St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

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

AGENDA				Paper	Purpose	Presenter
10.00	1.	Employee of the Month Film - July 2022		Verbal	Assurance	Chair
10.15	2.	Patient Story		Verbal	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 29th June 2022		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.45	6.	Integrated Performance Report		NHST(22) 054	Assurance	Gareth Lawrence
		6.1	Quality Indicators			Sue Redfern
		6.2	Operational Indicators			Rob Cooper
		6.3	Financial Indicators			Gareth Lawrence
		6.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
11.00	7.	Committee Report – Executive		NHST (22) 055	Assurance	Anne-Marie Stretch
11.10	8.	Committee Report – Audit (Including approval of the annual report and accounts)		NHST (22) 056	Assurance	Ian Clayton
11.20	9.	Committee Report – Quality		NHST (22) 057	Assurance	Rani Thind

11.30	10.	Committee Report – Finance & Performance	NHST (22) 058	Assurance	Jeff Kozer
11.40	11.	Committee Report – Strategic People	NHST (22) 059	Assurance	Lisa Knight

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.50	12.	Data Security Protection Toolkit 2021/22	NHST (22) 060	Assurance	Christine Walters
12:00	13.	Board Assurance Framework Quarterly Review	NHST (22) 061	Approval	Nicola Bunce
12:10	14.	Corporate Risk Register Quarterly Review	NHST (22) 062	Assurance	Nicola Bunce
12:20	15.	Learning from Deaths Quarterly Report	NHST (22) 063	Assurance	Dr Peter Williams
12.30	16.	People Plan - Key Indicators Report	NHST (22) 064	Assurance	Anne-Marie Stretch
12.45	17.	Information Governance Annual Report	NHST (22) 065	Approval	Christine Walters
Closing Business					
13.00	17.	Effectiveness of Meeting	Verbal	Assurance	Chair
	18.	Any Other Business		Information	
	19.	Date of Next Meeting – Wednesday 28th September 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

Public Board

Title of paper: Patient story: New Brain Tumour Optimisation Pathway – Aileen's experience

Date of meeting: 27/7/2022

Background

Most patients with primary brain tumours (>60%) are diagnosed following emergency presentation. Despite small patient numbers, this category of patients can have the poorest prognosis of cancers. When they present to Hospital it is at an Acute Trust, where in most cases, there is no specialist brain Multidisciplinary team (MDT). A referral to the regional neurological centre is then necessary to guide management.

Previously at STHK (and most other Trusts) the patients management fell between ED, AMU, Acute Oncology and specialist palliative care without any specific team having ownership of the patient.

Lessons learned

Due to the small number of patients affected, most acute Trusts do not have a brain cancer Clinical Nurse Specialist (CNS) unlike other forms of cancer. This affected a patient's overall experience, patients spoke of feelings of isolation and not having a single point of access for support and guidance.

Following this feedback and data analysis, work was undertaken to improve the pathway for this patient group to ensure that every patient had access to support and a coordinated diagnostic pathway in line with best practice for patients who had other forms of cancer. Fundamental to this improvement was the commitment to provide a named key worker to deliver support and personalised care in line with the Trust 5-star patient care ethos delivered through our values. Improvements also ensure access to information and support and coordination of care during and following admission. The pathway is all led by our Acute Oncology teams with support from SPCT at weekends.

The new Brain Tumour Pathway commenced on 21st December 2021 led by Diane Dearden, Lead Cancer Nurse. It was an extensive collaboration project that involved acute oncology, ED, AMU, the Walton neurological Centre, oncologists, National brain tumour charities and patients. The pathway is delivered by the Acute Oncology team with support from Specialist Palliative Care.

The patient experience.

This story is about Aileen, a 52-year-old nurse who presented to Whiston Hospital as an emergency who was diagnosed with a brain tumour. What is unique about this Aileen's experience is that she was also able to compare the experience of her father being diagnosed with a brain tumour in 2015 before the implementation of the new brain tumour pathway.

Aileen spoke of her overwhelming fear upon diagnosis that was exacerbated by her previous experience with her father and spoke about previous feelings of isolation, uncertainty, and helplessness. These fears were quickly overturned with timely and frequent contact with a named key worker. Aileen spoke overwhelmingly about the relationships formed and the support and guidance provided not just for her, but her family. This support has not been specific to management plans but has also included advice and guidance with personal affairs.

The pathway has been in place for 6 months and is continuously reviewed. Subsequent changes have made to the pathway in collaboration with other departments. The pathway now also includes management of patients presenting with a new diagnosis of brain metastases. Collaboration with cancer site specific MDT's and cancer CNSs in the Trust to improve this pathway and coordination of care. Current work ongoing to change the referral process to Walton neurological centre to ensure that the quality and accuracy of referrals is improved following optimisation of their symptoms.

Next steps

The pathway work has been presented at a cancer Alliance learn and share event, a same day emergency care conference and the British neurological oncology society annual conference and have received commendation by the Brains trust charity for improving the care and management for this patient group. The Walton Centre team are keen to work with all acute trusts across the cancer alliance to replicate what we have implemented at StHK.

St Helens and Knowsley Teaching Hospitals NHS Trust

MINUTES OF THE TRUST BOARD PUBLIC MEETING HELD ON TUESDAY 29TH JUNE 2022 VIA MICROSOFT TEAMS

IN ATTENDANCE	
Richard Fraser	Chairman (Chair)
Geoffrey Appleton	Board Advisor
Jeff Kozer	Non-Executive Director
Alan Sharples	Board Advisor
Paul Growney	Non-Executive Director
Ian Clayton	Non-Executive Director
Gill Brown	Non-Executive Director
Lisa Knight	Non-Executive Director
Rani Thind	Non-Executive Director
Anne-Marie Stretch	Deputy Chief Executive & Director of Human Resources
Rob Cooper	Director of Operations & Performance
Nicola Bunce	Director of Corporate Services
Christine Walters	Director of Informatics
Rowan Pritchard Jones	Medical Director
Gareth Lawrence	Director of Finance
Devina Halsall	Controlled Drugs Accountable Officer, NHSE NW
Caroline Dawn	Assistant Director of Operations, Clinical Support Services
Dr Christopher Dewhurst	Clinical Director, Neonatal Care, Liverpool Women's Hospital
Katie Fielding	Executive Assistant (Minutes)
APOLOGIES	
Ann Marr	Chief Executive
Sue Redfern	Director of Nursing, Midwifery & Governance

1.	**Employee of the Month Film – June 2022**	
	1.1. The Employee of the month for June is Michelle Duckworth, Fitness to Practice & Governance Lead, HR, who had been nominated by Ngozi Anya, Head of HR. 1.2. SR made the presentation, and the film will be uploaded to the staff intranet.	
2.	**Apologies for Absence**	
	2.1. As above. 2.2. RF asked the Board to observe a minute of silence to reflect and formally recorded the condolences offered to AM.	
3.	**Declaration of Interests**	

	3.1. No new declarations were made.	
4.	**Minutes of the Board Meeting held on 25th May 2022** 4.1. Correct Record and Matters Arising 4.1.1. The minutes were approved as an accurate record of the meeting. 4.2. Action Log 4.2.1. It was agreed that action 30 should be removed from the action log as the focus of the NHS had now shifted. **CLOSED** 4.2.2. Action 41 - Ambulance to performance – RC confirmed the Trust receives the data from NWAS too late to include in the IPR. RC therefore planned to give a verbal report on the NWAS performance each month as part of the IPR operational update. **CLOSED** 4.2.3. Action 42 - Cancer survival rates – RC advised this information has now been shared with Trust board members. The information is obtained from the Cheshire and Merseyside Cancer Alliance and is population based and updated annually. **CLOSED** 4.2.4. Action 43 - Quality Ward Rounds – NB advised these have now re-started and some invites have already gone out for July. **CLOSED**	
5.	**Integrated Performance Report (NHST(22)046** 5.1. Quality Indicators 5.1.1. In the absence of SR, RC presented the Quality metrics. 5.1.2. There have been no never events in May or year to date. 5.1.3. There have been no cases of MRSA Bacteraemia in May or year to date. 5.1.4. There were 4 C. Difficile positive cases reported in May 2022 (3 hospital onset and 1 community onset). There have been 9 cases year to date. The annual tolerance for CDI for 2022-23 is 56. 5.1.5. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May 2022 was 94.2%. The 2022-23 year to date rate is 93.8%. 5.1.6. During the month of April 2022 there was 1 fall resulting in severe harm. 5.1.7. There were no validated grade 3 hospital acquired pressure ulcers with a lapse in care reported in April.	

5.1.8. Community incidents reported in April decreased to 99 compared to 120 incidents in March. 10 were low harm, 1 moderate harm and the remainder were no harm.

5.1.9. Performance for VTE assessment remains suspended.

5.1.10. The year to date rate for HSMR (April -January) for 2021/22 is 98.1.

5.2. Operational Indicators

5.2.1. RC presented the report.

5.2.2. Performance against the 62-day cancer standard was above the target of 85.0% in April at 90.3%. Year to date performance was 90.3%. The 31-day target was achieved in April with 98.0% performance in month against a target of 96%, and year to date 98.0%. The 2-week rule target was not achieved in April with 82.5% in month and 82.5% year to date 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.

