Lawrence (Director of Finance)
Rob Cooper (Director of Operations
Nicola Bunce (Director of Corporate Services
Rowan Pritchard Jones (Medical Director)
Clare Barrow (Deputy Director of Finance)
Alan Sharples (Board Advisor)
Peter Williams (Deputy Medical Director)
John McCabe (Divisional Director Surgery & CSS)

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was above the 85% target in March, at 86.3%.
- Target 31 day performance was met in March, at 98.4% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in March, at 84.3% delivery against a target of 93.0%, but an improvement against February performance of 79.1%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 50.7% in April 50.7% year to date. All type mapped STHK Trust footprint performance was 74.4% in April and 77.1% year to date. The Trust saw average daily attendances of 321, which is a decrease compared to March at 337. Total attendances for March were 9,627.
- The ambulance turnaround time target was not achieved in April, at 55 minutes on average (70 minutes March). The Trust was the busiest in C&M and third busiest across the North West.
- The UTC had 5,319 attendances in March 2022, which is an increase of 18% (938) compared to the previous month. Overall, 97%of patients were seen and treated within 4 hours.
- In March, overall sickness had slightly increased to 7.16%, from 7.00% in February.

B) Finance Report Month 1

- No formal M1 reporting required to regulator but usual set of management accounts produced for internal monitoring and assurance purposes.
- The Trust's final 22/23 plan gives a deficit of £24.5m. At Month 1 we are in line with plan at a £2.3m deficit.
- Surplus/Deficit - At the end of Month 1, the Trust is reporting a deficit position of £2.3m, with £41.3m of income and £43.6m of expenditure year to date.

- CIP - The Trust's CIP target for 22/23 is £18.5m. Godd progress has been made identifying opportunities.
- Cash - At the end of M1, the cash balance was £56.5m.
- Capital - Capital expenditure for the year to date [including PFI lifecycle maintenance] totals £0.6m.
- Financial plans will require resubmission in June'22 to include recently announced tariff changes which incorporates additional inflation for energy and PFI costs.

C) CIP

- The Trust has a CIP target of £18.5m for financial year 2022-23 which is to be delivered recurrently. As at month 1 low risk schemes either delivered or at finalisation stage total £12.6m in year and £3.2m recurrently. Work is on-going via the CIP council to identify further schemes for inclusion in the plan with positive engagement across the organistaion.

- The Medical Care Group presented the process for identification and delivery of CIP within the Care Group. The Careg Group has delivered £619k in savings as at Month 1 and has plans under development to deliver the £4.2m target by year end. The team demonstrated a strong ethos within the department for cost control and making the best use of resources without compromising the quality of patient care.

For Approval

D) Finance & Performance Committee 22/23 Workplan

- The proposed committee workplan for 22/23 was presented for approval. The updated work plan included previously suggested changes to:
- include regular updates on CIP progress from each of the care groups on a rotational basis.
- The workplan was approved by the committee.

E) Annual Meeting Effectiveness Review

- The Annual Meeting Effectiveness Report was deferred.

For Information

CIP 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: 25th May 2022

Trust Board

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(22)040

Title of paper: Incidents, Complaints, Concerns & Claims – Quarter 4

Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 4 2021-22

Summary

Incidents

- Total incidents reported in Q4 = 4330 (2.24% decrease on Q3 = 4424)
- Total patient incidents in Q4 = 3574 (4.79% decrease on Q3 = 3754)
- Total patient incidents graded as moderate/severe/death in Q4 = 38 (7.32% decrease on Q3 = 41)
- The highest number of incidents reported relate to:
    - Pressure ulcers = 753 (which include pressure ulcers acquired prior to admission to Trust services)
    - Patient slips, trips or falls = 593

Complaints

- 53 first stage complaints were received in Q4, 15.9% decrease from Q3
- Clinical treatment was the main reason for complaints, in line with previous quarters
- There was a continuing decrease in the number of open complaints
- The Trust closed 86 first stage complaints in Q4, including 45 in March 2022

Claims

- There were 43 claims in Q4, 13 fewer than Q3
- Pre-action claims (requests for records from solicitors) account for 39 of these, with 4 NHS Resolution (NHSR) instructed claims
- 10 pre-action claims converted to NHSR instructed claims in Q4
- 18 inquests were notified by the Coroner in Q4 compared to 13 in Q3, with 41 inquests files closed during that period

PALS

- 1279 contacts were received in Q4, which is a 2.16% increase from Q4 2020-21 and 9.23% increase from Q3 2021-22
- 96.47% of PALS enquiries were resolved in Q4 (3.53% conversation rate to complaints)
- Top 5 themes remain consistent with previous quarters, with a decrease in PALS enquiries relating to communication throughout 2021-22 compared to 2020-21

Corporate objectives met or risks addressed: Care and safety

Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 25th May 2022

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarter 4 2021-22, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

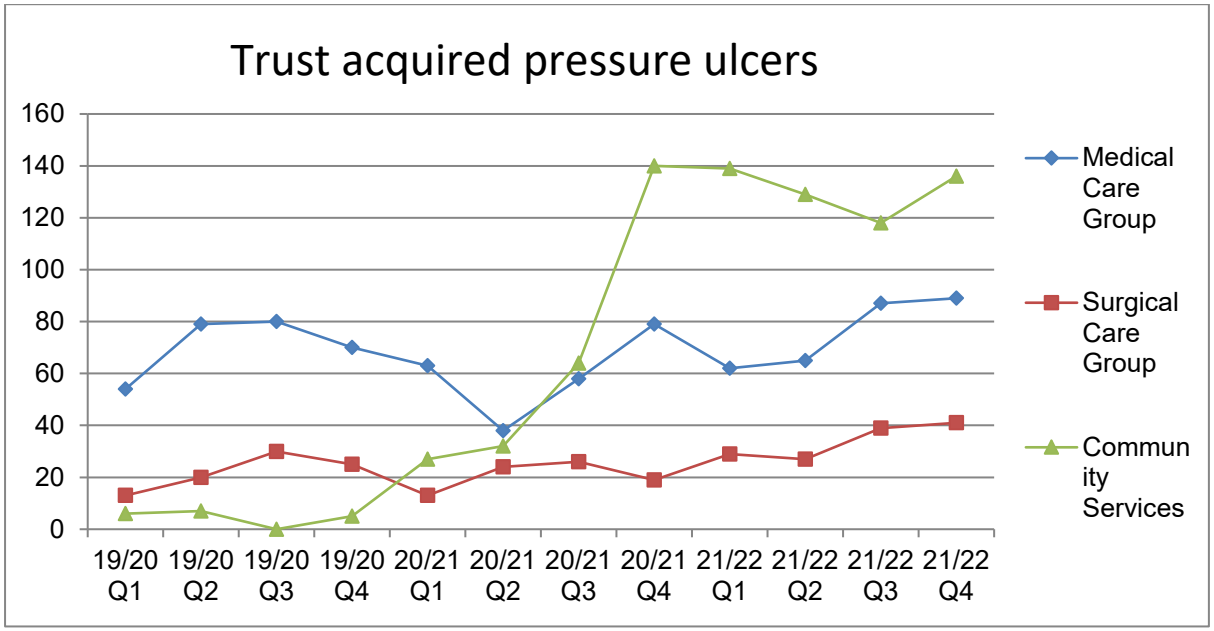
During Q4 there were 4330 incidents reported, of which 82.54% (3574) were patient safety incidents. This represents a decrease from Q3 2021-22 of 2.24% in all incidents and 4.79% decrease in patient incidents.

	21/22 Q4
Incidents affecting patients	3574
Incidents affecting staff	361
Incidents affecting the Trust or other organisation	352
Incidents affecting visitors, contractors or members of the public	43
Total	4330

Q4 had 22 incidents reported to StEIS, compared to 18 in Q3 2021-22. During Q4 there were 38 patient safety incidents categorised as moderate harm, severe harm or death whilst in Q3 there were 41 incidents reported. In comparison, there were 37 incidents categorised as moderate harm, severe harm or death in the same period last year (Q4 2020-21).

	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4
Moderate	16	17	27	31	23	31	27	25
Severe	11	12	13	3	8	5	10	13
Death	4	1	9	3	2	0	4	0

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories during Q4 were pressure ulcers (753), which includes all patients who are admitted with pre-existing pressure ulcers, and slips, trips and falls (593). These are consistently the highest reported incidents as in Q3 there were 785 pressure ulcers reported and 634 falls.

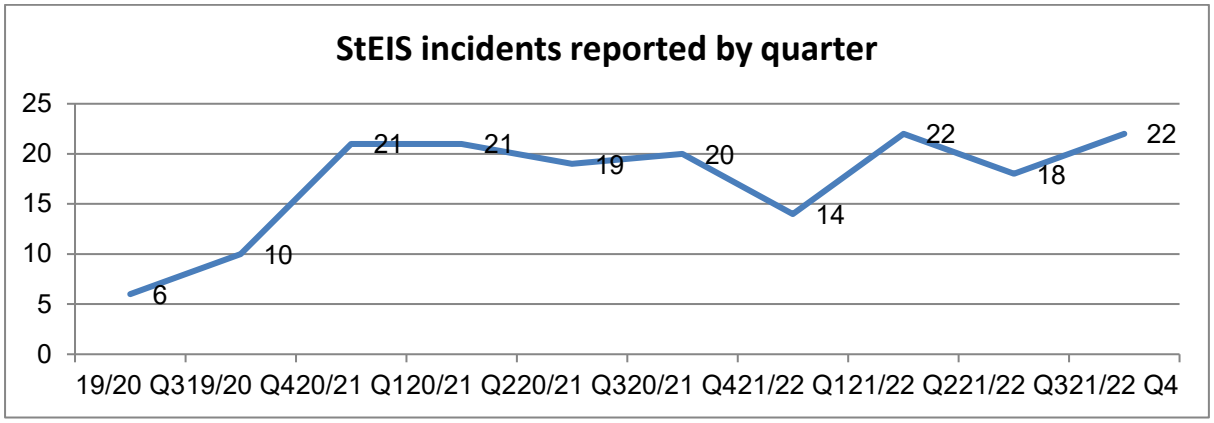


No severe harm Trust acquired pressure ulcers, with lapses in care were identified in Q4 2021-22.

STHK Acquired PU	2019/20				2020/21				2021/22			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
None	9	17	7	3	7	8	14	77	73	79	110	156
Low	58	85	97	95	92	86	134	158	156	133	116	92
Moderate	6	4	5	0	2	0	0	1	0	0	0	0
Severe	0	0	1	0	0	0	0	0	1	0	1	0
Ungraded to date	0	0	0	2	2	0	0	2	0	9	17	18
Total	73	106	110	100	103	94	148	238	230	221	244	266

2.1. Review of incidents reported to StEIS in Q4 2021-22

During Quarter 4 2021-22 the Trust had 22 incidents which were reported to StEIS. In comparison, the Trust reported 18 incidents during Q3 2021-22.



All 22 incidents reported to StEIS during Q4 are outlined in the table below.

Description	Total
Inpatient fall suffering fractured neck of femur	6
Maternity divert on service	4
Allegation of abuse	3
Baby cooling incident meeting Healthcare Safety Investigation Branch (HSIB) criteria	2
Unstageable \pressure Ulcer	1
Patient choked and required resuscitation	1
Press interest – Baby fall from pram	1
Press interest – Lead Employer	1
Central line inserted in artery instead of vein	1
Chemo induced cardiomyopathy	1
Coronary artery occlusion. Missed opportunities for 2nd trop T and ECG*	1

*Incident graded as death

During Q4 there were 19 StEIS reports submitted to the CCG, all of which were submitted within the agreed timeframe. Actions taken and lessons learned are shared both internally and with the CCG.

2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q4. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm incidents and Level 1 incidents are monitored within the Care Groups.

2.3. Benchmarking

The table below shows the most recent data (September 2021) provided by NHS England comparing patient safety incidents reported to the NRLS by the Trust to the national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe or death vary due to the relatively small numbers. National figures are published every September.

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

2.4. Dissemination of learning

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

3. Complaints

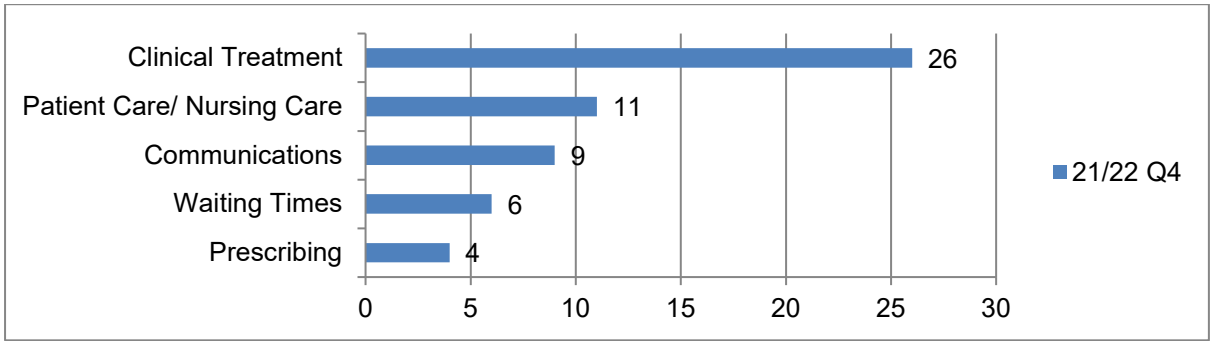
The table below shows the number of received and opened first stage complaints by quarter. The Trust experienced a 7% increase in complaints compared to 2020-21, but there were still significantly less than 2019-20. There have been 34 2nd stage complaints so far this year. This is significantly more than 2020-21 (23), but broadly in line with 2018-19 and 2019-20 (36 each).

The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved in 2019-20 and 2020-21. The Trust's response time to first stage complaints increased to 88.1% in Q4, but remained below target due mainly to the impact of the pandemic and severe operational challenges; continued efforts are being made to improve the timeliness of responses. This includes the provision of additional temporary resources within the Complaints Team and additional hours for existing staff. As a result the Trust completed and sent out 86 first stage responses in Q4 of 2021-22, including 45 in March 2022.

Indicator	2018-19	2019-20	2020-21	2021-22				
				Q1	Q2	Q3	Q4	Total
Total number of new complaints including community services	273	325	251	77	73	63	56	269
Total number of new complaints received (excluding community services)	267	320	242	69	73	61	51	254
Acknowledged within 3 days – target 100%	99.3%	100%	100%	100%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	92.1%	93.4%	94%	81.1%	83.6%	70.3%	88.1%	80%
Number of overdue complaints	1	1	4	3	5	5	12	12*
Second stage complaints	36	36	23	7	4	10	11	32

*data correct as a 1 April 2022. There may be some subsequent changes if complaints are discontinued or reclassified.

3.1. Top five reasons for complaints Q4 2021-22

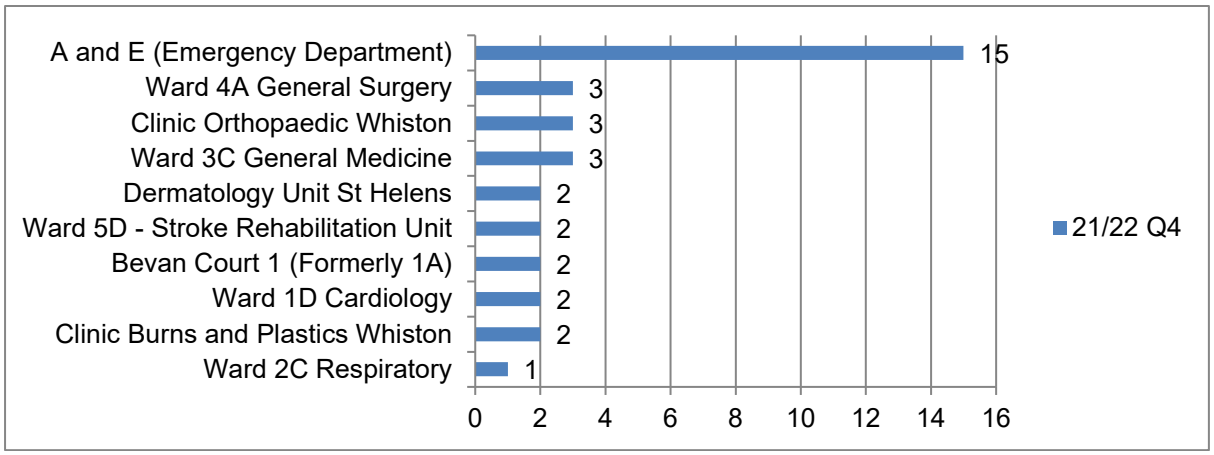


Clinical treatment remained the main reason for complaints; there were 26 each in Q3 and Q4. Admissions and discharges, which was 2nd in Q3 (12) does not feature in the top 5 in Q4. Complaints about communications remained consistent. Waiting times and prescribing were not in the top 5 in Q3, but attracted a total of 10 complaints in Q4. One of the prescribing complaints related to a delayed delivery of medication, two related to a lack of information about the side effects of medication and one related to incorrect take home medication.

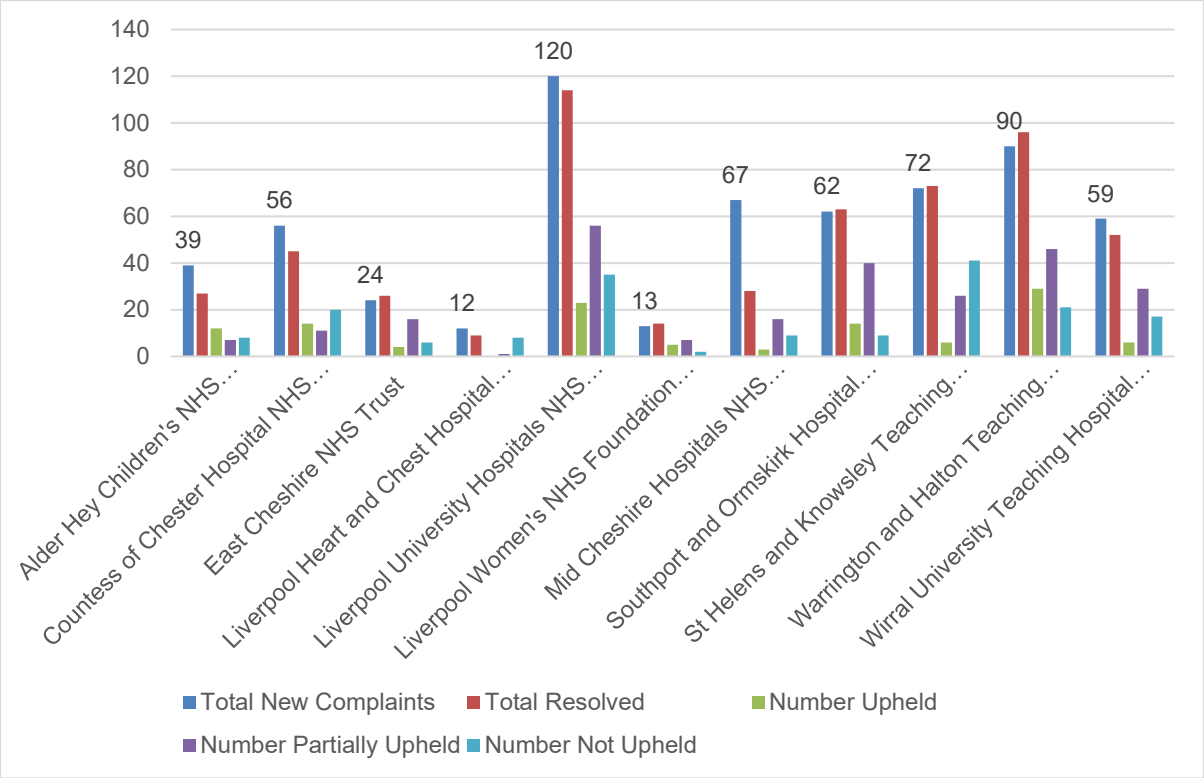
3.2. Complaints by top location

The Emergency Department received the highest number of complaints in Q4 2021-22, which is consistent with previous quarters, with 15 and can be attributed to the high levels of activity, although there were 5 less than Q3 and 10 less than Q2. No other location received more than 3 complaints. The Whiston Orthopaedic Clinic had the 2nd most complaints in Q3 (7) and is joint 2nd in Q4.

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



3.3. Comparison of written complaints received with neighbouring trusts



NHS Digital publishes data on written complaints for each of the NHS trusts in the country on a quarterly basis. The latest publicly available data available and shown above is for Q2 2021-2022.

3.4. Closed complaints

During Q4, 86 first stage complaints were closed, with 70% closed within the timescales agreed with the complainant. In March 2022, the Trust closed 45 1st stage complaints and 54 complaints in total, closing 28% more complaints in Q4 than in Q3, the best quarter performance for the last 3 financial years. It should be noted that the majority of the complaints are not upheld. Additional information on complaints is contained in Appendix 1.

3.5. Dissemination of learning

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

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

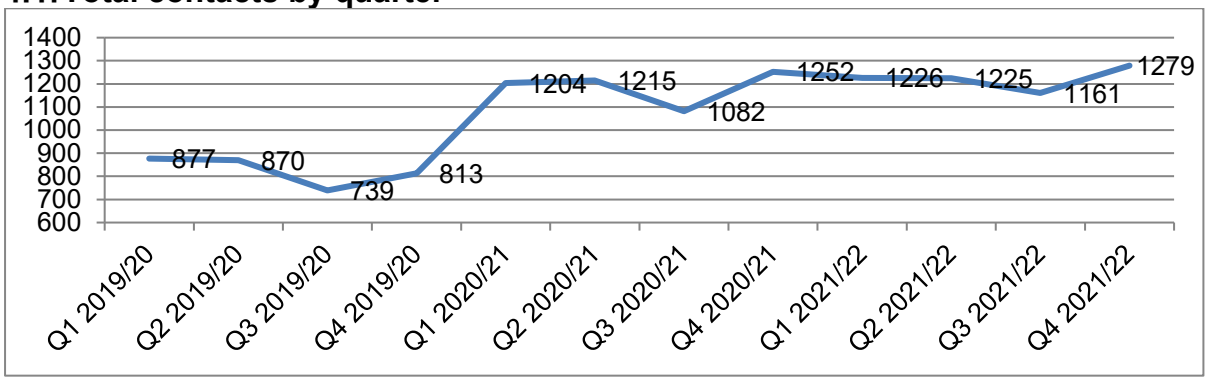
In Q4 the Trust was provided with the formal results of an investigation, which concluded that there were some failings in the care provided. These issues were identified as part of its complaint response and actions have been identified to improve the care provided following this case, including updating the end-of-life leaflet provided for patients and their carers.

The Trust has also been notified of one potential investigation and asked for its views on a potential small compensation payment to the complainant.

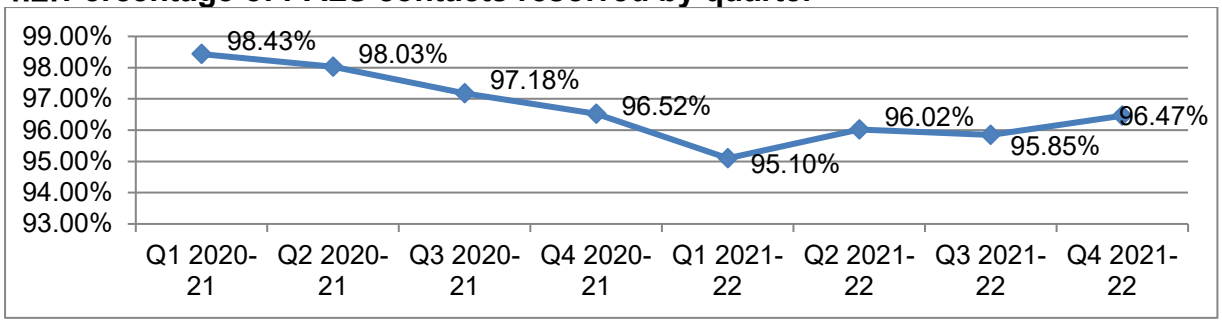
4. PALS

1279 contacts were received in Q4, which is a 2.16% increase from Q4 2020-21 and 9.23% increase from Q3 2021-22.

4.1. Total contacts by quarter

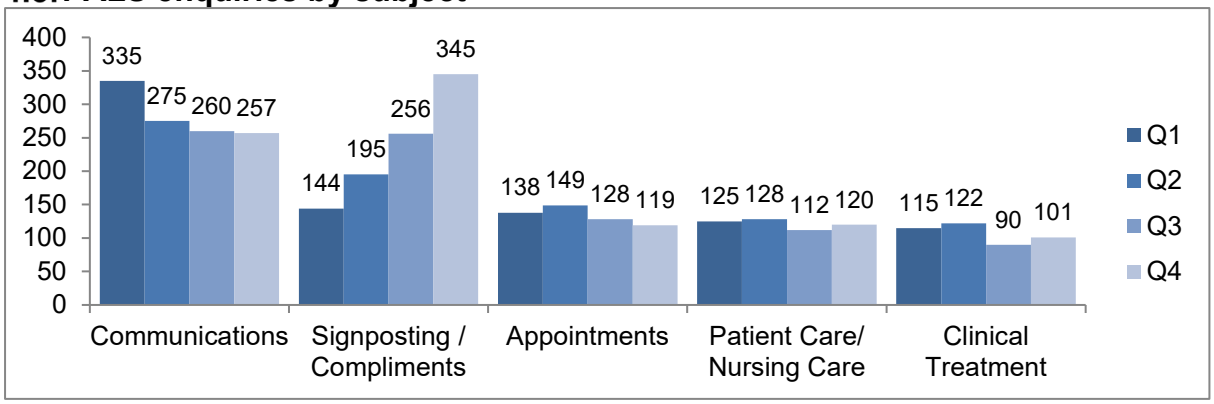


4.2. Percentage of PALS contacts resolved by quarter



In Q4 2021-22, 96.47% of PALS enquiries were resolved, with 33 PALS enquiries being converted to formal complaints, a 3.53% conversion rate, which is a decrease from 4.15% in Q3 2021-22.

4.3. PALS enquiries by subject

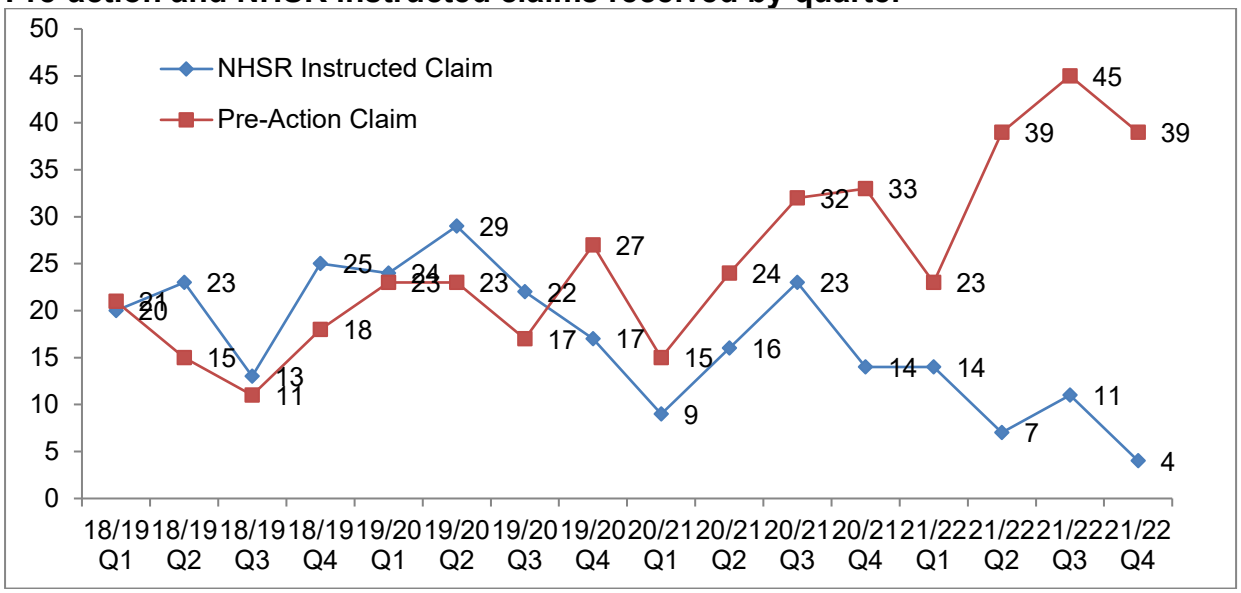


The top 5 themes remain consistent with previous reports. There has been a decrease in PALS enquiries relating to communication throughout 2021-22 compared to 2020-21.

5. Clinical Negligence Claims

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

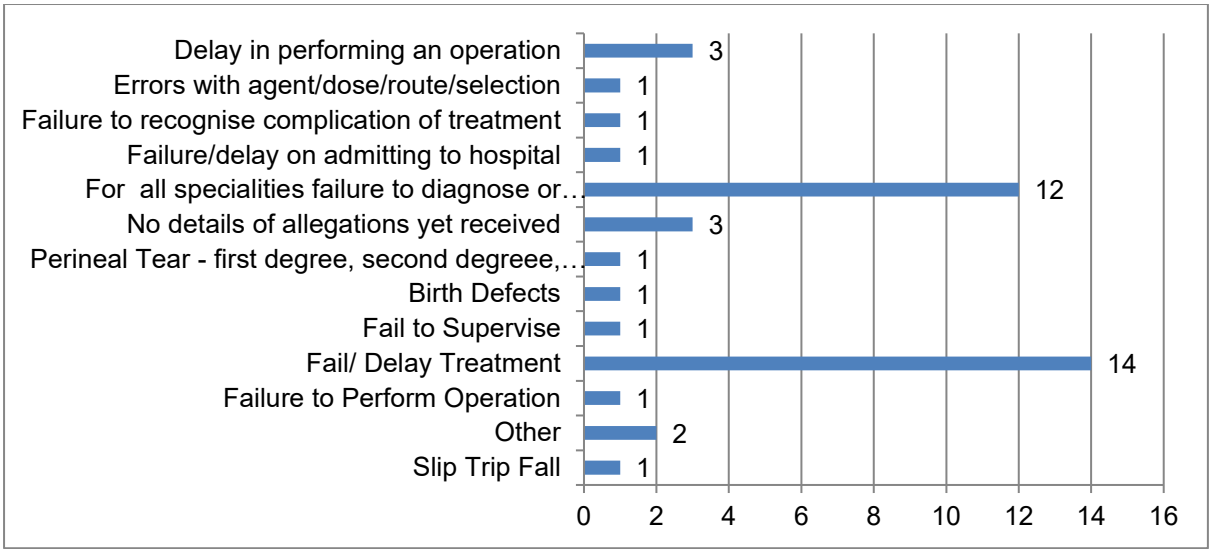
Pre-action and NHSR instructed claims received by quarter



The limitation of this data is that when a pre-action claim becomes an NHSR instructed claim, the status is changed on Datix. It is of note that 10 of the claims identified as pre-action in Q3 have now become NHSR instructed claims.

Failure/delay in treatment was the main reason for claims. This is consistent with Q2 and Q3 2021-22. Failure/delay in diagnosis was the second highest cause of claims, and is often the main cause identified.

Main reasons for new claim



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

6. Inquests

18 inquest notifications were received in Q4, an increase of 5 from Q3, but still significantly less than the 34 received in Q2. The Trust is identified as an interested party in all of these, although this is likely to reflect a change in the way inquests are classified; the Trust is now presumed to be an interested party where statements have been requested on anything other than specific cause of death.

41 inquests were closed in Q4, although this followed a review of historic inquest files. There were no Prevention of Future Deaths (PFD) Orders this quarter.

There continue to be a number of inquests involving patients who have experienced falls, which are being co-ordinated centrally by the Trust's appointed solicitors. We are also monitoring a number of inquests where discharge paperwork features as part of the care the coroner is reviewing; this was the subject of the last previous PFD the Trust received in March 2021.

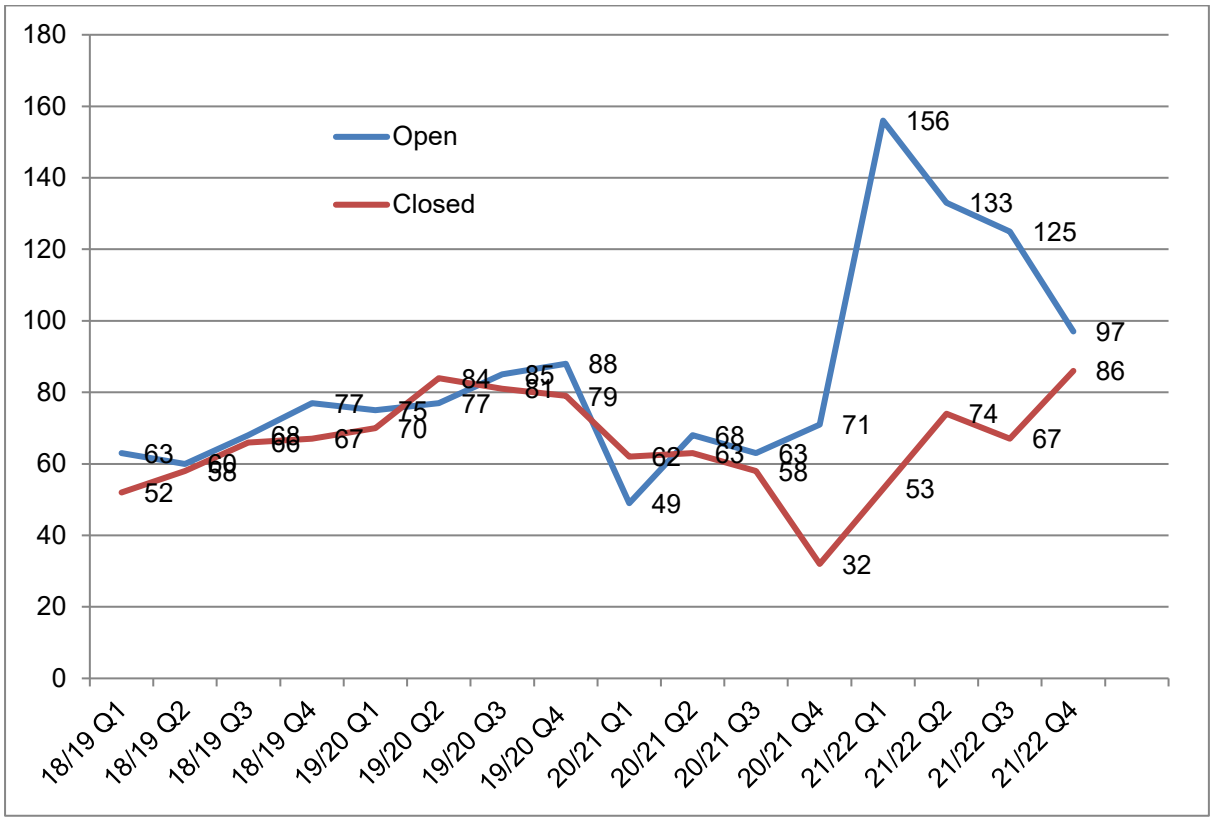
7. Recommendations

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

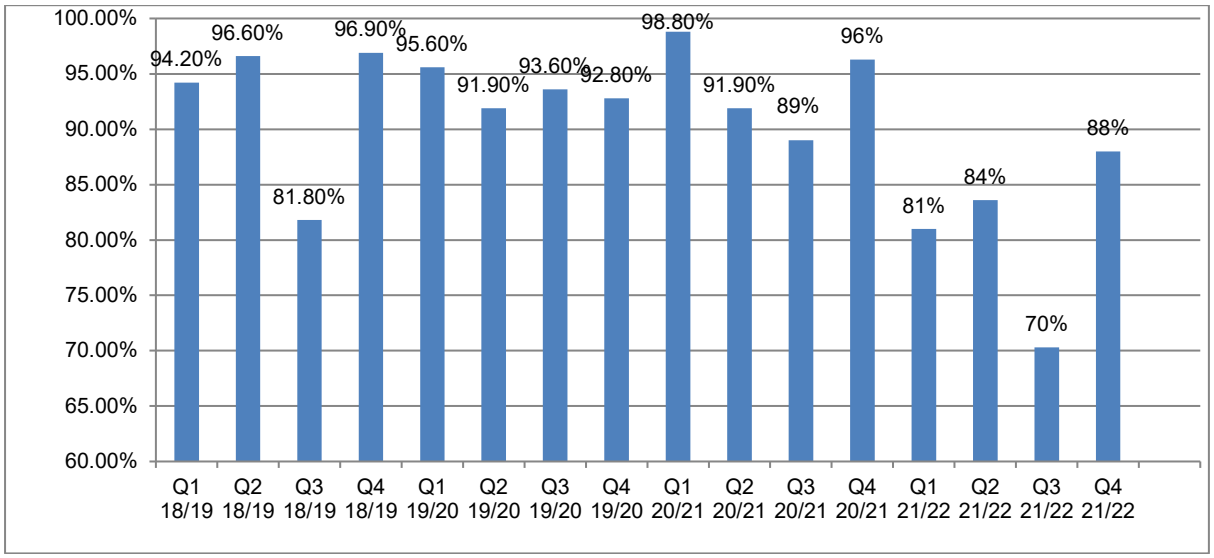
ENDS

Appendix 1 – summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in 2021-22

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
Not Upheld Locally	33	42	30	36	141
Partially Upheld Locally	11	26	29	33	99
Upheld Locally	9	6	8	17	40
Total	53	74	67	86	280

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)041
Title of paper: Quality Account 2021-22
Purpose: To submit to the Board the final draft version of the Quality Account for 2021-22 for review and approval.
Summary: The final draft of this year's Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012. The deadline to publish the Account is 30th June. The Quality Committee reviewed and approved the draft at their meeting held on 17th May. The Director of Nursing, Midwifery and Governance and Deputy Director of Governance will present the draft Account to a number of partners including CCGs at an event that is scheduled for 10th June and the feedback received from our partners will be included in the final published account. There was no requirement for the Account to be reviewed by our External Auditors this year, which is the same as last year. The final draft is attached as Appendix 1.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch
Recommendation(s): Members are asked to review and approve the Quality Account.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 25th May 2022

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Quality Account 2021-22

Our Vision

To provide five star patient care

Trust's values and ACE behavioural standards

What our patients said about us in 2021-22

Mohs skin cancer surgery

I was referred for a specialist assessment for Mohs surgery following a recent diagnosis with skin cancer. The patient care and sensitivity that I received from the consultant were excellent. The planned treatment was discussed with me and I felt involved in the planning for my treatment. I had the opportunity to share my personal anxieties and I was made to feel assured and safe about my feelings.

Prior to my planned appointment I had massive anxieties about the planned treatment but due to the consultant's approach, respect, engagement and communication and the provided explanations I was made to feel much clearer and safe about my planned treatment.

I now feel like I will be in safe hands and the best decisions will be made to ensure I have the best treatment as possible.

Of course I remain anxious about my future treatment but now I have had the opportunity to share my anxieties and ask the questions I have been worried about I now feel more prepared and feel in safe hands.
Thank you for the care and support I have been given so far with the planned treatment.

Orthopaedics

I'd just like to contact you with regard to my recent stay in Whiston for a total hip replacement operation.

My check in was quick and easy and it was nice that A recognised me as a previous 'customer' having been there in … 2019 for the opposite side hip replacement. Everything was so well organised and every single member of staff that I interacted with was professional and efficient…my heartfelt thanks go to all the team for all of their hard work during this fantastically challenging time.

Learning Disability & Autism Specialist Practitioner

I wanted to thank you for your excellent support …in ward 4B. Your kindness was very much appreciated, especially by Dad. He was so pleased with how everything went. What a great job you do and what a fantastic service the hospital offer. We couldn't have asked for anything better.

Whiston Hospital – various wards and departments

This is to say, thank you to all the staff from A&E, ICU 4E, 1B, 1C, 1D, 1E. These are all the departments my son was in since x November 2021 till x December 2021.

My son developed a syndrome post COVID that is not something we see all the time, he was extremely ill, ended up ventilated and in ICU then Coronary Care (1E) due to complications of this syndrome.

This was a stressful period, many tears and worried nights. But I cannot mention staff by name as there are too many to mention. We as parents had support from staff, compassion and care at all times. The staff were empathetic and supportive. Each and everyone in ICU touched us. Doctors in ICU brilliant!!! They acted accordingly and ensured that they looked at all treatment plans, and that was reassuring. My son was treated so well, and I could not fault the care at all. My son was important to them, and it was evident in the care. Doctors, nurses, catering, domestic, porters every single person. Thank you for taking such good care of our son. We are thankful he is home and well.

I can honestly say from experience NHS is the best health care in the world, and Whiston Hospital is outstanding.

2C Respiratory Ward

My husband was admitted to 2C with COVID. We cannot fault the care - the staff were friendly caring and extremely kind. Nothing was too much trouble for them. Everyone from doctor, nurses to "dinner lady" were lovely. Food was surprisingly very tasty too. Very happy the ambulance took him to Whiston…

I have attended St Helens Pre-op today for my appointment. From arrival to Nurse 1, Nurse 2, bloods and ECG the service, care and professionalism has been outstanding.
It is easy to take the NHS for granted but from the gentleman who got me water to every member of staff they have been exceptional. I have observed them dealing with every age group and demographic today. Plus they were sensitive to my condition, nerves and questions regarding the procedure.
Their duty of care is second to none.

Contents

1. Section 1

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

We are pleased to present the Trust's 13th annual Quality Account, which demonstrates our commitment to continually reviewing, developing and improving the care and services that we provide.

Last year we stated that 2020-21 had been the most challenging year we had ever had to face, during which staff had to work in different ways and in difficult circumstances as the COVID-19 pandemic unfolded. This continued during 2021-22, which brought sustained demands on an already stretched workforce. Staff have continued to work incredibly hard to provide the best care and treatment for our patients, maintaining essential services, as well as meeting the needs of patients with the virus, using telehealth and virtual wards to enable patients to be treated at home, when possible.

The Trust has retained its outstanding Care Quality Commission (CQC) rating and has maintained contact with our CQC relationship manager throughout the year. A number of routine systems and processes, including some nationally reported quality metrics remained suspended, however the Trust has continued to monitor key quality indicators via the monthly comprehensive Integrated Performance Report (IPR), which is reviewed by the Board and its Committees.

I was, however, extremely disappointed that during the year there were two methicillin-resistant staphylococcus aureus (MRSA) bacteraemia and one never event relating to the inadvertent connection of an air flow meter. Actions have been implemented in relation to this as part of the Trust's commitment to learning from incidents and these are outlined in more detail in section 3.

Our vision to provide 5-star patient care remains the Trust's primary objective so that patients and their carers receive services that are safe, person-centred and responsive, aiming for positive outcomes every time. The mission and vision have remained consistent and embedded in the everyday working practices of staff throughout the Trust, where delivering 5-star patient care is recognised as everyone's responsibility. The vision is underpinned by the Trust's values, five key action areas and the ACE behavioural standards of **A**ttitudes, **C**ommunication and the **E**xperiences we create.

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

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils, both of which report to the Trust Board's Quality Committee, and the Equality and Diversity Steering Group which reports to the Workforce Council. This ensures effective external representation in the oversight and governance structure of the Trust. Meetings have continued to be held virtually to ensure social distancing could be maintained.

The Trust has a Patient Participation Group, which met virtually in January 2022 and patients have continued to share their experiences of their care via patient stories for the Board and the Patient Experience Council.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the particular challenges faced during the year. It outlines our quality improvement priorities for 2022-23.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2021-22 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and services we have continued to deliver during the ongoing challenges in 2021-22.

I remain extremely proud of all our staff who continue to give the best of themselves to care for the people who need us, as well as supporting each other through these very difficult times. Their enduring courage and unwavering commitment during the pandemic are appreciated by all members of the Board and I would like to offer my sincere gratitude and ongoing thanks to all our staff for everything they continue to deliver during the most challenging times we have faced.

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

1.2. Summary of quality achievements in 2021-22

Quality of services overall
Outstanding rating awarded by the CQC, the best possible rating, in the latest report received in March 2019.

Well-led
- Extremely honoured to be awarded the Freedom of the Borough of Knowsley in March 2022 and the Freedom of the Borough of St Helens in April 2022 for the outstanding efforts of the staff during the pandemic, in providing exceptional service to the local community
- Ranked 4th acute Trust for quality of care in the latest national inpatient survey
- Successfully reaccredited as a Veteran Aware Trust with the Veterans Covenant Healthcare Alliance (VCHA) for the second year running, noting the outstanding service improvement that has continued since the original accreditation was first awarded for the work that is undertaken for the Armed Forces Community
- Disability Confident Leader status (in place until 2023)
- Mid-Mersey Digital Alliance (MMDA) successfully completed the Skills Development Network Excellence in Informatics re-accreditation assessment. The assessment is designed to improve leadership and professional development skills, raise standards and share best practices with other organisations. This outcome clearly indicates that MMDA's processes are innovative and at the forefront of informatics best practice
- The Trust's Digital Aspirant Programme was shortlisted for the "Delivering Value with Technology" category in the Healthcare Financial Management Association (HFMA) Awards
- Mid-Mersey Digital Alliance's Informatics Service Desk were awarded level 3 accreditation following a recent Service Desk Institute (SDI) assessment, demonstrating that this is a customer-led support function which has a continued focus on patient care and COVID support, particularly supporting staff working remotely
- Secured reaccreditation for annual Safe Effective Quality Occupational Health Services (SEQOHS)
- The Trust scored well in the latest national Staff Survey results, ranking equal 3rd nationally and equal 1st across the North-West and Cheshire and Merseyside for 'Morale' and 'We are safe and healthy'
- 84.6% of staff agreed that care of patients/service users is the organisation's top priority, well above the national average of 75.5%
- Winner of the Health Service Journal Partnership award in the staffing solution of the year category in conjunction with Patchwork Health for establishing the North West Collaborative Bank, the largest staff bank in the UK
- Highly Commended in the Health Service Journal Partnership awards in the best elective recovery initiative category with Warrington and Halton Teaching Hospitals FT, Liverpool University Hospitals FT, NHS England and NHS Improvement and Attain for the elective surgery waiting list risk stratification, putting patients in the right place with the right team at the right time

Staff
- The Health, Work & Wellbeing Department won the Occupational Health & Wellbeing Team of the Year 2021 with Personnel Today, the United Kingdom's (UK's) leading free-access Human Resources (HR) website. The Department

was recognised for its work throughout the pandemic, offering a wealth of services and support during sustained periods of pressure across the National Health Service (NHS)
- Dr Andrew Hill, Stroke Consultant and Chief Clinical Information Officer (CCIO), was shortlisted for the CCIO of the Year at the Digital Health Network Awards. He was nominated for his tireless work in driving forward the Digital Aspirant Programme (DAP) with clinical colleagues, influencing peers to develop and adopt new and better ways of working and caring for our patients through the use of technology
- Jackie Owen, Clinical Procurement Specialist, was shortlisted in the NHS Procurement Outstanding Contribution category in the Excellence in Supply Awards 2021 for her tenacity and determination to get the best for both patients and staff
- Simon Collins, Head of Capital and Treasury Services, was shortlisted for the NHS Champion in Support of Procurement in the Excellence in Supply Awards 2021, for playing an integral part in the Procurement Team's ability to deliver a challenging capital programme and to obtain equipment in the midst of the pandemic

Patient safety
- Reductions in incidents resulting in harm in 2021-22 compared with 2020-21:
  - 0 prescribing incidents resulting in moderate or severe harm
  - 6.12% reduction in inpatient falls per 1000 bed days, decreasing from 9.119 falls per 1000 bed days in 2020-21 to 8.561 in 2021-22
  - 1.63% reduction in inpatient falls of moderate harm or above per 1000 bed days, decreasing from 0.245 falls per 1000 bed days in 2020-21 to 0.241 in 2021-22.
  - 31.25% reduction in severe harm or above patient incidents, decreasing from 32 during 2020-21 to 22 during 2021-22
- 91.2% average registered nurse/midwife safer staffing fill rate for the year, above the 90% target
- Acute Medical Unit (AMU) Team were shortlisted for Innovation of the Year category at the British Journal of Nursing Awards for the creation of an Enhanced Care Emergency Care Trolley to improve the time-critical management of patients diagnosed with conditions that require management on the Enhanced Care Unit on ward 1C

Patient experience
- Winner of the Cheshire and Merseyside Nursing, Midwifery and Allied Health Professionals (AHPs) in Health and Social Care Sharing Best Practice award for the Carer Passport poster, following the launch of the updated Carer Passport, developed in collaboration with Liverpool University Hospitals NHS Foundation Trust and Carers' Centres
- 95.72% of inpatients would recommend the Trust, as recorded by the Friends and Family Test
- Whiston Hospital Intensive Care Family Liaison Service was shortlisted for the Royal College of Physicians' Excellence in Patient Care Awards for their work in improving communication with families, continuity of care for patients and freeing up clinical staff to care for their patients at the bedside
- The Trust's partners, Vinci Facilities Management (FM), won the Frontline Heroes Award at the Institute of Workplace and Facilities Management Impact Awards for

ensuring that the hospital environments are always welcoming and well-maintained to make a massive difference to the experiences of all patients and visitors

Clinical effectiveness

- Shortlisted for Health Service Journal (HSJ) Partnership Award, Best Elective Care Recovery Initiative for reducing waiting times for those patients whose care was unavoidably delayed due to the pandemic - putting patients in the right place, with the right team, at the right time. This involved partnership work with Warrington & Halton Hospitals NHS Foundation Trust, Liverpool University Hospitals Foundation Trust and Attain UK, the largest independent health advisory and delivery organisation in the UK. The Trust has used artificial intelligence systems to review patient lists, ensuring those in need of the most urgent care are prioritised and surgical lists are effectively managed
- Shortlisted for HSJ Partnership Award, Most Effective Contribution to Clinical Redesign for the work with Refero, using video technology to conduct patient consultations, ensuring continuation of care and safety of patients during the pandemic
- Highly Commended Award at the Health Tech Newspaper (HTN) Awards in October in the Excellence in Electronic Prescribing and Medicines Administration (ePMA) and Care Coordination category for the work in improving care through Careflow and the associated applications such as Connect and Vitals
- Finalist in conjunction with Edge Hill University as one of the leading nurse education providers in the Nurse Education Provider of the Year (Post Registration) category in recognition of the development of its postgraduate certificate (PGCert) Urology Practice Programme
- Genitourinary Medicine (GUM) service received a Liverpool School of Medicine commendation for performance, for achieving excellence over and above the standard expectations in providing an exceptional Special Advanced Medical Practice (SAMP) experience in a supportive and welcoming environment where students are encouraged to make the most of all opportunities available
- Maintained International Organisation for Standardisation (ISO) accreditation via remote surveillance visits throughout the four pathology disciplines
- Radiology Services retained their Quality Standard for Imaging (QSI) accreditation. This accreditation allows the department to benchmark itself against national quality standards and promotes continuous improvement.

1.3. Celebrating success

The Trust has continued to share positive comments from patients and carers via the weekly Thank You Thursday email sent to all members of staff. In addition, the Employee of the Month award recognises and rewards the ongoing dedication and commitment of staff throughout the year. In January, thirty of the latest Employees of the Month were invited to attend Anfield football stadium to watch a league game as VIP guests of Liverpool Football Club. This was an incredible, once in a lifetime, experience for all those who attended.

Unfortunately, due to the ongoing pandemic, the Annual Staff Awards were not held for the second year running. However, the event has now been booked for July 2022 to continue with the tradition of celebrating the many achievements of staff.

2. Section 2

2.1. About us

2.1.1. Our services

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

The Trust has 717 beds overnight general and acute beds, which includes paediatrics, as well as 37 maternity beds and 30 intermediate care beds at Newton Hospital. The majority of its services are provided from two main sites at Whiston and St Helens Hospitals, both of which are state-of-the-art, purpose-built modern facilities that are well-maintained. Whiston Hospital houses the Emergency Department, the Maternity Unit, Children and Young People's Service and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, rehabilitation beds, the Lilac Centre (a dedicated cancer unit, linked to Clatterbridge Centre for Oncology) and Marshalls Cross Medical Centre (primary care services). St Helens Hospital became one of the first Community Diagnostic Hubs, as part of the Cheshire and Merseyside COVID-19 recovery plan.

The Trust also provides an Urgent Treatment Centre (UTC) at the Millennium Centre in St Helens and intermediate care and community services at Newton Hospital. In addition, the Trust delivers a range of community services, including adult community nursing (for St Helens), Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy, plus outpatient and diagnostic services from a range of other community premises.

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

The pandemic has now been impacting on attendances and admissions for two years, making meaningful comparisons about activity difficult as illustrated in the table below. The North West has experienced 4 waves of COVID-19 since March 2020, the latest being the Omicron variant from December 2021 onwards. Each wave has impacted on the provision of the Trust's routine services and activities and the Trust has maintained as many services as possible for patients needing urgent, emergency or elective treatment.

	2018-19	2019-20	% change 2018-19 to 2019-20	2020-21	% change 2019-20 to 2020-21	2021-22	% change 2020-21 to 2021-22	% change 2019-20 to 2021-22
Outpatient attendances (seen)	451,044	467,811	3.72%	388,403	-16.97%	468,724	20.68%	0.20%
Non-elective admissions (less Obstetrics)	57,446	56,458	-1.72%	49,771	-11.84%	54,166	8.83%	-4.06%
Elective admissions	50,444	52,141	3.36%	34,614	-33.61%	48,706	40.71%	-6.59%
Births	4,051	3,983	-1.68%	3,738	-6.15%	3,995	6.88%	0.30%
Emergency Department attendances (as reported)	115,742	119,181	2.97%	102,404	-14.08%	121,809	18.95%	2.21%
Emergency Department attendances (excluding GP Assessment Unit)	109,613	112,743	2.86%	97,885	-13.18%	116,728	19.25%	3.53%

The average length of stay for non-elective admissions was 6.8 days compared to 6.5 days in 2019-20 and 6.3 in 2020-21.

2.1.2. Our staff and resources

The Trust's annual total income for 2021-22 was £524 million.

St Helens and Knowsley Teaching Hospitals NHS Trust employs over 6,600 members of staff. In addition, the Trust is the Lead Employer for Health Education North West, Health Education Midlands, Health Education East of England, Thames Valley Region and Palliative Care London and is responsible for almost 12,000 specialty doctors, dentists and public health trainees based in hospitals, with general practitioners (GP) and in local authority placements throughout England.

The average rolling 12 months' staff turnover rate in the Trust in 2021-22 was as follows:
Q1 – 12.22%
Q2 – 13.27%
Q3 – 14.37%
Q4 – 15.41%

The average is 10.6% for acute teaching hospitals in the North West and 15.6% for acute teaching hospitals nationally (data to January 2022).

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

Significant recruitment challenges remain within specific specialties and for specific roles, in particular within nursing and medical staff. The Trust has a successful and well-established international recruitment programme, which brings on average 50 new international nurses into the Trust per year to supplement the existing nursing workforce. Despite the recent challenges of COVID, the Trust recruited 77 additional nurses via this route during 2021-22. The Trust is constantly looking for new ways to address workforce gaps and continues to work, as a founding member, with the Pan Merseyside International Nurse Recruitment Collaboration programme, which aims to deliver international nurses across most of the Merseyside region. This pipeline will continue to bolster existing recruitment plans with a total of 100 new international nurses expected to start within the Trust during the 2022-23 financial year. The Trust is also a member of the North West Regional International Midwifery Collaboration programme and the North West International Radiography Collaboration programme both of which are intended to bolster the NHS workforce over the next 12 months. In addition, the Trust continues to proactively work towards ensuring there are no Healthcare Assistant (HCA) vacancies and providing a “New to Care” induction, training and career pathway for those without care experience who wish to become a healthcare assistant in the NHS. This has been supported by £102K funding from NHS England and Improvement (NHSE/I).

There have been 25.07 medical gaps on average from April 2021 to March 2022. The current medical gaps across the trust are 35.17 with the majority in the Medical Care Group. A number of actions have been taken to address these, including developing new roles such as advanced clinical practitioners. In addition, the Trust hosts regular recruitment events and uses international recruitment to ensure vacancies are filled. The Trust has collaborated with Masaryk University, Brno, Czech Republic, in the recruitment of newly qualified doctors who trained in Brno using the English syllabus since 2014. The Trust has made offers to an additional 86 doctors through these means since 2016. These new recruits join the Trust for two years as Clinical Fellows at foundation year one and two, to support the wards and fill the gaps and vacancies resulting from reduced numbers of allocated posts from the North West Deanery. The scheme saw 22 newly qualified doctors successfully join the Trust in August 2021 following a 4-week clinical induction process. Plans are already in place for the scheme to return to Brno in March 2022, to recruit more newly qualified doctors for the August 2022 intake. This programme provides the opportunity to reduce agency spend and maintain continuity of care for our patients.

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

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

- On-boarding and retention of new and existing staff including flexible working, internal staff transfer scheme (21 people have used this from 1st April 2021 to 28th February 2022), itchy feet discussions, assigning a buddy, welcome packs/information and encouraging retire and return. Between 1st April 2021 and end of February 2022, 62 staff members took advantage of the retire and return offer. The Trust continues to explore other retention options and has recently relaunched the exit questionnaire to gain a better understanding of why people leave and what can be done to retain staff
- An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally. This includes the reintroduction of both face to face and virtual open events
- Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and ODP apprenticeships
- Implementation of the nursing associate role with 15 trainees completing their training in March 2022 and further trainees commencing training in Autumn 2022
- Implementation of e-rostering in 98% of the organisation, with the remaining 2% being introduced in the early part of the 2022-23 financial year. E-job planning is being taken forward for other staff groups to include medics
- Launch of a new online appraisal and personal development plan system, which includes an enhanced focus on health, wellbeing and staff support
- Equality, Diversity & Inclusion champions appointed to lead new staff networks created e.g. Carers, Building a Multi-Cultural Environment, Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex (LGBTQI+), Menopause, Armed Forces and supporting a healthy workforce

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

The acceptable monthly fill rate is 90% and over, which throughout the COVID-19 pandemic has been very challenging to achieve. Senior nurses, led by the Director of Nursing, Midwifery and Governance held twice daily staffing meetings at times of increased pressure to redeploy staff across the Trust to maintain patient safety. The average registered nurse/midwife safer staffing fill rate for the year was 92.1%, above the 90% target and similar to the 92.2% rate achieved last year.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total inpatients in the ward at midnight. The Trust's position is reported monthly as part of the mandated safer staffing report.

The Trust continues to work incredibly hard to maintain patient safety during the pandemic, using a range of approaches to ensure available staff are deployed effectively across the whole Trust. The actions taken include:

- Identified staff from across the Trust redeployed for block periods to areas needing additional capacity
- Ward managers cancelled management days to work clinically
- Matrons/specialist nurses worked clinical shifts where possible
- Increased the daily Matron staffing meetings to twice daily when required, led by the Director of Nursing, Midwifery and Governance, with members of the temporary workforce resourcing team attending. Staffing levels across the Trust were reviewed at each meeting, with every area identifying any gaps identified for the following 24 hours and the number of patients requiring supplementary care (1-1 or bay tagging) on each ward. Staff moves were then jointly agreed to provide the safest care possible
- A plan for further moves, should this be required for unexpected absence, was communicated by the matrons covering the late shift to the operational managers and the general manager on call each day
- Worked with the Trust's staff bank and external agencies to provide a pool of staff to cover each shift for areas experiencing last minute gaps due to sickness
- Block booked agency staff to provide continuity where possible
- Approached off framework agencies to cover any unfilled shifts (subject to Executive approval)
- Successfully secured £439k funding from NHSE/I to support the recruitment of international nurses
- 148 bank HCAs offered positions and 172 substantive HCAs joined the Trust between 1st April and end of February 2022.
- 78 international nurses commenced their training for the national Nursing and Midwifery Council's (NMC) Objective Structured Clinical Examination (OSCE) test
- Established a redeployment hub for a short period during the year to identify staff who were able to be moved to support other areas
- Proactive support for staff who were absent to ensure they were able to return to work as soon as possible
- Utilised staff who were absent from the workplace due to shielding/self-isolation to undertake work that could be completed from home wherever possible

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

2.1.2.1. Supporting our staff

The Trust appreciated the huge impact that the pandemic had on all staff and hosted a special Big Thank You Week to thank staff in January 2022, with a number of activities and opportunities to show staff how much they were valued. This included random acts of kindness, with bouquets of flowers, gifts and lunches handed out to various groups of staff, including staff working from home, thank you messages and thank you videos posted on the intranet and Trust branded thermal cups and water bottles available for all staff.

Staff continue to have access to the Health, Work and Wellbeing Department (HWWB) which provides a wide range of supportive services, including Occupational Health and those listed below:

- Wellbeing Hub which supports staff affected by physical or non-physical health matters that can have an impact both in and outside of work. Support is available for all staff, including those that have been affected by COVID-19. This includes:
  - Mental wellbeing delivered by counsellors, mental health nurses and psychologists for stress, anxiety, depression and other diagnosed conditions, including round the clock support through an employee assistance programme (EAP) service provider
  - Physical wellbeing delivered by PhysioMed, physiotherapists and occupational health clinicians for musculoskeletal conditions, injury or other diagnosed conditions
  - General health delivered by occupational health clinicians or onward referrals to specialist support for any other health related condition(s) that may impact on work
- Trust staff engagement application (app) and the staff COVID website which have specific wellbeing sections
- Wellbeing apps including meditation, mental health in the workplace, mindfulness and sleep aides
- Staff wellbeing events and engagement sessions to promote and support wellbeing and resilience, these included mindfulness, sleep hygiene, stress, relaxation and building resilience
- Rugby League Cares (RLC), which is a charity commissioned by NHS England as a pilot for three NHS organisations in the North West, including this Trust. RLC support with engagement sessions for staff which can include mental fitness and team building. RCL also support with recruitment via community engagement programmes

The Assistant Director of Health, Work and Wellbeing is chairing the ‘’putting our people first group’’, which champions the health and wellbeing agenda, including the health and wellbeing strategy and related policies.

HWWB are also responsible for the creation and development of the Trust's wellbeing network. The network consists of key people throughout the organisation who champion health and wellbeing agendas for the greater good of our people, please see the information graphic below. Currently there are over 70 health and wellbeing champions, 30 mental health first aiders and a wellbeing guardian all driving the wellbeing network forward with support from the wellbeing lead and coordinator.

2.1.3. Our communities

The Trust provides services to the communities of St Helens, Knowsley and Halton, as well as attracting some patients from Liverpool and parts of Warrington, Wigan and Ormskirk. The Trust is the regional burns centre providing specialist care for the whole of Cheshire and Merseyside, as well as North Wales and the Isle of Man.

The communities served by the Trust are characterised by high levels of deprivation, with the local population being generally less healthy than the rest of England, with a higher proportion having at least one long-term health condition.

Our local communities are not ethnically diverse, but do experience high levels of health inequalities, leading to reduced life expectancy, poorer health and higher demands for health and social care services. Rates of obesity, smoking, cancer and heart disease remain higher than the national average. Our local communities have been hit hard by COVID-19, with some of the highest community infection rates in the country. The impact of the pandemic will continue to be felt for many years as people have had to wait longer for outpatient referrals, diagnostic tests and elective procedures. The Trust made good progress with its elective backlog in the first half of 2021-22 but, unfortunately, the situation deteriorated again as a result of the Omicron wave of COVID-19 which caused significant staff absence, due to both sickness and the requirement to self-isolate, in addition an increase in the number of patients hospitalised with the virus.

2.1.4. Our partners

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

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

The Trust has worked in collaboration with the Primary Care Networks in St Helens to deliver the COVID-19 vaccine programme and, since December 2020, has operated a Mass Vaccination Site at St Helens Saints Rugby Ground which has delivered first, second, third and booster doses to help protect the local population. This is covered in more detail in section 3.6.5 below.

In September 2021 the Trust entered into a formal Agreement for Long Term Collaboration (ALTC) with Southport and Ormskirk Hospital NHS Trust. The aim of the collaboration is to find a safe and sustainable solution for services in Southport and Ormskirk. The ALTC provides for STHK's Board to provide strategic and operational management of the Trust. During the first 6 months a baseline assessment has been completed and work has been undertaken to stabilise a number of fragile clinical services.

2.1.5. Technology and information

This year, the Trust has made tremendous progress with the Digital Aspirant Programme (DAP), continuing to move ever closer towards its digital maturity ambitions and in line with NHS plans to have fully digitised hospitals.

The Careflow Electronic Patient Record (EPR) is now fully embedded across the Trust and the focus this year has been to fully maximise the potential of Careflow by introducing additional clinical functionality and system capability within it.

As a result, clinicians now have more information available to them digitally than they have ever had before, with more and more electronical patient information following the patient through their hospital journey. This gives clinicians the information they need immediately and agilely, supporting consistency and safety of a patient's treatment.

Processes have been digitised, removing about 70% of manual paper forms from use across many areas. This is a key target for the Trust, through the EPR Digital

Maturity Programme, the focus on digitisation will continue to build on this, with the aim of achieving a 90% target of paper removal in clinical processes in the coming year.

These digitised processes mean that patient information held within the EPR is now structured and complete, which has enriched the quality of information available to clinicians at their fingertips and to operational teams resulting in greater accuracy of reporting of management information.

Outside of the EPR, the Trust has seen several infrastructure improvements including the continued hardware refresh of information technology (IT) equipment across the Trust, the completion of migration to Windows 10 and Office 365, support for improved agile working and a better Microsoft Teams experience as staff continued to work remotely and flexibly because of the COVID-19 pandemic, as well as, enhanced security and monitoring tools to combat the constant threat of cyber-attacks.

The Informatics Service Desk achieved a fantastic result with the accreditation to the Service Desk Institute, achieving Level 3 rating, and the whole Informatics Team successfully achieved “Excellence in Informatics” accreditation through the Informatics Skills Development Networks.

The achievements in 2021-22 were a collective effort across all teams within the Informatics Department, working alongside clinical and administrative staff to improve patient experience, safety and outcomes, in line with the Trust vision for 5-star patient care.

2.1.5.1. Systems

The electronic patient record, Careflow EPR, was deployed in 2018 and is now at the heart of the care provided. In 2021-22 the Trust continued to maximise Careflow EPR modules and functionality in tandem with a number of other key systems:

a. **Careflow Connect** – already used for both medical and nursing handover has now become a key component of patient care co-ordination across the Trust.

   This digital application is used by clinicians on their mobile devices or desktop computer for patient referrals from the Emergency Department (ED) to a ward or from one ward to another. Careflow Connect now also provides:
   - **Specialist Referrals** – Careflow Connect can now be used by clinicians to make a patient referral to specialist teams e.g. Diabetes, Pain Team, Safeguarding, Palliative Care, Tissue Viability, Burns and Plastics, Alcohol Substance Misuse, Dietetics and Medical Photography. Careflow Connect enables all patient information to be sent to the specialist team, along with any notes from the referring clinician. Advice from the specialist team is provided in a timelier manner and patients receive specialist care and advice sooner
   - **Critical Alerts** – enabling faster electronic notification of a patient’s abnormal results from tests conducted by the laboratories to clinical staff and teams
   - **Tasks** – Careflow Connect Team Task Management allows any user of the network to raise a task for a patient for another colleague or team to action

- **Photography function** – allowing clinicians to take images to help identify any improvement or deterioration in patient wounds

Careflow Connect ensures structured digital communications between clinicians to allocate patient care within their own teams or seamlessly refer to colleagues in other teams. Patient information follows the patient on their journey through the hospital, so any clinician involved in their care has access to the right patient information at their fingertips, making the process quicker and easier for all clinical teams, as well as enabling improved communications between teams.

b. **Careflow Vitals** – has been pivotal in ensuring national standards of care are provided, reducing the likelihood of incidents, avoiding high-cost care transfers to critical care, providing better patient outcomes in general but specifically for sepsis and cardiac arrest and helping to reduce length of stay.

During 2021 electronic assessments have been developed and deployed for fluid balance, dementia & delirium, nutrition, carbapenemase-producing enterobacteriaceae (CPE), urinalysis, Maelor (risk assessment for skin/tissue damage), moving & handling and falls. Patients are assessed at the bedside and electronic referrals can be made to specialist teams using Careflow Connect ensuring a prompt intervention for quality patient care.

This year, work has commenced on the digitisation of additional nursing forms within Careflow Vitals to further streamline and improve the quality of patient information collected and to save valuable nursing time spent on administration.

- **The Nursing Admission Form** – completed when a patient arrives on a ward for admission and can take up to 45 minutes for each form to be written out with the information the nurse obtains from the patient
- **The Social History Form** – completed by a therapist to collate information on aspects of a patient's life and home environment, outside of the hospital, which could impact on their recovery
- **The Activities of Daily Living Form** – completed by a nurse, with some duplication of the information gathered on the Social History Form

Over the past year, Digital Lead Nurses have collaborated with nursing colleagues from across the Trust to build these forms into a digital format, taking requirements from all areas to build standardised forms, based on best practice that works for all nurses across the Trust. The Social History and Activities of Daily Living Form are to be combined into one form to remove duplication of patient information. The Nursing Admission Form will be quicker to complete, saving valuable nursing time.

These forms are currently being piloted in advance of a Trust-wide roll out next year, when it is anticipated there will be a further reduction in paper forms being used and nurse and therapist time and duplication of effort reduced. Importantly, the forms can be completed on a mobile device, whilst at the patient's bedside.

Since Careflow Vitals observations were introduced in 2019, over 2.5 million patient observations have been taken which provide early indication of a

deteriorating patient.

c. Further deployment of the Trust's **electronic prescribing and medicines administration (ePMA) system** across the GP Assessment Unit (GPAU). This system ensures legible prescriptions, 100% availability of the patient's drugs record from multiple locations simultaneously, reduction in allergy and drug interaction incidents, removal of the need for transcription and rewriting of the prescription chart as the patient moves from location to location, therefore improving patient safety and clinical decision-making.

d. **Mobile Order Comms & Results –** increasing the use of Careflow digital orders and results, our clinicians can now request tests for their patients and receive the results digitally and agilely on mobile devices, providing further ability for our doctors and nurses to work in an agile way, caring for their patients from any location.

   Although digital orders were already in place in some areas, the team collaborated with clinicians to improve the usage of digital orders, removing the need for paper order forms, thus representing a major contribution to the Trust's ambition of removing paper from clinical processes and improving patient safety with digitised forms and information accurately captured.

2.1.5.2. Infrastructure

The safety of the infrastructure, networks and systems continues to be a priority, along with strengthening the infrastructure and IT platforms on which all the Trust's critical systems reside, to ensure the Trust's systems are accessible, safe, secure and reliable.

The upgrade of all desktops to Windows 10 and the roll out of Office 365 across clinical staff has now been completed and staff can now access their email and Trust applications both on and off the Trust's premises, without impacting on the security of the Trust network. The Informatics Team also supported the development and deployment of the new Trust Staff Intranet.

In addition, the Informatics Team has deployed:

a. **Intrusion Prevention System** – to continuously monitor the network for malicious activity and takes action to prevent it, including reporting and blocking such activity, when it does occur.

b. A new **Mobile Device Management Solution** - to enable improved security and management of approximately 1,100 Trust issued mobile devices.

c. **Hardware Refresh Programme** – as part of the Trust's 5-year commitment to update computers and laptops used by staff, this year saw the roll out of:
   a. 215 iPads
   b. 196 iPods
   c. 54 computers on wheels
   d. 680 desktop computers

2.1.5.3. Our continued response to the COVID-19 pandemic

Following on from the huge amount of work and actions taken at the start of the pandemic, 2021-22 saw the Informatics Team continue to ensure that staff could still work agilely and safety when caring for patients.