5.2.3. Accident and Emergency all types mapped performance for the STHK Trust footprint performance for May was 72.9% and YTD 73.7%**.** The Trust saw average daily attendances of 340 in May, compared to 321 in April. Total attendances in May were 10,546.

5.2.4. The 30 minutes total ambulance turnaround time target was not achieved in May with 36 mins on average. There were 2,332 ambulance conveyances, which was the most for all Trusts in Cheshire and Merseyside.

5.2.5. The St Helens UTC had 5,357 attendances in April, an increase of 18% compared to March. 99% of patients were seen and treated within 4 hours.

5.2.6. The average daily number of super stranded patients in general acute beds in May was 116 compared with 135 in April. Work is ongoing both internally and externally, with all system partners, to improve the current position to reduce acute bed occupancy and congestion in ED.

5.2.7. The 18-week referral to treatment target (RTT) was not achieved in April with 67.3% against the target of 92%. There were 1,642 patients on the waiting list who had waited 52 weeks or more. RC reported that the Trust had now eliminated all 104 week waiters and was now moving to the next stage of the recovery programme to eliminate 78 week waiters as the next milestone target. RC stressed that the waiting list continues to be managed based on clinical priority as well as time waiting.

5.2.8. The 6-week diagnostic target was not achieved in April with 80.5% compliance. (Target 99%).

5.2.9. There were 517 new referrals to the District Nursing Service in April; Caseload size remains within normal range (1,256 in April compared to 1,233in March). Community matron caseloads was 110 in April. The teams are working with Primary Care, via the 4 Primary Care Networks to develop a collaborative approach to caring for this group of patients.

5.2.10. RC informed the Board that the Cancer Services Team have been nominated for a national parliamentary award for the work they have done to improve access to services.

5.2.11. LK commented that it was impressive to see improvements being made in such a challenging context and congratulated the Cancer Services Team on their nomination.

5.2.12. RF reported that 104-week waiters had been discussed at the recent Northwest Chairs meeting and he was pleased that the Trust had been able to clear this backlog.

5.3. Workforce Indicators

5.3.1. AMS presented the workforce indicators

5.3.2. In May 2022, all staff sickness was 6.0% which was a reduction from April (6.7%). All Nursing & Midwifery sickness absence was 7.7% which also reflected a decrease from April (9.0%).

5.3.3. Mandatory Training Compliance continues to improve slowly but remains below the target at 77.1%.

5.3.4. Appraisal compliance has reduced in month to 60%. This is because staff who were appraised in the first quarter of 2021/22 are now falling out of compliance.

5.4. Financial Indicators

5.4.1.1. GL presented the financial indicators and explained that the report was based on the previously submitted draft financial plan, the revised plan was submitted on 20th June and will be used for reporting from June (month 3)

5.4.2. At month 2 the Trust had received £86.1m income and had expenditure of £89.3m. The income figures assumed 100% of Elective Recovery Fund (ERF) is achieved. Based on operational performance this should be secure, but confirmation is awaited from NHSE on the criteria for allocating ERF in 2022/23.

5.4.3. At month 2 £12.9m of CIP schemes have been identified including £3.3m recurrently. The revised financial plan increases the total CIP target to £28.1m (£22.1m recurrent and £6m non-recurrent).

5.4.4. At the end of Month 2, the cash balance was £66.0m.

	5.4.5. Capital expenditure for the year to date (including PFI lifecycle maintenance) was £1.3m. 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 yet fully signed off nor drawn down from DHSC. 5.4.6. GA asked if there was confidence that a further £10m of CIP could be delivered in 2022/23. GL responded that the new target was challenging and asked how realistic it was to go from £18m to £28m. GL acknowledged that the revised target was challenging but noted that most Trusts had now accepted a portion of the system "problem" and that circa £6m would be non-recurrent. Therefore, GL believed the revised target was achievable based on the current planning assumptions. 5.4.7. RF noted that a 5% CIP with 4% recurrent was one of the highest targets. 5.4.8. IC was pleased that the waiting list recovery targets were being achieved. Having personal experience of a long wait for a procedure at another Trust, he understood the stress and anxiety this caused for patients. IC also commended the Trust on being transparent about its waiting list figures in the IPR. 5.4.9. RF agreed that the IPR set out the Trust position across the range of performance metrics openly and honestly, which was the right thing to do. 5.4.10. The IPR was noted	
6.	**Committee Report – Executive NHST(22)047** 6.1. In the absence of AM, AMS presented the report and highlighted a number of key issues. 6.2. There were four Executive Committee meetings held in May 2022. 6.3. The Executive Committee had approved a business case to implement Careflow for Maternity. The Trust had made a successful bid for national funding (capital and revenue) from the NHSX Digital Maternity Fund to implement the system. The system would enable the service to have digital patient records that could be accessed remotely and comply with the new maternity minimum contract data set requirements. 6.4. The committee had approved plans to improve access to visitor disabled parking and traffic management at Whiston Hospital, following an increase in demand because of additional elective activity and the resumption of visiting, following the pandemic. AMS also highlighted item 4.5 in the report and confirmed that the review had demonstrated that the process for making DNACPR decisions were appropriate but further analysis was being undertaken to provide assurance that the DNACPRs were also removed in a timely manner when they were linked with COVID.	

	6.5. RF noted the plans for increased utilisation of the discharge lounge and was pleased that the facility was being optimised. 6.6. The report was noted	
7.	**Committee Report – Quality NHST(22)048** 7.1. RT presented the report and highlighted that: 7.2. The committee had been assured by the action plan that had been put in place to increase capacity for the rapid access chest pain clinic. 7.3. The committee had also noted that the Executive were in the process of reviewing the Maternity quality and performance dashboard to ensure that all the metrics aligned to the recommendations from the Ockenden report. In relation to patient safety the committee had been assured by the learning and actions taken to improve the chemotherapy pathway for patients who could become hypoglycaemic. Further work was now being planned to electronically record blood glucose monitoring information and create a red flag in the digital notes. 7.4. Freedom to speak up – the committee had noted the actions being taken to raise awareness of how to raise a concern and improve staff engagement in Theatres. It had been noted that there were a number of safety initiatives that had been undertaken with Theatres, which now needed to be formally evaluated and reported back. 7.5. The committee had received the revised Continuity of Carer action plan and supported the recommendation that this should be implemented when safe to do so, in line with the Ockenden report recommendations. 7.6. The Clinical Effectiveness Council chairs assurance report had highlighted an issue with coding capacity, which meant that R codes were delayed. The management action planned to address this had been noted. 7.7. The committee approved the revised falls strategy and freedom to speak strategy. 7.8. IC asked if the Quality Committee had discussed the perinatal deaths and increase in percentage of C-Sections in month, reported in the IPR. RT confirmed that the committee receives detailed reports once the RCAs had been completed on any incidents and had been briefed in relation to the incidents that had occurred in the period covered by the IPR none of which had been STEIS reportable events. The reasons for C-Sections are routinely monitored. 7.9. RT also provided assurance that these metrics are monitored at the Maternity Champions Meeting, which she attends.	

	7.10. RF reflected that the Board needed to keep in mind the recommendations from the Ockenden report and recognise that this should impact on the way services are delivered. 7.11. RC and RPJ reported on a pilot project being undertaken with the Cheshire PLACEs in Cheshire and Merseyside to improve discharges. RC was meeting with the new PLACE leads to ensure they were properly briefed and had regular information about the delayed discharges in their borough. 7.12. The report was noted	
8.	**Committee Report – Finance & Performance NHST(22)049** 8.1. JK presented the report and highlighted the key issues. 8.2. The IPR had showed ambulance turnaround times remained challenged, and committee had been briefed on the management action being taken internally and with system partners to try and improve patient flow. 8.3. Committee had received the month 2 finance report and a full briefing on the revised 2022/23 financial plan submission. 8.4. The committee received the report on the Trust's CIP programme and was assured by the level of schemes that had already been identified for this year. 8.5. The committee had noted the capital plan for 2022/23 and that the internal plans to deliver before year end. 8.6. The committee had received a CIP presentation from the Primary and Community Care Group. 8.7. A report was also received in relation to business case benefits realisation and the improvements to the process that were being implemented. 8.8. IC added that the committee had queried the inpatient and outpatient e-discharge letter performance, which had deteriorated. Actions put in place to date had not yet made the impact expected, and committee had requested an improvement plan and trajectory for the next meeting. 8.9. The report was noted	
9.	**Committee Report – Charitable Funds NHST(22)050** 9.1. PG presented the report 9.2. The committee had noted the value of invested funds had fallen slightly and the portfolio was reviewed. 9.3. The income and expenditure report had been noted.	