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

Collaboration between informatics and microbiology has delivered COVID test results to staff and COVID pre-operative (pre-op) swab results to patients via secure text messaging. Since May 2020 when Patient Hub was introduced, 121,000 COVID test results have been sent to patients and staff.

2.1.5.4. Place-based care

The St Helens Shared Care Record (SCR) is the local digital solution at the leading edge of place-based care.

Over the past 12 months, Informatics, along with SCR partners, have developed the St Helens Cardiovascular Disease (CVD) Dashboard and Case Finding tool. CVD intervention is a clinical priority and was identified in the NHS Long Term Plan as the single biggest condition where lives could be saved over the next 10 years. The Cheshire and Merseyside population are at particularly high risk of CVD and 80% of CVD and strokes are preventable through lifestyle changes, although this requires early detection of at-risk individuals. This detection can be carried out and managed effectively within primary care.

The CVD dashboard identifies those at-risk sections of the local population through case finding, including both clinical and sociodemographic markers, helping to inform decision-makers on which groups could be targeted for early detection and further intervention, reducing the incidence of CVD, including stroke.

2.1.5.5. Service Accreditations

d. **Service Desk Institute –** In May 2021, the Informatics Service Desk Team joined an elite and prestigious body of organisations to be awarded a three-star rating by the Service Desk Institute (SDI), becoming one of only twenty-three service desks globally to have been awarded a three-star rating. Further to this fantastic feat, Informatics are one of only sixteen organisations to achieve this rating on the first full audit.

   A three-star rating establishes that MMDA operate a ‘customer-led’ Service Desk, confirming/certifying that it operates with the 14,000 users across two hundred sites at the forefront of the service. This achievement highlights our commitment to providing customers with the highest level of IT support and solutions.

e. **Informatics Skills Development Network (ISDN) "Excellence in Informatics" Accreditation** – In September 2021, the Informatics Team gained re-accreditation to the ISDN Excellence in Informatics standards (Level 1), which recognises good practice in organisational workforce development.

   The standards are aimed at promoting the personal and professional development of Informatics staff, helping to ensure that the Informatics community in the North West are recognised nationally for their initiative-taking approach in supporting healthcare and encouraging staff to see professional development as important.

2.2. Summary of how we did against our 2021-22 Quality Account priorities

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

2.2.1. Progress in achieving 2021-22 quality goals

Objective	Measurement	Status
Continue to ensure the timely and effective assessment and care of patients in the Emergency Department	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Partially achieved - to be rolled over to 2022-23 • Triage Times for ambulance attendances – 36 minutes and for walk-ins – 37 minutes • First Clinical Assessment average – 178 minutes and median – 140 mins· • Latest audit results show 100% compliance with NEWS policy • Latest audit data (March 2022) demonstrate above 90% screening and 100% compliance with treatment for sepsis for Q2 2021-22

Objective	Measurement	Status
		• Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits • 57% compliance noted in latest audits, however, review of nursing documentation confirms that relevant assessment and treatment is in place • Head of Nursing and Quality for Urgent Care has been made a permanent position and continues to monitor that safety checks are being undertaken for patients waiting to be seen
Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of hospital-acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Achieved – however to be rolled over to 2022-23 to ensure improvements fully embedded Regular audit cycle for hydration now in place with results shared with individual teams, as well

Objective	Measurement	Status
		as the Hydration Steering Group indicating improvements made in all areas, including accurately completing fluid balance charts, up from 83.2% in February to 87.1% in March 2022 and 95.7% of patients were identified as having special requirements. CRAB data indicates that AKI rates are within expected range across both medicine and surgery.
Reduce avoidable harm by preventing falls	• Reduction in the number of inpatient falls per 1000 bed days from 9.03 to 7.7 or less • All patients to have a documented falls risk assessment within 6 hours of admission, which is reviewed at least every 7 days or sooner if the patient's condition indicates • Audit to demonstrate that all preventative actions are implemented following falls risk assessments	Partially achieved - to be rolled over to 2022-23 • 2021-22 8.56 falls per 1000 bed days, reduction of 6.12% compared with 2020-21 • On-going sample audit undertaken, with latest results showing 87% of patients audited had falls risk assessment completed at the time of the audit, with 45%

Objective	Measurement	Status
		completed within 6 hours of admission. Electronic dashboard being implemented across wards, to enable visual prompt to improve performance. • Audit carried out in February 2022 found 74% of patients audited had all interventions implemented.
Improve the effectiveness of the discharge process for patients and carers	• Ensure sufficient and appropriate information is provided to all patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information • Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards • Implementation of standardised patient equipment ordering process for aides required at home	Partially achieved - to be rolled over to 2022-23 Service Improvement – Discharge Improvement Programme has been finalised and recommendations and areas for improvement agreed. The inpatient survey scores improved for all of the following questions relating to receiving information:

Objective	Measurement	Status
		•Written information about what to do after discharge improved by 18% •What would happen next with your care by 3% •Told who to contact if worried after discharge by 9% •Staff discussing the need for health or social care support after discharge by 4% Weekday and weekend discharges before noon remain a challenge due to availability of social care. System trajectory for discharges now set at place level, with place leads being held accountable for delivery. Internal work continues, including a programme of improvement work planned for May 2022
Increase the proportion of patients who report that they have received an appropriate amount of information about their care	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	Achieved A number of questions in the inpatient survey relate to information, including

Objective	Measurement	Status
		the following increases in scores from the previous year's survey: 2% improvement in receiving understandable answers from doctors to questions; 11% for receiving understandable answers from nurses; 18% improvement for written information when leaving hospital

2.3. Quality objectives for improvement for 2022-23

The Trust's quality priorities for 2022-23 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff, commissioners and patient representatives, as well as being placed on the Trust's website for public participation. In addition, staff were asked about the proposed objectives during a senior team quality engagement walkabout in February.

The consultation was undertaken using SurveyMonkey with 129 responses received, an increase from 84 received in the last survey conducted (2019-20).

Analysis of the responses showed overall agreement and support for the proposed quality objectives, in particular the priority to ensure timely and effective assessment and delivery of care within the Emergency Department, which scored 100%. Reducing avoidable harm by preventing falls and improving the effectiveness of the discharge process for patients and carers both scored 97%. Ensuring patients in hospital remain hydrated scored 95%.

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Continue to ensure the timely and effective assessment and care of patients in the Emergency Department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety, whilst also responding to increased demand for services	Director of Operations and Performance	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Quality Committee

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Reduce avoidable harm by preventing falls	Patient safety and embedding a culture of safety improvement that reduces harm remain priorities for the Trust and whilst there was a slight reduction in falls in 2021-22 this remains a key focus for further reduction.	Director of Nursing, Midwifery and Governance	• Reduction in the number of inpatient falls per 1000 bed days by 10% compared to previous year • 95% of patients to have a documented falls risk assessment within 6 hours of admission measured through quarterly audit of sample of patients • Audit demonstrating that patients at risk of falling have a completed falls prevention care plan in place as per hospital policy	Quality Committee

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

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
Improve the effectiveness of the discharge process for patients and carers	A key theme from patient feedback during 2021-22 has been a need to improve the discharge experience for patients and their carers	Director of Operations and Performance	• 85% of take-home medications to be dispensed within 2 hours of prescription being received in pharmacy • Improved Inpatient Survey satisfaction rates for receiving discharge information • Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 20% target for patients discharged before noon during the week with achievement of 30% at least once each week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards • Implementation of standardised patient equipment ordering process for aides required at home	Quality Committee

2.4. Statements of assurance from the Board

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

2.4.1. Review of services

During 2021-22, the Trust provided and/or sub-contracted £433m NHS services.

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

The income generated by the NHS services reviewed in 2021-22 represents 97% of the total income generated from the provision of NHS services by St Helens and Knowsley Teaching Hospitals NHS Trust for 2021-22.

The above figures relate to income from patient care activities. The remaining total operating income arose from other sources such as NHS North West Deanery for the education and training of junior doctors and services provided to other organisations, such as IT, HR and Pathology Services.

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2021-22

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

It should be noted that some audits are listed as one entity on the published list, however, involve a number of individual projects being undertaken under this single heading: e.g. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) had 3 additional audit projects undertaken.

During 2021-22, 45 national clinical audits and 2 national confidential enquiries covered relevant health services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

During that period, St Helens and Knowsley Teaching Hospitals NHS Trust participated in 96% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust was eligible to participate in during 2021-22

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in during 2021-22
- The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
1.	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Yes	Yes	Continuous monitoring
2.	NCEPOD	Yes	Yes	Active
	1) Transition from Child to Adult Health Services	Yes	Yes	Active
	2) Epilepsy study 3) Crohn's disease study	Yes	Yes	Active
3.	Elective Surgery National Patient Reported Outcome Measures (PROMs) Programme	Yes	Yes	Continuous monitoring
4.	Royal College of Emergency Medicine (RCEM): Pain in Children	Yes	Yes	Active
5.	RCEM: Infection Control	Yes	Yes	Active
6.	National Audit of Inpatient Falls	Yes	Yes	Continuous monitoring
7.	National Hip Fracture Database	Yes	Yes	Continuous monitoring
8.	Inflammatory Bowel Disease (IBD) Programme (registry)	Yes	Yes	Continuous monitoring
9.	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE–UK) – Maternal Infant and New-born	Yes	Yes	Continuous monitoring
10.	National Diabetes Core Audit (NDA)	Yes	Yes	Continuous monitoring
11.	National Pregnancy in Diabetes Audit	Yes		Continuous monitoring
12.	National Diabetes Foot Care	Yes	Yes	Continuous monitoring

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
	Audit			
13.	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	In progress
14.	National Inpatient Diabetes Audit (NaDIA)	Yes	Yes	100%
15.	National Asthma & Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Paediatric Asthma Secondary Care	Yes	Yes	Continuous monitoring
16.	NACAP Adult Asthma Secondary Care	Yes	Yes	Continuous monitoring
17.	NACAP Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	Continuous monitoring
18.	National Audit - Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Active
19.	National Audit of Cardiac Rehab	Yes	Yes	Continuous monitoring
20.	National Audit of Care at the End of Life (NACEL)	Yes	Yes	Completed
21.	National Audit of Dementia	Yes	Yes	Active
22.	Epilepsy 12- (round 3) - Paediatrics	Yes	Yes	Continuous monitoring
23.	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous monitoring
24.	National Cardiac Audit Programme (NCAP) (includes the Myocardial Infarction National Audit Programme - MINAP)	Yes	Yes	Continuous monitoring
25.	National Heart Failure Audit	Yes	Yes	Continuous monitoring
26.	2021 Audit of Patient Blood Management & National Institute for Health and Care Excellence (NICE) Guidelines	Yes	Yes	Completed
27.	National Clinical Audit Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Continuous monitoring
28.	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring
29.	National Gastro-Intestinal	Yes	Yes	Continuous monitoring

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
	Cancer Programme: Bowel Cancer (NBOCA)			
30.	National Gastro-Intestinal Cancer Programme: Oesophago-Gastric Cancer (NAOGC)	Yes	Yes	Continuous monitoring
31.	National Joint Registry (NJR)	Yes	Yes	Continuous monitoring
32.	National Lung Cancer Audit (NLCA)	Yes	Yes	Continuous monitoring
33.	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Continuous monitoring
34.	National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous monitoring
35.	National Perinatal Mortality Review Tool	Yes	Yes	Continuous monitoring
36.	National Prostate Cancer Audit (NPCA)	Yes	Yes	Continuous monitoring
37.	National Vascular Registry (NVR)	Yes	Yes	Continuous monitoring
38.	British Thoracic Society (BTS) National Outpatient Management of Pulmonary Embolism	Yes	Yes	100% completed
39.	BTS National Smoking Cessation 2021 Audit	Yes	Yes	100% completed
40.	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Continuous monitoring
41.	Serious Hazards of Transfusion: (SHOT) UK National Haemo-Vigilance Scheme	Yes	Yes	Continuous monitoring
42.	Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	100% completed
43.	Trauma Audit & Research Network (TARN): Major Trauma Audit-ED	Yes	Yes	Continuous monitoring
44.	UK Cystic Fibrosis Registry	Yes	Yes	Continuous monitoring
45.	Transurethral Resection and Single Instillation Mitomycin C Evaluation in Bladder Cancer Treatment British Urology Researchers in Surgical Training (BURST)	Yes	Yes	Active
46.	Management of the Lower Ureter in	Yes	No	

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
	Nephroureterectomy Audit (British Association of Urological Surgeons (BAUS))			
47.	Fracture Liaison Service Database	Yes	No	No capacity to participate

The following were included on the 2021-22 Quality Account list, however the study was postponed and did not start in this audit year.

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
1.	2021 Audit of the Perioperative Management of Anaemia in Children Undergoing Elective Surgery	Yes		NHS Blood and Transplant - postponed until spring 2022
2.	Royal College of Emergency Medicine (RCEM): Consultant sign off	Yes		RCEM delayed the start of audit - planned for spring 2022

2.4.2.2. Other National Audits participated in during 2021-20 (Not on Quality Account list)

National audits
GlobalSurg-CovidSurg Week
Management of Primary Biliary Cholangitis
Type 2 Diabetes NPDA Spotlight Audit
Audit of Maternity Records for Antenatal Screening Quality Assurance
Rapid Access Chest Pain Clinic Audit Programme
Flash Glucose Monitoring Audit – Paediatrics (Freestyle Libre)
Flash Glucose Monitoring Audit - Adults (Freestyle Libre)
Sepsis Review Health & Care Partnership for Cheshire & Merseyside through Advancing Quality Alliance (AQuA)
National Ophthalmology Audit
Sprint Audit – NHS Tackling Serious Violence
Transurethral Resection and Single Instillation Intravesical Chemotherapy Evaluation in Bladder Cancer Treatment
Mastitis and Mammary Abscess Management Audit (MAMMA)
Study of Ibrutinib +/- Rituximab for Upfront Treatment of Mantle Cell Lymphoma (MCL)
Diverticular Abscess Management: A Snapshot Collaborative Audit Study (DAMASCuS)
Management of Early Acute Pancreatitis

Tranexamic Acid in Elective Colorectal Surgery (TEXAS)
Rectal Cancer Management during the COVID-19 Pandemic (ReCaP) Audit
BTS Pleural Services Organisational Audit
Glycaemic Management during Enteral Feeding in Stroke: Joint British Diabetes Society (JBDS)
NHSE COVID-19 Commissioning for acute myeloid leukaemia
National Unilateral Nipple Discharge Study
Growth Assessment Protocol Standardised Case Outcome Review and Evaluation (GAP SCORE) Missed Case Audit
National Children and Young People Diabetes and Quality Programme
Breast and Cosmetic Implant Surgery
National 3rd Corrective Jaw Treatment Audit
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)
Data Quality Audit (DQA) – Elbows: National Joint Registry
Cascade: Cardiovascular Outcomes After Major Abdominal Surgery: Eurosurg Collaborative Audit

The reports of 50 national clinical audits were reviewed by the provider in 2021-22 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Emergency Department – Royal College of Emergency Medicine (RCEM)	
Self-Harm Audit	The audit demonstrated continuous improvement in suicide risk assessment, suicidal intent and risk of repetition and significant improvement in the performance of Mental State Exam. However Mental Health triage was not achieved. Actions: the need for a mental health assessment at triage has been addressed by the lead nurses. A subsequent spot audit carried out to assess for impact of change has also showed a substantial improvement. Trial of a pro forma for mental health assessment was undertaken and version 2 will be available in 2022.
Urology - British Association of Urological Surgeons (BAUS)	
Renal Colic Audit 2020-2021	Although the audit contained a very small sample the Trust's Urology Unit's current practice is in keeping with international and national standard. Actions: all emergency stented patients are listed on an urgent basis in 4 weeks and record stent in situ on listing form.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Surgical & Medical/Child Heath Programme	
The Trust has participated in all eligible studies. During 2021-22, 1 completed study report was received and disseminated:	
Completed Studies: • Dysphagia (published August 2021)	Active Studies: • Epilepsy (adults) • Transition from Child to Adult Services • Crohn's

Audit Title	Outcome/actions
NCEPOD (Surgical & Medical) & NCEPOD (Child Health) have the following studies planned: • Community Acquired Pneumonia • Testicular Torsion	
NCEPOD Out of Hospitals Cardiac Arrest (OHCA) Study 2019-20	The report was disseminated and reviewed. The Trust is compliant with all the eligible recommendations of the report.
General Medicine - NLCA	
2020 - Annual-Report (2018 cohort)	The Trust diagnoses and treats approximately 36% more lung cancer cases per year compared to the national average. The Trust was a positive outlier in 4 out of 6 key performance indicators for lung cancer. Further education has been delivered on recording of lung function.
Paediatrics – NPDA	
Patient/parents reported experience measures 19 (PREM) Survey report	Good results were received from parents/patients in many areas assessed. The following actions have been implemented to improve on areas where needed: • A Clinical Psychologist has been appointed and is available in clinic • Waiting times in clinic and communication with patient/carer as regards HbA1c and how to manage blood glucose levels have been discussed with patients • Patients will be invited to a group session so they can keep up to date with any new technology and help manage their diabetes • Awareness raising with patients/families about arrangements for obtaining out of hours help line with an update on telephone numbers and email address for specialist diabetes advice • Glucagon injection awareness and training in the previous 6 months period, assessment to be undertaken after every 6 months and patients will be invited annually for training • A detailed assessment and re-configuration of adolescent transition process in the light of this survey and the feedback received from youngsters/families that have been transitioned to adult diabetes service has been undertaken • A newsletter is regularly sent to young people/families to inform them of updates to service and ask them for feedback
Paediatrics - National Asthma & COPD Audit Programme (NACAP)	
Children & Young People Asthma Audit	Actions included the delivery of educational sessions to staff, inclusion of smoking/referral to smoking cessation services on health record pro forma to improve

Audit Title	Outcome/actions
	documentation and to develop a multi-disciplinary team (MDT) meeting involving paediatrician, psychologist, dietician, pharmacist, physiotherapist, respiratory nurse, consultant and patient representative going forward.

2.4.2.3. Local clinical audit information

The reports of 157 local clinical audits were reviewed by the provider in 2021-22 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Anaesthetics/Theatres	
Re-audit request to attendance time of epidural	The audit demonstrated high compliance of over 94% attendance within 60 mins. Awareness has been raised at Induction sessions of the 30-minute standard and the need for documentation. New induction pack for trainees and new epidural chart have been implemented.
Obstetric anaesthesia follow-up audit	New induction pack for trainees and a new information leaflet have been implemented.
Critical Care	
Documentation audit of target oxygen saturations and mean arterial blood pressure (MAP) in Critical Care	As a result of the audit the observation chart will be reviewed and modified in order that target oxygen saturations (saturation of peripheral oxygen (SpO2)) and target MAP can be recorded.
Community - Cardiac Rehabilitation	
Record keeping audit programme	All standards assessed were met for the quarter 1 audit, 93% of the standards were achieved for subsequent audits in quarters 2 & 3 2021-22.
Emergency Department (ED)	
Hypertension audit	Generate a pathway to manage hypertension in the ED in conjunction with the team on Acute Medical Unit (AMU).
Reducing unnecessary investigations and interventions of bronchiolitis	A bronchiolitis pathway was implemented. This topic has since been re-audited and the pathway is working well.
Cardiac arrest documentation audit	As a result of the findings a documentation point of access pro forma was implemented. A re-audit is underway with findings due to be presented in March 22
Improving the clinical confidence and knowledge in the management of common overdoses in the ED	Plan: Implement Top 10 overdoses manual

Audit Title	Outcome/actions
Time to CT: To audit if national standards are being met when performing CT scans for adult patients presenting with head injury	The audit found100% of patients who required a CT head scan within 8 hours of the scan being requested, achieved this target. 96% of all patients who had a CT head had a written provisional report available within 1 hour of the scan being performed. Planned actions: To update ED head injury proforma, to focus on contacting CT radiographers and performing neck assessment. Further education to be deliver at induction and at handover regarding scan discussion with Radiographer.
Audit - standardising management of Bell's Palsy patients in ED	A new Bell's Palsy pro forma to be designed and implemented in the ED
ED record keeping audit programme	Actions: To print stickers that can be used and re-educate the importance of this. To consider giving new starters a stamp to use in the notes. Educate people during handover about making corrections. Re-education of paediatric triage staff re: weighing all patients. Having a specific area for patient discussion that has to be completed in the ED documentation.
Diabetes & Endocrinology	
Management of enteral feeding in patients with diabetes	Actions implemented: Dieticians add stickers to notes to remind ward staff to check that all patients who are started on enteral feeding have capillary blood glucose levels monitored when feed first initiated. Diabetes Inpatient Guidelines has been updated to include information on how to manage patients requiring enteral feeding.
Diabetes foot glucose balance – telephone support clinic audit	On average a patient's HbA1C (average blood sugar reading) shows an improvement of 10mmolL after having the Diabetes Specialist Nurse Foot Glucose Telephone Support appointment. Actions implemented include: • New patient leaflet is now in use • New clinic template is also now in use • Increased telephone clinic appointment times from 10 to 20 minutes
Management of hyponatraemia in patients with COVID-19	The audit resulted in planned actions to the develop Trust guidelines for investigating inpatients with hyponatraemia.
Outpatient diabetes record keeping audit programme	All standards assessed were met for the quarter 1 audit. 95% of the standards assessed were achieved for subsequent audits in quarters 2 & 3 2021-22.

Audit Title	Outcome/actions
Cardiology	
Accidental omission of cholesterol assay in patients with acute coronary syndrome (ACS)	Actions planned are to create a cardio test pack which will automatically include full lipid profile on admission and to design a pro forma for the cardiology rehabilitation nurses as a re-check cholesterol prompt.
Department of Medicine for Older People (DMOP)	
The use of psychotropic medications in older patients with delirium who are agitated and distressed	An educational session has been delivered to staff on prescribing and appropriate process for assessing patients including an approach to the clinical assessment, the use of non-pharmacological de-escalation techniques, capacity assessment and the appropriate documentation standards to make further improvements.
Intermittent pneumatic compression compliance in stroke patients	Plan actions include: Delivery of staff education on importance of correct use and importance of intermittent pneumatic compression stockings. Feasibility of implementing a regular reminder on EPMA hospital system to check intermittent pneumatic compression in-situ
Dermatology	
Regional basal cell carcinoma audit	The Trust performed well for surgical excision of basal cell carcinomas. Documentation of size of basal cell carcinoma documented in the clinic letter was one of the highest in the Merseyside region.
Orthopaedics	
Audit on the dose of vitamin K required for the reversal of International Normalised Ratio (INR, the time taken for blood to clot) in warfarinised neck of femur fracture patients	An increased first dose of vitamin K to be given to warfarinised neck of femur fracture patients has been implemented
Antibiotic prescribing on orthopaedic wards re-audit	Improvements were demonstrated with some high percentage compliance compared to the previous audit. Actions: to continue education for junior doctors and ensure documentation is fully completed on the discharge summaries.
Palliative Care	
Hospital to hospice transfer audit	As a result of the audit, a new Palliative Care Discharge Tool (SAFE TRANSFER) has been developed. Education for all ward staff on this topic is being delivered.
Paediatrics	

Audit Title	Outcome/actions
Gastroesophageal reflux disease (GORD) treatment in infants	Patient leaflet was updated May 2021 and is due for further update in May 2022. Teaching is given to every new group of trainee doctors starting, covering the NICE guidance for GOR/GORD as the main core of presentation. The teaching sessions receive very good feedback from trainees.
Audit of the use of dexamethasone in viral induced wheeze and asthma	Asthma prompts have been added to the asthma care pathway. The pathway is being audited as part of NACAP.
Audit of outpatient medical management of cystic fibrosis conforms with NICE guidlelines	Good results were demonstrated at both the annual and routine reviews when audited with high compliance. Actions: Non-Tuberculous Mycobacteria (NTM) sputum and medication adherence tick boxes have been added to review forms.
Anaemia in neonates	Planned actions include: Further teaching session for medics on Direct Antiglobulin Test reporting. Update of the Trust Transfusion Policy.
Obstetrics & Gynaecology	
Waterbirth Audit	The audit showed that women are using the birthing pool. Teaching sessions have been given to further highlight the importance of completing risk assessments, observations when caring for a woman using the pool and the use of temperature charts for the pool.
Audit of management of women who attend maternity triage with spontaneous rupture of membranes (SRoM) at term	Plan: creation of SRoM at term pro forma.
Management of ovarian masses in pre- & post-menopausal women	Actions following the audits included guidelines being updated and the introduction of a new pro forma for the pelvic mass clinic to assist with documentation and investigations.
Audit of maternity records for antenatal screening quality assurance	The audit demonstrated some excellent results with standards reaching 100% in several areas. Some areas still required improvement. Actions: Digital Screening Test for You & Your Baby booklets are made available to women via a website link on the booking letter. The guideline for antenatal screening tests has been updated and reminders to staff regarding discussions and documentation have been given at mandatory training and in newsletters.
Detection and treatment of anaemia including administration of	Actions: Learning has been disseminated through audit presentation.

Audit Title	Outcome/actions
Monofer (Reaudit)	1) Clinic midwife who picks up the result and sends the GP letter also to request a repeat Full Blood Count in 4 weeks 2) If dietary advice given, this to be documented on the hospital Careflow system
Audit of Guideline for Antepartum, Intrapartum and Postpartum Care of the Pregnant Obese/ Bariatric Woman	Planned actions following the audit are to create a new pathway to detail the care of the bariatric patient during pregnancy.
Quality Improvement & Clinical Audit	
Audit of compliance with the Trust Clinical Audit Policy 2021-22	Overall good practice in the administration of audit projects and quality improvement proposal registration. A further increase in the number of projects where a final action plan was received following presentation or dissemination of the results was shown compared to the previous audit (up by 10%). The audit found that not all 'no support' audits notified of completion/presentation dates when presenting in-house nor returned all final presentation/reports to Quality Improvement & Clinical Audit (QICA) Department. Actions: for audits not supported by QICA Department - review the whole process for notification of completion /dissemination of projects.
Therapy Services	
Clinical audit: To determine whether written action plans are being actioned in a timely manner	The audit demonstrated improvements in the timing of action plans being actioned following initial contact with patients. Changes to working systems and streamlining practices have had a positive effect on team working. Actions include therapy handover for all staff to fill in after morning handover and update daily with discharge and current therapy input plans.
Burns and Plastic Surgery	
Pain management in burns audit	The audit demonstrated 100% compliance against national standards for pain management. However the time and frequency of pain assessment standard was felt to be inadequate. Planned actions: Change timing and frequency of pain assessment. Revision of the pain management in burns standard operating procedure with better categorisation of local standards.
Compliance of Plastic Surgery doctors, obtaining informed consent in trauma cases involving ionising radiation,	Actions include: Production and dissemination of information email to all surgeons and trainees regarding doses of ionising radiation and associated risks. Distribution of information leaflets and posters regarding

Audit Title	Outcome/actions
regarding the radiation doses and their associated risk	ionising radiation doses and risks in Trauma Assessment Unit and Ward 3A as most plastics trauma cases are assessed in these areas. Introduction of a "The patient is aware of the mean doses of ionising radiation and associated risks that is going to receive during the operation by leaflet provided or verbally informed from consenting surgeon" tick box on plastics trauma pro forma. Liaise with radiology department to calculate Dose Reference Levels (DRLs) for most common open and close cases. Distribution of information leaflets and posters regarding department-specific (after DRLs are extrapolated from daily practice) ionising radiation doses and risks in Trauma Assessment Unit and Ward 3A as most plastics trauma cases are assessed in these areas.
A clinical re-audit of the flexor tendon repair outcomes	Successfully re-audited full year of flexor tendon repairs. Achieved aim to see 80% patients by therapy within 5 days after surgery, a vast improvement from the previous audit. Time to surgery was good. Significant improvement and nearly achieved aim of having only 40% patients to be in poor/fair outcome group. Actions: aim to lower the percentage of patients' outcome in poor or fair range of motion outcome group. Increase follow up rate with formal outcomes to 60%.
Evaluating the compliance of the hand trauma injury pro forma	The audit demonstrated good compliance; plan to look at the feasibility of implementing an electronic hand trauma injury pro forma with pre-existing boxes to further improve documentation.
Radiology	
Are we grading thyroid nodules accurately?	The aim was to correlate radiological grading with cytological grading to ensure grading accurately. The audit results showed good practice with 100% accuracy.
Cholecystostomy in acute cholecystitis	As a result of the audit a new referral form will be introduce based on the NICE guidance.
Resuscitation Services	
Unified do not attempt cardiopulmonary resuscitation (DNACPR) documentation audit: re-audit	The audit noted some improvements compared to the first audit, with further improvements required. Planned actions: Focussed DNACPR teaching for all grades of doctors. Discussions regarding adding alerts/mandatory fields to electronic patient records. Guidance on how to input DNACPR decision status on to hospital system has been re-circulated.

2.4.3. Participation in clinical research

Clinical research is a vital part of the work of the NHS and plays a critical role in driving medical advances that improve and save countless lives. In March 2021 the government published a bold and ambitious vision for the future of clinical research "Saving and Improving Lives - The Future of UK Clinical Research Delivery". Important lessons were learned from the pandemic about how the UK can improve in the delivery of research. The vision has five key themes which underpin the improvements that will be taken forward in the coming months and years:

- Clinical research embedded in the NHS
- Patient-centred research
- Streamlined, efficient and innovative research
- Research enabled by data and digital tools
- A sustainable and supported research workforce

As the NHS slowly moves towards 'business as usual' the impact of the pandemic on non-COVID research has been significant. In response to this, the Trust has worked hard to re-open as much non-COVID research as practical under the National Institute for Health Research (NIHR) Managed Recovery process. This process was developed and delivered through the UK Clinical Research Recovery, Resilience and Growth (RRG) programme. In 2021-2022 the Trust received additional funding from the Clinical Research Network North West Coast (CRN NWC) to help support the Managed Recovery Process. We are pleased to report that the Trust met the planned target of ensuring that 70% of our non-commercial studies and 80% of our commercial studies met the NIHR metrics.

The number of non-COVID research studies open to recruitment at the Trust during 2021-2022 was 99 compared to 96 in 2020-2021. This includes the OPTIMAS trial which was mentioned in the "Saving and Improving Lives - The Future of UK Clinical Research Delivery". This is a study looking at whether starting newer Direct Oral Anticoagulants (DOACs) early is associated with a low risk of intracranial bleeding. This randomised controlled trial compares early and delayed treatment to answer this important question. The Stroke Team, supported by the CRN NWC taskforce, are to be congratulated on their efforts in setting up and recruiting to this study.

The number of patients with cancer entering clinical trials fell by 60% during 2021-2022. However, the cancer portfolio at STHK has remained stable with no drop in the number of cancer studies open to recruitment (18). There was only a slight decrease in the number of patients recruited, from 111 in 2020-2021 to 99 in 2021-2022, which proves that we are moving in the right direction to getting the Trust's cancer research portfolio back on track and are continuing to offer patients the opportunity to take part in these important studies.

The number of studies that the Trust sponsored increased to 7 in 2021-2022 compared to 4 in 2020-2021. The Sponsor is the individual, company, institution or organisation that takes on the ultimate responsibility for the initiation, management (or arranging the initiation and management) and/or financing (or arranging the financing) for that research.

In order to enable the NHS to concentrate on priority COVID research a substantial

number of commercial research studies were paused, which meant a reduction in this income stream. It is recognised that there is a huge potential in the Trust to increase our commercial activity, therefore, funding was secured from the CRN NWC for the Trust to pump prime this activity. In January 2022 the Trust employed a dedicated Commercial Research Nurse, for 12 months, to expand and increase the number of new commercial studies.

In December 2021 the Trust recruited the first patient in the UK to the commercial study: TAK-018 study - (randomized, double-blind, placebo-controlled, multi-centre, phase 2a study to evaluate the safety, tolerability, and early proof of concept of TAK-018 for the prevention of postoperative Crohn's disease recurrence). The Gastroenterology Team at the Trust continue to expand their research portfolio and have an excellent national reputation for delivering clinical research in this area.

Although the pandemic has been challenging, our research staff have responded with enthusiasm and adapted to new ways of working. Collaboration with our partner organisations has been high on the agenda and is the direction of travel for the future, thus offering our patients research opportunities regardless of location or condition.

The Team have continued to support the Liverpool School of Tropical Medicine by following up participants on the Oxford Vaccine Study and have also supported recruitment to the Moderna Vaccine Study at the Halton Research Unit. These vaccines have helped to save lives and are the best way to protect people and prevent the emergence of new variants.

The following table demonstrates recruitment to COVID studies during 2021-2022 (691).

Short title	Subject	Number of participants recruited 2021-22	Total
RECOVERY	A clinical trial to test the effects of potential drug treatments for patients admitted to hospital with both suspected and confirmed COVID-19.	30	255
ISARIC	A study aiming to discover the background of the virus so attempts can be made to find better ways to manage and treat the infection in the future	608	1481
GenOMICC	A study aiming to find the genes that cause some people to be more vulnerable to COVID-19.	47	152
MERMAIDS study	Multi-centre EuRopean study of MAjor Infectious Disease Syndromes: Acute Respiratory Infections in Adults	6	10

It is important to note that in addition to the recruitment to COVID studies the Team have also been following up participants in the SARS-COV2 Immunity and Reinfection Evaluation (SIREN) study, which looks at the impact of detectable anti SARS-COV2 antibody on the incidence of COVID-19 in healthcare workers. The study was extended beyond the original recruitment period to answer valuable questions following the roll out of the vaccination programme. Over 200 members of the Trust's staff agreed to continue in the trial which is an excellent indicator of the commitment to supporting this study.

In October 2021, the Trust was congratulated for their contribution to the Genomic Study, a study aiming to find the genes that cause some people to be more vulnerable to COVID-19 and was the third top recruiter out of the 48 sites taking part in the study. This is a remarkable achievement and is due to the hard work of the whole Research Team, including Medics, Research Nurses and support staff.

Continuing on the theme of collaboration, the Trust has also forged links with the Primary Care sector and has supported a number of Doctor of Philosophy (PhD) students conducting research that cuts across Primary and Secondary Care; this research is exploring valuable questions that will help shape how patients' treatment, journey and experiences are managed in the future.

The Trust has progressed with the collaboration with Clatterbridge Cancer Centre (CCC) and are working closely to ensure that combined research pathways are in place that allows us to offer our patients access to new treatments, particularly those that require both surgical and oncology interventions.

It has been recognised that although the number of patients recruited to research studies is important, there is a shift towards ensuring that the Recruiting to Time and Target (RTT) metric is met. This is the number of clinical trials that meet the target recruitment before the closure of the study. In 2021-22 (85%) of research studies met the RTT. The recruitment target set for 2021-22 was 1324 and we successfully recruited a total of 1308 participants. Currently the Trust ranks 8 out of 20 Trusts across the CRN NWC. This is the same as last year and is remarkable considering the challenges of COVID and once again demonstrates our commitment to offering patients and the public the opportunity to take part in research.

The number of patients receiving relevant health services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2021-22 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 1308.

The Trust is still committed to developing future Principal Investigators (PIs) and this year we have seen an increase in the number of Research Fellows employed across various specialities, including Intensive Care, Stroke and Cardiology.

The Participant in Research Experience Survey (PRES) is conducted annually by the NIHR. In 2021-22 the Trust received the second highest number of responses. One recurring theme that emerged from the findings was the uncertainly of clinic appointments, often moved at the last minute due to outpatient capacity and lack of dedicated research clinic space. In 2021-22 the Trust Board supported a move

towards a dedicated research space with 2 clinic rooms/treatment areas, a research office and a research laboratory. The new unit, scheduled to open in Spring 2022, allows a number of participants to be seen at any one time for screening, randomisation, study visits and procedures and follow-up visits. This was supported by the CRN NWC who funded some essential equipment for the clinic rooms and laboratory. The PRES continues to be a priority as participant experience is at the heart of research delivery by providing an opportunity for as many research participants as possible to share their experience of taking part in research.