	9.4. The committee had discussed future fundraising opportunities and activities following the pandemic and noted that a new Charity Manager had been appointed and this created an opportunity to update the objectives for the Hospital Charity. 9.5. The Annual effectiveness review had been undertaken, and the recommendations had been noted.	
10.	**Fit and proper persons annual declaration NHST(22)051** 10.1. RF presented the report. He explained that this is a requirement that has been in place since 2014 and CQC issued their guidance in 2018. 10.2. RF assured the Board that the Trust has a robust policy and the FPPT requirements of Directors are tested annually. RF has reviewed the results for each Director and the Deputy Chair had reviewed RF's results. The These reviews had not identified any issues that would prevent the annual declaration being made. 10.3. The Board noted the annual FPPT declaration.	
11.	**Nursing & Midwifery Strategy 2022/2025 NHST(22)052** 11.1. In the absence of SR, RC presented the strategy. 11.2. This strategy was designed to focus on the Nursing and Midwifery workforce but would be implemented in conjunction with a number of other workforce strategies. The aims and objectives are also aligned with the Trust operational plan and annual objectives. 11.3. GB felt the strategy showed the level of ambition the Trust had for the nursing profession and thought it was a good document. 11.4. GB asked if SR could provide detail about the proposed role of Professional Nurse and Midwifery Advocate. **ACTION: SR** 11.5. RC confirmed that the quality metrics included in the strategy would be part of the new IPR. 11.6. GB also asked for more information on the QCAT system of ward quality accreditation. RC advised that an excellent presentation had recently been given at the Operational Meeting and he would circulate this to Board members. **ACTION: RC obo SR.** 11.7. RF particularly liked the "we care" strapline for the strategy and was impressed by the detailed action plans for the next 3 years. 11.8. The Board approved the Nursing and Midwifery Strategy.	
12.	**2021/22 Trust Board and Committee Effectiveness Reviews NHST(22)053**	

	12.1. NB presented the report and explained that a meeting effectiveness review had been undertaken for the Board and each Board committee, with the results informing the Annual Governance Statement. 12.2. One of the key outputs from these reviews was for the Board to approve any recommended changes to the Terms of Reference (ToR) for each meeting for 2022/23. The changes proposed were minor to reflect changes in regulatory requirements and to update nomenclature. 12.3. RF commented that this was an important piece of work to maintain the highest standards of governance. The Board approved the updated Board and committee ToR for 2022/23.	
13.	**Effectiveness of Meeting** 13.1. RF invited each of the observers to comment on the effectiveness of the meeting. 13.2. Caroline Dawn felt it had been an interesting experience and would support her development. She could see the links between the discussions taking place at her level and what was reported and discussed at Board. 13.3. Chris Dewhurst thanked RF for the opportunity to observe the meeting. He felt that the values of the Trust came through in language that was used. He felt that there had been good challenge and had been pleased to see maternity issues on the agenda. Chris commented that at some points reassurance was provided rather than assurance and he queried how the Board was tackling diversity as this was not discussed at today's meeting. 13.4. Devina thanked for observing. She echoed what has been said by others. She liked the tone in terms of values around people and humanity and the celebration of an individual who has done well. She added the silence showed compassion and she liked that Katie was thanked for minutes. She asked how this filters down to front line from ward to board and also the celebrations. Devina Halsall also noted that there had not been much workforce or ED&I information presented at this meeting. AMS responded that a detailed workforce indicators report comes to Board twice a year with the next report scheduled for July. In addition, the Trust has a People Council that meets monthly and a Strategic People committee which meets quarterly, and they review these metrics in detail. AMS offered to have a follow up conversation on Workforce information and assurance if this would be helpful. 13.5. DH had liked the way that things were explained and the NEDs constructive challenges. Of particular interest was the reference to controlled drugs storage, given her role at NHSE.	

	13.6. RF thanked everyone for their feedback and commented that the Board make up reflects the local community against a range of protected characteristics and takes its commitment to ED&I very seriously.	
14.	**Any Other Business** 14.1. RF undertook to circulate the presentations from the recent regional chairs meeting to the Board members. 14.2. RF noted that this was RPJs last Board meeting and thanked him for his contribution and hard work as Medical Director over the last three years. On behalf of the Board RF wished PRJ every success in his new role at the Cheshire and Merseyside ICB. RPJ responded that it had been a privilege to serve as a Director at STHK and thanked all the directors for their help and support.	
Date of Next Meeting: Wednesday 27th July 2022		

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 27th JULY 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.~~ **CLOSED**	~~NB/NK~~	~~Next Board Time Out~~
~~41~~	~~30.03.22 (6.2)~~	~~Provide additional information about category 2 ambulance performance~~ **CLOSED**	~~RC~~	~~29.06.22~~
~~42~~	~~30.03.22 (7.5)~~	~~Include information about cancer survival rates in future reports on the impact of health inequalities~~ **CLOSED**	~~RC~~	~~29.06.22~~
~~43~~	~~27.04.22 (11.6)~~	~~Develop plans for the reinstatement of Quality Ward Rounds for consideration at Quality Committee.~~ **CLOSED**	~~SR~~	~~29.06.22~~
44	29.06.22	SR to provide detail about the proposed role of Professional Nurse and Midwifery Advocate	SR	27.07.22
45	29.06.22	RC to circulate Nursing and Midwifery Strategy presentation from Operational Meeting to Board members	RC	27.07.22
46				

47				
48				

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(22)054
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 June 2022. (YTD = 0).

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

There were 11 C. Difficile (CDI) positive cases reported in June 2022 (9 hospital onset and 2 community onset). (YTD = 20). Of the 20 cases, 10 have been reviewed at RCA panel, 7 cases were deemed unavoidable as no lapses in care. The annual tolerance for CDI for 2022-23 is 56.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for June 2022 was 94.4%. 2022-23 YTD rate is 94.0%.

During the month of May 2022 there was 1 fall resulting in severe harm or death category . (YTD severe harm or above category falls = 2).

There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in April 2022. (YTD = 0).

Community incidents reported in May increased to 107 compared to 99 incidents in April. 7 were low harm 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: 27th July 2022

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (May 2022) at 83.2%. YTD 86.7%. The 31 day target was achieved in May 2022 with 98.9% performance in month against a target of 96%, YTD 98.4%. The 2 week rule target was not achieved in May 2022 with 88.3% in month and 82.5% YTD against a target of 85.6%. 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 June 2022 was 47.3% and YTD 48.9%. The all type mapped STHK Trust footprint performance for June 22 was 72.1% and YTD 73.1%**.** The Trust saw average daily attendances of 333, which is down compared to May, at 340. Total attendances for June 2022 was 10,004.

Total ambulance turnaround time was not achieved in June 2022 with 47 mins on average. There were 2,206 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 2,332 in May 22.

The UTC had 5,498 attendances in May 2022, an increase of 3% (141) compared to the previous month of April. Overall, 99% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in June 2022 was 129 compared with 116 in May. 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 May 2022 with 69.5% compliance and YTD 69.5% (Target 92%). Performance in April 2022 was 67.3%. There were (1,711) 52+ week waiters. The 6 week diagnostic target was not achieved in May 22 with 86.3% compliance. (Target 99%). Performance in April 2022 was 80.5%.

There was a slight increase in referrals received within the District Nursing Service in May however, the levels are still within average range (589 in May compared to 517 in April). Caseload size is within normal range (1,266 in May compared to 1,253 in April). Community matron caseloads have slightly reduced to 106 this month compared to 110 in April. 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

Following resubmission of plans to support submission of an updated system wide plan in June 2022, the Trust has agreed a final 22/23 financial plan at a deficit of £4.9m, including a CIP target of £28.1m (5%). At Month 3, we are in line with plan (£3.3m deficit).

Surplus/Deficit - At the end of Month 3, the Trust is reporting a deficit position of £3.3m for the year to date, with £127.6m income and £130.9m expenditure year to date. This is in line with plan.

CIP - The Trust's final CIP target is £28.1m for financial year 2022/23, of which £22.1m is to be delivered recurrently and £6m non-recurrently. As at Month 3, low risk schemes either delivered or at finalisation stage total £13.2m in year and £7.8m recurrently.

Cash - At the end of Month 3, the cash balance was £69.8m.

Capital - Capital expenditure for the year to date [including PFI lifecycle maintenance] totals £1.9m. 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

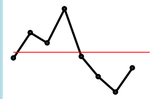
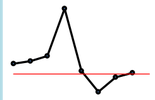
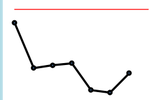
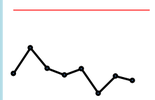
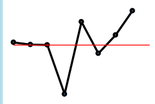
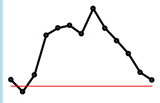
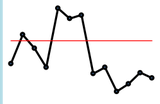
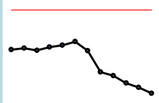
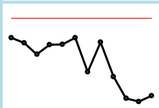
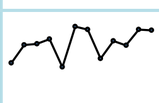
In June 2022, all staff sickness was 6.2% which was an increase from May (6.0%). The rate for Nursing and Midwifery ward areas was 7.7% which remained static from May (7.7%).
Appraisal compliance in June is 59.1% which is a slight reduction from May (60%). Mandatory training compliance continues to improve in June 78.0% (May 77.1%).