2.4.3.1. Research aims for 2022-23

- Update the Research Development and Innovation (RDI) Strategy to reflect that across the UK the journey towards integrated care is well underway. In England, the Integrated Care Systems (ICSs) are partnerships between organisations to coordinate services and deliver healthcare in a way that improves population health and reduces inequalities between different groups within their region. Research and innovation should be considered as key contributors to this planning and coordination of services, ensuring equal access to research across an ICS footprint. In preparation for this we will update the Strategy in line with ICS and CRN NWC strategies. The strategy will set clear goals and objectives that will enable us to promote a culture where RDI drives better patient care and improves the Trust's capacity, capability and delivery of clinical research
- Appoint a Clinical Director of Research who will provide strategic leadership in further developing the Trust's output of clinical research and work in partnership with the Medical Director, external organisations and stakeholders
- Increase the number of commercially sponsored studies as these are valuable source of support for NHS trusts. This income can be used to encourage key stakeholders to develop capacity for new research within the Trust and increase the volume, and, therefore, future income generation
- Raise the clinical and academic profile of the Trust, by encouraging collaborations with other NHS organisations and Universities
- Review Standard Operating Procedures (SOPs) as the RDI Department has a suite of SOPs which cover all aspects of the set up and conduct of a research project. A number of these SOPs are due for renewal in 2022- 2023 and will be amended to reflect changes in processes and regulations
- Develop and update our social media and website platforms to help promote research and reach out to people in an increasingly virtual world
- Continue to ensure that the NIHR PRES is embedded into patients' research journeys and that both positive and negative feedback is considered
- Encourage engagement with the NIHR in accordance with the Department of Health strategic direction for research, development & innovation

In summary, it has been a hugely challenging year that the Trust has responded to for the benefit of all of our patients. Our ambitions continue to grow with our capability to deliver the highest quality research and we move forward to a new chapter with high-profile positions to support the important research that we deliver to improve the care of our patients every day.

2.4.4. Clinical goals agreed with commissioners

In normal circumstances, a proportion of St Helens and Knowsley Teaching Hospitals NHS Trust income in 2021-22 would have been conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework (CQuIN). However, the COVID-19 pandemic resulted in NHS England/NHS Improvement (NHSE/I) suspending the operational delivery of CQuIN schemes for all NHS providers during the whole of the 2021-22 financial period (1st April 2021 – 31st March 2022). Instead NHS providers were awarded full payment of their CQuIN allowance. Financial sanctions associated with the delivery of all NHS national operational standards and national quality requirements were also suspended for the whole of 2021-2022 financial period.

2.4.4.1. CQuIN proposals 2022-23

For 2022-23, NHSE/I have reintroduced the operational delivery of CQuINs in order for the Trust to receive CQuIN income. The table below reflects the CQuINs currently being finalised between the Trust and its Clinical Commissioning Groups (CCGs), noting that of the CQuINs listed in the table below, 5 of the 6 acute CQuINs will have payments attached to their delivery, along with all of the 4 Community and 1 Specialised Commissioning CQuINs. The Director of Nursing, Midwifery and Governance will confirm the final 5 acute CQuINs once agreed with Commissioners.

CQuIN Ref	Provider Type	CQuIN Brief Description
CCG1	Acute & Community	Flu vaccinations for frontline healthcare workers
CCG3	Acute	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
CCG4	Acute	Compliance with timed diagnostic pathways for cancer services
CCG6	Acute	Anaemia screening and treatment for all patients undergoing major elective surgery
CCG7	Acute	Timely communication of changes to medicines to community pharmacists via the discharge medicines service
CCG8	Acute	Supporting patients to drink, eat and mobilise after surgery
CCG13	Community	Malnutrition screening in the community
CCG14	Community	Assessment, diagnosis and treatment of lower leg wounds in the community
CCG15	Community	Assessment and documentation of pressure ulcer risk in the community
Specialised Commissioning	Acute	Achieving high quality shared decision-making conversations in specific specialised pathways

		(chemotherapy & hepatitis still to be confirmed) to support recovery

2.4.5. Statements from the Care Quality Commission (CQC)

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

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

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

The latest comprehensive CQC inspection took place in July and August 2018. The Use of Resources review was undertaken on 5th July, the unannounced inspection took place during the week commencing 16th July, the inspection of Marshalls Cross Medical Centre was completed on 14th August and the planned well-led review was completed during the week commencing 20th August.

Teams of inspectors visited Whiston, St Helens and Newton hospitals and the Trust's directly provided community and primary care services during the inspection period to talk to patients, carers and staff about the quality and safety of the care provided. They reviewed care records and observed the care provided. The Trust was able to demonstrate to the inspection team the high standard of work that is undertaken on a daily basis to ensure patients receive excellent care.

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

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2021-22.

St Helens and Knowsley Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2021-22.

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

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

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

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

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

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

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

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2022 in taking such action:

- Delivery of action plans to address the areas of non-compliance in Marshalls Cross Medical Centre and all of the should do recommendations, including those areas where the Trust requires improvement in the ED, including clarifying and monitoring the quality and completion of ligature and clinical risk assessments to ensure they are completed as appropriate for all patients requiring them in ED

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

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

During 2021-22 the CQC continued with transitional monitoring arrangements with no concerns raised.

2.4.6. Learning from deaths

2.4.6.1. Number of deaths

During Quarters 1-4 2021-22 1,840 of St Helens and Knowsley Teaching Hospitals NHS Trust's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:
411 in the first quarter
449 in the second quarter
508 in the third quarter
472 in the fourth quarter

By end of Q4, 259 case record reviews and 3 investigations (reds and ambers) have been carried out in relation to the 1,840 deaths included in item 2.4.6.1.

In 3 cases (reds and ambers), a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
1 in the first quarter
0 in the second quarter
2 in the third quarter
0 in the fourth quarter

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

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

173 case record reviews and 3 (reds and ambers) investigations completed after 31-12-2020 which related to deaths which took place before the start of the reporting period.

1 representing 0.2% (reds) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the St Helens and Knowsley Teaching Hospitals NHS Trust's Structured Judgement Review (SJR) (which uses NCEPOD quality score and red, amber, green (RAG) rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance. This represents the final position for Quarter 4 of 2020-21.

3 representing 0.1% (reds) of the patient deaths during 2020-21 are judged to be more likely than not to have been due to problems in the care provided to the patient. This represents all four quarters of 2020-21.

2.4.6.2. Summary of learning from case record reviews and investigations

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

- **Check Alerts**

If the alert sign is visible in the 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 is included in alerts?

- **Communication with families / carers**

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; this is even more challenging over the phone. Staff must remain aware of verbal or physical cues from families / carers suggesting key messages have not been fully appreciated, so the communication can be reinforced accordingly

- **Learning Disability Deaths**

Following an audit carried out on all patients who have a learning disability who have died in the Trust since Structured Judgement Reviews (SJRs) began, we are able to confirm that all patients had received not only a SJR but also a learning disability review. The outcomes of all of these reviews were either green or green with learning, thus confirming that we have robust systems in place for looking after this complex cohort of patients. For any further advice or support in caring for learning disability patients or feedback on these reviews then please contact the Trust's Learning Disability Specialist Nurse.

- **Falls that result in Death**

Falls are the most common cause of injury-related deaths in people over the age of 75 (Age UK 2019) and out of the 39 serious harm falls investigated between January 2020 and April 2021, 12 (30%) died within 28 days of the fall in hospital.

All patients aged 65 or over or anyone aged 55-64 with a condition that could increase their risk of falling (e.g. a neurological condition) must have a falls risk assessment carried out within 6 hours of attendance at ED/admission to a ward. This should be done from both a nursing and medical perspective and falls risk factors should be considered irrespective of the acute reason for attendance/admission. In addition, end of life and palliative patients should also be considered for their increased risk of falling. When the risk assessment has been completed, we must ensure that appropriate actions to minimise the risks identified are taken and documented e.g. supervision level, low rise bed. If a fall does take place, it is essential that a post fall medical review and nursing pro forma are completed/documented and the risk assessment and any associated care

plan/actions are updated accordingly.

- **Documentation – Identify yourself**

Our record keeping policy clearly states:
"Records should be accurately dated, timed, signed and the signature printed to ensure that each entry can be attributed to an individual". It is your responsibility to ensure that you practice within the confines of the policy and the standards contained within. In addition to this, good practice would be also to include the ward concerned.

- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – We're getting there**

During the COVID pandemic, early discussion and consideration of DNACPR status was encouraged for all patients. The junior doctors rose to this challenge well with many of these conversations taking place over the phone, rather than face to face. However we failed to follow Trust policy, as below:
Every DNACPR decision made during their inpatient stay MUST be reviewed upon discharge by the Senior Clinician authorising the discharge, this led to a number of complaints from patients and their families.

2.4.6.3. Actions taken resulting from learning

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

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

As learning generated from SJRs continues to be shared, evidence of changes to practice, in particular with DNACPR, can be seen. A project group has been working with clinicians to determine where problems lie. Training and support have been put in place and this continues to have an impact on the SJRs in that less DNACPR concerns are seen. This theme has also been evidenced with a decrease 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 the DNACPR still in place.

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

- A working group has been developed to determine the complexities clinicians face in engaging with patients and their families in determining ceilings of treatment and DNACPR decisions. These have been made even more evident by challenges faced during the COVID pandemic
- Trust level project to evaluate and determine the best course of action in the management of the deteriorating patient at Whiston site, including aggregated,

comprehensive review of patients who have required multiple calls to the Medical Emergency Team (MET)
- Case review sharing with junior doctors in line with the Royal College of Physicians Lessons Learned Programme https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6616793/
- Recognition of exceptionally good care, which is acknowledged by the Mortality Surveillance Group in writing and used by individual clinicians to support appraisal and revalidation

In addition, there is a Medical Examiner service at the Trust that will refer cases that require a review, providing further opportunities to learn lessons and make improvements to the care provided.

2.4.6.4. Impact of actions taken

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

2.4.7. Priority clinical standards for seven-day hospital services

The Seven Day Hospital Services Programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. Ten clinical standards for Seven Day Hospital Services (7DS) were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. The four priority Clinical Standards (CS) were selected to ensure that patients have consistent and timely access to consultant assessment (CS 2), diagnostics (CS 5), interventions (CS 6) and ongoing review (CS 8) every day of the week. Reporting of 7DS was suspended during the COVID-19 pandemic, however it was recommenced when the standards were reviewed in 2021 by a clinical reference group which confirmed that they remain relevant and important in the NHS today, with new guidance on how assurance should be provided released in February 2022.

The four priority Clinical Standards are:
- Clinical Standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties (eg. Acute Medicine) consultant presence into the evening is likely to be needed every day.
- Clinical Standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.
- Clinical Standard 6 states that emergency and urgent access to appropriate

consultant-led interventions should be available every day.
- Clinical Standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

The majority of patients who are admitted to the Trust are under the care of the Medical Team via the Emergency Department, Acute Medical Unit, Acute Stroke Unit and Acute Frailty Unit. Planned consultant staffing in these areas enables the majority of patients to be seen within 14 hours of admission to hospital. Haematology is the only medical speciality where there are no job planned weekend consultant sessions, however direct admission (not via ED) of patients to this area is uncommon and processes are in place to ensure that complex or unwell patients will receive consultant review at weekends if required. The volume of patients admitted as an emergency to surgical specialities are smaller than medicine. The level of surgical consultant staffing allows most patients to receive consultant review within 14 hours of admission to hospital. Weekend review in both General Surgery and Urology, however, may be delayed if patients are admitted after the morning ward round until the following day, breaching the 14 hour standard for review.

The Trust is able to provide all emergency diagnostic tests and the majority of emergency interventions on site at weekends with the remainder provided via local clinical networks.

There is medical staffing presence to ensure that there is a consultant or their nominated deputy available to review almost all medical inpatients across the Medical Care Group regardless of the day of the week. The only current gap within this is weekend cover for haematology patients where there remains consultant on-call cover (across multiple sites) for review or discussion of any unwell patients. There are job planned consultant sessions allowing all emergency inpatients to be seen each day by a consultant or their nominated deputy in medicine. This is not available at weekends due to reduced numbers of medical staff and conflicting demands on their time (eg. emergency admissions through ED and operating lists) but a system is in place to provide review of any unwell patients highlighted by nursing or medical staff.

Length of stay data suggests that patients who are admitted at a weekend tend to stay longer in hospital, by an average of 0.8 days. There is also a stark difference in the volume of patients discharged on weekdays compared to weekends, the reasons for which are multifactorial and include other factors (such as Social Care Support and Trust Discharge Coordinators being unavailable at weekends) so cannot be solely ascribed to consultant presence. There is no evidence of any increase in harm reporting via the Datix system at weekends compared to weekdays.

Actions to ensure continuous improvement in delivery of 7DS:
- Work with surgical teams to ensure consistency of twice daily ward rounds on both weekdays and weekends
- Work with Operational Services Team to clear assessment areas
- Repeat audit of Trust performance against CS 2 and 8
- Work with wards, allied health professionals, social care and system-wide

partners to maximise weekend discharges
- Liaise with NHSE/I regarding the application of standards across smaller specialities

The Trust currently meets the 7DS Standards for 14 hour consultant review in the highest admitting specialities across medicine and surgery. It also meets the standards for daily consultant review across the highest admission specialities on weekdays. Further work is required across the Trust to ensure that as many patients as possible receive Consultant review within 14 hours at weekends with collaboration required with Social Care and system-wide partner teams to optimise patient discharge at weekends.

2.4.8. Information governance and toolkit attainment levels

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

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

St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall submission position for 2020-21 was published in June 2021. To provide assurance that the Trust's DSPT for 2020-21 was of a good standard, it was audited by Mersey Internal Audit Agency and achieved substantial assurance.

The Trust has assigned specific roles to ensure the IG framework continues to be adhered to and remains fully embedded:
- Christine Walters, Director of Informatics – Senior Information Risk Owner (SIRO)
- Mr Alex Benson, Assistant Medical Director - Caldicott Guardian
- Camilla Bhondoo – Head of Risk Assurance and Data Protection Officer

All three staff are appropriately trained.

The Trust has a Data Breach Management Procedure in place which is adhered to when a personal data breach/incident occurs. All incidents are risk assessed and scored and if an incident is scored highly, it must be reported to the Information Commissioner's Office (ICO). The Trust reported five incidents in the year via the DSPT reporting tool, however no further escalation was required and these incidents were managed locally.

2.4.9. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2021-22 by the Audit Commission.

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security & Protection Toolkit 2021-22. The error rates reported in the latest published audit for that period of diagnoses and treatment coding (clinical coding) were:

Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
Data Security & Protection Toolkit	5%	9.51%	3.39%	4.7%

2.4.10. Data quality

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

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

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

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

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

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

2.4.10.1. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during

2021-22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which includes the patient's valid NHS number and registered GP practice contributes to the overall Data Quality Maturity Index (DQMI) scores, which are shown in the table below:

DQMI	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
STHK score	92.2	92.2	92.1	91.9	92.1	91.4	91	90.9	91.1
National average	81.9	81.8	82.5	81.1	80.5	82.1	85.1	79.9	79.9

(Source: DQMI)

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

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

- The Data Quality team will monitor the nationally mandated submissions via the NHS Digital toolkit and a formal report will be presented at the Information Steering Group meeting. Any elements requiring action will be agreed at this meeting
- Data Quality Team will continue to monitor data quality throughout the Trust via the regular suite of reports
- Provide data quality awareness sessions about the importance of good quality patient data and the impact of inaccurate data recording

2.4.11. Benchmarking information

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

2.4.11.1. Benchmarking Information

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

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Summary Hospital-level Mortality Indicator (SHMI)	NHS Digital	Dec-20 to Nov-21	1.051	1.000	0.716	1.195	
SHMI	NHS Digital	Nov-20 to Oct-21	1.065	1.000	0.719	1.186	
SHMI	NHS Digital	Oct-20 to Sep-21	1.073	1.000	0.713	1.191	
SHMI	NHS Digital	Sep-20 to Aug-21	1.053	1.000	0.716	1.185	
SHMI Banding	NHS Digital	Dec-20 to Nov-21	2	2	3	1	
SHMI Banding	NHS Digital	Nov-20 to Oct-21	2	2	3	1	
SHMI Banding	NHS Digital	Oct-20 to Sep-21	2	2	3	1	
SHMI Banding	NHS Digital	Sep-20 to Aug-21	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Dec-20 to Nov-21	45.9%	39.0%	11.2%	64.3%	
% of patient deaths having palliative care coded	NHS Digital	Nov-20 to Oct-21	44.6%	38.9%	11.5%	63.9%	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
% of patient deaths having palliative care coded	NHS Digital	Oct-20 to Sep-21	44.3%	38.8%	12.0%	63.3%	
% of patient deaths having palliative care coded	NHS Digital	Sep-20 to Aug-21	43.7%	38.6%	12.0%	63.5%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (NHS Digital). St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by: Monthly monitoring of available measures of mortality. Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned as noted in section 2.4.6.							
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-20 to Mar-21 (final)	N/A	N/A	N/A	N/A	The mandatory varicose vein surgery and groin-hernia surgery national PROMs collections have ended Provisional data for Apr-21 to Mar-22 will be published in August 2022
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-19 to Mar-20 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-20 to Mar-21 (final)	0.430	0.472	0.393	0.574	
EQ-5D adjusted health gain:	NHS Digital	Apr-19 to Mar-20	0.406	0.459	0.352	0.539	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Hip Replacement Primary		(final)					
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.428	0.465	0.348	0.557	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-20 to Mar-21 (final)	0.314	0.315	0.181	0.403	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-19 to Mar-20 (final)	0.252	0.335	0.215	0.419	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.309	0.338	0.266	0.405	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-20 to Mar-21 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-19 to Mar-20 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:							

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

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	10.66	10.01	0.00	14.11	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The data was consistent with Dr Foster's standardised ratios for re-admissions. The readmissions: 30 day relative risk score is monitored monthly by the Trust Board. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by: Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient	NHS Digital	2020-21	76.0	74.5	67.3	85.4	As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
survey focussing on the responsiveness to personal needs.							corresponding score regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2019-20	66.2	67.1	59.5	84.2	
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2018-19	69.5	67.2	58.9	85.0	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does.
The Trust was rated outstanding overall for caring by the CQC following their latest inspection in 2018.
The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website.
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by:
Promoting a culture of patient-centred care.
Responding to patient feedback received through national and local surveys, Friends and Family Test results, complaints and Patient

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning.							
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2021	79.4%	66.9%	43.6%	89.5%	
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2020	88.1%	73.4%	50.0%	92.0%	Data for 2020 is for Acute and Acute & Community Providers only Data for 2018 and 2019 is for Acute Providers only
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2019	87.7%	70.1%	40.6%	87.7%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2021	15.1%	19.5%	27.2%	12.3%	Low scores are better performing trusts
% experiencing harassment, bullying	NHS staff surveys	2020	12.2%	19.8%	26.3%	12.2%	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
or abuse from staff in last 12 months							
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2019	12.9%	20.3%	26.5%	12.9%	
% believing there are opportunities to develop their career in this organisation	NHS staff surveys	2021	52.5%	52.1%	64.6%	38.8%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2020	93.2%	84.9%	66.5%	94.3%	Note – new wording to this question in 2021 survey
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2019	91.9%	84.4%	70.7%	91.9%	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons;
The Trust provides a positive working environment for staff with a proactive Health, Work and Wellbeing Service.
An independent provider, Quality Health, provides the data.
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by:
Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff.
Engagement of staff at all levels in the development of the vision and values of the Trust.

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.							
Friends & Family Test – A&E – Response Rate	NHS England	Mar-22	13.0%				National response rates no longer published
Friends & Family Test – A&E – Response Rate	NHS England	Feb-22	13.6%				
Friends & Family Test – A&E – Response Rate	NHS England	Jan-22	13.6%				
Friends & Family Test – A&E – Response Rate	NHS England	Dec-21	12.0%				
Friends & Family Test – A&E – % recommended	NHS England	Mar-22	78.5%	73.3%	49.1%	100.0%	
Friends & Family Test – A&E – % recommended	NHS England	Feb-22	81.6%	77.5%	28.6%	100.0%	
Friends & Family Test – A&E – % recommended	NHS England	Jan-22	85.6%	80.6%	55.9%	100.0%	
Friends & Family Test – A&E – % recommended	NHS England	Dec-21	82.2%	79.7%	53.8%	100.0%	
Friends & Family Test – Inpatients –	NHS England	Mar-22	32.6%				

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Response Rate							
Friends & Family Test – Inpatients – Response Rate	NHS England	Feb-22	36.0%				
Friends & Family Test – Inpatients – Response Rate	NHS England	Jan-22	34.7%				
Friends & Family Test – Inpatients – Response Rate	NHS England	Dec-21	34.3%				
Friends & Family Test – Inpatients – % recommended	NHS England	Mar-22	95.5%	93.9%	65.8%	100.0%	
Friends & Family Test – Inpatients – % recommended	NHS England	Feb-22	95.0%	94.4%	77.4%	100.0%	
Friends & Family Test – Inpatients – % recommended	NHS England	Jan-22	95.7%	94.3%	68.7%	100.0%	
Friends & Family Test – Inpatients – % recommended	NHS England	Dec-21	96.6%	94.4%	78.1%	100.0%	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust actively promotes the Friends and Family Test across all areas.
The data was submitted monthly to NHS England (recommencing in December 2020).
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by:
Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology.

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Actively working with ward staff and the Trust's Patient Experience and Dignity Champions to improve levels of engagement with the system, to ensure the latest results are shared at local level.							
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2019-20	96.24%	95.25%	71.59%	100.00%	All data is for Acute Providers only Data for Q4 2019-20 onwards is suspended
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2019-20	95.23%	95.40%	71.72%	100.0%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2019-20	95.23%	95.56%	69.76%	100.0%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Sustained delivery of the 95% target for patients having a venous thromboembolism (VTE) risk assessment within 24 hours of admission to ensure that they receive the most appropriate treatment, having achieved 95.4% for April 2019 to February 2020, prior to submissions being suspended nationally due to the pandemic. Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed. 77 patients have been identified who developed a hospital acquired thrombosis during quarter 1&2 2021-22, of which 77 clinical reviews have been completed to date and 94% were found to have received appropriate care. 3 of the 77 patients reviewed who had developed a hospital acquired thrombosis tested positive for COVID-19 and were receiving treatment. COVID-19 related VTE has been identified nationally and internationally as a complication of the virus and, therefore, in response the Trust developed new guidance in 2020 for clinicians to consider in planning VTE prophylaxis. St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed.							

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Sharing any learning from these reviews and providing ongoing training for clinical staff.							
Clostridium Difficile (C Difficile) rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-20 to Mar-21	9.6	15.4	0	80.6	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-19 to Mar-20	15.7	13.6	0	51.0	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-18 to Mar-19	10.2	12.2	0	79.7	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over	GOV.UK	Apr-17 to Mar-18	11.4	13.6	0	90.4	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
(Trust apportioned cases)							
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Infection prevention remains a priority for the Trust. All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory external reporting. The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea. Cases are thoroughly investigated using RCA, which is reported back to a multidisciplinary panel to ensure appropriate care was provided and lessons learned are disseminated across the Trust. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: Focussing on ensuring staff compliance with mandatory training for infection prevention. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.							
Incidents per 1,000 bed days	Internal	Apr-21 to Mar-22	35.87	-	-	-	Data now published once a year rather than every six months Next data to be published in Sep 2022 Data for Apr-20 to Mar-21 is based on acute (non-specialist) trusts with complete data (12 months data) Data for Apr-19 to Sep-19
Incidents per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	37.20	57.63	27.20	118.70	
Incidents per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	35.31	49.70	27.52	110.21	
Incidents per 1,000 bed days	NHS Improvement	Apr-19 to Sep-19	35.70	48.80	26.29	103.84	
Incidents per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	37.20	57.63	27.20	118.70	
Number of incidents	Internal	Apr-21 to Mar-22	9235	-	-	-	
Number of incidents	NHS Improvement	Apr-20 to Mar-21	8124	12644	3169	37572	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Number of incidents	NHS Improvement	Oct-19 to Mar-20	4370	6607	1758	22340	and Oct-19 to Mar-20 is based on acute (non-specialist) trusts with complete data (6 months data)
Number of incidents	NHS Improvement	Apr-19 to Sep-19	4429	6314	1392	21685	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-21 to Mar-22	0.14	-	-	-	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	0.14	0.25	0.03	1.08	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	0.04	0.15	0.00	0.52	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-19 to Sep-19	0.01	0.15	0.00	0.67	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Apr-18 to Sep-18	0.09	0.15	0.00	0.54	
Number of incidents resulting in severe harm or death	Internal	Apr-21 to Mar-22	37	-	-	-	
Number of incidents resulting in severe	NHS Improvement	Apr-20 to Mar-21	31	54	4	261	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
harm or death							
Number of incidents resulting in severe harm or death	NHS Improvement	Oct-19 to Mar-20	5	19	0	93	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-19 to Sep-19	1	19	0	95	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-21 to Mar-22	0.4%	-	-	-	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-20 to Mar-21	0.4%	0.4%	0.0%	2.8%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-19 to Mar-20	0.1%	0.3%	0.0%	0.9%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-19 to Sep-19	0.0%	0.3%	0.0%	1.6%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:							

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
The Trust actively promotes a culture of open and honest reporting within a just culture framework. The data has been validated against National Reporting and Learning System (NRLS) and NHS Digital figures. The latest data to be published is up to March 2022. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.4% St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by: Undertaking comprehensive investigations of incidents resulting in moderate or severe harm. Delivering simulation training to enhance team working in clinical areas. Providing staff training in incident reporting and risk management. Monitoring key performance indicators at the Patient Safety Council, Quality Committee and the Trust Board. Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.							
Due to reasons of confidentiality, NHS digital has supressed figures for those areas highlighted with an * (an asterisk). This is because the underlying data has small numbers (between 1 and 5)							

2.4.11.2. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2021-22 is shown in the table below:

Performance Indicator	2020-21 Performance	2021-22 Target	2021-22 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Not Achieved	100.0%	99.8%	Apr21-Mar22
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Not Achieved	92%	68.2%	Apr21-Mar22
Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	98.3%	Apr21-Mar22
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	96.7%	Apr21-Mar22
- anti-cancer drug treatments	Achieved	98%	100.0%	Apr21-Mar22
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	85.2%	Apr21-Mar22
- from consultant upgrade	Achieved	85%	90.8%	Apr21-Mar22
- from urgent screening referral	Achieved	90%	93.6%	Apr21-Mar22
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Achieved	93%	84.6%	Apr21-Mar22
- symptomatic breast patients	Achieved	93%	66.5%	Apr21-Mar22

Performance Indicator	2020-21 Performance	2021-22 Target	2021-22 Performance	Latest data
Emergency Department waiting times within 4 hours - All Types	Not achieved	95%	77.1%	Apr21-Mar22
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	84.8%	Apr21-Mar22
Clostridium Difficile	Achieved	54	25 54 total with 29 identified as no lapses in care	Apr21-Mar22
MRSA bacteraemia	Not achieved	0	2	Apr21-Mar22
Maximum 6-week wait for diagnostic procedures: % of Diagnostic Waits who waited <6 weeks	Not achieved	99%	78.4%	Apr21-Mar22

3. Additional information

3.1. Equality, Diversity and Inclusion Strategy

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

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

The Patient Experience and Inclusion Team is currently working on the new Patient Experience and Inclusion Strategy which will be launched in April 2022 following consultation with internal and external stakeholders. It will include objectives for equality, diversity, inclusion and engagement for the first time, rather than having two strategies.

In September 2021, the Trust gained Veteran Aware accreditation and now has dedicated areas on both the Trust website and intranet containing lots of supporting information for veterans and staff to access. This includes support services in the community for veterans to access, ranging from information about breakfast clubs to information regarding mental health issues and suicide prevention.

3.1.1. Equality Objectives 2019-23

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

2021 EDS2 approved grades

Goal	Outcome	2018	2019	2021
Better health outcomes	1.1	Developing	Achieving	Achieving
	1.2	Developing	Achieving	Achieving
	1.3	Developing	Achieving	Achieving
	1.4	Achieving	Achieving	Achieving
	1.5	Developing	Achieving	Achieving
	2.1	Achieving	Achieving	Achieving
	2.2	Developing	Achieving	Achieving

Improved patient access and experience	2.3	Achieving	Achieving	Achieving
	2.4	Developing	Achieving	Achieving
A representative and supported workforce	3.1	Achieving	Achieving	Achieving
	3.2	Excelling	Excelling	Excelling
	3.3	Developing	Developing	Achieving
	3.4	Achieving	Achieving	Achieving
	3.5	Achieving	Achieving	Achieving
	3.6	Excelling	Excelling	Excelling
Inclusive leadership	4.1	Achieving	Achieving	Achieving
	4.2	Achieving	Achieving	Achieving
	4.3	Developing	Achieving	Achieving

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

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

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

- Additional training for admissions staff to ensure they ask the right questions
- Increased publicity, including poster displays and via GPs, social media and Healthwatch
- Regularly auditing the alerts on patients' records to ensure the correct information is recorded
- Production of a British Sign Language (BSL) patient accessible information leaflet, which has a QR code on the front for patients to access a signed version of the leaflet
- Relaunched the communication cards with the new accessible information leaflet for patients to complete to tell us what their additional communication needs are
- Launched 'I need a BSL interpreter' cards, which include full details of how staff can contact the Deafness Resource Centre in an emergency/unplanned visit
- New healthcare passport produced for patients who have a learning disability or autism to help them communicate their needs/likes/dislikes and about their regular medications
- Selected to take part in the newly launched NHSE/I Rainbow Badge Scheme which involves a team of assessors reviewing our policies, procedures and the experiences of LGBTQI+ patients accessing services provided by the Trust

Increasing accessibility

- Introduction of new carer passport, produced in collaboration with other patient experience teams across Cheshire and Merseyside
- Currently trialling virtual interpreting via DA Languages (provider of interpreting services) Application (App) on the four wards with the highest usage of interpreters, which can be booked in advance or, can be accessed 'on demand'. Once trialled on the wards it will be rolled out to other areas, for example, endoscopy and the emergency department where not being able to access a face-to-face interpreter when needed causes the most issues
- Text on the new Trust website can be viewed in over 100 alternative languages, in addition other accessibility features including:
  - Change colours/contrast levels and fonts
  - On screen magnifier – zoom in up to 300% without the text spilling off the screen
  - Listen to most of the website using a screen reader (text to speech) – Job Access with Speech (JAWS), non-visual desktop access (NVDA), Voice Over)
  - Navigate most of the website using just a keyboard
  - Navigate most of the website using speech recognition software

Members of local Healthwatch groups and St Helens Deafness Resource Centre were invited to all project meetings regarding accessibility during the development of the new website to ensure that it was fully accessible. They tested the site with members of their own groups who had varying disabilities/communication needs to ensure that the website was as accessible as possible.

Collaborative working

- Introduction of new carer passport, produced in collaboration with Liverpool University Foundation Trust and other patient experience teams across Cheshire and Merseyside
- Working with other trusts and organisations across Cheshire and Merseyside to develop resources and guidance regarding veterans and armed forces personnel for both patient and staff use
- Currently working with other trusts across Cheshire and Merseyside and other specialist services to develop 'best practice' transgender policies to be rolled out across the region once completed
- Working with other Heads of Patient Experience/Patient Experience Managers across the UK to review current PALS services, in order to develop standardised performance indicators, response times for concerns, staffing levels and structures

3.1.1.2. Engagement and consultation

Although the COVID pandemic greatly reduced our opportunities to consult and engage with our local communities, activity was maintained where possible including:

- Patient Participation Group members consulted electronically regarding the development of the new Patient Experience and Inclusion Strategy, carers' passport and quality objectives for 2022-23. Dates in diary for 2022-23 will include meetings on different days/times to allow more flexibility for participants to join in

- Access audits will restart as soon as it is safe to do so and external individuals are able to attend in person to help inform these audits
- Lay reader scheme for Trust leaflets and literature had new members recruited, including members with a vast range of experiences to help ensure our patient information leaflets are fit for purpose
- Feedback surveys carried out with users of foreign language interpreting service, with the majority of responses being positive and a response rate of 33%
- Every Experience Matters survey relaunched, and discharged patients who consent to further contact from the Trust were sent a copy of the survey and accompanying letter. Sending these by post was much more successful than relying on electronic means to advertise this survey. 150 paper surveys are posted out each week with an average response rate of 32%
- Members of the Patient Participation and Staff Dignity Champions Groups, local Healthwatch, carers and the Lay Reader Group were consulted on the new draft Patient Experience and Inclusion Strategy in March 2022 and the Strategy was approved at April's Quality Committee

3.1.1.3. Workforce Equality, Diversity & Inclusion Strategy

The Trust continues to meet its legal and statutory obligations for workforce equality, diversity and inclusion returns including Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap.

The Trust has well established Staff Networks and is currently working with them to review the Workforce Equality, Diversity and Inclusion (ED&I) Strategy.

The Trust has been successful in a number of bids to support the development of ED&I initiatives for the workforce including Rainbow Badge Accreditation, Project Search and WDES funding to support Health passports

3.2. Workforce Strategy

In July 2020 NHSE/I and HEE set out what our NHS people can expect from their leaders and each other. The plan focused on how we must look after each other and foster a culture of inclusion and belonging, as well as actions to grow and train our workforce, working together differently to deliver patient care.

The Workforce Strategy and action plan is built upon these principles and direction and demonstrates the Trust's commitment to driving forwards these aims and ambitions.

Delivery of the strategy focusses on four pillars, aligned to the NHS Long Term Plan and with the work plan of the Strategic People Committee. The four pillars are:
1. Looking after our people – with quality health and wellbeing support for everyone
2. Belonging in the NHS – with a particular focus on the discrimination that some staff face
3. New ways of working and delivering care – capturing innovation and transformational change

4. Growing for the future – how we recruit, train and keep our people and welcome back colleagues who want to return

The NHS People Promise shown below is central to the plan and will help to embed a consistent and enduring offer to all staff in the NHS.

The strategy is managed and monitored through Workforce Council with reporting through to the Strategic People Committee that reports to the Trust Board.

3.2.1. Freedom to speak up

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

- Freedom to Speak Up

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

raising a concern.

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

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

The Trust works in partnership with the National Guardian's Office and North West Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns. The Trust recorded a mean Freedom to Speak Up Index score of 82.3% in 2020 (published in 2021), an increase from 81.9% for the previous year. The Trust score is significantly higher than the national mean score for acute trusts of 77.9%, confirming the positive culture for raising concerns. Due to changes in the national staff survey, the index measurement was discontinued by the National Guardian's Office in 2021-22. There were 24 concerns raised in 2021-22 , which is in line with the national average for acute trusts of 24.4 concerns recorded in 2020-21 but higher than the peer group of trusts rated outstanding by the CQC with an average of 17 cases per organisation.

- Speak in Confidence system

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

- Raising concerns hotline

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

- Health, work and wellbeing hotline

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

- Hate crime reporting

A hate crime is when someone commits a crime against a person because of their

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

An education session was provided to the Clinical Directors CD forum by the Assistant Medical Director on hate crime, including the process for reporting and contact details, as well as discussions on a specific case.

- Policies and procedures

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

Trust staff raised 48 concerns through the various raising concerns routes in 2020-21, including Guardians, speak in confidence system and AskAnn portal, compared to 24 in 2021-22. All concerns are taken seriously and changes made where appropriate, including making changes to the working environment, providing support and information to staff and reviewing staffing levels in key areas.

3.2.2. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. For the 2021 survey, reported in 2022, the Trust conducted a full census staff survey for the first time. 2388 completed questionnaires were returned from the eligible staff group of 6534. This provided a 37% response rate, which is a lower %, but a significantly larger number of responses compared to last year when the Trust surveyed a sample of staff.