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

Jun-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	Jun-22	2.2%	2.3%	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.	PW
Mortality: SHMI (Information Centre)	Q	▲	Jan-22	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.	PW
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	Jun-22	1.2%	1.6%	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	Jun-22	33.3%	33.3%	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	▲	May-22	61.9%	62.7%	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. Work currently in process with admin team to review capacity to meet demand for outpatient clinic letters and provide alternative solutions if required. ED performance improving due to change in system for completion and sending of eDischarges from SDEC Area. Dip in reporting reflects the changeover of process and current reporting evidences 82%.	PW
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	May-22	26.8%	24.5%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	May-22	97.9%	97.9%	95.0%	97.2%					

Jun-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	▲ £	Jun-22	0	0	0	1		No never events YTD	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	Jun-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.	PW
Number of hospital acquired MRSA	Q F&P	▲ £	Jun-22	0	0	0	2		There were no MRSA cases in June 2022. (YTD = 0). There were 11 C. Difficile (CDI) positive cases reported in June 2022 (9 hospital onset and 2 community onset). (YTD = 20). Of the 20 cases, 10 have been reviewed at RCA panel, 7 cases were deemed unavoidable as no lapses in care. The annual tolerance for CDI for 2022-23 is 56. Internal RCAs on-going with more recent cases of C. Diff.	Quality and patient safety	The annual tolerance for CDI for 2022-23 is 56. Improvement actions in place and completed based upon RCA .	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Jun-22	11	20	56	32					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jun-22	0	5	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Apr-22	0	0	No Contract target	2		No validated category 3 pressure ulcer YTD.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from reported pressure ulcer incidents and learning.	SR
Number of falls resulting in severe harm or death	Q	▲	May-22	1	2	No Contract target	22		1 falls resulting in severe harm category in May 2022 (Ward 1D).	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 June 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. eVTE assessment tool currently undergoing rollout in ED as part of Electronic Medical Assessment Proforma.	PW
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-21	4		No Target	12					
To achieve and maintain CQC registration	Q		Jun-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	Jun-22	94.4%	94.0%	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	Jun-22	3	6	No Target	30					

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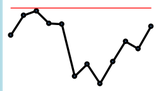
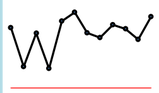
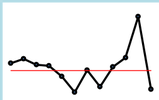
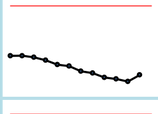
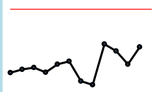
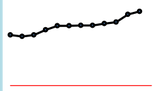
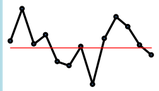
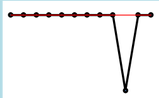
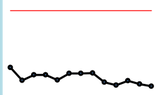
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲ £	May-22	88.3%	85.6%	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	▲ £	May-22	98.9%	98.4%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	May-22	83.2%	86.7%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-22	69.5%	69.5%	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	▲	May-22	86.3%	83.5%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-22	1,711	1,711	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jun-22	0.7%	0.9%	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	▲ £	May-22	100.0%	100.0%	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	▲	Jun-22	47.3%	48.9%	95.0%	55.8%		Accident and Emergency Type 1 performance for June 2022 was 47.3% and YTD 48.9%. The all type mapped STHK Trust footprint performance for June 22 was 72.1% and YTD 73.1%. The Trust saw average daily attendances of 333, which is down compared to May, at 340. Total attendances for June 2022 was 10,004. Total ambulance turnaround time was not achieved in June 2022 with 47 mins on average. There were 2,206 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 2,332 in May 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	▲	Jun-22	72.1%	73.1%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Jun-22	0	0	0	0					

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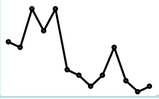
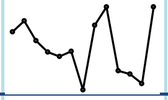
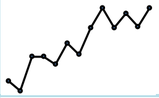
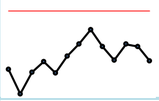
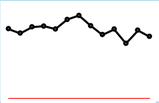
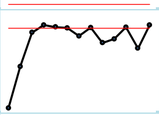
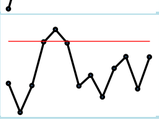
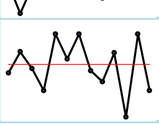
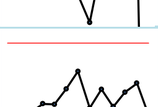
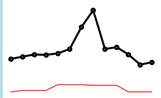
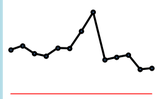
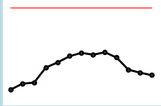
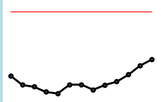
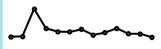
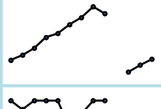
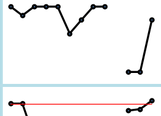
NHS St Helens and Knowsley Teaching Hospitals NHS Trust

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	▲ £	Jun-22	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Jun-22	14	42	No Target	254		% new (Stage 1) complaints resolved within agreed timescales remains below the target.	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 remain in place to increase response rates within the Medical Care Group which has the largest number of open complaints, although the total number of open complaints is reducing.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jun-22	12	67	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jun-22	100.0%	71.6%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to June 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	Jun-22	360	353		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Jun-22	129	127		108					
Friends and Family Test: % recommended - A&E	Q	▲	Jun-22	78.2%	80.7%	90.0%	79.0%		Recommendation rates are above target for inpatients and postnatal community, but below target for the remaining areas.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team as a valuable mechanism for receiving up-to-date patient feedback. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. At least two members of staff have been identified in each area to produce the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides are available for each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jun-22	94.9%	94.9%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jun-22	100.0%	94.2%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jun-22	95.5%	93.6%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jun-22	90.9%	91.9%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jun-22	N/A	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jun-22	93.5%	93.9%	95.0%	93.8%					

Jun-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	▲	Jun-22	6.2%	6.3%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In June 2022, all staff sickness was 6.2% which was an increase from May (6.0%). The rate for Nursing and Midwifery ward areas was 7.7% which remained static from May (7.7%). N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include COVID absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.	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	Jun-22	7.7%	8.1%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Jun-22	59.1%	59.1%	85.0%	65.9%		Appraisal compliance in June is 59.1% which is a slight reduction from May (60.0%). Mandatory training compliance continues to improve in June 78.0% (May 77.1%)	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, particularly in clinical services. For Appraisal, all staff on AFC will have an appraisal to meet the 85% compliance before 30th September. For Mandatory Training the detailed recovery plan to meet compliance developed by SMEs is having an incremental effect and continues to be monitored through People Council .	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jun-22	78.0%	78.0%	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.	The Staff Survey Pulse Check is now live until 31st July. Results will be published at the end of August. The national staff survey actions associated with the responses to these 2 questions form a key component of the Staff Survey action plan for 2022. This action plan 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	Jun-22	0.8%		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	Jun-22	Discontinued	Discontinued	N/A				Delivery of Control Total		GL
Progress on delivery of CIP savings (000's)	F&P	T	Jun-22	7,937	7,937	28,100						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Jun-22	(3,265)	(3,265)	(4,949)						
Cash balances - Number of days to cover operating expenses	F&P	T	Jun-22	28	28	10						
Capital spend £ YTD (000's)	F&P	T	Jun-22	1,900	1,900	26,100						
Financial forecast outturn & performance against plan	F&P	T	Jun-22	(4,949)	(4,949)	(4,949)						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jun-22	96.1%	96.1%	95.0%						

APPENDIX A

			May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022-23 YTD	2022-23 Target	FOT	2021-22	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	100.0%	93.1%	83.3%	88.7%	85.0%		96.0%		
	Total > 62 days		1.0	1.0	1.0	0.0	0.5	0.5	0.0	1.0	1.0	0.0	0.0	1.0	2.0	3.0			6.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.5		
Lower GI	% Within 62 days	▲ £	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	86.7%	90.5%	76.5%	84.2%	85.0%		79.7%		
	Total > 62 days		3.5	0.0	1.0	2.5	0.0	3.0	4.0	3.0	2.0	1.0	1.0	1.0	2.0	3.0			24.5		
	Total > 104 days		0.0	0.0	0.0	1.5	0.0	0.0	1.5	1.0	0.0	0.0	0.0	0.0	0.0	0.0			4.0		
Upper GI	% Within 62 days	▲ £	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	36.4%	90.0%	84.6%	87.0%	85.0%		83.2%		
	Total > 62 days		0.0	0.0	1.0	3.0	1.0	0.0	0.0	1.0	0.0	0.0	3.5	0.5	1.0	1.5			9.5		
	Total > 104 days		0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.0	0.5			3.0		
Urological	% Within 62 days	▲ £	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	93.9%	90.0%	81.0%	82.3%	85.0%		80.5%		
	Total > 62 days		2.0	4.5	1.5	4.5	2.0	1.0	3.5	0.5	8.5	1.5	1.0	1.5	4.0	5.5			32.5		
	Total > 104 days		0.0	0.0	0.0	0.5	2.0	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	0.0			4.0		
Head & Neck	% Within 62 days	▲ £	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	16.7%	0.0%	7.7%	85.0%		24.4%		
	Total > 62 days		3.0	1.0	2.0	1.0	1.0	2.0	0.5	2.0	0.0	1.0	1.0	2.5	3.5	6.0			15.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0			2.0		
Sarcoma	% Within 62 days	▲ £	100.0%		100.0%									100.0%		100.0%	85.0%		100.0%		
	Total > 62 days		0.0		0.0									0.0		0.0			0.0		
	Total > 104 days		0.0		0.0									0.0		0.0			0.0		
Gynaecological	% Within 62 days	▲ £	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	60.0%	75.0%	66.7%	70.0%	85.0%		67.3%		
	Total > 62 days		0.0	0.5	0.0	2.5	2.0	1.0	0.5	3.0	0.0	5.0	2.0	1.0	2.0	3.0			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.0	1.0	0.0	1.0			2.5		
Lung	% Within 62 days	▲ £	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	55.6%	50.0%	92.3%	78.9%	85.0%		77.2%		RC
	Total > 62 days		2.0	0.0	2.0	0.0	2.5	3.0	1.5	1.0	2.5	1.5	2.0	1.5	0.5	2.0			18.0		
	Total > 104 days		0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0			1.5		
Haematological	% Within 62 days	▲ £	100.0%	37.5%	37.5%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	85.0%		60.5%		
	Total > 62 days		0.0	5.0	5.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0			17.0		
	Total > 104 days		0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0			5.0		
Skin	% Within 62 days	▲ £	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	100.0%	97.7%	93.4%	95.7%	85.0%		93.3%		
	Total > 62 days		3.0	3.0	0.0	1.0	3.5	4.0	4.5	3.0	3.0	2.0	0.0	1.0	2.5	3.5			29.5		
	Total > 104 days		1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0			1.5		
Unknown	% Within 62 days	▲ £		50.0%		100.0%		100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	85.0%		88.2%		
	Total > 62 days			1.0		0.0		0.0	0.0		0.0	0.0		0.0		0.0			1.0		
	Total > 104 days			0.0		0.0		0.0	0.0		0.0	0.0		0.0		0.0			0.0		
All Tumour Sites	% Within 62 days	▲ £	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	86.3%	90.3%	83.2%	86.7%	85.0%		85.2%		
	Total > 62 days		14.5	16.0	13.5	14.5	12.5	14.5	15.5	15.5	17.0	12.0	12.5	10.0	17.5	27.5			170.5		
	Total > 104 days		1.0	1.0	4.0	3.0	2.5	1.5	2.0	1.5	0.5	2.0	3.0	1.5	3.0	4.5			24.0		
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%	66.7%	100.0%	80.0%	85.0%		100.0%		
	Total > 31 days			0.0		0.0	0.0	0.0		0.0			0.0	1.0	0.0	1.0			0.0		
	Total > 104 days			0.0		0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)055
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 June 2022. There were two Executive Committee meetings held during this period due to the Platinum Jubilee bank holiday and the Board time out. The investment decisions made were: 1. Equality, Diversity, and Inclusion Team Capacity – Business Case 2. Temporary expansion of visitor disabled car parking spaces at Whiston Hospital. At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration.
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: Anne-Marie Stretch, Deputy Chief Executive & Director of HR
Date of meeting: 27th July 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were two Executive Committee meetings in June 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. 9th June 2022

2.1 Nursing and Midwifery Strategy 2022-2025

The Director of Nursing, Midwifery and Governance presented the draft Nursing and Midwifery Strategy. The strategy had been developed to demonstrate how Nursing and Midwifery could support the delivery of the Trust's strategic priorities. It was also aligned to the national and Cheshire and Merseyside strategies for nursing, and had taken account of the recent Ockenden recommendations for Midwives. The action plans included detailed objectives for each year of the strategy with outcome metrics. The Executive Committee supported the strategy to be presented to the Trust Board for approval.

2.2 Continuity of Carer Action Plan

The Director of Nursing, Midwifery and Governance introduced the plan, which demonstrated how the Trust would achieve the continuity of carer model for pregnant women to meet national policy guidance. The revised plan was to be submitted to the Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) by 10th June. Committee discussed the contradictory messages in relation to the continuity of carer model, which seemed at odds with the recommendations of the Ockenden Report. It was agreed that the action plan was reasonable and should be approved but could only be implemented if there were no detrimental safety impacts on other parts of the service.

2.3 Financial Plan 2022/23

The Director of Finance and Information briefed the committee on the latest discussions with the Cheshire and Merseyside ICS about the financial plan for 2022/23. This included the proposed share of the "stretch target" that was to be allocated to the Trust and the impact on CIP. On the basis that part of the CIP challenge could be delivered non-recurrently in 2022/23 the committee agreed the recommend approval of the revised financial plan.

2.4 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agendas for review. The cyber security training session was to take place following the formal Board meeting.

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

The Chief Executive briefed the committee on the ALTC Quarterly Joint Meeting that had taken place the previous day.

2.8 National Infection Prevention Control Guidance

The Director of Operations and Performance reported that updated national guidance had now been issued, which removed the COVID-19 measures that had been in place during the pandemic e.g., mask wearing and social distancing in general healthcare settings. It was agreed that the guidance to staff, patients and visitors would be updated to reflect this revised guidance and the signage at the Trust sites would be removed.

3. 23rd June 2022

3.1 Equality Diversity and Inclusion (EDI)Team Capacity Business Case

The Deputy CEO/Director of HR presented the business case for additional resources to allow the Trust to increase capacity to respond to the growing EDI agenda and meet statutory, mandatory, and contractual obligations. The business case included a self-assessment against the best practice standards that the Trust aspires to and address the issues raised in the 2021 Staff Survey. Committee approved additional resources for the ED&I team, some recurrent posts, and others non-recurrent. The key performance metrics and impact of the investment would be tracked via agreed success criteria.

3.2 Safer Staffing Report – May 2022

The Deputy Director of Nursing presented the paper. The fill rates for May had been 94.24% for registered nurses and midwives and 113.11% for Health Care Assistants (including supplementary care requests). The paper then provided a detailed analysis of patient safety impacts, comparing month 12 (2021/22) and month 1 (2022/23).

The paper also included a recruitment update. 71 offers had been made for Nurses and HCAs during May. Further recruitment events were planned for June with a particular focus on recruiting to the emergency department.

A further 81 OSCE international nurses were expected to join the Trust between July and November 2022.

3.3 Whiston Hospital – Temporary Overflow Visitor Disabled Car Park

The Director of Corporate Services presented proposals to increase the provision of visitor disabled car parking spaces to respond to the increased demand. This proposal was designed as a temporary solution to maintain patient experience, site safety and access for emergency vehicles until the substantive hospital entrance roadway and parking redesign scheme could be completed. The proposal involved expanding the visitor disabled car parking into staff car park 1. The current staff disabled parking spaces would be re-provided in car park 1 but some other staff spaces would be displaced to the hard standing area on the other side of Warrington Road. The Committee approved these emergency measures and agreed the communications plan for staff.

3.4 Southport and Ormskirk NHS Trust update

The Deputy CEO/Director of HR reported that there had been a regional Maternity Insight visit and a follow up was scheduled for 27th July to gain assurance that the agreed improvement actions had been delivered.

The recent Patient Experience Conference had been successful, and S&O had been shortlisted for an HSJ award for the work they had done on human factors training.

3.5 Strategic Issues

The Director of Operations and Performance briefed the committee on discussions about increasing dermatology capacity to respond to increased referrals from Cheshire and Merseyside and to provide a service for the population of West Lancashire.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)056
Title of paper: Committee Report – Audit Committee 30th June 2022
Purpose: To report to the Trust Board on the Audit Committee, 30th June 2022
Summary **Meeting attended by:** J Kozer – NED & Chair G Brown – NED G Lawrence – Director of Finance & Information Clare Barrow - Deputy Director of Finance Alan Sharples - Non-Executive Director John Farrar - Grant Thornton Georgine Philps - Grant Thornton Nicola Bunce - Director of Corporate Services **Agenda Items** **For Assurance/Approval** A) Annual Report and governance statement • The committee reviewed the annual report and governance statement and were pleased with the content included within the report which reflected a good year for the Trust. B) Annual Accounts 2021/22, Audit Findings Report, Letter of represnetation • The committee reviewed the annual accounts, the audit findings report and the letter of representation. • It was noted that the audit findings report was not complete and that audit work was still on going on certain aspects of the accounta. • The committee was informed in the national delay on the Value for Money opinion and accepted that this would be received at a later date as per the revised timetable. • The committee reviewed the actions within the audit report and were happy that the proposed changes going forward would mitigate these in future years. **The committee approved the accounts for formal approval at the Board and be signed off by the Chief Executive, subject to the final audit report and opinion being received from Grant Thornton. It was agreed that the final report would be circulated to all members of the committee on completion.** **Note, The final report was received and distributed to the committee on the 26/07/2022.*
Corporate objectives met or risks addressed: Finance and Performance
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 27th July 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)057
Reporting from: Quality Committee
Date of Committee Meeting: 19th July 2022
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Geoffrey Appleton, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery & Governance Peter Williams, Medical Director Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance **In attendance:** Debbie Stanway, Head of Nursing and Quality, Medical Care Group Stephen Beckett, Head of Quality, Clinical Support Services Anne Rosbotham-Williams, Deputy Director of Governance Lynn Ashurst, Associate Head of Nursing and Quality, Quality and Risk Su Hobbs, Associate Head of Nursing and Quality Urgent Care **In attendance to deliver reports:** Sue Orchard, Head of Midwifery Anne Monteith, Assistant Director of Safeguarding Simon Gelder, Head of Pharmacy
Matters Discussed **Action Log** All open actions reviewed and closed, other than two ongoing actions. **Integrated Performance Report** (IPR) highlighted: • No new Never Events or MRSA bacteraemia reported in June and no category 3 or 4 hospital acquired pressure ulcers reported in April • 11 cases of C difficile reported in June • 1 fall resulting in severe harm reported in May (year to date 2) • Safer staffing fill rate for registered nurses/midwives for June 2022 was 94.4% and year-to-date rate 94% • HSMR (April to January 2022) is 98.1 • Continued achievement of 31-day target in May, although 62 day target was slightly below target in month at 83.2% (above target year to date) • 2-week rule target was not achieved in May but did improve slightly in month, however 75% faster diagnosis was achieved

- Continued challenges in meeting emergency care access targets, however 99% of patients were seen and treated within 4 hours at the Urgent Treatment Centre despite an increase in attendances
- Ambulance turnaround times were not achieved
- Average daily number of super stranded patients (length of stay over 21 days) increased from 116 in May to 129 in June
- 18-week referral to treatment and 6-week diagnostic targets were not achieved, but did improve in May; there were no patients waiting more than 104 weeks and the team are now reducing the number of patients waiting more than 78 weeks, with assurance provided that any patients who are deemed clinically urgent are treated as soon as possible
- It was noted that the Trust is still receiving referrals via choose and book service
- The Committee members sought assurance that actions were being taken to increase the number of e-discharge summaries sent to GPs and noted that this is monitored by the Finance and Performance Committee
- Increase in sickness absence noted in June, with improvement in mandatory training; work continues to improve training compliance and appraisal rates

The Committee noted that work is being undertaken to agree the maternity metrics to be included in the new IPR. Information was provided on the new ED performance targets and how these could support appropriate prioritisation of patients.