It is important to note that this year saw some significant changes to the questionnaire content. The questions are now related to the themes of the NHS People Promise with additional themes of staff engagement and morale retained from previous surveys. In order to accommodate this some questions have been removed, some altered and some new ones added. Furthermore, the questions relating to COVID-19 that were used in 2020 were removed and new questions about personal development were instated. Therefore, direct comparison is not possible across some areas.

The survey compares results with similar trusts via the use of benchmarking groups, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. It should be noted that the Trust's benchmarking group was amended in 2020 to incorporate organisations that were previously in both the benchmarking groups for acute and acute & community trusts. This has increased the number of organisations in the Trust's benchmarking group from 85 in 2019, to 126 in 2020 and remains the same for the 2021 survey.

Results are reported both as individual question responses and as ten themes, aligned to the NHS People Promise which for 2021 are:

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

Plus the two recurring themes:

- Morale
- Staff engagement

The themes are scored on a 0 to 10 point scale, a higher score indicating a better result. Overall, the Trust's results were above average in 8 out of 9 themes. The Trust's best theme scores in national comparison were in 'morale' and 'We are safe and healthy' where we ranked equal 3rd nationally and equal 1st across the North-West and Cheshire and Merseyside. With regard to more detailed figures, the 'motivation' subset of staff engagement showed a significant improvement which was contrary to the national trend.

Whilst the majority of responses remain positive, consideration is being given to the areas with lower scores. This includes flexible working and re-establishing the value of appraisal or development conversations that were suspended during COVID-19. The considerably increased number of responses has enabled the Trust to do significantly more detailed analysis than before and be more specific in identifying areas of good or poor performance down to department or team level in some instances. Action plans are being developed with senior leaders and team managers to inform suitable interventions at directorate and department level as appropriate.

It should be noted that scores across all trusts in all areas are down on the previous year, much of which reflects the challenges of dealing with the pandemic. However, 84.6% of staff agreed that care of patients/service users is the organisation's top priority, well above the national average of 75.5%.

3.2.3. Clinical education and training

The COVID pandemic created significant interruptions to training for the workforce, with implications for programme progression, which are now being addressed. Guided by NHS England and NHS Improvement, NHS Employers, the Department of Health and Social Care and governing bodies, the focus is now on training recovery to mitigate the impact of the COVID pandemic on the future healthcare workforce.

Health Education England (HEE) has captured workforce data to identify challenges in obtaining core training and educational experiences. They have also worked closely with Directors of Medical Education (DME) to understand the size and scale of disruption to clinical training at a local level. In response to these challenges,

there have been a number of financial opportunities provided from HEE to support the reintroduction and creation of additional training opportunities with support for both trainers and educators. An Education Recovery Programme was established in April 2021 to reset, recover and re-establish clinical education for the workforce which was to be completed in three phases:
Phase 1: Support learners/trainees and educators with wellbeing and immediate opportunities for training recovery
Phase 2: To optimise innovations, explore and utilise funding provided by HEE, to harness and optimise Technology Enhanced Learning (TEL)
Phase 3: Deliver long-term improvements in clinical education, building future resilience into the workforce pipeline

As part of the recovery programme, the Clinical Education Department are now reintroducing education provision with key subjects and specialties prioritised, including working collaboratively with key stakeholders to support the health and well-being of the workforce.

3.3. Patient safety

One of the Trust's key priorities in 2021-22 was to continue to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. There was a particular focus on reducing avoidable harm by preventing falls.

3.3.1. Pressure ulcers

The Trust has continued to focus on reducing the risk of patients developing hospital acquired pressure ulcers, as a result of lapses in care. During 2021-22, there were two incidences of a hospital acquired category 3 or above pressure ulcer with lapse in care reported. A thorough and in-depth investigation was commissioned to identify the root causes, with improvement actions taken, including education for staff members to improve risk identification and appropriate care planning to prevent the development of a pressure ulcer. The Trust also developed a new electronic risk assessment tool and electronic documentation to improve information about the care of pressure ulcers and wounds, which supports more effective handover of care.

The Trust is continuing with improvements to reduce the number of Trust-acquired category 2 pressure ulcers with lapses in care. This includes improved access to preventative devices and specialist mattresses, as well as the development of care pathways and enhanced education.

3.3.2. Falls

The Falls Team continues to develop strategies to minimise the occurrence of inpatient falls. In 2021-22, the Trust reported:

- 6.12% reduction in inpatient falls per 1000 bed days, decreasing from 9.119 falls per 1000 bed days in 2020-21 to 8.561 in 2021-22
- 1.63% reduction in inpatient falls of moderate harm or above per 1000 bed days, decreasing from 0.245 falls per 1000 bed days in 2020-21 to 0.241 in 2021-22.
- 31.25% reduction in severe harm or above patient incidents, decreasing from 32

during 2020-21 to 22 during 2021-22

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

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

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

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

3.3.3. Venous thromboembolism (VTE)

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

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

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

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

The Trust has continued to maintain appropriate prevention interventions by:

- Using an electronic VTE risk assessment tool, which is integrated into the patient administration system, enabling real time performance reviews
- Sharing risk assessment compliance daily dashboards
- Undertaking a root cause analysis investigation of all cases of hospital acquired thrombosis in order to reduce the risk of it happening again

- Providing immediate feedback/education to ward staff, disseminating learning points and implementing any actions for improvement
- On-going VTE training for all clinical staff

3.3.4. Medicine safety

Staff have continued to work to gain the best advantage of the electronic prescribing and medicines administration (ePMA) system's safety features. Since last year's Quality Account report the system has been rolled out for outpatient prescribing at both of the Trust's main sites. In early 2022, work has commenced to implement a major upgrade of ePMA to version 8. This version has significantly more functionality, allowing the removal of all remaining paper prescribing of fluids and drugs given on supplementary kardexes. The new version is designed to work on mobile devices and will allow staff to use barcode scanning to provide 'closed loop medication administration' where the patient, administered drug and prescription are all positively identified prior to administration. Closed loop medication administration is the 'gold standard' for reducing medication administration errors. The Trust's medicine handling continues to be closely monitored and improved through the use of electronic prescribing, for example, one important example identified and managed in 2021 related to erroneous recording of penicillin allergy as allergy to penicillamine. Additional work was performed to help ensure appropriate doses of paracetamol infusion in low weight patients. Work on the ePMA upgrade is being done jointly with Southport and Ormskirk Hospital NHS Trust who will be joining this Trust's ePMA system in 2022-23. This will result in Southport and Ormskirk gaining the benefits of a mature ePMA system and, ultimately, a larger ePMA team working to develop the system across the two Trusts will enable progress on advanced functionality such as support for complex intravenous infusions.

From April 2021, following creation of a new digital transformation pharmacist post, outputs from ePMA have been combined with other clinical information systems to create a 'live' clinical pharmacy dashboard. This enables clinical pharmacy staff to view the medicines status of patients on their wards at a glance. A range of data such as acute kidney injury (AKI) alerts, infection control alerts, missed doses, critical medicines, time since last review, laboratory results, medicines reconciliation status and more are displayed. This dashboard has proved invaluable to our clinical pharmacy team, especially during the staffing challenges as a result of COVID. The dashboard enables signposting of high priority patients and supports best use of our staff resources. The system was shared with the Trust's CQC medicines specialist in June 2021 and received very positive feedback.

From December 2021, two new pharmacy posts (pharmacist & technician) commenced to support the Emergency Department during the winter pressures. Their work has prioritised the review of patients being admitted, particularly patients on complex, critical and high-risk medicines. They have helped to ensure that these newly admitted patients are on the correct, appropriate medicines and supplies are available to minimise delayed or omitted administration. The post-holders have been working closely with the management of ED to measure the benefits of this new service to support a business case to continue and expand the service in 2022.

In the summer of 2021, we welcomed a new medicines safety pharmacist and a new

quality & safety pharmacy technician. Both post-holders have quickly established themselves as valuable contributors to medicines safety within the Trust. Examples of completed and ongoing medicines safety work includes:

- More detailed reporting of medicines safety incidents from Datix
- Increased participation in North West Medicines Safety Officer Network meetings
- Support for initiatives to minimise delays and omission of critical medicines
- Multidisciplinary work regarding safety in preventing and treating steroid emergencies
- Setting up medicines storage and security and pharmacy-led controlled drugs audits on Tendable (electronic system used to record audits)
- Reforming the multidisciplinary Medicines Link Group
- Participation in multidisciplinary weekly ward quality engagement events
- Temperature monitoring of vaccines and COVID neutralising monoclonal antibodies (nMABs) using the COMARK system
- Guidance on safe use of paracetamol infusions
- Guidance on medicines which may increase risk of falls
- Revised arrangements for medicines storage in Radiology
- Referral of about 35% of discharged patients through the Discharge Medicines Service for follow up by community pharmacists. This is particularly important when medicines have been changed during inpatient admissions
- Well-established system for reviewing the medicines of AKI patients

The Trust has adopted new technology such as Omnicell cabinets for computer-controlled storage of medicines which are now installed in Pharmacy, ED and in the following wards: Bevan Court, 1B and 1C. These will be linked to ePMA during 2022 to further support safe administration of medicines.

In March 2022, Pharmacy's old RoboPharma automated dispensing systems (robots) were replaced with Omnicell Medimat systems. The new robots have many advanced features which will support medicines safety and efficiency, including the ability to automatically load deliveries of new drugs, read batch numbers and expiry dates embedded into 2D bar codes on packs of medicines and electronically link to the Omnicell cabinets based on wards.

3.3.5. Theatre safety

The Trust Operating Theatre Department has continued to develop and refine patient safety initiatives in keeping with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures.

The department reported no never events in 2021-22, although did report 2 in the previous year relating to wrong site administration of nerve block prior to surgery. There was intensive improvement work carried out across theatres and the Anaesthetic Department to embed robust safety checking processes during the administration of anaesthetic nerve block, via "STOP BEFORE YOU BLOCK". The national stop before you block methodology has recently been amended and the changes in practice implemented.

The World Health Organisation (WHO) surgical safety checklists continue to evolve in response to learning from incidents and other improvement work. Completely redesigned charts are in the final approval stages and are due to be implemented in quarter 1 2022-23. The new form is clearer and provides more space for additional checks, in particular relating to recording of surgical implant details.

3.3.6. Being open – duty of candour

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

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

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

3.3.7. Never Events

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

The Trust reported 1 Never Event in 2021-22 relating to the unintentional connection to an air-flow meter and not the oxygen meter. The Trust remains committed to using Root Cause Analysis (RCA) to investigate adverse events. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and to feed back in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

Improvement actions have been implemented to minimise the chance of any recurrence, including capping off the medical air ports by medical engineering. Debriefing sessions have taken place and communication has been undertaken to share the lessons. All staff within respiratory wards are trained by link nurses in the use of compressed air using portable air compressors. Additional air compressors have been procured to ensure appropriate and adequate equipment is available to deliver clinical treatments.

3.3.8. Infection prevention

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

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

The Trust's infection prevention priorities are to:

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

During the reporting period April 2021 to March 2022, the Trust reported the following:

- MRSA bacteraemia (MRSAb): two bacteraemia cases against a threshold of zero
- NHS Improvement (NHSI) set a threshold for Clostridium difficile infection (CDI) cases for 2021-22 as 54 cases and the Trust has reported 54 in total with 29 cases deemed unavoidable
- Root cause analysis (RCA) executive reviews were held for 49 cases, with no lapses in care or lessons learned identified in 29 of these cases; 20 cases had lapses in care and five cases did not undergo an RCA executive review due to organisational pressures resulting from the pandemic.
- Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb): The Trust had 50 cases of (MSSAb), of which 24 were hospital onset healthcare associated and 26 were community onset healthcare associated
- Lessons learned from the post infection reviews (PIRs) of MRSAb and CDI cases are shared Trust-wide via a monthly infection prevention report. Lessons learned include good practice identified, as well as areas for improvement. A new process for undertaking PIRs was initiated in 2021 resulting in the care groups having increased ownership and targeted lessons learned. This information is also shared monthly with the CCGs

The latest surgical site infection (SSI) rates related to elective hip and knee

procedures from January 2021 to December 2021 are shown below:
- Hips 1.325% against a national average of 0.8%
- Knees 1.15 % against a national average of 1.125%

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

The Trust has 24 consultant infection prevention champions and over 146 link nurses who attend education and training and complete local audits to monitor compliance.

Key achievements for 2021-22 were:
- 341 Aseptic Non-Touch Technique (ANTT) key trainers in the Trust who are responsible for ensuring all staff are compliant with ANTT
- 100% compliance with carbapenemase-producing enterobacteriaceae (CPE) and MRSA screening
- Infection prevention input into environmental monitoring systems and implementation of national standards for cleanliness and validation of standards
- Infection prevention input into new builds and building modifications
- Bristol Stool Chart observations and CPE risk/screening assessment undertaken electronically via vitalpac
- Continued bi-weekly multi-disciplinary ward inspections with estates and facilities, Medirest, Vinci and new buildings to monitor ward cleanliness and estates and facilities provision
- Changes to the RCA processes to improve and prioritise cases that require oversight and input from the Executive Team and clinical teams. The timely RCA review for CDI cases has improved the dissemination of lessons learned and enabled the infection prevention team to target input to ward areas that required support
- 72.06 % of frontline staff received their flu vaccination

3.3.8.1. COVID-19

Members of the Infection Prevention Team continued to be responsible for the following during the pandemic:
- Advising the Trust on the most up-to-date and continually changing guidance from United Kingdom Health and Security Agency (UKHSA) (previously Public Health England (PHE)) and NHS England via silver and gold command
- Education for staff on how to care for COVID patients, providing the highest quality care and protecting themselves while caring for them
- Working closely every day with the Procurement Department to ensure personal protective equipment (PPE) for wards and departments was available and fit for

purpose
- Communicating Trust-wide any changes to PPE requirements issued by PHE and NHS England
- Continuous surveillance and reporting/advising of new infection in patients and staff
- Uploading outbreak data to NHS E/I surveillance system daily
- Attendance at weekly regional infection prevention meeting
- Working with estates and facilities in altering existing services and buildings to create additional non-invasive ventilation (NIV) and critical care unit beds, COVID wards, staff changing and break out rooms etc.
- Provided the fit test service and expertise throughout the pandemic, including training staff on the new quantitative fit testing machines purchased during the pandemic
- Visiting wards and departments to provide support and reassurance for staff
- Providing learning aids, posters on PPE, hand hygiene and environmental cleaning
- Providing advice to community colleagues and care homes
- Contributing to clinical protocols for COVID patients
- Providing a 7-day week infection prevention service on site
- Providing advice and support to Medirest and Vinci colleagues
- Surveillance and reporting throughout the day on new COVID cases
- Providing support to staff self-isolating or at home with suspected/confirmed COVID

3.3.9. Safeguarding

The Trust takes its statutory responsibilities to safeguard patients of all ages very seriously and welcomes external scrutiny. The Trust submitted quarterly key performance indicator (KPI) data to the CCGs throughout 2021-22. The Trust is rated as green, significant assurance, in all areas of KPI monitoring except training compliance which is set at 90% compliance. Pressures throughout the pandemic have affected safeguarding training compliance across all NHS trusts, however CCGs have recognised that safeguarding activity continues to increase in the Trust which, as well as the quarterly improvements in training compliance, provides assurance that staff are aware of their responsibilities.

The Trust has a dedicated Safeguarding Team covering safeguarding children and the unborn child, safeguarding adults, domestic abuse, those with a learning disability or autism, those lacking capacity and those who require a Deprivation of Liberty authorisation with specialist staff for Learning Disability and Mental Capacity embedded into the Safeguarding Team. The Team provides support and advice to staff and delivers mandatory safeguarding supervision and training to all staff as per requirements throughout the Trust. The Safeguarding Team have continued to be visible and accessible to staff by remaining on site during the pandemic.

Safeguarding activity, contacts with those who have a Learning Disability and Deprivation of Liberty referrals have continued to rise throughout the year confirming that staff identify and recognise those with additional vulnerabilities or risks.

The Safeguarding Assurance Group reports to the Patient Safety Council. Quarterly

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

Partnership work has continued throughout the pandemic with the majority of meetings held virtually. This has included Safeguarding Board meetings and Board sub-group attendance, strategy meetings, learning events and review meetings. Requests for attendance at multi agency meetings has increased to address actions required of Local Authorities following inspection.

3.4. Clinical effectiveness

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

3.4.1. National Institute for Health and Care Excellence guidance

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

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

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

A total of 228 pieces of new or updated NICE guidance were released during 2021-22. 135 of these were identified as applicable to the Trust by the Assistant Medical Director. There is a system in place to ensure all relevant guidance is then distributed to the appropriate clinical leads to assess its relevance and the Trust's compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance will be rigorously assessed by mandatory departmental compliance audits reportable through the Trust audit meetings. The Trust is fully compliant with 60 of the relevant guidance issued, 19 are partially compliant and 12 were terminated appraisals. The team is working towards achieving the remainder. Compliance reporting was 99% for 2020-21.

3.4.2. Clinical audit

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

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

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

3.4.4. Copeland Risk Adjusted Barometer (CRAB)

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

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

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

Monthly reports for the benchmarking group meetings are prepared prior to the meetings taking place and distributed to the members for review. During the meetings, the report is reviewed for performance at the Trust level and sub-specialty level and recommendations for review are made. It is the responsibility of each CRAB specialty representative to feed back the review to the CRAB lead and the reports are amended accordingly. Action plans are generated for each of the monthly meetings and reviewed by all members of the CRAB team to ensure that the issues have been addressed.

Issues and concerns identified at the CRAB meetings are reviewed by the group as a whole and reviewed in more depth by specialty CRAB representatives. This more

detailed review is fed back to the CRAB lead and the reports are adjusted to reflect this. If improvements in performance are not seen then it is the responsibility of the CRAB representative to escalate to the clinical director of that specialty and persistent concerns are relayed to the Clinical Effectiveness Council. These can then be further escalated up to the Quality Committee and on to Trust Board.

CRAB Medical is now embedded in the Trust and is already being used to support projects addressing acute kidney injury (AKI) and hydration where there is evidence of halving hospital acquired AKI as well as improvements in pneumonia as well.

In addition, where CRAB is used it supports the assessment of departmental performance, individual performance and crucially move to better support the consent process by accurately describing risk for individual patients. The system is being evolved by the Trust to stratify risk on the waiting list and identify those at highest risk of deterioration if their surgery is delayed. In addition, the Trust is launching a pre-habilitation programme targeting patients at highest risk of respiratory complications that will go live in April 2022.

The system has been used to triangulate performance during COVID where Hospital Standardised Mortality Ratio/Standardised Mortality Ratio/Summary Hospital-level Mortality (HSMR/SMR/SHMI) were unable to function with the new diagnosis, and thus confirm a quality performance benchmarked against a large number of trusts across the UK also using the CRAB methodology.

3.4.5. Promoting health

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

The Trust works in partnership with other agencies to provide holistic services throughout the patient's journey to ensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the work of our Community Falls Team, who work collaboratively with the local council, primary and community care and our Infection Prevention Team who liaise closely with community teams and GP services.

3.5. Patient experience

The Trust acknowledges that patient experience is fundamental to the quality of healthcare and that a positive experience leads to better outcomes for patients, as well as improved morale for staff. Patient experience is at the heart of the Trust's

vision to provide 5-star patient care and staff continuously learn from patient and carer experience to drive improvements and share best practice.

Patient information can come in many different formats, including verbal, written and electronic. Successful communication with patients and their families is vital throughout the patient journey and effectively delivered information forms part of this. In addition, having information available at any time for anyone to access (in a range of formats) can ensure that patients have the most up-to-date information at all times and feel more confident in the overall service being delivered.

In response to feedback from patients that this was an area the Trust could improve, a12-month communication project was commissioned, which has now concluded. The project recommended a number of areas to develop, including the creation of a multi-dimensional patient experience feedback dashboard for ward areas, which pulls together information from a wide range of areas, including Friends and Family Test (FFT), Open and Honest surveys, complaints and PALS concerns. A dashboard has been created for all inpatient areas (including ED, with 35 in total) to triangulate this feedback, which highlights positive patient experiences and helps to identify both positive and negative trends for each ward/department. The dashboards are updated every month and quarterly posters are generated for clinical areas for display. A central location allows easy access to the data and the triangulated information at a local level helps to identify themes, as well as increase ownership of any issues at ward/departmental level, enabling a more targeted approach to tackling areas of concern.

The Trust is committed to learning from patient, service user and carer experiences. Listening to patient stories is one way to achieve this. Patient stories continue to be a critical part of the patient experience agenda throughout the Trust, with stories shared in their own words in a number of forums across the Trust. Many of these have been presented to the Board by patients remotely this year, due to COVID, as well as being shared by the Quality Matron at the Patient Experience Council.

Patient stories have contributed to a number of service improvements including increased accessibility of hypnotherapy for patients with procedural phobias, awareness raising of the psychological impact of restricted visiting and lack of home leave and improvements to communication for patients with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. They have also served to assure and contextualise decision making at Board level. To improve the accessibility of stories and their inclusion to reinforce learning, a move to a digital story telling platform that uses a patient's own voice put together with images to create short authentic videos has begun with additional training in sound and video editing for the Patient Experience Team.

To improve inclusion and specifically the capture of feedback about the Trust's services from patients with Learning Disabilities and Autism, two initiatives have been introduced. The Trust Learning Disability Specialist Nurse worked closely with the Patient Experience and Inclusion Team to amend the standard Friends and Family Test (FFT) feedback cards to capture learning disability, autism, dementia, acquired brain injury and physical disability in the demographic information completed. In addition, a pilot initiative involved the Learning Disability Specialist

Nurse working with one of the volunteer team to conduct telephone surveys with patients with a learning disability or autism that have been recently discharged from hospital to obtain feedback on their experience. Feedback is captured from the individual patient, their carer or other relative. Feedback received to date has been extremely positive and related to patients saying that they felt listened to, included in their care and being treated with respect. The initiative has been extended for a further 6 months.

The five a day programme is face to face contact with inpatients, outpatients, carers and families. This enables direct contact with the Patient Experience Team and provides an opportunity for real time experiences to be shared. It is about actively listening and acting on immediate concerns if any are raised. It also provides the opportunity to inform patients of services and campaigns and gain specific feedback about different areas within the Trust.

The programme has recently been revised to focus on exploration of what matters most to patients, addressing worries and concerns, expectations not met and involvement in decision-making and care. Ongoing work by the Patient Experience Team will enable individual ward areas to receive a quarterly breakdown report of feedback received.

The Trust promotes patient and family engagement through a number of forums, many of which have continued virtually during the year. These include collaboration with Carers' Centres who delivered a 'train the trainer' carer awareness session to members of the Patient Experience Team. Key messages will be disseminated through face-to-face contact with staff and also via the Trust intranet.

The Trust-wide Patient Participation Group consists of patients, carers and members of the public. Through participation in this group, patients have provided feedback and supported service developments to ensure progress with the Patient Experience Strategy 2019 -22 and the development of the Patient Experience and Inclusion Strategy 2022-2025. There has been a focussed campaign to recruit additional patients to the membership of that Group.

As part of recognising the contribution of carers and to make caring visible and valued, St Helens and Knowsley Teaching Hospitals NHS Trust collaborated with Liverpool University Hospitals NHS Foundation Trust and worked with 13 other trusts in the Cheshire and Merseyside region, representatives from local Carer Centres and local Healthwatch groups to co-design a new Carer Passport. Collaboration also included support agencies across the area and details of their services are provided within the document.

The passport is recognised and agreed locally in all participating trusts across Merseyside and Cheshire Network, so the information and support for carers is consistent across the region. There are clear benefits to patients and carers from implementing the passport, with improved individualised care and greater carer involvement in discharge discussions reported. A poster presentation about the passport was submitted to the Cheshire and Merseyside NHS sharing best practice event in the person and family centred care category in March and was awarded first prize. The project and co-production with carers and other trusts across the regional

network was co-presented with Liverpool University Hospitals NHS Foundation Trust to the Heads of Patient Experience (HOPE) group at a national webinar and the group has endorsed the passport and are interested in introducing it as a nationally recognised document.

A number of changes have been made throughout the year as a result of patient feedback, including, reviewing procedures for managing patient property and relaunching protected mealtimes.

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

During the Christmas period, the Patient Experience Team launched an appeal for school pictures/messages for our inpatients to receive on Christmas Eve, as this was very well received in 2020. The appeal was very successful and the team received over 2000 messages. These were included in the packs distributed to all inpatients, with a Christmas message from the Trust and quizzes. The packs were delivered with the support of the volunteers at Whiston, St Helens and Newton hospitals. In total 775 packs were created and delivered to each inpatient. The Patient Experience Team has written to every child and school who sent pictures in with a thank you from the Trust. The team also worked with the Mid-Mersey Digital Alliance Team regarding supporting the wards with virtual visiting and telephone calls, throughout the Christmas and New Year period. Staff from all over the Trust volunteered their personal time to support this initiative and were allocated specific wards to support.

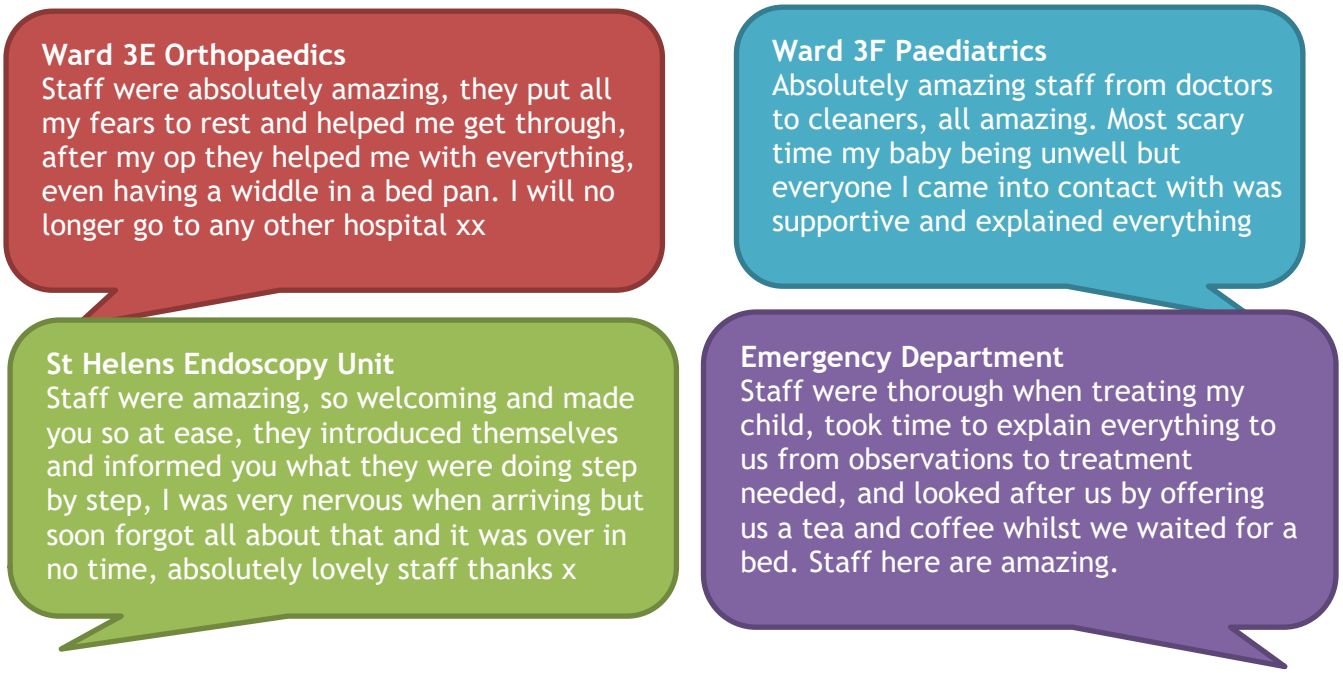
New patient experience surveys have been developed Trust-wide and via specialties. The Trust have revised the Every Experience Matters survey and now contact patients by post to improve response rates, surveying 150 discharged patients per week following their inpatient stay.

Bereavement Guiding Principles have been developed and approved to provide a framework for all staff to help shape and deliver high quality care before and after bereavement, with support across the Trust for patients, those identified as important to them, staff and volunteers. In addition, clinical teams were involved in the review of mementos provided to families following the death of a loved one.

A successful bid for monies was made by the volunteering service to NHSE/I Volunteering Services Fund to support the restoration of NHS services after the COVID-19 pandemic. The money will be utilised in the main to recruit a dedicated Project Administrator to support the roll out of dining companion volunteers across a number of wards and to provide initial support to ensure the success of the project is maximised.

The Chaplaincy Service now includes an ordained minister who will be able to officiate marriages in hospital for patients that are terminally ill in the last weeks and days of life.

3.5.1. What our patients said about us in 2021-22



3.5.2. Patient case studies

The two case studies described below provide anonymised examples of changes made as a result of patient feedback.

Person-centred care
A patient was unable to proceed with planned surgery and experienced two cancelled operations due to a severe phobia of anaesthesia. The surgery was re-scheduled with a good window of opportunity for the patient to come in and work closely with the theatre and ward teams to create an individualised plan of care to prepare for surgery in order to overcome her phobia. The plan included coordinating the same team to be present throughout the peri-operative journey to ensure it was as comfortable as possible. Staff took the time to learn the patient's story and discover the basis for her fears and how the phobia developed, identifying key triggers. There was a real partnership in agreeing strategies and adhering to them in an open and supportive environment with good team communication.

The surgery proceeded with a very positive patient journey/experience and the patient reported feeling proud of how she had overcome her phobia, supported by the multi-disciplinary team effort to ensure she felt calm and so that the surgery went ahead. She described real pride and confidence in what she had overcome, an achievement that will stay with her and continue to shape her future goals and achievements. This experience highlighted a shift in the focus of the desired outcome for the patient, from just getting through the operation and having the procedure completed to a wider goal of addressing her fears more broadly.

The pre-operative clinic now offers patients hypnotherapy for such things as phobias prior to surgery on a case-by-case basis as a result of this patient story. Two-way texting between the patient and pre-operative admissions department seven days

before surgery has also been introduced. This service provides the ability for the patient to use a text response if they feel more comfortable discussing worries or fears before surgery, as well as speaking to someone face-to-face if they need to.

Inclusive care
A patient with learning disabilities attended the Emergency Department and their carer did not feel that their needs were fully identified and met and that not all staff were aware that the patient had additional needs. As a result of this feedback a pilot was initiated to enable patients with a learning disability and/or autism to be more easily identified within the Emergency Department and the acute medical admissions unit. Orange wristbands are now worn by patients where reasonable adjustments are required. The wristband aids discreet and easy identification by Trust staff to ensure that patients with receive treatment, care and support that is safe and personalised. If the patient does not wish to wear the orange wristband, it is applied to the bed, trolley or stretcher.

Feedback has been extremely positive from both staff and carers. Carers reported feeling confident that their loved ones are easily identified as requiring additional support with communication and require a personalised approach in care interventions.

3.5.3. Friends and Family Test

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

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

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

The Trust's inpatient recommended care rate for 2021-22 was 95.7%, similar to the 95.8% in the previous year. Wards and departments across the Trust monitor the patient feedback and create 'you said, we did' posters for display to highlight the actions being taken to continuously improve the care we provide, as well as maintaining staff motivation and influencing change.

You Said	We Did
My letter said I was having a colposcopy but I was having loop excision so felt a bit distressed and didn't have treatment ***(Gynae OPD St Helens)***	I am sorry you didn't receive all the information required to prepare you for your appointment. We have ensured that all patients coming in for any sort of procedure receive an information leaflet with their appointment letter to ensure patients can

	prepare themselves as we understand this can be a very anxious time for patients.
Did everything you asked. Couldn't do enough for you. The only part I don't like is waiting all day for pills that are prescribed for you when you are leaving. They say they like getting you home after dinner; it's never been like that on two occasions. ***(Ward 3B)***	I am very sorry you had to wait for your discharge medication. I will ask the ward doctors to complete the discharge prescriptions in a timely manner in order to obtain the medications more quickly from pharmacy.
My only comment would be with discharge information, I've been told different things, none of which has happened. I don't mind if I need to stay but this has to be communicated. Other than that the staff were absolutely lovely people. ***(Ward 4A)***	We try our best to be consistent with information, and inform patients if their plan of care changes. I will feed this information back to the team

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

3.5.4. Our Volunteers

The Trust boasts a robust and effective volunteer service which operates 7 days a week. Although many trusts stood down their volunteers throughout the pandemic the Trust continued to recruit volunteers. The Trust has over 300 volunteers who dedicate their time, skills and enthusiasm to enhance patient experience.

Many of the volunteers who were shielding /self-isolating have returned to their volunteer duties. There has been an increase in the number of younger age volunteers as volunteering is a recognised route into employment and the Team offer a Volunteer to Career pathway which was recently showcased through the Healthcare Support Worker Programme run by NHS England and NHS Improvement (NHSE/I).

The volunteer pharmacy driver service which was implemented at the start of the pandemic has continued and, to date, they have made over 1500 deliveries to vulnerable patients. Volunteers continue to support the large vaccination programme across Cheshire and Merseyside.

In November 2021 the Volunteer Service was successful in securing £25k funding from NHSE/I for the restoration of volunteer services. This funding is being utilised to employ an administrator who will reinstate and grow the Dining Companion programme within the Trust, gather feedback and measure the impact of the service. The Trust has trained 45 volunteers so far who will be placed on 6 pilot wards, as more are trained this programme will be rolled out throughout the Trust.

Training for volunteers has continued and learning disability and autism awareness training had recently been introduce, which has had CCG recognition and wider recognition by the Lead for Cheshire and Merseyside learning disability improvements work stream.

3.5.5. Complaints

The Trust takes patients' complaints extremely seriously. Staff work hard to ensure that patients and carers' concerns are acted on as soon as they are identified and that there is a timely response to rectify any issues that are raised at a local level, through the Trust's PALS Team, or through the AskAnn email, askann@sthk.nhs.uk. Ward and departmental managers and matrons are available for patients and their carers to discuss any concerns and to provide timely resolution to ensure patients receive the highest standards of care. Each area has a patient experience notice board to highlight how patients and carers can raise a concern and this is also included on the information table placemats available for patients. At times, however, patients and their carers may wish to raise a formal complaint, which is thoroughly investigated so that complainants are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust internet. A new Head of Complaints and Legal Services came into post on 14 June 2021.

In 2021-22, the Trust received 269 new complaints that were opened for investigation. This represents a 7% increase on 2020-21, when the Trust received 251. This is significantly below the figures for 2019-20 (325 complaints) which was the last year largely unaffected by the pandemic.

There were 34 complainants that were dissatisfied with the initial response and raised a stage two complaint in 2021-22. This is an increase of 11 compared to 2020-21, but a reduction compared to the 36 in 2019-20.

The challenges of working within the COVID-19 pandemic has affected the timeliness of responses to those who highlighted concerns about their care. The percentage of new complaints responded to within the agreed timescale has decreased from 94% in 2020-21 to 79.5% in 2021-22.

The Trust has taken significant steps to try and address a backlog of complaints. This has included increasing the resources within the Medical Care Group complaints team by offering overtime to existing staff members, setting up an additional support role serviced by an internal secondment and obtaining additional external complaint response writing support. In March 2022, the Trust responded to 43 first stage complaints (52 complaints in total). This is the highest number of responses (first stage and total) in any month in the last 3 financial years.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2021-22, with a copy of the survey sent out with all response letters.