The Committee received assurance that Radiology was included in the review of scans following an obstetric haemorrhage to enable any learning to be identified.

Patient Safety Council Report
A number of reports were received including, patient safety report which noted 5 StEIS reportable incidents in May 2022 and reduction in patient falls; CAS report which noted that all alerts received in May and June were actioned; medicines safety highlighting actions taken to continue to improve in this area; infection prevention noting actions being taken for outbreak areas; and nursing care indicators, which demonstrated an improvement in audit scores for most areas. The Committee noted the actions taken in relation to increased diabetes education following an incident and ongoing work to improve documentation for cannula management.

Safeguarding Activity Report Quarter 1 2022-23
The Safeguarding Team continue to promote training which is below target, however safeguarding activity remains significant providing some assurance to commissioners that staff are competent in managing issues. The Team continue to monitor the number of looked after children health assessments and are working with the Local Authority to ensure these are completed within 20 days of child entering care system. Work is required to improve timeliness of DoLS applications.

There has been a sustained increase in the number of referrals to the Learning Disability Specialist Nurse and the report noted that learning disability training became mandatory for all Trust staff from 1st July 2022.

An update on the introduction of Liberty Protection Safeguards and the implications for the Trust was provided and the development of a service level agreement with Mersey Care to support Mental Health Act Administration. Quarter 1 saw a decrease in the number of patients detained under the Mental Health Act to more usual levels following a sharp increase in quarter 4 2021-22.

Significant work is being undertaken to secure appropriate placements for three CAMHS patients and the Committee had a detailed discussion about the current position and challenges and noted that this had been escalated regionally by the Director of Nursing, Midwifery and Governance.

A business case is currently in development to increase staffing levels within the Safeguarding Team, due to the increase in activity and in anticipation of Liberty Protection Safeguards being introduced.

Infection Prevention Report Quarter 1 2022-23

The report noted the increase in COVID-19 cases, with the Trust reporting the lowest level of nosocomial infection rates in Cheshire and Merseyside. High levels of compliance with MRSA screening (98.5%) were noted. There was an increase number of clostridium difficile in June, with 20 reported throughout quarter 1, of which 7 were deemed unavoidable following 10 reviews by RCA panels. Additional key trainer dates have been arranged to increase levels of mandatory training, which are below target. A task and finish group has been established to oversee compliance with the new cleaning standards due by December 2022.

Maternity Services update Quarter 4

The Committee received an update on progress in delivering the recommendations from both Ockenden 1 report and the final report as well as NHS Resolution's Maternity Incentive Scheme. A summary of the most recent perinatal mortality reviews, serious incidents and red flags were discussed. The Committee were notified that there will be an external regional Ockenden oversight visit on 15th August to review first-hand the evidence of compliance with the Ockenden immediate and essential actions.

The report included confirmation of compliance with Saving Babies Lives, information on safety champions and workforce issues, noting that a detailed report would be brought to the Board following analysis of Birthrate Plus.

It was agreed that any areas where the Trust is an outlier compared to other trusts would be included in future quarterly reports.

Hospital Pharmacy Transformation Programme and Medicines Optimisation Strategy update

Progress in delivering the transformation programme was provided, noting key achievements, including increase in use of technology, increase in pharmacy technicians to support clinical areas, clinical pharmacy in ED and increase in the number of pharmacists who are non-medical prescribers. The rise in take home medications (TTOs) dispensed on wards has shortened TTO pathway times, supporting patient flow. The work of the pharmacy team during the pandemic was also highlighted.

There are a number of priority areas for the revised Medicines Optimisation Strategy 2022 onwards, including review of weekend cover, development of training packages and continued enhancement of technology to improve clinical care and patient safety. The use of the pharmacy dashboards has enabled smarter working and deployment of resources where needed the most.

Patient Experience Council report

The Council met in July and received a number of reports, including a patient story outlining the benefits of the new brain tumour pathway to ensure every patient had access to support from the acute oncology team and a coordinated diagnostic pathway. The Council noted the self-assessment against the National Patient Experience Improvement Framework with ongoing actions to achieve full compliance.

The latest maternity services national survey results were discussed, noting that whilst the scores were similar to other trusts a number had declined. There is a detailed action plan in place to improve the scores and the team are working with the Maternity Voices Partnership to co-produce leaflets to ensure appropriate information is provided.

A detailed Nursing Care Indicator report highlighted improvement in audit scores and the Council discussed the need to make the patient experience audit on Tendable mandatory supported by each area's Patient Experience and Dignity Champion. The Medical Care Group quarterly report noted the significant drop in formal complaints and the ongoing work to share lessons learned and actions. The Cancer Patient Experience and Quality Assurance meeting highlighted the actions being taken following lower scores in colorectal service relating to pain management.

Complaints, Concerns, Claims and Friends and Family Test Quarter 1 report
The Committee noted a decrease in the number of first stage complaints received in Quarter 1 and the decrease in the number of overall open complaints. However there was an increase in the number of responses that breached the timeframe, with additional hours being allocated to address this within the Central Complaints Team.

There was a slight increase in the number of pre-action claims received and a decrease in the number of inquests involving the Trust opened by the Coroner. The report contained some examples of the actions taken as a result of both complaints and claims.

PALS continue to receive a high number of contacts but are maintaining a low level of conversions to formal complaints, despite some temporary staffing gaps which are currently being recruited to. Friends and Family Test results continue to show high levels of satisfaction with the majority of areas, although waiting times within the ED are adversely affecting recommendation rates within that service.

Clinical Effectiveness Council report
A number of reports were received including presentations from Clinical Psychology, highlighting the challenges and successes within the service; and Resuscitation Services, noting ongoing efforts to increase compliance with mandatory training and the outcomes following emergency calls with a better than national average of survival following a cardiac arrest. Additional items included review of the IPR, mortality data, maternity key performance indicators, progress in achieving NICE compliance, update on the delivery of the clinical audit programme, pharmacy aseptic unit report, learning from deaths and Research, Development and Innovation Annual Report. The Council approved a number of procedural documents.

The Committee noted that the high number of R-codes reported last month was due to COVID-19 as there was no International Classification of Diseases (ICD10) code for this.

Assurance Provided:

- Continued reduction in the rate of patient falls per 1,000 bed days
- Delivery of Medicines Optimisation Strategy
- Excellent work carried out by the Research, Development and Innovation Team
- Improvement seen in some key performance indicators in the IPR, including falls, pressure ulcers, 12 hour waits and reduced number of complaints
- Actions identified to increase compliance with Ockenden reports

Decisions Taken:

- No formal approvals required

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

- Required support for staff managing CAMHS patients and long-term solutions to be considered
- Increased monitoring of assurance process for compliance with NICE guidelines

Matters for escalation:

- Impact of delayed transfers of care for CAMHS patients

Recommendation(s): That the Board note the report, the assurances provided and the actions being taken to address areas of concern.

Committee Chair: Rani Thind, Non-Executive Director

Date of Meeting: 27th July, 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)058

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 21st July 2022

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton – NED
P Growney – NED
G Lawrence – Director of Finance & Information
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
P Williams –Medical Director
C Oakley – Deputy Director of Finance & Information

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was Below the 85% target in May, at 83.2% with YTD at 86.7%.
- Target 31 day performance was met in May, at 98.9% against a target of 96.%.
- Target 2 week wait cancer performance was not achieved in May, at 88.3% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 47.3% in June and 48.9% year to date. All type mapped STHK Trust footprint performance was 72.1% in June and is 73.1% year to date. The Trust saw average daily attendances of 333, which is down compared to May. Total attendances for June 2022 were 10,004.
- The ambulance turnaround time target was not achieved in June, at 47 minutes on average. There were 2,206 ambulance conveyances in June.
- In June all staff sickness was 6.2% which is a reduction from 6.7% in April.

B) Finance Report Month 3

- At Month 3, the Trust is reporting a YTD deficit of £3.3m which was in line with plans.
- The position includes ERF funds that were allocated by C&M ICS. It is assumed that ERF performance will be reviewed quarterly in arrears for the system.
- As at M3 the Trust has identified and delivered CIP schemes of c£13.2m in year and continues to work towards the recurrent target.
- The Trust's full capital allocation is expected to be utilised by the end of the 22/23 financial year. The Trust awaits decisions on external business cases for capital.
- At Month 3, the Trust has a cash balance of £9.86m and is acheiving the Better Payment Practice Code (BPPC) target, at 99% performance (non-NHS invoices by value).

C) CIP Programme Update (CIP)

- The committee received the report on the Trust's CIP programme.

- The committee were assured with the level of schemes that have been identified for this year especially given the increased CIP target following the revision of the plan.
- The committee noted that the recurrent position had improved compared to M2 with over 1/3 of the recurrent target delivered.

D) Elective recovery Update

- The committee reviewed the progress on the elctive recovery programme
- The committee noted the operational challenges in delivering the plan but was assured by the progress that had been made despite the demand.
- The committee noted that more work was to be doen throughout the year but the progress in reducing 104 week waits etc had been very positive.

E) Clinical Support Services - CIP

- The committee reviewed the progress on the care groups CIP delivery
- They noted the clinical engagement that was demonstrated in identifying the financial plans.
- The committee were assured around the ownership of the plan and the progress in delivery.

For Approval

F) National Cost Collection Approval

- The committee reviewed the processes included in the national cost collection and approved their utilisation for the return.

For Information

G) Council Updates

- The committee noted the updates from:
  - CIP Council
  - Procurement Council

Risks noted/items to be raised at Board

Corporate objectives met or risks addressed: Finance and Performance
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 27th July 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Chairs Report for Trust Board

Paper No: NHST(22)059

Reporting from: Strategic People Committee

Date of Committee Meeting: 12th July 2022

Reporting to: Trust Board

Attendance:

- Lisa Knight, Non-Executive Director (Chair) (LK)
- Gill Brown, Non-Executive Director (GB)
- Ian Clayton, Non-Executive Director (IC)
- Rob Cooper, Director of Operations & Performance (RC)
- Sue Redfern, Director of Nursing, Midwifery & Governance (SR)
- Gareth Lawrence, Deputy Director of Finance & Information (GL)
- Claire Scrafton, Deputy Director of HR & Governance (CS)
- Malise Szpakowska, Deputy Director of HR (MS)

Apologies:

- Anne-Marie Stretch, Deputy CEO/Director of HR (AMS)
- Nicola Bunce, Director of Corporate Services (NB)

In Attendance:

- Laura Codling, Assistant Director of Workforce Development & Resourcing (LC)
- Alexandra Baker, Head of Strategic Resourcing (AB)
- Hayley McCann, Senior HR Administrator/PA (HM)

Matters Discussed

- <u>SPC future dashboard</u>
  This was designed to provide assurance to Trust Board that all key workforce metrics have the oversight of the committee. Additional metrics may be added following feedback from the Council, such as:
  - Staff Survey
  - Mandatory training
  - Covid sickness
  - Reasons for leaving
  - Demand and capacity
  - Top 5 reasons for sickness broken down by staff group

  SPC would also like regular updates on ED&I KPI's e.g.: Gender pay, WRES & WDES. An update on the dashboard will be presented at the next meeting.

- Workforce Development – Operational plan
  The following details were highlighted as part of this plan:
  - Clinical Models of Care
  - Workforce Planning
  - Widening Participation
  - Career Pathways

- Recruitment & Retention - Operational plan
  This was plan included details around the following:
  - Retention
  - Recruitment
  - Routes into Health Care
  - Attraction

  There was an action to consider opportunities for improved marketing of STHK as an employer of choice

- Health, Work & Wellbeing – Operational plan

This plan focuses on three distinct areas called ''foundations'' which form part of the overall NHS people plan pillar ''looking after our people''. These three foundations are as follows:

1. Health, Work and wellbeing services
2. NHS and Trust people plans
3. COVID-19 recovery people plan

- Trust Board objectives/People Plan Strategy

An action plan update was delivered for Q1 2022/23, This will be monitored by the People Council quarterly with the first period Q1 of achievements and BRAG rating being updated and presented to the People Council on the 20th July 2022. Further updates will be delivered in the next SPC meeting.

- Employee Relations Oversight Group

Complexity of cases and availability of management/investigator and HR resources is impacting on time to conclude cases. A further update will be given at the next SPC meeting.

- Chairs reports from People Council meetings April - June 2022

These were added to the Papers and received before the meeting.

- Meeting effectiveness review report was reviewed, and actions noted

Assurance Provided:

- SPC future Dashboard
- Trust objectives/People Plan Strategy – Action Plan update – Q1 2022/23
- Employee Relations Oversight Group

Decisions Taken:

The following Operational Plans that support the Trust People Strategy 2022 – 2025 were approved by the SPC:

Workforce Development – Operational plan 2022 - 2025
Recruitment & Retention - Operational plan 2022 - 2025
Health, Work & Wellbeing – Operational plan 2022 – 2025

Risks identified and action taken:

- No risks were identified

Matters for escalation: None noted

Recommendation(s):

- That the Board receives and notes the report.

Committee Chair: Lisa Knight

Date of Meeting: 12th July 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)060
Title of paper: Data Security and Protection Toolkit (DSPT) - Final Submission Report 2021/22
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Teaching Hospitals Trust operates within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.
Summary: This Report summarises the Trust's status of the Data Security and Protection Toolkit (DSPT) for its 2021 -22 submission. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to and process patient / personal data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly and in line with data protection legislation. When considering data security as part of the 'Well Led Key Line of Enquiry' as part of the Care Quality Commission (CQC) inspections, they will consider how organisations are assuring themselves against these standards. The submission date for the DSPT is now the end of June and there are no plans to move it back to the month of March (as it was up until 2020). The Trust has submitted the DSPT assessment at the end of June 2022 for the 2021-22 submission and was able to submit evidenced items for all the assertions as required as part of the submission, the Trust achieved a "standards met" rating for the submission. Mersey Internal Audit Agency (MIAA) have audited a number of the assertions and evidenced items. The Trust has received the rating of 'Substantial Assurance' against its DSPT.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: *None directly from this report.*
Stakeholders: *Staff, Patients, Executive Committee, Trust Board and Commissioners.*
Recommendation(s): • The Board to note and approve the content of this paper. • Be assured that robust arrangements are in place to support a successful submission of the DSPT.
Presenting officer Christine Walters, Director of Informatics/SIRO
Date of meeting: 27th July 2022

Introduction

The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. It is based on the National Data Guardian ten data security standards (covering topics such as staff responsibilities and continuity planning (National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) and legal rules relevant to IG and personal data (UK General Data Protection Regulation 2016 and the Data Protection Act 2018).

All organisations that have access to and process patient / personal information must provide assurances that they are practising good information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The DPST this year contained 109 mandatory 'assertions' that required evidencing. Each mandatory requirement has to be addressed in order to submit a successful assessment - if this was not achieved the Trust would have been considered non-compliant.

The DSPT submission date up until 2020 had always been the end of March, this has now changed and is the end of June. The Trust submitted a successful DSPT before the deadline and met all mandatory requirements.

Larger organisations, such as Acute Trusts, are also required to have their DSPT submission externally audited to ensure the accuracy of their submission. The objective of this exercise is to provide independent assurance over a nationally determined sample of evidence items and to highlight areas for improvement to inform the 2022-23 DSPT submission.

Failure to complete the DSPT can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact the Trust's ability to bid for new services in the future. In addition could place the Trust's reputation at risk. The Information Commissioner has also indicated that satisfactory completion of the DSPT can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2021/22 Submission

Evidence has been provided for the self-assessment against the 10 standards and the associated assertions that sit under each standard. These items are recorded under assertions and represent an indicator of maturity in that area. There are in 109 mandatory assertion items that require evidence.

For example, in order to comply with part of Section 1 for 'Personal Confidential Information', the Trust has to provide evidence for the assertions as detailed below:

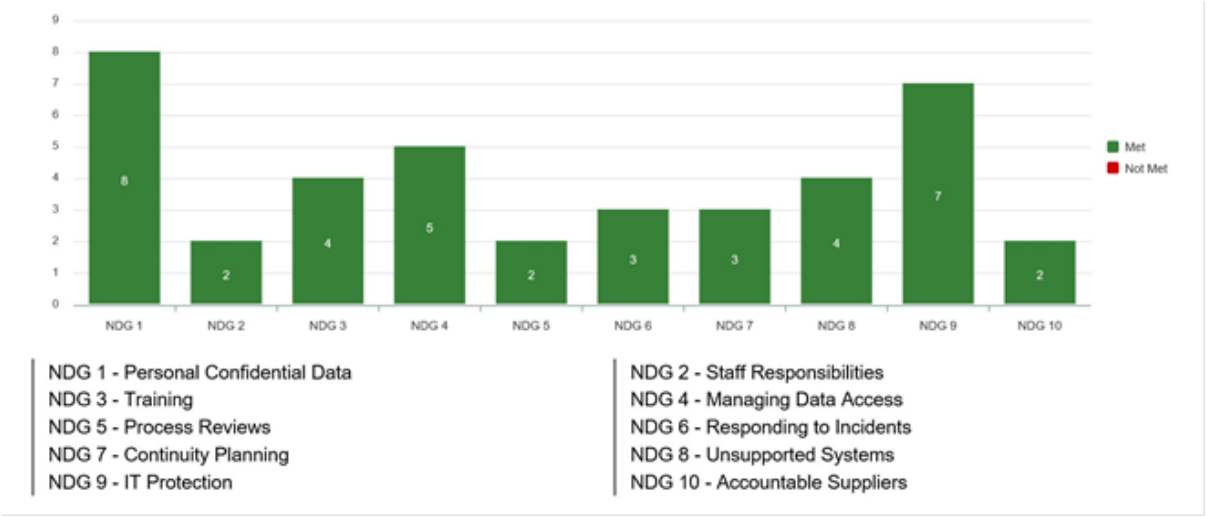
1.1	There is senior ownership of data security and protection within the organisation.		
1.1.1	Has SIRO Responsibility for data security been assigned?	Mandatory	**COMPLETED**
1.1.2	List the names and job titles of your key staff with responsibility for data protection and/or security.	Mandatory	**COMPLETED**
1.1.3	Are there clear lines of responsibility and accountability to named individuals for data security?	Mandatory	**COMPLETED**
1.1.4	Is data security direction set at board level and translated into effective organisational practices?	Mandatory	**COMPLETED**