There were 17 responses in total received in 2021-22, a 6.4 response rate. A summary of the findings is below:

- 13 respondents confirmed that the written response included a clear explanation

of the options available to them if they were not satisfied with the findings, 2 did not and 2 respondents did not answer the question
- 13 respondents found it very or fairly easy to complain, with 2 finding it fairly difficult and 1 found it very difficult
- 8 respondents felt that their complaint had been responded to in a reasonable timescale whilst 7 respondents felt that their complaint had not been responded to in a reasonable timescale; 1 of those respondents did acknowledge they were expecting this due to COVID, but 1 said 6 months was too long for an outcome
- 10 respondents confirmed that they felt that they had been treated with respect throughout the process, whilst 2 respondents confirmed that they had been treated with respect some of the time in the process and 3 people felt they had not
- 9 respondents were very or fairly satisfied with the way the complaint was handled, 1 said they were neither satisfied nor dissatisfied, 3 stated they were very dissatisfied, 2 were fairly dissatisfied and 1 did not answer the question
- 11 respondents confirmed that the reasons for the Trust's decision were made clear to them whilst 4 respondents stated that the decision was not made clear to them; 1 respondent did not answer the question

The Complaints Team are continuing to work hard on reducing the time taken to provide complaints responses, whilst maintaining the quality of the investigations and responses. At the start of the pandemic response times for complaints were increased from 30 or 60 days to 6 months. Response times against 100 days are also now being reviewed, with a view to reducing the response times to this target initially. During 2021-22, 23.9% of complaints were responded to within 100 days.

A number of actions were taken as a result of complaints made in 2021-22:
- Guidance has been provided to administrative reception staff informing them why self-identification information is gathered and the patient's right to refuse to provide it
- Staff were reminded of the importance of reducing noise on the wards to ensure that they provide an environment conducive to allow our patients to sleep. Matron has asked the Ward Manager to monitor noise levels on the ward and review the use of the radio. Steps taken to ensure that patients agree for a radio to be on and that it is turned off during the evening and night
- Staff were reminded of the importance of ensuring all patients have their weight checked regularly
- Complaint information to be considered as part of the proposal to merge the orthopaedic trauma service with the fracture clinic service to offer a more streamlined multi-disciplinary service
- Complaint information will inform the updates to the Transfer of Care and Discharge Policies, with a focus on ensuring any delays in discharge, particularly Rapid Enhanced Discharge, are communicated to the patient's family
- Supplementary Care Policy has been revised and relaunched across the Trust. Each ward has identified a lead member of staff who received training on the revised policy and then disseminated the learning at ward level; each ward will also keep a signed register of those staff that have read and understood the policy. Patients requiring supplementary care are identified at handover and at the safety huddles and staff providing supplementary care are given a full handover ensuring that they are aware of their responsibilities, have received the training and feel able to provide the supervision of patients as required

- Further training and guidance were given to all secretaries on managing external tertiary referrals, and advised to read the Standard Operating Procedure again to ensure they are following all administrative processes that are in place
- Implementation of new Electronic Prescribing and Medicines Administration system to allow doctors to prescribe medications for patients on a computer and nurses can electronically record when they give medication. In addition, a pharmacist now regularly attends wards to ensure the risk of medication errors is reduced

3.6. Care Group Summary

3.6.1. Surgical Care Group

In line with 2020-21, 2021-22 has continued to present unprecedented challenges for the NHS nationally, for the Trust and, particularly, for surgical care services.

Coronavirus, and particularly the new omicron variant, continued to impact significantly, both on patients and on staffing resulting in the cancellation of routine elective activity. However, all urgent and cancer surgery continued to be maintained, enabling patients to receive their surgical treatment in a timely manner. A number of measures introduced during earlier waves were reintroduced, including the re-establishment of COVID-19 cohort wards within surgery and the redeployment of theatre and anaesthetic staff to support Critical Care. Other measures, such as the pre-operative swabbing of patients and infection prevention restrictions continue to remain in place.

Despite the continuing challenges, the focus during the year has been the restoration and recovery of elective activity. In the determination to return to pre-pandemic levels of activity, a number of initiatives were introduced. These have included 'Mega Weekends', where resources were consolidated at weekends on one type of surgical procedure in order to treat patients who have been identified as being at higher clinical risk due to treatment delays. These highly productive weekends have been highlighted nationally as model initiatives, have been published in recognised surgical journals and other trusts have been in contact to learn from these experiences.

In addition to maximising the available in-house capacity and productivity, the Trust has continued to transfer suitable procedures from theatres to outpatient settings to free theatre capacity and to undertake more procedures as day cases rather than inpatients. The appropriate utilisation of the independent sector for specialities such as orthopaedics, ophthalmology and general surgery has also continued, as well as maintaining the focus on the clinical prioritisation of surgical patients across all specialities. This has included the priority coding of all patients and the introduction of a cutting-edge artificial intelligence (AI) system of risk stratification of patients. This has been introduced in conjunction with regular clinical harm reviews for those identified as being at higher risk due to lengthy delays for surgery. Further work is also underway to clinically optimise patients prior to surgery through the AI programme and for those deemed to be at higher risk, in order to ensure that patients are fit and well enough to undergo their surgery, therefore, reducing the risk of cancellation.

During 2021-22, outpatient activity has continued through a mixture of face to face and virtual appointments. The reduction of social distancing from 2m to 1m also enabled clinic templates to return to pre-pandemic levels.

Other key measures introduced during earlier waves included the facilitation of home working for large numbers of administrative staff, with a full risk assessment programme to support this. This initiative continues due to the social distancing requirements across the Trust and has proven to be highly successful.

Despite the unprecedented and ongoing challenges, our staff, as always, have responded magnificently and continue to ensure that patient care and patient safety remain at the very heart of everything we do.

3.6.2. Medical Care Group

The Trust experienced the most challenging year ever known in the NHS in 2020-21, which continued in 2021 across all areas of the Medical Care Group, encompassing emergency care, critical care, paediatrics and adult medicine.

COVID-19 care continued to be provided in our emergency admissions with ongoing care in respiratory wards and Critical Care Unit with staff remaining flexible and committed to delivering the best care possible. The ongoing need to manage both new COVID-19 patients alongside patients with other acute and chronic illnesses kept demand high for medical admissions with management of demand an ongoing challenge.

There was a need to keep relatives informed as visitor restrictions remained in place with investment in dedicated ward family liaison staff to help keep communication flowing alongside the use of technology. In addition, new ways of working continued to develop with increasing 'virtual' activity as staff adjusted to a new normal.

New challenges came from the need to recover from work that was paused during the height of the pandemic which included clinical activity such as medical elective care, for example Endoscopy and Cardiology diagnostics and a wide range of outpatient services and other activity such as staff training, well-being and governance. This focus on restoration of activity such as seeing and treating those patients waiting for appointments and tests and reducing administrative backlogs has required a significant adjustment in working practice with clinical and managerial staff working together to ensure recovery is achieved and sustained.

Despite such challenges, our services continued to develop which has included:

- High focus on managing demand in the Emergency Department (ED) with investment in staffing posts and equipment to optimise patient care and safety in a challenging environment. Collaborative working with North West Ambulance Service (NWAS) has enabled Direct Access/referrals to Same Day Emergency Care areas and initiatives to stream from ED to urgent treatment centres and primary care/GPs thus avoiding admissions with a system wide collaborative approach

- The introduction of new medical rotas in August following investment resulting in increased numbers of doctors on duty
- Implementation of three transformational changes within the stroke service:
    - Introduction of CT perfusion scans to improve identification of strokes which may benefit from intervention outside of the traditional treatment windows
    - Introduction of machine learning tools (Brainomix) to help interpret stroke CT scans and look for early signs of stroke damage
    - Commencement of weekend thrombectomy service since the start of 2021, in conjunction with the Walton Centre, and provision of 24/7 thrombectomy for stroke patients from autumn 2021, which has significantly increased the proportion of patients who can access life-saving treatment for major stroke. The Walton centre has become only the third interventional team in the UK to provide this 24/7 service and St Helens and Knowsley Teaching Hospitals NHS Trust is by far the biggest user of this service
- Continued development of Frailty Services supporting older people requiring admission to hospital and early supported discharge with ongoing community support
- New investment has been made into haemodialysis machines in Critical Care Unit to reduce the length of time taken to dialyse patients improving patient experience
- Working with the Cheshire and Merseyside Cancer Network to optimise patient pathways within Endoscopy services
- Development of ante-natal service in Diabetes & Endocrinology to reduce a variety of foetal and maternal complications in line with NICE guidance and successfully implementing the offer of Continuous Glucose Monitoring to all pregnant women as mandated by NHS England
- Commencement of collaborative service with Southport & Ormskirk Hospital NHS Trust in Haematology and nurse-led survivorship service commenced to support patients post chemotherapy and provide advice to colleagues in primary care.
- Close partnership working with Cheshire and Merseyside Paediatric Network including covering respiratory syncytial virus (RSV) surge planning, Mental Health/Child and Adolescent Mental Health Service (CAMHS), NWAS 111 CAS and improving Diabetes Transition Service with adult colleagues
- The introduction of a new community Hub in collaboration with St Helens CCG that streamlines diagnosis and treatment of patients with chronic obstructive pulmonary disease (COPD)

The commitment and dedication of the entire team in Medical and Urgent Care continues to support the Trust in the delivery of 5-star patient care.

3.6.3. Primary and Community Services Care Group

St Helens Urgent Treatment Centre (UTC)
The UTC experienced a surge in attendances in 2021-22, with 62,170 attendances, compared to 2020-21 when there were 39,725 attendances.

On average over 97% of patients were seen and treated within 4 hours in line with the national target, which was a great achievement given the staffing challenges and

COVID-19 restrictions.

Heart Failure Telehealth Pilot
The St. Helens community Heart Failure Service commenced delivery of a telehealth 12-month pilot scheme in September 2021. This is a joint initiative funded by St. Helens CCG. The telehealth function is currently hosted by Mersey Care NHS Foundation Trust and provides daily monitoring of inputted observations such as blood pressure, heart rate, oxygen saturations and weight, all significant markers to highlight early detection of any deterioration in heart failure. This early detection of any deterioration can help to prevent acute hospital admissions. The pilot is designed for a group of up to 75 patients suffering from decompensating heart failure in the community setting. Feedback to date from service users and staff has been positive with patients feeling more in control of their long-term condition and assurance that their health is being closely monitored. There has been a reduction in the requirement for patients to attend a clinic appointment and staff reporting increased assurance in prescribing safety.

Long COVID
Following the publication of guidelines by NHS England for all regions to establish a long COVID assessment service across England, this was broadened to create local borough provision of this service to reduce the burden of travel for patients requiring access to long COVID support. Mersey Care were allocated the funding to set up the long COVID clinic provision for our local population, which is supported clinically by our Community Matron Service, who form part of the multi-disciplinary team (MDT) led clinic. This provides physical, cognitive and psychological assessments for people experiencing suspected post-COVID-19 syndrome, ensuring this patient group has the right support.

This service commenced in November 2021 and is available for patients with signs and symptoms that develop during or after an infection consistent with COVID-19, where this continues for more than 12 weeks and are where these symptoms are not confirmed with alternative diagnosis. The clinic is accessible following referral from the patient's GP following a series of investigations to rule out any other cause. Each patient is assessed, with the focus on a plan of care aimed at recovery and rehabilitation with the support of the MDT.

District Nursing Service
The District Nursing Service continued to provide a frontline role in supporting patients in their own homes throughout the pandemic, supporting patient flow and discharges from hospital to home and often picking up social care packages to help facilitate a patient's wishes regarding their preferred place for end-of-life care. The service experienced an increase in end-of-life care but managed to achieve the patient's wishes whilst managing workforce demands due to staff COVID-19 sickness/shielding and isolation.

Sexual Health Service provision
The Sexual Health Service provision has remained open, with a total of 20,906 patients seen in 2021-22, with 7,192 patients accepting telephone assessments and 13,714 patients were offered and accepted face to face consultations, including treatment provision.

GP with Extended Roles (GPwER) **in community services**
The Care Group provides GPwER services for ear, nose and throat (ENT), dermatology and gynaecology. Since April 2021, the services have continued to receive high numbers of new referrals following the initial months of the COVID-19 pandemic. The services are now focussing on restoring face-to-face clinics.

Marshalls Cross Medical Centre (MC)
Marshalls Cross MC is responsible for the primary care of the following care homes:

- Elizabeth Court Care Home - all 40 patients
- Madison Court Care Home - one floor with18 patients
- Broadoak Manor Nursing Home, Stapely Unit plus single figure outliers in other units - 25 patients

In the Spring of 2021 the staff vaccinated the above cohort for their second vaccinations and in September/October 2021 the patients received their booster vaccinations. This was combined with the seasonal flu vaccination programme. Logistics and circumstances prevented 100% vaccine coverage, however over 90% of those eligible were vaccinated. In total, across the practice 3,594 COVID-19 vaccines have been offered and accepted.

Enhanced Services
In December 2021 neutralising monoclonal antibody therapy (nMABS) was licenced to treat COVID-19 patients in the Community. This potentially lifesaving treatment reduces COVID-19 symptoms, hospitalisation and ED attendance when administered as soon as possible after a confirmed positive polymerase chain reaction (PCR) test. It works by binding to the specific sites on the protein of the SARS-CoV-2 virus particle, blocking its entry into cells and therefore inhibiting its replication. The Trust's community Intravenous (IV) Therapy Team were identified as providers to deliver nMABS to our St Helens and Knowsley residents, working collaboratively with our pharmacy colleagues, CCGs and local authority partners to implement this service within 3 weeks, in line with national guidance.

The Enhanced Community Services Directorate have continued to support the organisation's patient flow, achieving higher than national average bed occupancy and lower than the national average length of stay in the latter part of 2021. This was achieved through daily intermediate care huddles with key partners across our health and social care services. Staffing challenges faced have been supported by the whole directorate working flexibly with staffing resources across all of our services and exploring new ways of pathway working.

3.6.4. Clinical Support Services Care Group

The Clinical Support Services Care Group includes Pathology, Radiology, Clinical Psychology, Therapy Services, Neurophysiology, Patient Access Services and Cancer Support Services. These services have been integral to the Trust's recovery and optimisation plans to deliver against key targets.

The Care Group will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct

consequence of the pandemic. The future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, however, the Trust is aware of the need to continue to increase capacity and resilience to deliver safe, high-quality services that meet the full range of people's health and care needs.

Outpatients
Outpatient Transformation has been fundamental in supporting the elective recovery planning, with expansion of Advice & Guidance, Telehealth, Virtual and Patient Initiated Follow Up (PIFU) across specialties to champion this agenda; supporting patient education to facilitate self-care and health and wellbeing, in addition to enabling the required reduction in unnecessary hospital follow up appointments per specialty.

Clinical Psychology
Clinical Psychology is supporting specialist Trainee Clinical Psychologists programme this year to ease clinical pressures. These Trainees are 6-12 months away from qualifying as Clinical Psychologists and it is anticipated this will also assist with future recruitment. Waiting list initiatives have been in action since December 2020 and waiting lists remain low compared to other comparable services outside of the Trust. The service has applied to take part in a national research project improving the care of early cancer diagnosis which will impact positively upon specialist areas.

Cancer Services
Cancer services have continued to maintain performance in contrast to the local and national picture. The Cancer Symptoms Advice Line that was implemented in May 2020, in response to the significant reduction in cancer referrals from GPs during the pandemic, was successful in finding 3 cancers. There is now national interest in how this initiative might be adopted and adapted to support rapid diagnostic centres across the country. The roll out of the Faecal Immunochemical Test (FIT) test project to all CCGs in the catchment area during COVID-19 has improved endoscopy prioritisation and capacity utilisation and has been included in the commissioning intentions for 2022-23. The Rapid Diagnostic Pathway programme is progressing well and will conclude in 2024 when all patients will have access to a rapid pathway that enables them to have cancer excluded or a firm diagnosis of cancer within the new 28-day Faster Diagnosis Standard (FDS). The Trust continued to rank very highly in the National Cancer Patient Experience Survey (NCPES) with an overall score of 9.1/10. In addition to the other 4 personalised care supported self-management programmes (breast, colorectal, prostate and haematology) the Trust has also implemented a supported self-management follow up and surveillance pathway to support and empower patients with skin cancer.

Therapy Services
Within Therapy Services fast track staff development was employed to upskill competencies safely, developing additional skills where appropriate, outside of the usual scope of practice to support critical care and to buddy with nursing staff. This practice supports a flexible workforce that can morph in response to need, when appropriate, in order to maintain patient safety and high-quality care.

Close working relationships and practices with community therapy colleagues have

been maintained providing timelier and seamless transfers of care building on models of Discharge to Assess. This practice of integrated care with external organisations continues to grow and develop in order to maximise patient flow. Service redesign is in progress to maintain a senior therapy triage in ED following a successful pilot evidencing the impact of this on patient flow through the department.

Pathology
Pathology continues work with our Cheshire and Merseyside colleagues towards a combined Pathology network. The Trust has undergone and maintained ISO15189:2012 accreditation with remote surveillance visits this year throughout the four pathology disciplines with a full inspection to follow this coming year. New glycated haemoglobin (HbA1c) analysers have been introduced into Biochemistry to deliver greater capacity to support the increasing numbers of diabetics for monitoring and diagnosis. COVID-19 testing continued to dominate with shorter required turnaround times to assist with patient flow. Phlebotomy successfully introduced a new booking system to improve patient experience and patient overcrowding across all phlebotomy clinics.

Radiology
Radiology Services have retained their Quality Standard for Imaging (QSI) accreditation. This accreditation allows the department to benchmark itself against national quality standards and promotes continuous improvement. Radiology achievements for 2021-22 include:

- Successfully training a new Reporting Radiographer
- Appointment of a clinical tutor in ultrasound
- Recruitment of new Breast Radiologist
- Successful recruitment drive for band 5 radiographers
- Training of a new Assistant Practitioner
- Facilitation of a Masters' student
- Awarded the status of University of Cumbria training hub, and as part of this securing new machines and additional trainees in ultrasound
- New installation of an Interventional Room with computerised tomography (CT) capability
- New plain film room with X-ray table in ED radiology
- Supporting improved patient pathways for same day elective care and brain, abdomen and prostate conditions

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

Community Diagnostic Centre
The Trust was able to implement the first Community Diagnostic Centre in Cheshire and Merseyside, running services from 13th July 2021. The key focus is to improve patient experiences by joining up specialities to allow patients to have all diagnostic tests on the same day and not just to increase activity or reduce waiting lists in isolation. Less invasive procedures have been introduced at the start of pathways to prevent unnecessary instigations, for example, FIT. The Cancer Rapid Diagnostic Service (RDS) programme is well underway with three pathways up and running

which are, breast, upper gastrointestinal and prostate, as well as non-specific RDS pathways and brain tumour pathways which are due for review and audit in 2022. A recruitment drive in phlebotomy is underway to support extra clinics from April 2022.

Fibroscan (a specialised ultrasound machine for your liver) is also coming on board in the next few weeks and the Trust has agreed to be a test site for PinPoint, which is a test using machine learning to simplify a range of blood measurements into a single number to indicate a patient's chance of having cancer. The test helps doctors triage, stratify, prioritise and safety net patients by their risk of cancer, thereby helping manage diagnostic capacity.

An example of the joining up of modalities to streamline care and improve patient experience is the breast team's triple assessment clinic for under 35-year-olds followed by the breast multidisciplinary team meeting. Urology has a rapid access prostate clinic with biopsies and results clinics ongoing at the same time, demonstrating the value of having diagnostics all under one roof. There are also one stop clinics for postmenopausal bleed patients.

3.6.5. COVID Vaccination Programme

The Trust began vaccinating at Whiston Hospital in December 2020 and has provided 17,675 1st, 2nd and booster dose vaccinations to staff between opening and mid-October 2021.

The Trust opened the first Mass Vaccination Site (MVS) in Cheshire & Merseyside at St Helens Rugby Club on 18th January 2021 and has vaccinated over 263,000 citizens in 12 months providing 1st, 2nd, 3rd primary and booster doses. It was one of the first sites nationally to be able to offer all 3 vaccines: Astra Zeneca, Pfizer and Moderna.

The MVS has continued to be considered an exemplar site and has supported training of the military before deployment to other sites and has worked collaboratively in utilising other workforces such as Merseyside Fire & Rescue Service, St John Ambulance and other voluntary sectors.

In October 2021, the MVS commenced vaccination of 12–15-year-olds and by mid-January 2022 had vaccinated 5500 children. The Trust is also supporting the whole of Cheshire and Merseyside in the delivery of this and the 5–11-year-olds programme, working with partner organisations, including CCGs, Primary Care Networks, Community Pharmacies, other acute hospital providers, School Age Immunisation Service and Alder Hey Children's NHS Foundation Trust.

The Trust is also Lead Employer for Cheshire and Merseyside, providing a trained and competent workforce across the region to support the vaccination programme.

3.7. Summary of national patient surveys reported in 2021-22

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

3.7.1. National Inpatient Survey

The Trust participated in the annual National Inpatient Survey 2020 coordinated by the Care Quality Commission. The results from the survey are used in the regulation, monitoring and inspection of NHS Trusts in England and were published in January 2022.

The Adult Inpatient 2020 survey was significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content, therefore, the results are not directly comparable to previous years' data and trend data is not available. In future years, trend data will be incorporated into the reports.

In addition, this year the CQC amended its analysis and reporting, in an attempt to provide trusts with a higher level of feedback from the survey, by including additional levels for the bandings. Previously all questions were banded as either 'better', 'about the same' or 'worse', with the addition of 'much worse', 'somewhat worse', 'somewhat better' or 'much better' bandings for the 2020 survey.

Other changes to the Adult Inpatient Survey in 2020 included the transition from a paper only method to a 'push-to-web' method, offering an online option. This did not have an impact on the Trust's response rate, which remained at 39%. The survey was sent to those who were inpatients during the month of November 2020.

The Trust's results were:

- Much better than most trusts for 1 question relating to the hospital and ward
- Better than most trusts for 4 questions relating to care and treatment (1), operations and procedures (2) and leaving hospital (1)
- Somewhat better than most trusts for 4 questions relating to the hospital ward (1), leaving hospital (3)

The Trust was banded about the same as other trusts for the remaining 36 questions and was not banded as worse, somewhat worse or much worse than most trusts for any questions.

The overall results show an improvement in a number of key areas from previous surveys including the information questions that were targeted following last year's survey. The Trust ranked 4th nationally when compared to other acute trusts for the question relating to overall quality of the care provided, with a score of 8.7/10.

Themes for improvement have been identified including ensuring patients receive more help with meals, patient and family involvement in discharge planning, information about discharge medication and improving communication by medical teams in a way that the patient can understand. An action plan has been developed focusing on the main priorities and actions for improvement from the survey.

3.7.2. National Maternity Survey 2021

A CQC maternity survey was undertaken in 2021 where women aged 16 years or over who had a live birth between 1st and 28th February 2021 at Whiston Hospital were asked to participate. The findings of this survey were released in February

2022 with some comparisons to the previous maternity survey which was undertaken in 2019. 131 women responded to the survey which was a response rate of 44%

The overall findings identified that the maternity service was:

- Better than most trusts for 1 question
  - F17. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?
- Somewhat better than most trusts for 2 questions
  - C9. Were you given enough information on induction before you were induced?
  - D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?
- Somewhat worse than most trusts for 3 questions
  - B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
  - B15. Thinking about your antenatal care, were you involved in decisions about your care?
  - F7. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?
- About the same as other Trusts for 44 questions

Within these 44 responses although the Trust was rated as the same compared to other trusts it was noted that 13 of these questions had a reduced scoring in comparison to the 2019 survey. The report acknowledges that that COVID-19 may have had an impact and consideration of changes within the maternity services due to the pandemic when interpreting the results is required when making comparisons with the previous year, e.g. Question D7 which asks 'In the postnatal period, if a partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?', which was directly affected by the visiting restrictions in the postnatal period for women and their families.

The priorities for 2022-2023 are:

- Dissemination of findings and shared learning
- A focus upon communication and ensuring women and their families are provided with adequate information to ensure they have continued and improved involvement in their care to empower them to make informed choices
- Development of an action plan in order for maternity and obstetric staff to understand their own results and enable engagement in actions on areas where improvement will be undertaken.
- Some key actions will include:
  - Reintroduction of a support partner onto the antenatal and postnatal ward between 9am and 9pm which was restricted to one 3 hour visiting session per day due to the COVID-19 pandemic
  - Redesign and recommencement of parent education sessions which were suspended due to the COVID-19 pandemic. These sessions include discussions regarding personalised care, information provision and shared decision-making processes
  - Collaboration with the Maternity Voices Partnership (MVP) to include the findings of the maternity survey as a key priority for 2022 to attempt to identify specific areas for improvement in which to focus in the forthcoming year

3.7.3. National Children and Young People's (CYP) Survey

The survey covered inpatients discharged during November/December 2020 and January 21, with three different questionnaires depending on the patient's age, 0-7 (completed by the parent/carer), 8-11 and 12-15 years (completed by the child and the parent/carer). All surveys were postal or telephone due to poor online uptake in previous years.

The Trust's response rate was 15%, with 610 questionnaires sent out and 89 completed and returned; a slight improvement on the 13% response rate for the previous survey in 2018. There was a 24% average response rate for all trusts.

The overall report indicated excellent feedback in relation to the experience of parents/carers and CYP. The Trust scored amongst the top scoring 20% of trusts for 63% of questions and within the intermediate 60% of trusts for the remaining 37% of questions. The Trust had no scores within the lowest scoring 20% of trusts and scored in the top 20% for the overall experience question in that parents/carers felt their child was well looked after by the hospital staff (this score was much better than the national average score and a significant increase on the Trust's 2018 survey results). Patients and their families scored their experience as 9/10 with 10 being the maximum score.

Areas of note where the Trust scored amongst the highest scoring 20% of trusts were:

- The high quality and choice of the hospital food provided (this has been an area of concern in previous surveys, so this indicates a significant improvement)
- The ability to sleep uninterrupted when needed in the hospital and the cleanliness of the hospital room/ward (always score very highly)
- The privacy afforded when receiving care and treatment.
- Parents/carers felt involved in agreeing a plan for their child's care, that they could ask questions and had confidence/trust in the staff treating their child
- Parents/carers felt involved in decisions about their child's care and treatment and felt they were kept well informed
- Parents/carers felt staff worked well together (much better than national average score and improvement on 2018 survey results)
- Different members of staff were aware of the child's medical history and did not give conflicting advice/information
- Parents/carers felt listened to by staff looking after their child (significant improvement against 2018 survey result)
- CYP said hospital staff talked with them about how they were going to be cared for
- Parents/carers were given information about their child's care and treatment in a way that they could understand
- Parents/carers felt looked after by the staff and highly rated the overnight facilities with access to hot drinks facilities and ability to prepare food in the hospital
- Parents/carers felt that staff did everything to help their child if they felt pain
- CYP knew who to talk to if they were worried about anything when they got home
- Parents/carers were given advice about caring for their child when they went

home and knew what was going to happened next with their child's care

As always, there were some areas requiring improvement based on the feedback received. However, given that the survey took place during the COVID pandemic, there were a lot of restrictions in place to maximise patient safety, including the closure of playrooms, strict social distancing and visiting restricted to one parent at a time. As a result of this feedback the Trust will be looking at:

- Ways to ensure age-appropriate playthings are available and that play specialists adapt their ways of interacting with CYP so that they are aware of the wide variety of play options that are available to them (noting that the playrooms are still closed and staff must still work in line with COVID infection control/social distancing guidelines)
- How to provide younger children with a more age-appropriate environment, which, where possible, should be separate from older CYP
- Reviewing methods by which staff can involve CYP in decisions about their care and treatment, where appropriate
- Completing an audit of the communication skills and competencies of staff to identify any training (include induction) required given that some CYP did not always fully understand what staff were saying about their care
- Reviewing information and advice given on discharge to ensure that parents/carers know who to talk to if worried about their child when they got home and that CYP have appropriate advice on how to look after themselves after they go home

3.7.4. National Urgent and Emergency Care Survey

The results of the Urgent and Emergency Care survey 2020 were published by the CQC in September 2021 and outlined the experiences of patients who had used the services in September 2020. The Trust's response rate was 23% (277 usable responses), which is decrease from 25% in the previous survey undertaken in 2018.

Reviewing the responses, the Trust performed better than other trusts in the following questions:

- Did doctors or nurses talk to each other about you as if you weren't there?
- Were you able to get suitable food or drinks when you were in A&E?
- Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?

All the other responses were rated about the same as other trusts, with none scoring worse than other trusts. The overall section for environment and facilities put the Trust amongst the best performing trusts.

The Trust has produced an action plan to focus on areas where the score either fell from the previous survey in 2018 or was at the lower end of the scale when compared to other trusts. The action plan includes ongoing work to reduce the waiting time in the Department, enhancing privacy at the Reception Desk and ensuring patients have sufficient time to discuss their condition.

3.7.5. National Cancer Patient Experience Survey (NCPES)

Due to the pressure COVID-19 has put on the NHS, the 2020 NCPES was offered to

all NHS Trusts on a voluntary basis and 55 trusts participated. For this reason, it was not possible for the national team to produce a national level report or reports at Cancer Alliance or CCG level. It was also not possible for national comparisons to be made against previous years. The 2021 survey launched in November 2021 will return to covering all trusts.

The 2020 NCPES was carried out from 29th April to 8th July 2021. The survey results are a snapshot in time and give some insight into the impact of the pandemic on patient experience. It should be noted that during the sampling period there was variation in the effects of the pandemic on services, impacting on the results.

When asked how patients rated their overall care on a scale 1-10, 167 Patients responded to Q61 maintaining the Trust top score of 9.1, placing us second nationally by a close margin.

A comparison in the Trust's results has been made between the 2019 and 2020 scores to highlight areas for improvement. It is acknowledged that this period of time was extremely difficult time for patients, families, clinical teams and front-line staff and, despite unprecedented challenges, the Trust continued to deliver care and treatment to cancer patients, at a time when other trusts withdrew some services.

Key findings show that:
- 48% (24) questions had higher scores than in 2019; the percentage range of improvement was from 1 % to 10%
- 42% (21) questions had lower scores than in 2019; percentage range was from -1% to -19%
- The remaining questions were unchanged.

The areas where the scores improved include:
- Once cancer treatment finished, being given enough care and support from health or social services
- Confidence and trust in the ward nurses
- Easy to contact the Clinical Nurse Specialist (CNS)
- While being treated as an outpatient or day case, finding someone to discuss worries and fears
- Before cancer treatment started, treatment options were discussed
- Having enough nurses on duty
- Waiting times in clinic
- The way in which patients were told they had cancer
- Provision of information to the GP
- Understandable explanations of what was wrong

The areas where scores fell included:
- Family member or someone close being able to speak to a doctor
- Help in controlling pain
- While being treated in hospital, finding someone to discuss worries and fears
- Provision of written information on discharge
- Once treatment started being given enough information about whether the radiotherapy was working in an understandable way
- Hospital staff talking in front of the patient as if they were not there

- Being given the option of having a family member/close someone present when being told about the cancer

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

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

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

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

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

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2021-22
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Trust Board

Richard Fraser, Chairman

Ann Marr OBE, Chief Executive

5. Written statements by other bodies

5.1.

5.2. Healthwatch Halton

Ann Marr
Chief Executive
St Helens & Knowsley Teaching Hospitals NHS Trust
Warrington Road
Prescot L35 5DR

Healthwatch Halton
Suite 5, Foundry House
Widnes Business Park,
Waterside Lane
Widnes WA8 8GT

Tel 0300 777 6543

6 May 2022

Dear Ann

Re: Quality Account report 2021-22

We welcome this opportunity to provide a commentary on St Helens & Knowsley Teaching Hospitals NHS Foundation Trust Quality Account for 2021-22, which was provided to Healthwatch Halton in a timely manner to allow for a response.

We thank the Trust for its willingness to work with Healthwatch Halton during the past 12 months and for the opportunity to meet with the Trust quarterly to highlight and discuss any patient experience issues. As in previous years, we have found the Trust to be very cooperative and responsive to any issues that we have brought to its attention.

From our experience working with the Trust throughout the past year, and from the public feedback we've received, we believe this report gives a good reflection of people's real experiences of the service.

There is evidence that the Trust is committed to learning from patient, service user and carer experiences, however we feel it would be useful to highlight some actual case studies from patients and how they have been responded to.

We noted some progress against the 2021-22 quality goals. It wasn't overly clear to us, from the draft report, exactly how much progress had been made towards meeting the quality goals. There is evidence of how

improvement has been measured, but not information on the progress made during the year towards these targets.
The ongoing commitment from the Trust to ensure that patient experience is at the heart of its vision is to be commended.

The Trust has listened and acted on patient feedback from Healthwatch. We were pleased to note the changes made due to patient feedback, such as the review of procedures for managing patient property.

We'd also like to congratulate the Trust on the launch of the updated carer passport which recognises the importance and contribution of carers.

The Equality Delivery System (EDS2) grades provide reassurance and highlight the excellent work the Trust does in addressing health inequalities in our local communities.

Finally, we would like to pass on our thanks and appreciation to everyone at the Trust for their absolutely tremendous work on behalf of our community during the past year.

Kind regards

Dave Wilson
Manager - Healthwatch Halton

5.3. Healthwatch Knowsley

St Helens and Knowsley Teaching Hospitals NHS Trust – Quality Account Commentary 2021-22
Healthwatch Knowsley welcomes the opportunity to provide this commentary in support of the St Helens and Knowsley Teaching Hospitals NHS Trust Quality Account for 2021/22, which was provided to Healthwatch Knowsley in a timely manner to allow for a response.

We would like to thank the Trust for their willingness to work with Healthwatch Knowsley, and for providing us with the opportunity to meet on a quarterly basis to discuss any patient experience issues and trends in feedback that are emerging. We also attend the Patient Experience Council, Cancer Patient Experience and Quality Assurance Group, Equality, Diversity and Inclusion Steering Group and the Patient Participation Group. This collaborative working has been a consistent theme over many years and is very much appreciated.

We welcomed the opportunity to contribute to the shaping of the 2022/23 priorities as part of the Quality Account process.

The Trusts retention of its outstanding Care Quality Commission (CQC) rating reflects the quality of services that are provided by the Trust and it is also really pleasing to see that the trust has been reaccredited as a Veteran Aware Trust for the second year running.

It is noted that the progress in achieving most of the quality goals for 2021-22 has been partially achieved and is to be rolled over to 2022-23, and the objective to increase the proportion of patients who report that they have received an appropriate amount of information about their care has been achieved, which is positive. All of the quality objectives for improvement for 2022-23 appear to be suitably challenging and appropriate. We feel that it is appropriate to continue with the focus on this set of quality objectives moving forward. However, in terms of the Improving effectiveness of the Discharge process, we feel that an action/measurement around improving timeliness of medications dispensed by the hospital pharmacy would contribute significantly to achieving this priority.

It is reassuring to see that the 2021 Equality Delivery System (EDS2) approved grades are all achieving or excelling and the work that is being carried out around communication support for those with disabilities and increasing accessibility highlights the work that the Trust is doing to address health inequalities.

We feel that the Patient Participation Group is a really positive step to enable patients, carers and community members to provide feedback and support service development within the Trust. Healthwatch Knowsley were involved in the development of the Patient Experience and Inclusion Strategy 2022-2025. The move to a digital story telling platform is really encouraging allowing to improve the accessibility of stories and to reinforce learning.

Overall, the Trust currently holds a patient experience rating of 4.1 out of 5 stars (Good/Excellent) based on the 663 reviews held on the Healthwatch Knowsley online feedback centre. This rating has been collated through feedback provided by patients and family members.

From our experience of working with the Trust, we have always found staff to be extremely helpful and responsive to the patient experiences shared through Healthwatch Knowsley.

Healthwatch Knowsley wishes to place on record their appreciation of the Trust's work on behalf of our local community throughout 2021-22.

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

The following amendments were made following feedback from other bodies:

Page	Amendment/addition
26-27	Additional detail added to demonstrate the progress made in achieving the quality objectives in 2021-22
33	Included an additional measurement for the objective to improve the effectiveness of the discharge process
102	Added actual patient case studies leading to improvements
132	Included a central telephone number as a non-digital means of contact if there are any queries relating to the Quality Account

6. Abbreviations

ACE	Angiotensin-converting enzyme
ACP	Advance care planning
ACS	Acute Coronary Syndrome
AF	Atrial fibrillation
AHPs	Allied Health Professionals
AI	Artificial Intelligence
AKI	Acute Kidney Injury
ALTC	Agreement for Long Term Collaboration
AMD	Age-related Macular Degeneration
AMU	Acute Medical Unit
ANTT	Aseptic Non-Touch Technique
App	Application
AQuA	Advancing Quality Alliance
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BAPEN	British Association of Parenteral and Enteral Nutrition
BAUN	British Association of Urology Nurses
BAUS	British Association of Urological Surgeons
BBA	Born before arrival
BC	Blood culture
BPH	Benign prostatic hyperplasia
BSI	Blood stream infection
BSL	British Sign Language
BTS	British Thoracic Society
BURST	British Urology Researchers in Surgical Training
CAMHS	Child and Adolescent Mental Health Service
CaSH	Contraception and Sexual Health
CBT	Cognitive behavioural therapy
CCC	Clatterbridge Cancer Centre
CCGs	Clinical Commissioning Groups
CCIO	Chief Clinical Information Officer
CCS	Clinical Classifications Service
CCU	Coronary Care Unit
CDI/C diff/C difficile	Clostridium difficile infection
CHPPD	Care Hours per Patient per Day
CMP	Case Mix Programme
CMPA	Cow's milk protein allergy
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Airways Disease
CP	Chest pain
CPAP	Continuous Positive Airway Pressure
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRAB	Copeland Risk Adjusted Barometer

CRN NWC	Clinical Research Network, North West Coast
CS	Clinical standards
CT	Computerised tomography
CTG	Cardiotocography
CVD	Cardiovascular Disease
CYP	Children and Young People
DAMASCuS	Diverticular Abscess Management: A Snapshot Collaborative Audit Study
DAP	Digital Aspirant Programme
Datix	Integrated Risk Management, Incident Reporting, Complaints Management System
DIPC	Director of Infection Prevention and Control
DKA	Diabetic keto-acidosis
DME	Directors of Medical Education
DMOP	Department of Medicine for Older People
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DOAC	Direct oral anticoagulants
DQA	Data Quality Audit
DQMI	Data Quality Maturity Index
DRLs	Dose Reference Levels
DSPT	Data Security and Protection Toolkit
DVLA	Driver and Vehicle Licensing Agency
DVT	Deep vein thrombosis
EAP	Employee Assistance Programme
ED	Emergency Department
ED&I	Equality, Diversity and Inclusion
EDS or EDS2	Equality Delivery System
ENT	Ear, nose and throat
EoLC	End of life care
ePMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
eTCP	Electronic Transfer of Care to Pharmacy
FDS	Faster Diagnosis Standard
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
FFP3	Filtering Face Piece
FIT	Faecal Immunochemical Test
FM	Facilities Management
GAP SCORE	Growth Assessment Protocol Standardised Case Outcome Review and Evaluation
GI	Gastrointestinal
GIRFT	Get It Right First Time
GMC	General Medical Council
GNBSIs	Gram-negative bloodstream infections
GORD	Gastroesophageal reflux disease
GP	General Practitioner
GPAU	General Practitioner Assessment Unit

GPSI	GP with special interest
GPwER	GP with Extended Role
GUM	Genitourinary Medicine
HASU	Hyper-Acute Stroke Unit
HbA1c	Haemoglobin
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HEE	Health Education England
HES	Hospital Episode Statistics
HF	Heart Failure
HFMA	Healthcare Financial Management Association
HNA	Health Needs Assessment
HR	Human Resources
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
HSRC	Hyper-acute Stroke Research Centre
HST	Higher Specialist Trainees
HTN	Health Tech Newspaper
HWWB	Health, Work and Well-being
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICS	Integrated Care System
IDDSI	International Dysphagia Descriptor Standardisation Initiative
IG	Information Governance
IMT	Internal Medicine Trainee
INR	International Normalised Ratio
IPR	Integrated Performance Report
IQILS	Improving quality in liver services
ISDN	Informatics Skills Development Network
ISO	International Organisation for Standardisation
IT	Information Technology
IV	Intravenous
JAG	Joint Advisory Group
JAWS	Job Access with Speech
JBDS	Joint British Diabetes Society
KPI	Key performance indicator
LARC	Long-acting reversible contraception
LGBT	Lesbian, gay, bisexual, transgender
LGBTQI+	Lesbian, gay, bisexual, transgender, questioning and intersex
LocSSIPs	Local Safety Standards for Invasive Procedures
LSCB	Local Safeguarding Children Board
LUTS	Lower urinary tract symptoms
MAMMA	Mastitis and mammary abscess management
MAP	Mean arterial blood pressure
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK

MC	Medical Centre
MCL	Mantle Cell Lymphoma
MDT	Multi-disciplinary Team
MEOWS	Modified Early Obstetric Warning System
MET	Medical Emergency Team
MINAP	Myocardial Ischaemia National Audit Programme
MLU	Midwife-led Unit
MMDA	Mid-Mersey Digital Alliance
MMU	Manchester Metropolitan University
MOP	Medicine for Older People
MR	Magnetic Resonance
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MRSAb	Methicillin-resistant staphylococcus aureus bacteraemia
MSSA	Methicillin-sensitive staphylococcus aureus
MTI	Medical Training Initiative
MUST	Malnutrition Universal Screening Tool
MVP	Maternity Voices Partnership
MVS	Mass Vaccination Site
NABCOP	National audit - breast cancer in older patients
NACAP	National asthma and COPD audit programme
NACEL	National Audit of Care at the End of Life
NaDIA	National Inpatient Diabetes Audit
NAOGC	National Audit Oesophago-Gastric Cancer
NatSSIPs	National Safety Standards for Invasive Procedures
NBOCA	National Bowel Cancer Audit
NCAA	National Cardiac Arrest Audit
NCAP	National Cardiac Arrest Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NDA	National Diabetes Audit
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NG	Naso-gastric
NHS	National Health Service
NHSE	National Health Service England
NHSE/I	National Health Service England/Improvement
NHSI	National Health Service Improvement
NHSX	National Health Service X - joint unit of NHS England and the Department of Health and Social Care
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIPE	Newborn and Infant Physical Examination
NIV	Non-Invasive Ventilation
NJ	Naso-jejunal
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
nMABs	Neutralising monoclonal antibodies

NMC	Nursing and Midwifery Council
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NOAC	New oral anticoagulant
NoF	Neck of femur
NPCA	National Prostate Cancer Audit
NPDA	National Paediatric Diabetes Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting & Learning System
NSTEMI	Non-ST-segment elevation myocardial infarction
NTM	Non-Tuberculous Mycobacteria
NVDA	Non-visual desktop access
NVR	National Vascular Registry
NWAS	North West Ambulance Service
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OHCA	Out of hospital cardiac arrests
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapist/Therapy
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PBS	Patient Booking Services
PCN	Primary Care Networks
PCNL	Percutaneous Nephrolithotomy
PCR	Polymerase chain reaction
PGCert	postgraduate certificate
PE	Pulmonary Embolus
PEG	Percutaneous Endoscopic Gastrostomy
PEWS	Paediatric Early Warning Score
PFI	Private Finance Initiative
PhD	Doctor of Philosophy
PHE	Public Health England
PI	Principal Investigator
PIFU	Patient Initiated Follow Up
PIR	Post infection review
PLACE	Patient-Led Assessments of the Care Environment
PMRT	Perinatal mortality review tool
PN	Parenteral Nutrition
PoCT	Point of Care Testing
PPD	Preferred place of death
PPE	Personal Protective Equipment
PREM	Patient Reported Experience Measures
PRES	Participant in Research Experience Survey
PROMs	Patient Reported Outcome Measures
QCAT	Quality Care Accreditation Tool
QICA	Quality Improvement & Clinical Audit
QIP	Quality Improvement Project
QOF	Quality Outcomes Framework

QSI	Quality Standard for Imaging
RACPC	Rapid Access Chest Pain Clinic
RAG	Red, amber, green
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RCM	Royal College of Midwives
RDI	Research, Development and Innovation
RDS	Rapid Diagnostic Service
ReCAP	Rectal Cancer Management during the COVID-19 Pandemic
RLC	Rugby League Cares
RN	Registered Nurse
RRG	Recovery, Resilience and Growth
RTT	Recruiting to Time and Target
RSV	Respiratory Syncytial Virus
SALT	Speech and Language Therapy
SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit
SAMP	Special Advanced Medical Practice
SARS-CoV1/SARS-CoV	Severe acute respiratory syndrome coronavirus 1
SAU	Surgical Assessment Unit
SCR	Shared Care Record
SDEC	Same Day Emergency Care
SDI	Service Desk Institute
SEQOHS	Safe Effective Quality Occupational Health Services
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SHSCR	St Helens Shared Care Record
SIREN	SARS-COV2 Immunity and Reinfection Evaluation
SIRO	Senior Information Risk Owner
SJR	Structured Judgement Review
SLA	Service level agreement
SMR	Standardised Mortality Ratio
SOP	Standard Operating Procedure
Sp02	Saturation of peripheral oxygen
SRoM	Spontaneous Rupture of Membranes
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
STEMI	ST-segment elevation myocardial infarction
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
STI	Sexually Transmitted Disease
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
TEL	Technology Enhanced Learning
TEXAS	Tranexamic Acid in Elective Colorectal Surgery
ToP	Termination of pregnancy
TPN	Total Parenteral Nutrition

TWOC	Trial without catheter
UK	United Kingdom
UKAS	United Kingdom Accreditation Services
UKHSA	United Kingdom Health and Security Agency
UPH	Urgent Public Health
US	Ultrasound
VCHA	Veterans Covenant Healthcare Alliance
VTE	Venous Thromboembolism
WALANT	Wide-Awake Local Anaesthesia, No Tourniquet
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
2D	Two dimensional
2WW	Two week waits
7DS	Seven-day hospital services

7. Contact

Additional information about the Trust is available on the website:

www.sthk.nhs.uk

If you have any queries relating to this Quality Account please direct them to the following email: askann@sthk.nhs.uk.

Alternatively please contact the Executive Office on 0151 430 1371.

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (22)042

Title of paper: Year-end Review of Trust Objectives

Purpose: To present the year-end review of progress against the 2021/22 Trust objectives.

Summary:

1. The Trust Board agreed thirty three objectives for 2021/22 at the start of the financial year.
2. The objectives are split into 9 categories; 5 representing the Trusts 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
3. This paper summarises the progress achieved to date and gives an assessment of the likely delivery by the end the financial year;

Category	Current Status	Number	% of total
	Completed/achieved	19.5	59%
	Progress made but not fully achieved/completed by 31st March 2022	11	33%
	Delayed or not achieved by 31st March 2022	2.5	8%

*	Indicates where the objective has been rolled forward to the 2022/23 Trust objectives

4. Setting and monitoring the delivery of the annual plan and objectives is a key role for the Board and part of the CQC Well Led assessment.

Trust objective met or risk addressed: provides assurance to the Board that the Trust had made sufficient progress in delivering its strategic objectives and annual plans.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff, patients and all stakeholders.
Recommendation(s): The Board is asked to note the progress made in delivering the 2021/22 Trust objectives.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 25th May 2022.

2021/22 Trust Objectives – Year End Review

Key: Current Status Assessment

	Achieved		Progress made but not fully achieved/completed by 31st March 2022		Delayed or not achieved by 31st March 2022

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)*	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Use lessons learnt from incidents, complaints and claims to improve practice and reduce similar incidents in the future	Quality Committee	Regular audit cycle for hydration now in place with results shared with individual teams, as well as the Hydration Steering Group indicating improvements made in all areas in March 2022, including accurately completing fluid balance charts.
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)*	DoOp	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits	Quality Committee	Triage Times - Ambulance Attendances – 36 Mins And walk-in's – 37 Mins First Clinical Assessment - Average – 178 mins Median – 140 mins·

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
		• Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits		Latest audit results show 100% compliance with NEWS Latest audit data (March 2022) demonstrate above 90% screening and 100% compliance with treatment for sepsis for Q2 2021-22 57% compliance noted in latest audits, however, review of nursing documentation confirms that relevant assessment and treatment is in place The Head of Nursing and Quality for Urgent Care which has been made a permanent position and continues to monitor that safety checks are being undertaken for patients waiting to be seen.
1.3. Increase capacity at Whiston Hospital and improve clinical adjacencies at the Trust to optimise patient flow *	DoOp/ DoCS	• Continue to progress the strategic site development plans for the Trust and the capital schemes that are planned for 2021/22 to improve patient facilities and increase capacity; • Paediatric Emergency Department and Children's Observation Ward • Theatre capacity • Same Day Emergency Care and optimisation of clinical adjacencies/pathways	Trust Board	Paediatric ED and CHOBs ward scheme is in progress. Theatre Capacity business case was approved by the Trust Board and has attracted TiF funding. Capital programme – planned building schemes progress achieved in 2021-22 and plans to progress the site development strategy are on track. Trust SDEC lead appointed. Clinically led Trust SDEC strategy in place to ensure pathways are embedded and optimised.
1.4 Review and improve the management, monitoring and tracking of patients on waiting lists to ensure a consistent approach by all elective specialties, learning lessons from previous incidents.	DoOp	• Number of Datix incidents related to issues with waiting list management • Embed learning from harm reviews • Adequate Business Intelligence (BI) reporting to flag priority patients	Quality Committee	The number of incidents has steadied since June with no further serios incidents reported in relation to waiting list management. Learning is shared across all relevant staff groups.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
		• Standardisation of patient pathway management across all specialties • Implementation of end to end automated patient tracking		Pathway management standardisation is in place across all specialties with review and validation continuing. BI monitoring and reporting is in place across all specialities. Proposals for automating the process completed by IT system supplier This requires implementation, which is currently at testing phase with 2 pilot specialties identified to undergo the suggested reconfiguration before roll-out across all specialties. For other specialities manual process remains in place.
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Continue to learn lessons and change practice by improved measuring of the outcomes for our patients	MD	• Use available data to identify where care for patients can be improved, allowing targeted projects to make long lasting changes to practice. • Reduce hospital acquired AKI by 20% • Reduce hospital acquired pneumonia by 10% • Reduced rates of AKI and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee	Regular audit cycle for hydration now in place with results shared with individual teams, as well as the Hydration Steering Group indicating improvements made in all areas, including accurately completing fluid balance charts, up from 83.2% in February to 87.1% in March 2022 and 95.7% of patients were identified as having special requirements. CRAB data indicates that AKI rates are within expected range across both medicine and surgery. Better hydration supports mobility and reduces thickened secretions and chest infection rates have also improved to be within the expected range.
2.2 Reduce avoidable harm by preventing falls (QA)*	DoN	• To reduce the number of inpatient falls per 1000 bed days from 9.2 to 7.7 (QA target; 7.2 internal stretch target) or less	Quality Committee	• 2021/22 8.56 falls per 1000 bed days, reduction of 6.12% compared with 2020/21 • On-going sample audit undertaken, with latest results showing 87% of patients audited had

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
		• All patients will have a documented falls risk assessment within 6 hours of admission and this is reviewed at least every 7 days or change in the patient's condition • To audit that all preventative actions are implemented following falls risk assessments		falls risk assessment completed at the time of the audit, with 45% completed within 6 hours of admission. Electronic dashboard being implemented across wards, to enable visual prompt to improve performance. Audit carried out in February 2022 found 74% of patients audited had all interventions implemented.
2.3 Evaluate best practice and develop proposals for improving the Trust wide safety culture/methodology	DoN	• Involve and engage staff across the organisation to co-design a Trust-wide "Safe and Sound" Quality Improvement Methodology • Develop a business case to support implementation of preferred methodology • Develop a "Safe and Sound" work programme and celebrate achievements	Quality Committee	External support has been sourced and the Trust is working with AQUA to develop a proposal but this objective was significantly impacted by operational pressures and has not been achieved.
2.4 Implement the recommendations of the Ockenden Report into the safety of Maternity Services*	DoN	• To monitor the delivery of the Ockenden report implementation plan • To meet the requirements of the 51% for continuity of carer target by March 2022	Quality Committee	The Trust made good progress throughout the year and has declared compliance with 11 of the 12 Essential and immediate actions from the Ockenden interim report.
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)*	DoOp	• Ensure sufficient and appropriate information is provided to all patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information	Quality Committee	Service Improvement – Discharge Improvement Programme has been finalised and recommendations and areas for improvement agreed. The inpatient survey scores improved for all of the following questions: •Written information about what to do after discharge – yes by 18%

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
		• Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards at weekends		•What would happen next with your care - yes definitely by 3% •Told who to contact if worried after discharge - yes by 9% •Staff discussing the need for health or social care support after discharge - yes by 4% Compliance audit with agreed process is now included in the regular Tendable ward audits. Weekday and weekend discharges before noon remain a challenge due to availability of social care. System trajectory for discharges now set at place level, with place leads being held accountable for delivery. Internal work continues to achieve this metric, including a programme of improvement work planned for May 2022.
3.2 Transformation of Urgent Treatment Centre (UTC) to maximise capacity, throughput and patient experience	DoOp	• Attendance rate at UTC and associated 4-hour performance • Reduced rate of A&E attendances and hospital admissions • Reduced deflection rate from UTC to A&E • Implementation of condition specific end to end integrated pathways • Improve patient satisfaction and experience ratings	Finance and Performance Committee	Attendance rate at St Helens UTC has increased as reported in the IPR. ED attendances at the Trust have increased from other boroughs. Improvement identified at St Helens UTC where range of conditions treatable has been expanded with further opportunity identified. Position with other local UTCs remains a challenge. Patient satisfaction ratings remain high.
3.3 Review Trust Acute medical care pathways to ensure optimal configuration	DoOp	Agree the optimal configuration of services to; • Reduced number of patient ward moves • Reduced number of FCEs • Implement direct to specialty pathways	Executive Committee	Inpatient survey results and audit has demonstrated reduction in the number of patient ward moves. Implemented new direct to speciality pathways for AMU and Frailty, with further work ongoing for Surgery, Medical Specialities and Paediatrics.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
		• Improve patient satisfaction and experience ratings		The number of direct to specialty referrals has increased for the established pathways. Inpatient survey demonstrated improvement in patient satisfaction. 95.7% of acute patients recommend the Trust in FFT.
3.4 Continue to redesign outpatient pathways through transformation and modernisation *	DoI/DoOp	• Continued roll-out of Telehealth across identified specialties and patient pathways • Optimisation of current systems to continue the reduction in DNAs • Reduction in complaints from patients due to late or over-running clinics • Reduced travelling time and costs for clinicians using the technology to provide outreach services • Extra clinical capacity that can now be invested back into patient care in the acute setting or scheduling more clinics • Reduced car parking congestion	Executive Committee	Sixty nine services now have the capability to use Telehealth. DNAs have reduced by 4.2% from 2019/20 levels. Only one formal complaint received from a patient due to late or over-running clinics in 21/22. OPD clinic templates reduced in order to maintain COVID IPC compliance, resulting in a reduction in clinic overruns, rescheduling of clinical time and reduced car parking congestion for patients. These templates were reviewed as IPC guidance was amended to maximise capacity.
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Increase the proportion of patients who report that they have received an appropriate amount of information about their care (QA)	DoN	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information compared to last published surveys in 2019	Quality Committee	Results of inpatient survey 2020/21 show an improvement in the responses relating to the provision of information.
4.2 Introduction of new Trust Website to improve access to information about the Trusts services	DoHR	• Develop and launch the new Trust website	Executive Committee	New Trust website launched in April 2021 and feedback positive with increased use and access.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
		• Monitor the impact and record and report access metrics e.g. number of clicks to required information		313,905 visitors visited the website 478,097 times and looked at 1,331,173 pages. Accessibility score = 82 Functionality score = 99 Mobile Experience score = 95
4.3 Ensure patients relatives are kept appropriately informed, whilst COVID-19 visiting restrictions remain in place	DoN	• Nominated relatives to receive an update on the patient's condition and care plan at least every 48 hours • Reduction in the number of concerns received about communication with relatives	Quality Committee	7.36% reduction in concerns raised via PALS in 2021-22 relating to communication with relatives, with 629 received compared to 2020-21 when 679 were received. Processes to contact relatives were not consistently effective and many relatives had difficulty contacting inpatient areas during the time that visiting remained restricted.
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Further develop the use of electronic patient information to replace paper based medical records e.g. observation charts, nursing assessments and care plans, AHP assessments and inpatient clinical narrative	DoI	• Reduce the amount of paper in Nursing documentation produced as part of the paper based medical record by 25% • Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need to access • Improve e- observation to facilitate early identification of deterioration leading to earlier intervention • Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care	Executive Committee	Reduction in amount of paper in Nursing documentation achieved, 30% less paper. e-Handover has been deployed in 80% of care settings. Nursing handover has been deployed to 90% of wards. CareFlow Connect has been deployed across 90% of inpatient wards for patient handovers and 55% of team referrals which has freed up clinician's time for care, enabling standardised and streamlined communications between teams. Enhanced e-observations have been achieved by deploying PEWS (Paediatric Early Warning Scores) into both ED and Paediatric Inpatients and aligning with National PEWS and Alder Hey model.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
				Speciality reviews are underway but were not completed in 2021-22.
5.2 Implementation an integrated bed management and discharge planning system to allow Clinicians to see patient status “at a glance” and improve the accuracy of information on patient flow, to support admission and discharge decisions by the Site Management teams	DoI/DoOp	• Reduced the time taken to admit patients to wards from A&E • Increase the % of patients discharged before midday. • Support the reduction in bed occupancy to 92% • Reduce the number of medical patients who have to outlie in surgical beds • Help support reduction in length of stay • Improve access to patient information for Clinicians, to enable more effective prioritisation	Executive Committee	Through CareFlow Connect clinicians have mobile access to diagnostic results, tasks, Covid and other alerts and to specialist medical and surgical teams for handover. Clinicians can now acknowledge results via CareFlow Connect. Over 55% of specialist teams are using CareFlow Connect to manage referrals from the Emergency Department and Inpatient Wards. Clinicians are now able to make referrals more quickly and with more relevant information to specialist teams, who are notified of new and updated referrals in real time. Patients are therefore seen and assessed sooner and communication between clinicians and teams is saved in the patient record which is fully auditable Clinicians have access to Vitals observations and assessments to identify deteriorating patients. The assumed impacts on; bed occupancy, medical outliers and LoS have not yet been realised. This is due to operational pressures in the NHS nationally during 2021/22, including the COVID Omicron wave, increased numbers of patients coming into the hospital, and delays in discharges due to wider system issues
5.3 Continue to develop the Trust’s digital maturity	DoI	• Deliver the agreed Digital Aspirant Programme objectives for 2021/22 • Continue to host and develop the CIPHA system and shared care record on behalf of the Cheshire and Merseyside ICS	Executive Committee	Digital Aspirant Programme objectives for 2021/22 have been met except the redevelopment of discharge summaries which will proceed in 2022/23. CIPHA continues to be hosted on behalf of C&M ICS.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				
6.1 Enhance health and wellbeing support and services for staff *	DoHR	Comply with NICE guidance and the NHS People Plan in the extended range of support services available to improve the health, well-being, and resilience of our staff , including supporting staff who have been impacted by the COVID-19 pandemic	Strategic People Committee	HWWB resources and the range of support available for staff have been expanded as reported in the HR updates to Trust Board. The Well Being Hub and ''Wellbeing Wednesdays'' continue Board approved a new Health and Wellbeing Strategy in October 2021 The Trust now has 91 wellbeing champions and 32 mental health first aiders across the organisation that form part of the "wellbeing network'' manage the impact and aftereffects of COVID-19. There are a comprehensive range of events and activities to meet staff needs The ''Putting Our People First Group'' has been established and met twice in 2021/22 The HWWB Department continue to work with key stakeholders across the Trust to support and manage the impact and aftereffects of COVID-19. There are a comprehensive range of events and activities to meet staff needs The Trust has partnered with the Rugby League Cares charity, 1 of 3 pilot sites in the NW, to further support staff and bring about a new initiative, focused of mental and physical fitness, personal resilience and recruitment and retention into in the NHS. NHSE have confirmed support for this initiative until 2023.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
6.2 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Maintain all efforts to recruit 80 additional permanent new nurses, 50 further nurses and 20 medical and dental posts are recruited via international recruitment programmes • Create more opportunities for staff to retire and return, transfer between wards for job enrichment, or adopt flexible approaches to working • Improve labour stability rates and reduce staff turnover rates in targeted areas • Increase the % of the apprenticeship levy that is allocated • Recruitment of 24 trainee nursing associates (TNA) and develop new posts and appropriate specialist training routes for 4 Advanced Care Practitioners and 10 Physician Associates • Enhance the provision of development opportunities to support talent management and retention	Strategic People Committee	• 78 International Nurses joined the organisation in 2021/22. 15 international Doctors have commenced employment and 170 band 5-7 Nurses have been externally recruited between 1 April 2021 and 31st March 20221. (31 are from the Pan-Mersey Collaborative and 30 from Trust recruitment). 15 international Doctors have commenced employment and 152 Band 5-7 Nurses have been externally recruited since 1 April. • The Trust has standard shifts alongside piloting 12-hour shift patterns. Retire & Return requests are reviewed by HRBPs to ensure all options have been fully considered • The internal staff transfer scheme has been embedded for 18 months. 161 staff members have taken advantage of the internal transfer scheme since its launch in June 2020 • Labour stability and turnover rates have not improved YTD. A new Retention Strategy is to be presented to the June 2022 Strategic People Committee. • Apprenticeship opportunities have been re-launched and widely promoted during 2021-22 after being paused by HEIs due to COVID. For all 2021-22 the levy used was 56.5% which is a significant increase in performance from 38.8% in 2020/21. • 10 TNAs started training in September 2021 with a further cohort due in January 2022. 8 ACPs started in September 2021 (4x Occ Health, 3x Community, 1x AMU). 1 ACP started in Spring 2022 in Community and further bids for course funding have been submitted for 3 x ACPs (2 x ED Paediatrics and 1 x Community Paediatrics) • Increased support to Apprenticeships and delivery of 3 cohorts of the Nursing Management programme.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
				• The new appraisal process has been well received with feedback about better quality conversations taking place. • The HCSW education programme has been created to upskill non health care staff who volunteered to support the mass vaccination programme. Staff will be awarded the national care certificate, and the Trust fundamentals of caring course. Staff will then be skilled to apply for health care work across the region
6.3 Continue to respond to feedback from staff to improve appraisals to support staff to deliver high quality patient care.*	DoHR	• Embed the new Trust appraisals process and evaluate the impact • Survey staff satisfaction with the quality of appraisals • Provide targeted training for managers on appraisal skills	Strategic People Committee	• Appraisal compliance rate recovery remains challenged, and the improvement trajectory will continue in 2022-23. • Feedback from staff on the new process is extremely positive. The Trust implemented a new appraisal window approach for Band 6 and above from May 2021 with the aim of completing appraisals outside of the winter pressure period. This will be extended to Band 5 and below in 2022-23. • Targeted support is provided to managers on the new process and paperwork with information also available on L&OD extranet site.
6.4. Improve the compliance delivery and ease of access of mandatory training for all staff	DoHR	• Fully implement the review of how mandatory training is delivered, including the innovations in training that were used during COVID-19 • Engage staff and managers in new ways of delivery	Strategic People Committee	• Mandatory training rate compliance remains challenging, and improvement will continue into 2022-23. • There has been an expansion of e-learning for the delivery of Mandatory training to support more flexible access for staff. This is resulting in an improvement in compliance for those subjects. • Engagement with staff and Subject Matter Experts to ensure the training delivery model meets the needs of staff and Managers. The Trust has also enhanced communication to increase awareness of the e-learning platform, Moodle.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
				• All actions from MIAA audit on mandatory training completed. There has been an expansion of e-learning for the delivery of Mandatory training to support more flexible access for staff. This is seeing an improvement in compliance for those subjects.
6.5 Continue to listen to our staff to ensure we remain an employer of choice	DoHR	• NHS Staff Survey Action Plan monitoring • WRES & WDES Action Plan monitoring • A refreshed Equality, Diversity and Inclusion Strategy and development plan	Executive Committee	• Monitoring of progress and escalation continues through Trust Executive Committee and Workforce Council. • WRES/WDES and Gender pay gap reports have been approved by Trust Board and published on Trust internet. Action plans are monitored by the Workforce Council. • The ED&I action plan was approved by Trust Board in September 2021 and will be monitored by the EDI Group. • Consultation with staff has commenced on a new ED&I Strategy, but this has not yet been finalised
6.6 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimum design of the workforce and the right number and skill mix of staff*	DoHR	• Implement e-rostering to 100% of all staff remaining staff to include non-clinical and corporates services staff • Restart the specialist nursing-job planning project with the aim of having 50% with refreshed job descriptions that reflect to needs of the service • Deliver the benefits realisation plan for “Better eRostering” for Medical Staff, Nursing & AHP’s • Produce reports from the ‘Roster Perform’ and Safe Care systems to demonstrate safe levels of staffing based on the acuity of patients	Executive Committee	• 100% of AFC & Medical and Dental staff are now on e-roster. Senior operational staff and Medics are rostered for unavailability. • Due to operational demands and resourcing this has not yet been started. • Due to operational demands and resourcing this has not yet been started. • Complete and being monitored via the safer staffing steering group.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Resume and restore corporate activities to business as usual standards following COVID-19, across all services	Executive Team	• Restore maximum possible capacity of clinical services, achievable with social distancing and compliance with Infection Prevention Control guidance • Ensure that patients requiring urgent care and treatment are identified and prioritised • Support staff as they continue to cope with the consequences of COVID-19 • Reduce the backlog of outstanding work were services or activities have been suspended or staff re-deployed	Trust Board	H2 trajectories achieved, and ERF income maximised. Risk based approach taken to elective pathways based on latest national IPC advice PTL monitored and all P1 and P2 patients are prioritised. Wellbeing support for staff detailed in 6.1
7.2 Achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including any new measures • 62-day cancer treatment standard • Diagnostic tests completed within 6 weeks • Ambulance handover times • Achieve the Trust level recovery trajectory for elective activity, as agreed with the Cheshire and Merseyside Hospital Cell	Finance and Performance Committee	ED access performance remains challenged. 62 day cancer treatment standard achieved (85.1%) 6 week diagnostic standard had improved to 87.3% in March Ambulance handover times remain challenged and a targeted improvement plan is in place across the North West Region, with joint work planned with NWAS in 2022-23. H1 and H2 targets for elective recovery were achieved.
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g. GiRFT and Model Hospital to ensure that all services meet best practice standards*	DoOp	• Continued participation in national programme of GiRFT reviews and delivery of the resulting action plans, when the national programme re-starts • Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery	Finance and Performance Committee	GiRFT programme restarted nationally in October 2021 and a number of reviews have been undertaken and action plans developed.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Embed the clinical, technological and process innovations achieved during COVID-19 into the future business as usual of the Trust	Executive Team	• Review the clinical and corporate changes that have been introduced during the COVID-19 major incident and assess the benefits • Wherever possible secure an ongoing return for the additional investments made during the COVID-19 and restoration periods • Work with stakeholders to ensure the changes that have improved patient care, become embedded in normal practice	Trust Board	COVID incident management approach has continued as required in response to the fluctuating incidence and for other operational pressures. Trust operating at full capacity in Q3 & Q4 2021/22. Principles of mutual aid have continued. National COVID escalation level 4 stepped down on 29th March 2022.
8.2 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaborative corporate services*	DoF	• Take forward the agreed collaborative projects for corporate functions, when the C&M Collaboration at Scale work stream resumes • Until corporate collaboration as scale resumes, to drive other opportunities in support services such as clinical support services (pathology & radiology)	Finance and Performance Committee	• Collaborative programmes have started to recommence. • The Trust was selected and delivered the first Community Diagnostic Hub, supporting the delivery of increased diagnostics across the health economy. • The Trust continues to participate in the development of plans to create a pathology hub and spoke model for C&M.
8.3 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2021/22 agreed under the new NHS financial regime. • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.	Finance and Performance Committee Audit Committee	• The Trust achieved its H1 and H2 targets and ended the year with a small surplus. • Cash balances continued to exceed 1.5 days and age debt remained below 1.5% of cash income. • The 2021-22 capital programme was delivered.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve system success*	DoCS	• Meet statutory and regulatory responsibilities • Prepare for the system changes which will be introduced by the NHS White Paper, including the changing responsibilities of the Cheshire and Merseyside Integrated Care System and shaping the development of effective Place structures.	Trust Board	C&M ICS MOU and Provider Collaborative ToRs reported to and approved by the Board in July. Briefings to the Trust Board on the NHS Bill and development of the ICS Trust in segment 2 of the new integrated NHSE oversight framework

9.2 Working with health and care system partners to develop and implement Place based Integrated Care Partnerships to improve the health of the local population*	DoInt	• Support our local boroughs to establish Integrated Care Partnerships (ICPs)
		• Establish a programme delivery infrastructure for St Helens ICP including a dashboard of key performance and health improvement indicators
		• Work closely with Primary Care Networks (PCNs) and community providers to improve locality service delivery and integration
		• Continue to develop more integrated care pathways through transformation of community services in St Helens
			Trust Board	• St Helens established their Placed Based Partnerships, governance arrangements and work programme. The Board has met monthly from April 2021.
				• Halton and Knowsley boroughs have established their Boards ahead of the transitional arrangements on 1 July 2022.
				• All three places have appointed a Place Director.
				• A dashboard of St Helens KPIs has been developed and programme delivery is monitored at the Place Partnership Board.
				• A Care Communities project has commenced that will wrap community services (health, social care and VCSE) around the PCN localities.
				• The partners have agreed a strategic plan for St Helens with three priorities to improve health inequalities:
				  ○ Mental Wellbeing
				  ○ Tackling Obesity
				  ○ Resilient Communities
				• The Trust continues to work with Halton and Knowsley and will support their Place Based workplans as they evolve.

Objective	Lead Director	Measurement	Governance Route	Progress report and current status assessment
9.3 Provide leadership and direction as part of the C&M ICS to achieve clinically and financially sustainable acute services	DoInt	• Develop areas for collaboration that bring benefits for patients and partner organisations • Support the development of effective Provider Collaboratives that enhance collaboration and integration with other providers	Trust Board	• The Trust entered into an Agreement for Long Term Collaboration to provide management support for S&O NHST in September 2021 • Two Provider Collaboratives (PC) have been established at C&M level, STHK's CEO is the lead for the Acute and Specialist Trust PC (CMAST) and is a member of the second PC for Mental Health, Learning Disabilities and Community Services providers. • CMAST had focused on: o Recovery of Elective Care (elimination of 104 week waits) o Restoration of Cancer Services o Planning for 2022/23 o Co-ordination of capital priorities o Implementation of Community Diagnostics Centres o Continuing with mutual aid and supporting fragile services

ENDS

TRUST BOARD

Paper No: NHST(22)043

Title of paper: Maternity Services Trust Board Report: Q4 2021/22 and Ockenden 2 Gap analysis

Purpose: To inform the Trust Board of the progress of the Maternity service to key priorities and the findings of the Ockenden 2 gap analysis prior to submission to Trust Board

Summary:

The paper provides an update of the maternity services compliance to the Ockenden 1 following publication in December 2020 using the Maternity Services Assessment and Assurance Tool identifying 4 outstanding actions. Three actions relate to audit and one action regarding the provision of an evening consultant led ward round.

The report provides details of the Ockenden final report published in March 2022 with an attached gap analysis undertaken using the standardised Assessment and Assurance tool.

The Maternity Incentive Scheme was relaunched on the 6th May with notification of changes to the submission timeframes which is now the 5th January 2023.The scheme's conditions have been reviewed and strengthened including information of the requirements for CEO and the Accountable officer for their Clinical Commissioning Group/Integrated Care System sign off.

There were 7 perinatal mortality review cases that have undergone a multidisciplinary review with 4 cases undergoing a PMRT review. Care was reviewed and assessed for all cases using the MBRRACE categorisation. Where learning has been identified the panels agreed that it was not likely this learning would have affected the outcome. Parental involvement is sought and included in the final report.

There were no never events and 6 serious incidents reported during Q4 2021/22. Two babies required cooling with both cases being reported to HSIB and reports awaited, and 4 maternity diverts. 3 diverts were due to increased activity and acuity and reduced staffing and 1 divert was as a result of the closure of the neonatal unit. 6 women were diverted who birthed elsewhere.

The Maternity service was required to escalate in line with the Cheshire and Merseyside escalation policy and close/ divert on 18 occasions between April 2021 - March 2022. 7 occasions related to increased acuity on Delivery suite, one occasion related solely to midwifery staffing; 9 occasions related to increased acuity and a reduction in midwifery staffing. One divert occurred following the closure of the neonatal unit although midwifery staffing, and activity was adequate. 53 women in total were diverted which resulted in 16 women birthing in another unit and 33 women attending another unit for assessment but who subsequently birthed in STHK.

A full Birth-rate plus maternity workforce assessment commenced in 2021 and a final report has been received in May 2022. A report is currently being complied and will be shared with the Division, Executive team, and Trust Board to discuss appropriate next steps.

Trust objectives met or risks addressed: Care; Safety; Pathways; Communication and Systems

Financial implications: Awareness of potential future investment into the maternity services

Stakeholders: The Trust, Staff, Patients, Commissioners

Recommendation(s): The Trust Board are requested to note the contents of the paper and discuss the actions required prior to submission to Trust board on 25 March 2022

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

Date of meeting: 25 May 2022

Maternity Services Trust Board Report: Q4 2021/22 and Ockenden 2 Gap Analysis

This standardised report template has been developed by the Cheshire and Mersey LMNS and includes the key issues identified within Maternity services. The report is intended to be a quarterly report however this initial report will cover Q4 2021/22 but also some recent data and information.

1. Ockenden Report

1.1 Compliance with the Immediate and Essential Actions (IEAs) outlined in Part One of the Ockenden Report

On 10th December 2020, Donna Ockenden published her first report following a clinical review of care provided at the maternity unit at The Shrewsbury and Telford Hospital NHS Trust and identified immediate and essential actions for maternity services.

The Maternity Services Assessment and Assurance Tool was utilised to assess its initial position and one year on thus providing evidence and assurance to the Trust Board, alongside identifying key actions required to maintain its current compliance and complete any outstanding actions in order to achieve full compliance.

Since publication the focus has been on embedding these essential actions with continued attention on the action plan resulting in compliance to 11/12 of the clinical priorities. This clinical priority is partially complaint and relates to the twice daily consultant led ward rounds with one ward round occurring during the night handover. One additional consultant has been appointed which will increase compliance and a business case is under development to enable full compliance to the evening consultant led ward rounds.

There is evidence to support compliance to 118 out of the 122 IEA criteria with 4 amber actions outstanding. Three of these actions relate to the undertaking and completion of audits, all of which are in progress. The fourth IEA is also the clinical priority outlined above. The Trust board received the Ockenden one year update on 30 March 2022.

1.2 Ockenden 2 Final Report

On 30th March 2022 the final report of the independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust was published.

The review examined cases involving 1,486 families between 2000 and 2019 and reviewed 1,592 clinical incidents and found repeated failures in the quality of care and governance at the Trust as well as failures from external bodies to effectively monitor the care provided. These combined failings led to missed opportunities to learn, with families experiencing repeated serious incidents and harm throughout the period of the review.

This final report identified new themes to be shared across the maternity system as well as building upon the immediate and essential actions of the first interim report.

The findings resulted in a further 15 overarching immediate and essential actions, subdivided into 92 specific actions, to support service improvements for women and their families which every Trust, ICS and LMS must consider and act upon.

15 overarching immediate and essential actions.

1	Workforce Planning and sustainability including training	9	Preterm Birth
2	Safe Staffing	10	Labour and Birth
3	Escalation & Accountability	11	Obstetric Anaesthesia
4	Clinical Governance and Leadership	12	Postnatal Care
5	Clinical Governance: Incident investigation and Complaints	13	Bereavement Care
6	Learning from Maternal Deaths	14	Neonatal Care
7	Multidisciplinary Training	15	Supporting Families
8	Complex Antenatal Care		

Trust gap analysis

Following receipt of the Ockenden 2 report the Maternity service has undertaken a comprehensive gap analysis using the assessment and assurance tool provided by NHSE/I (Appendix 1) against the 92 individual actions.
A comprehensive action plan will be developed in order to work towards full implementation with designated leads and timescales for completion
An overview has been provided to the Quality Committee and will be shared with the LMNS to support oversight and scrutiny and prioritisation of actions required regionally following approval from the Trust Board in May 2022.

The initial gap analysis has been BRAG rated and identified the following gradings:
Blue 35 actions: completed and embedded
Green 18 actions: completed or on track
Amber 30 actions: ongoing with actions
Red 4 actions: not started or actions to be undertaken
Grey: 5 actions: external actions required to be completed Nationally or regionally

Whilst the self-assessment template has not yet been submitted or reviewed by the LMNS the maternity service has assessed themselves as 'Red' in the following 4 actions of which Essential action 2: Safe Staffing and Essential action 3: Escalation & Accountability are high priority and work has commenced to address the actions

- **Essential action 1: Workforce Planning and sustainability including training**
  All Trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers.
  Within the maternity service we utilise leadership coaching sessions for our existing maternity managers with opportunities to attend leadership courses. This is planned to be further developed and extended to potential future leaders and managers
  Action:
  - Development of a gap analysis of all leadership and management roles including those held by Specialist midwives and Obstetric Consultants to be undertaken by The Head of Midwifery and Obstetric Clinical Director. Completion due June 2022.
  - Development of a strategy encompassing plans for succession planning of the Maternity workforce to be undertaken by the head of Midwifery. Completion due September 2022

- **Essential action 2: Safe Staffing**
  In Trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload.
  Within the Trust the clinicians cover both Obstetric and Gynaecology services however rotas specifically identify the identified areas of work within and between the services. Current communication and discussion already occurs between clinicians and the Maternity team in the event that any competing priorities occur however there is a requirement to formalise these discussion and actions
  Action:
    - A requirement to develop a formal risk assessment for clinicians which includes an escalation protocol in the event of competing workloads between obstetrics and gynaecology. An addition to the existing Maternity Services Document for Obstetric Staffing levels has commenced by the Clinical Director and will be completed by the end of June 2022

- **Essential action 3: Escalation & Accountability**
  All Trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns in cases of disagreement between healthcare professionals
  Action:
    - Development of a specific conflict of clinical opinion process is required. The formal process will be included as an addition into the Guideline for Communication/Handover of care in Maternity services. This action has been commenced by the Head of midwifery and will be completed by the end of June 2022
- **Essential action 4: Clinical Governance and Leadership**
  Every Trust must ensure they have a patient safety specialist, specifically dedicated to maternity services
  Action:
    - The Trust will liaise with the National team and the LMNS to identify the requirements of this role in order to develop a Job description and person specification and recruitment into this position.

Additional responses:

- The maternity service has suspended any immediate Maternity Continuity of Carer (MCoC) implementation until we are assured staffing levels are safe and meet recommendations as outlined in the report. Revised and updated MCoC action plans will continue to be revised and developed using the NHS document of implementing COC at full scale using the foundation building blocks in preparation for reintroduction when able.
- The requirement to explore the role and expectations of a Maternity Patient Safety Specialist as recommended by Ockenden
- Discontinuation of newly qualified midwives being allocated to community within one year of qualification

This was presented to the Executive Committee on 19 May 2022, prior to submission to Trust board.

Ockenden Report - Oversight and Scrutiny

- A regional Ockenden oversight visit is scheduled for the 5th August 2022. This is an assurance visit by the regional maternity team supported by the LMNS. The purpose of the visit is to provide assurance against the immediate and essential actions from the Ockenden report and discuss progress to date. Assurance will be gained through

a review of evidence, and discussion with key maternity stakeholders, including the maternity safety champions, MVP, members of the leadership team and clinical staff.

- Fortnightly support meetings with the LMNS are in place and attended by the Director of Nursing, Midwifery and Governance and the Head of Midwifery. This meeting includes representatives from all maternity units in Cheshire & Merseyside to support sharing lessons and collaborative working

2. Maternity Incentive Scheme (MIS)

The Maternity Incentive Scheme was introduced in 2017/2018 and is now enters its fourth year. The aim is to support the provision of safer maternity care through an incentive element to Trusts that meet all ten safety actions and designed to improve safety and the delivery of best practice in both maternity and neonatal care.

Year 4 safety actions were published on 5th August 2021 Year 4 Safety Actions with a number of amendments included to further embed and strengthen the previous safety actions.

On the 6 May 2022, the Maternity Incentive scheme was relaunched with changes to the submission timeframes which is now expected by the 5 January 2023.
The scheme's conditions have been reviewed and strengthened and include the following additional requirements:

- The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services
- The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution.

The publication of the Ockenden report has elicited some amendments to the safety actions and new requirements added. These changes are note in Safety action 5; Midwifery Staffing, Safety action 7; Maternity Voices Partnership and Safety action 9; Maternity Safety Champions.

From a financial perspective, Trusts' contributions towards year 4 of MIS will not be collected in the 2022/23 financial year but will be collected in 2023/24 financial year. Year 4 results and payments will also be shared with Trusts at the earliest in point possible in 2023/24 to enable Trusts to make best use of the funds available to them.

The Maternity service will review the updated actions and update the Trust Board accordingly on progress.

3. Quality and Safety

3.1 Perinatal Quality Surveillance Model (PQSM)

A national recommendation from the Ockenden Report was the proposed introduction of a Perinatal Quality Surveillance Model (PQSM).

The National PQSM model was developed to implement five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families.

The five principles are:

Principle 1 – Strengthening trust-level oversight for quality
Principle 2 – Strengthening Local Maternity System and ICS role in quality oversight
Principle 3 – Regional oversight for perinatal clinical quality
Principle 4 – National oversight for perinatal clinical quality
Principle 5 – Identifying concerns, taking proportionate action, and triggering escalation

These principles are intended to integrate perinatal clinical quality into developing integrated care system (ICS) structures thus providing clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

A perinatal Quality surveillance report is under development based on these principles and will be submitted to Trust Board once completed.

3.2 Clinical Outcomes/ Dashboard

Maternity Dashboards

Performance is monitored via our local and regional maternity dashboards. Regional dashboards are discussed at forums such as the Regional Clinical Expert Group and quarterly Safety Special Interest Group**.**
Local clinical dashboards are monitored via Obstetrics and Gynaecology clinical governance and quality meetings and presented via the IPR at Quality Committee.

Where Maternity Services are outliers with their peers, this is challenged by the Local Maternity System and Trust responses are required.

3.3 Perinatal Mortality

Perinatal mortality includes any fetal loss from 22-week gestation, stillbirths, and neonatal deaths in the first week of life. MBRACE-UK is notified of all eligible perinatal deaths. and these deaths are reviewed using the national Perinatal Mortality Review Tool (PMRT)
All perinatal mortality incidents have an initial multidisciplinary review to determine the degree of harm caused, to identify if there is any immediate learning or if the incident is required to be STEIS reportable.

Quarter 4: 2021/22	
January 2022	1 stillbirth
February 2022	1 stillbirth 2 late fetal losses
March 2022	2 stillbirths 1 late fetal loss

All 7 cases have undergone a multidisciplinary review with 4 cases undergoing a PMRT review. Care was reviewed and assessed for all cases using the MBRRACE categorisation. Where learning has been identified the panels have agreed that it was not likely the learning points would have affected the outcome.
As of the investigation, parental involvement is sought to enable the parent's point of view to be considered as part of the final review.

In January 2022, Cheshire & Merseyside Local Maternity System agreed a standardised regional reporting template for reporting stillbirths to Board which has been adopted.

3.4 Serious Incidents

Never Events
There have not been any never events for this reporting period.

STEIS Reportable Incidents

Serious incidents (SIs) are reported as they occur and are evidenced on the regional dashboard which is updated monthly. Serious incidents are detailed within the patient safety report presented at Quality Committee.

For Q4 2021/22 there were 6 serious incidents reported.

Jan 22	1 baby requiring cooling 1 maternity divert	Reported to HSIB and awaiting report Divert in place for 6 hours due to increased acuity on delivery suite and reduced midwifery staffing. 2 women were diverted, and both birthed in another unit.
Feb 22	1 baby requiring cooling 2 maternity diverts	Reported to HSIB and awaiting report The first divert was in place for 4 hours as was due to the neonatal unit closure which was outside of the criteria for the C+M divert policy. No women were required to be diverted. The second divert was for 6 hours and due to increased acuity on delivery suite and reduced midwifery staffing. 2 women were requested to divert. 1 woman declined to go to another unit and attended STHK after the divert was lifted and 1 woman birthed at another unit
March 22	1 maternity divert	Divert in place for 7 hours due to Increased acuity on delivery suite and reduced midwifery staffing. 3 women were diverted and birthed in another unit

Both babies that were cooled were reported to HSIB and reports awaited. The time frame for receipt of these reports is a minimum of 4-5 months. Both cases have undergone an initial Trust review as per process to determine if there was any immediate learning identified.

3.5 Health Care Safety Investigation Branch (HSIB)

HSIB undertake independent investigations into incidents within maternity services which fall under a defined criteria that includes maternal deaths, stillbirths and babies that require cooling**.**

HSIB triage reported cases following a Trust referral based on the following criteria:

- Baby's MRI result

- Family concerns regarding the care given
- Trust concerns regarding the care given

All investigations accepted by HSIB are reported on StEIS as a serious incident. Cases returned to the Trust are investigated with a full MDT review including an external representative from the Cheshire and Merseyside system.

The Trust is provided with a monthly update of cases by HSIB to support effective communication and to advise on the progression of investigations. HSIB case reviews are shared with the Trust for accuracy prior to being finalised and additionally shared with the woman and her family.

Cases to date: April 21-March 22	
Total referrals	12
Referrals/ cases returned to the Trust	4
Family declined HSIB investigation	1
Total investigations accepted	6
Total HSIB investigations completed	4
Current active cases	2 with 1 pending triage from HSIB

3.6 Saving Babies Lives Care Bundle (Version 2)

Saving Babies Lives Care Bundle (version 2) was developed to build on the recommendations from version one and to further address perinatal mortality. This bundle includes 5 elements which focus on the recognition and detection of risks associated with perinatal mortality and morbidity, reporting and referral processes, training of staff and auditing of practice and outcomes and are reflected in CNST Safety action 6.
The five elements being:

- Reducing Smoking in Pregnancy
- Risk Assessment and Surveillance of Fetal Growth Restriction:
- Raising Awareness of Reduced Fetal movements
- Effective monitoring in labour
- Preventing Preterm birth

StHK are fully compliant with all the elements of Saving babies lives care bundle 2. Annual audits were completed in 2021 and due to be repeated June 22

The Northwest Coast Saving Babies Lives quarterly bundle survey has been re implemented as of May 2022 and will be completed by STHK as requested by the submission date of 23rd May 2022

3.7 Care Quality Commission CQC Review

The maternity service was last inspected in March 2019. Our current ratings are:

Safe	Effective	Caring	Responsive	Well Led	Overall
Good	Good	Good	Good	Good	Good

3.8 Safety Champions

The aim of Safety Champions is to ensure seamless communication from 'floor to board' to ensure Board focus on Maternity issues and improving safety and outcomes.
The Maternity service has designated safety champions alongside a newly appointed Non-Executive Director Safety Champion with monthly Trust safety champion meetings. A schedule for weekly safety champion walkabouts is in place where Maternity and Neonatal Safety Champion's undertake a walk around Maternity and Neonatal services to meet frontline clinical and non-clinical staff to provide an additional opportunity for any safety concerns to be raised.
A walkabout of the Whiston site by the NED safety champion and Head of Midwifery was recently undertaken on 5th May 2022 with feedback to Director of Nursing.

4. Maternity Workforce

NICE guidance 'Safe Midwifery Staffing for Maternity Settings' (2015) sets out recommendations for systematically reviewing midwifery staffing at least every 6 months which is a criterion within CNST in Safety Action 5. The maternity service presented its Biannual staffing paper to Quality Committee and Trust Board in January 2022.
The report details the birth rate which was identified in the six-month reporting period as showing an increase compared to the previous six months reporting period. This increase has continued with end of year births for 2021/22 being 3944 compared to 3748 in 2020/21 resulting in an increase of 196 births in year and demonstrated a level of safety within maternity services despite the extreme staffing pressures and high levels of sickness. 16 women who were due to birth at StHK birthed in another unit when a maternity divert was in place.
The funded staffing at the time of the report was in line with the previous Birthrate plus assessment. The Trust additionally agreed to over establish by 6 WTE to cover maternity leave which is reflected in the contracted hours compared to funded hours.
Reduced staffing due to sickness and acuity had an impact during this time period and Matrons and maternity managers continued to undertake daily staffing meetings to ensure safe staffing across all areas, utilising redeployment of staff to the clinically required areas including senior management and specialist midwives as required.
COVID-19 had an impact on maternity staffing during this time period and the utilisation of bank / agency and overtime was used but the staffing shortfall was still acute at times and monitored and escalated as indicated. A minimum of weekly Maternity Gold command meetings across Cheshire and Merseyside were undertaken to discuss the regions staffing and share mutual aid if able.
There has been an ongoing rolling recruitment programme in an attempt to address any deficits in vacancies as early as possible and be proactive in an attempt to cover prospective maternity leave and retirements.

Birthrate Plus is a framework for workforce planning based on an understanding of the total midwifery time required to care for women with a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Five clinical indicators are utilised which are weighted to reflect the degree of need of both mother and baby throughout the antenatal, intrapartum and postnatal period in hospital and community setting. These are as follows:

Category	Need	STHK Maternity Services Generic Case Mix	
		2016	2020
1	Normal labour and outcome. These women are usually midwifery led care	7.7%	3.7%
2	This is also a normal outcome very similar to Category I, but may include perineal tear, longer labour or IV Infusion	17.0%	11.2%
3	Moderate risk/need such as Induction of Labour, instrumental deliveries, and continuous fetal monitoring.	23.4%	29.5%
4	More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight and women having epidural pain relief	29.2%	25.6%
5	This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy	18.1%	30.0%

It is evident that there has been a significant shift in women requiring more support and intervention with 55.6% of women requiring the top two highest categories of care.

A full Birthrate plus maternity workforce assessment commenced in 2021 and a final report has been received in May 2022. Following receipt of this assessment report, the findings are being analysed and a report compiled to be shared with the Division, Executive team and Trust Board to discuss appropriate next steps.

Ockenden (2022) has identified the requirement for professional bodies and NHSE to review the feasibility and accuracy of the Birthrate Plus tool and associated methodology and that minimum staffing levels must include a locally calculated uplift representative of the last three years data for all absences including sickness, mandatory training annual leave and maternity leave. This workforce analysis will be commenced shortly, and the findings presented at Trust Board accordingly

NICE Safe Midwifery Staffing guidance additionally recommends utilising nationally recognised red flag indicators.
A midwifery red flag event is a warning sign that there may be something wrong with midwifery staffing and these events are recorded via the Datix incident reporting system.
The following are the recommended red flags:

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (E.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Red Flag Indicators

January - March 2022			
Midwifery Red flag	Jan	February	March
Delayed or cancelled time critical activity			
Missed or delayed care (delay of 60 minutes or more in washing and suturing).			
Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).			1
Delay of more than 30 minutes in providing pain relief or medication			
Delay of 30 minutes or more between presentation and triage.			
Full clinical examination not carried out when presenting in labour.			
Delay of 2 hours or more between admission for induction and beginning of process.			2
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.			
Other staffing concerns			
Insufficient Midwives Reported			

The red flag data demonstrated an issue delay of 2 hours or more between admission for induction and beginning of process on 2 occasions and one occasion where there was a delay in administration of antibiotics. This related to high acuity and/or reduced staffing levels with the unit being on divert on one occasion for the delay in Induction of labour. These incidents have been reviewed and no harm was caused.

Maternity Diverts

The Maternity service was required to escalate in line with the Cheshire and Merseyside escalation policy and close/ divert on 18 occasions between April 2021 - March 2022. 7 occasions related to increased acuity on Delivery suite, one occasion related solely to midwifery staffing; 9 occasions related to increased acuity and a reduction in midwifery staffing. An inappropriate divert occurred on 1 occasion following closure of the neonatal unit.
53 women were diverted which resulted in 16 women birthing in another unit and 33 women attending another unit for assessment.

A total of 19 women were seen at STHK during the diverts. 4 women declined to attend other units and were seen at STHK after the divert was lifted; 9 women were seen at STHK as no other units were able to accept them; 1 woman who had been accepted at another unit was seen at STHK after the ambulance diverted for a clinical reason and 5 women who did not contact the unit were seen as emergency admissions.

All women who were required to be diverted were sent an apology letter from the Head of Midwifery in accordance with the duty of candour principles of openness and transparency.

The role of the Delivery Suite Shift Coordinator is a key role in the Intrapartum area and are present 24/7. The Delivery Suite Coordinator is supernumerary which is vital to enable them to undertake their role effectively and is pivotal in providing effective leadership, clinical expertise, facilitating communication between professionals and overseeing appropriate use of resources.

The Maternity services utilises an Intrapartum acuity tool with data inputted into the system every 4 hours by the Delivery Suite Coordinator to determine the 'acuity score'. This acuity score is defined by Birthrate as the 'midwifery staffing required to provide care at any one time based on the number of women and degree of their clinical dependency and adequately supports the deployment of staff around the unit during periods of high acuity.

The maternity service has a maternity Bleep holder present 24/7. The role is undertaken by a band 7 or Band 8a matron and has the responsibility of the overarching view of the Maternity service enabling a holistic view of clinic activity allowing redeployment of staff to the most areas of clinical need and escalating any concerns. The bleep holder undertakes a minimum of 4 hourly reviews assessing staffing, acuity and activity. These assessments may necessitate redeployment of staff including members of the senior management team or specialist midwives to undertake clinical care, request for the on-call community midwives to attend the inpatient areas or consideration of implementing the Cheshire and Merseyside escalation policy to ensure the provision of a safe service or request of mutual aid from other maternity units.

Maternity services aim to achieve 100% of 1-1 care to women in established labour and this is monitored and reported within the safe staffing report and the maternity dashboard. During the reporting period there have been no occasions when one to one care in labour was not provided.

5. Next Steps/Priorities

The following are priorities have been identified for the next 3 months:

- Continue to work towards completing the 4 outstanding actions for Ockenden 1 (2020)
- Develop a comprehensive action plan for the immediate and essential actions of the Ockenden Final Report (2022)
- Prepare a paper for Trust Board of the findings of the Birth-rate plus workforce assessment received in May 2022.
- Continue to work towards completion of CNST Year 4 Safety actions
- Prepare for regional Insight visit on the 5th of August 2022
- Finalise the Consultant obstetrician business case
- Revise the MCOC action plan using the principles of the foundation building blocks in preparation of submission to the LMS in June 2022
- Continue to work collaboratively with LMS and Maternity voice partnership
- Await direction from regional team regarding key priorities (expected to be June 2022 following East Kent report)

6. Recommendations

The Executive Committee are asked to note the contents of the report and the actions required to address the Ockenden 2 Gap analysis

Ockenden 2 recommends that all trust board members read the full report

Appendix 1: Ockenden 2 Gap analysis

Copy of STHK Ockenden FINAL V3.

			1: WORKFORCE PLANNING AND SUSTAINABILITY	BRAG Rating Grey= External actions	
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		Birthrate plus maternity workforce review completed identifying deficits in materntiy care. Report under development for executive team identifying current staffing requirments. Consultant obstetrician business case in development identifying the requirment for 5 additional consultant obstetricians to enable full residency presence. Neonatal deficits identified and a business case to support the full implementation of a transitional care service in progress. Anaesthetic staffing review to be undertaken
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		Compliance to CNST Year 3 based on previous BR+ workforce assessments. New Birth Rate plus workforce assessment completed. Final report received identifying midwifery deficits. Paper being prepared for Board. Current business case in developmen for additional Consultant obstetricians to ensure resident status 24/7 in view of increased acuity and complexity. Bi annual midwifery staffing paper presented to Board Risk register- Staffing identified for inpatient and Triage regarding BSOT. Rolling recruitment programme since October 2021.
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		Requirment to review maternity uplift calculated on last 3 years data including sickness, mandatory training, annual leave and maternity leave
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		National review awaited of BR+ Tool. Completion date TBC
			Essential Action : Training		
	We state that the Health and Social Care Select Committee view that a proportion of	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		Preceptorship programme Competency framework Evidence available via rosters
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		Currently NQM work within the community environment as part of their preceptorship programme. The Maternity service has taken the decision to discontinue NQM on the community following competion of this current placement in line with guidance and will await the outcome of National discussions.
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		Some Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion date TBC.
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		Evidence of training on rotas Orientation/Developmental package to be developedwith decision to work in collaboration with S+O on this action.

	maternity budgets must be ring-fenced for training in every maternity unit should be implemented	9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		Some enhnaced midwifery care trained midwives available on core rota. Evidence of designanted midwifery staff having completed an appropriate trained course to enable provision of HDU maternity care. Women requiring HDU care are transferred to HDU within the acute side of the Trust Work in collaboration with S+O to consider educational programme for enhanced midwifery care. Liaison with educational establishments for availability of full HDU trained course required.
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		Strategy and gap analysis required. Board and executive minutes for any business cases for financial approval required. Aditional Deputy Head of midwifery role in place following Halton TUPE but position will shortly be advertised due to vacancy.
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		Regional work re MMN ongoing with training available when appropriate. National update awaited. Completion date TBC.
2: SAFE STAFFING					
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		Use of C+M escalation policy. Recording of any diverts and discussions undertaken at Quality Committee and declaration of a Steis incident and subsequent review. Supernumary bleep holder 24/7 has an holistic view of staffing, activity and acuity with the ability to redeploy staff as required and escalate appropriately. Daily sit rep submitted to the LMS with weekly C+M gold command meetings that can be increased as required to enable discussion and potential provision of mutual aid. Need to discuss process of daily escalation to CN, MD and patient safety champion as this is not escalated when internal escalation in progress
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		Hot week consultant
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		JD and person specification in place and posts are supernummery.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		Current progress re COC. Requirement to completely review MCOC plans and develop the foundation buiding blocks for MCOC. Suspension of COC for STHK due to current vacancies. Recently received BR+ workforce assessment identifies midwifery staffing gaps.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction		Final National position statement to be formalised - completion date awaited. Current suspension from StHK however revised MCOC action plan requires complete review and prepardness for when MCOC is reinstated that details the foundation building blocks.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		Job plans for consultants, locums and locally employed doctors in progress

		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		0.8 WTE practice development midwife. Fetal surveillance midwives 1.0WTE Band 7 midwives support within maternity specific training. JD and person specification Requirement to review in future to determing if adequate training facilitators
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		Orientation policy for newly appointed midwives Process to be reviewed with the inclusion of transition into leadership and management roles and allocated a mentor Coaching available Consider collaboratively working with S+O to share expertise
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		Guidelines in place that cover community and hospital environment. Specific guideline for communication. Personalised care plans to ensure quality care and robust commuication between care settings. Audits of personalised care. Maternity medway processes and documentation that can be seen by community and hospital staff Rotation
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		Induction programme for locums recruitment process
3: ESCALATION AND ACCOUNTABILITY					
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		Conflict policy required in relation to clinical concerns
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Middle grade would not manage without a consultant recruitment process competency framework
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Consultant business case in progress to provide 24/7 residency Current provision 5/10 residency
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guideline for Maternity and Gynaecology Services for Staffing Levels (Obstetricians & Gynaecologists) in place
		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		24/7 general manager on call but no maternity specific manager on call. 24/7 maternity Band 7 bleep holder by a senior midwife.
4. Clinical governance and leadership					
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		QC minutes Work plan of maternity reports Standardsised Board reporting template
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		In progress and due for presentation at Trust Board in June.
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		Requirement to review the patient safety specialist role and appoint
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		Obstetric time identified in Consultant job plans
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Specific human factors training in 2018 and now included in maternity mandatory training. Governance team have undertaken root cause analysis training. Need to explore family engagement
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Guideline and audit midwife Band 7 specialist midwife role and Consultant lead Job descriptions available
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Job role and description and staff in post Yearly registered audit plan

5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		HSIB reports Meeting with family to discuss reports Review by corporate team before reports ar submitted to famiies
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		Lessons learned shared via newsletter and risk learning notice boards. Communication of lessons learnt provided by the education midwife and shared on local closed RCM social media page, global emails and via the 'quality bus'. Any learning with regards to fetal surveillance is shared by fetal surveillance midwives at CTG club. Various forums used to share lessons learnt
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Audits pending of testing of embedded changes Every sI that has a change in practice action has audit identiifed specifically in the action plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Innediate learning identified at the initial 72 hour review. If HSIB identify any additional learning this will be addressed following receipt of the report.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Evidence via reported SI's and associated investigation reports
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		MVP lead has been asked to support In response to concerns or themes identified to ascertain service user views and support changes in practice.
		7	Complaints themes and trends must be monitored by the maternity governance team.		Action plans tabled and monitored through maternity governance meeting.
6: LEARNING FROM MATERNAL DEATHS					
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Guidance awaited nationally
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Guidance awaited nationally
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Undertaken as a routine process to a SI following a maternal death but requires sharing with the LMS going forward. Steis reporatable incident monitored by CCG/ ICS. Guidance awaited nationally and regionally.
7: MULTIDISCIPLANRY TRAINING					
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		MDT training undertaken. Midwifery and obstetric involvement but difficulty in current staffing for full complinace in attendance to meetings and audit.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		but difficulty in current staffing for full complinace in attendance
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		MDT training undertaken. Midwifery and obstetric involvement but difficulty in current staffing for full complinace in attendance
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		MDT training undertaken. Midwifery and obstetric involvement but difficulty in current staffing for full complinace in attendance

	and emergency skills training	5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		MDT training undertaken. Midwifery and obstetric involvement but difficulty in current staffing for full complinace in attendance
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		but difficulty in current staffing for full complinace in attendance
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		MDT training undertaken. Midwifery and obstetric involvement but difficulty in current staffing for full complinace in attendance
8: COMPLEX ANTENATAL CARE					
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		however women who hav eundergone a previous pregnanacy with these medical conditions are aware of contact for an preconceptual or early pregnancy advice and support. Discussion required regionally at what can be offered preconceptually
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Designated consultant lead and specific clinic however no specific dedicated midwife
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but audit required.
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		Guidance and pathway in place although specific clinic not in place for this.
9: PRETERM BIRTH					
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Weekly pre term birth clinic
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Individual care plans and decision making Pre term birth clinic Guidelines Audit Maternity medway
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		BAPM guidance utilised. Regional policy
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Audit required
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Practice in place Risk assessment in labour Maternity medway / patient records Audit Personalised plans of care in place
		2	Midwifery-led units must complete yearly operational risk assessments.		STHK MLU is a co located MLU within the centre of DS.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		All staff attend maternity specificer training/Prompt Ad hoc Skills drills required to be increased
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		Included in homebirth risk assessment Transfer policy in place
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Guidelines C+M escalation policy Internal escalation plans require review
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		In place
11: OBSTETRIC ANAESTHESIA					

11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		A clear pathway and guideline is already in place for antenatal review of patients however the guideline requires review to include the conditions identified
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Reviews undertaken within inpatient areas however consideration of additional clinic capacity and anaesthetic staff will be needed
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Currently project is working towards paper light system using Maternity Medway exploring the possibility of including anaesthetic interventions. Currently no recoding of epidurals electronically and review of entering onto the Opera system or Maternity Medway
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		As above
	Obstetric anaesthesia staffing guidance to include:	**5**	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Continual review of staffing and development of a business case if required and especially if an increase in clinic capacity is required.
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Review od staffing model and consider rationalisation/ around Caesarean Section capacity and lists and ability to attend required meetings
		7	• The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.		PROMPT course attendance and demonstration of CPD in Obstetrics required
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		In place
12: POSTNATAL CARE					
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		In place. Designated Consultant ward round
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		In place. Designated Consultant ward round
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		Daily ard rounds in place with obstetric review
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		BR+ workforce assessment recently received and under review which will include postnatal ward staffing
13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife 0.6WTE in post but works Monday to Friday. Bereavement champions required to be developed to enhance the service and cover 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		Bereavement midwife, consultant obstetricians and registrars all trained in PM consent. An action to increase the numbers of midwifery staff able to take consent for PM to be reviewed.
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		Process in place De-briefs offered and telephone follow up from bereavement midwife postnatally. Community midwife postnatal visits also offered.
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway		Regional bereavement pathway in situ and in use.
14: NEONATAL CARE					

14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		Designated level 2 local neonatal unit Part of North West Neonatal Operational Delivery Network (NWNODN) which cares for babies >27weeks and above. Agreed pathways in place for all neonatal pathways of care Supporting Neonatal Critical Care Review in terms of capacity review and pathway redesign
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		Any care given outside of agreed pathway triggers exception reports. Weekly exception reporting as a network and reviews fed back into ODN Neonatal Steering Group, Clinical Effectiveness Group meetings and within ODN quarterly governance report . STHK exceeds min required 75% attendance at CEG/NSG meetings
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		C&M units are currently achieving 83% of <27 week gestation births in a NICU . ODN have completed a detailed report followed by deep dives into cases of the 10 babies born across the 6 C&M LNUs were 4 babies came from Whiston . ODN/LMS revisiting process of reviewing <27 weeks deliveries in non-NICU units . Appropriate place of birth being monitored as part of MatNeo Safety Improvement Programme focussing on optimisation of the pre-term infant . NW pre-term and updated IUT guidelines implemented.
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		Neonatal Education Nurse working with ODN Workforce & Education lead. Ongoing LNU staff participation in ODN study days (Cooling, Difficult Airways, NLS, IV training , LNU consultant webinars w/ANNPs and Trainees. New starters complete ODN Induction Programme
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		Spec Comm representation at quarterly Neonatal Steering Group meetings at locality level and at ODN twice yearly Board . Meetings. ODN provide Annual and ACD Reports
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		Designated Neonatologist of the Week Mon-Fri 9-5 based on the unit. Resident consultant readily available via crash bleep till 8pm Mon-Fri. Out of hours consultant is available via phone for advice and immediate return to the unit if required. Access to Network Advice Guideline and access to tel advice from Connect North West 24/7
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		aware of requirements. Monthly SIM training provided in house to enhance practice. All trainees have full NLS resus training at induction. ODN's Difficult Airways Guideline decribes stage when to increase airway pressure. New NLS algorithm is displayed in each delivery room, theatre and resus

		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		Current gaps against BAPM/ODN standards:. No full time B7 supernumerary lead (currently 50/50 mgmt/clinical) No supernumerary B7 shift co-ordinator per shift (only achievable when BAPM acuity allows and is B6). 1 additional RN req'd p/shift as currently babies allocated to B2/B4 nurses thereby being an outlier for B2's providing direct care. Requirement for 4.0WTE quality roles . IVAB currently delivered to babies on Postnatal ward by LNU nurses (Business case being finalised to increase workforce to support transitional care) . 1 ANNP Mon-Fri and increase needs consideration to provide out of hours support . Gap in T2 doctors due to insufficient funded posts (business case in development) From Aug 22, will cease complaince for T1 doctors due to unplanned reduction in Deanery FY2s (discussions remain ongoing but may result in a BC for extra T1 doc)
15: SUPPORTING FAMILIES					
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		Perinatal mental health midwife and lead consultant for this in place. Silver Birch Hub also referred to. Cheshire and Mersey Specialist Perinatal Mental Health Service/Parent in Mind.
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		FINE clinic in place that can be referred to in absence of formal diagnoses.
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Psychiatric liaison team/Lowe House/Crisis team