1.2	There are clear data security and protection policies in place and these are understood by staff and available to the public		
1.2.1	Are there board-approved data security and protection policies in place that follow relevant guidance?	Mandatory	**COMPLETED**
1.2.3	How are data security and protection policies made available to the public?		**COMPLETED**

1.8	There is a clear understanding and management of the identified and significant risks to sensitive information and services		
1.8.1	Does your organisation operate and maintain a data security risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility?	Mandatory	**COMPLETED**
1.8.3	What are your top three data security and protection risks?	Mandatory	**COMPLETED**

For the Trust to have achieved “standards met”, the Trust has had to complete all of the items in the DSPT. Our baseline assessment was submitted to NHS Digital in March 2022.

The Trust has successfully completed the DSPT in time for the end of June 2022 submission date. A summary of how the 2021/22 submission looked is shown below:

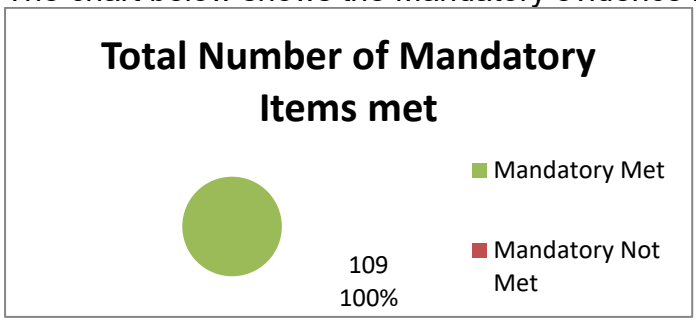


The table below shows the status of **Mandatory** evidence items met applicable for the Trust:

Data Standard	Number of Requirements	IT Sec Owner	IG Owner	DQ Owner	Total Evidence item provided
1	20	7	11	2	20/20
2	2	0	2	0	2/2
3	7	2	5	0	7/7
4	13	12	1	0	13/13
5	1	1	0	0	1/1
6	14	11	3	0	14/14
7	9	9	0	0	9/9

8	12	12	0	0	12/12
9	28	28	0	0	28/28
10	3	2	1	0	3/3
Total	109	84	23	2	109

The chart below shows the Mandatory evidence items met:



Summary of Results:
Total Number of Data Standards = 10
Total Number of Mandatory Evidence Items required = 109
Total Number of Mandatory Evidence Items achieved = 109

DSPT Approval

In order to submit and publish the DSPT once all evidence has been provided the SIRO must provide final approval. On the 28th June, the IG Team presented the SIRO with the evidence that had been provided for the DSPT. The SIRO has approved the submission of the DSPT for 2021/22, subject to recommendation from MIAA being actioned.

Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of the Trust's DSPT submission (as required of larger NHS organisations) during two visits in April and May 2022 to assess the Trust's compliance against these standards. MIAA audited assertions which covered each data security standard of the DSPT including, Personal Confidential Data, Staff Responsibilities, Business Continuity Planning and Unsupported Systems. These areas cover thirteen assertions (see below) which this year have been selected by NHS Digital. Due to the involvement of NHS Digital the audits have changed significantly with additional evidence and assurance required in all areas being reviewed. The scope of the review included mandatory elements only.

Area	Description
1.3	Accountability and Governance in place for data protection and data security
2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards

3.4	Leaders and Board members receive suitable data protection and security training
4.1	The organisation maintains a current record of staff and their roles
4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems
4.5	You ensure your passwords are suitable for the information you are protecting
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents.
6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents.
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.
8.3	Supported systems are kept up-to-date with the latest security patches.
9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities
10.1	The organisation can name its suppliers, the products and services they deliver and the contract durations

The Trust received the audit report from MIAA in June which has confirmed a rating of ‘Substantial Assurance,’ this is the same as last year.

Substantial Assurance

The Trust was also assessed against the risk rating score at the National Data Guardian Standard level.

National Data Guardian Standard level	Overall assurance rating at the National Data Guardian level
1. Personal Confidential Data	Substantial
2. Staff Responsibilities	Substantial
3. Training	Substantial
4. Managing Data Access	Substantial
5. Process Reviews	Substantial
6. Responding to Incidents	Substantial
7. Continuity Planning	Substantial
8. Unsupported Systems	Substantial
9. IT Protection	Substantial
10. Accountable Suppliers	Substantial

An assessment as to the veracity of the organisation's self-assessment / DSPT submission and the assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

As a result of the above, the overall assurance level across all 10 National Data Guardian Standards is rated as:

Substantial Assurance

Recommendations received from MIAA Audit Report

MIAA have identified the following areas that will require further attention in 2022-23. An action plan is in place with assigned owners and dates to ensure these areas are actioned. The action plan has been presented to the SIRO at the Information Governance Steering Group in July:

Assertion	Recommended Areas Requiring Improvement
1.3.5	Formally document processes for the identification, reporting and management of third party / supplier risks are ensure processes are linked to the corporate risk management framework
4.1.2	Ensure the master information asset register is updated and that Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) are aware of and understand their role and responsibilities for user management for the assets they have responsibility for.
4.5.3	Multi-Factor Authentication was enabled in some areas, e.g., for privileged users. It is recommended that the Trust considers its future strategy to expand use for users accessing the Trust's network externally / for web-based applications.
6.3.4	An assessment of which systems may be attractive to cyber criminals and fraud should also be completed.
8.3.1, 8.3.3, 8.3.4 & 9.3.6	Review and update the Patching Policy and or Network Security Policy to ensure it includes explicit requirements for encryption and for updating network infrastructure such as switches and firewalls. The process for managing CareCERTs should also include the steps for when to complete a risk assessment, alert and / or seek approvals from the SIRO.
9.3.8	Document plans for the completion of further network segregation and continue to mature and embed processes for the identification and management of all smart / medical devices that are / capable of connecting to the Trust's network
4.1.2, 9.3.8 & 10.1.1	Registers / systems used for recording and managing assets, medical devices and contracts should be reviewed, updated and fully populated with cross-department working arrangements in place to ensure robust governance and joined up processes

Conclusion

The Trust continues to build and improve on the Information Governance and IT Security foundations which have been embedded. This is demonstrated by successful completion of the Data Security and Protection Toolkit and a positive audit.

Report Ends.

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)061
Title of paper: Review of the Board Assurance Framework (BAF) – July 2022
Purpose: For the Trust Board to review and agree any changes to the BAF.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in April 2022. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** Risk 1 - given the continued operational challenges, the increase in COVID cases resulting in potential delays in urgent care and cancellations of elective procedures it is proposed that the score should remain at 20. Risk 2 – now that the Trust has agreed an operational plan with the ICB that it believes is achievable, it is proposed that the score for this risk is reduced to 12.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE/I, CQC, ICB
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 27th July 2022

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

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

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Original Risk Score	Key Controls	Sources of Assurance	Current Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with ~~lead CCG~~ • NHSE/I Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20	Development of a revised Clinical Strategy 2022/23 (September 2022)	Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, claims, inquests and mortality reviews ~~Development of the Nursing Strategy – currently subject to consultation (Now planned for May 2022)~~ Revise the maternity performance dashboard in line with Ockenden recommendations (October 2022)	Delivery of never event improvement plans and human factors training (Revised to September 2022) Deteriorating patient improvement project (revised to September 2022) Birth Rate Plus review of maternity staffing (report delayed now scheduled for August 2022) ~~Undertake self-assessment against the recommendations of Ockenden 2 and develop the Trust action plan (May 2022)~~ Improve mandatory and core skills training compliance (Revised to October 2022) Delivery of the 2022/23 CNST Maternity Safety Bundle (March 2023)	5 x 1 = 5	PW/ SR

Risk 2 – Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans. ~~two year operational plans and the agreed control total~~ • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • ~~Failure to respond to new models of care (FYFV)~~ • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSE/I Single Oversight Framework rating Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports (Inc. GIRFT) • Annual audit programme • CQUIN monitoring Other; • NHSE/I & ICB monthly reporting • Contract Monitoring Board • NHSE/I & ICB Review Meetings • Use of Resources reviews • Contract Review Boards • St Helens Place Based Partnership Board • ICB Reporting & Peer to Peer Reviews • Financial sustainability self-assessment	~~4 x 4 = 16~~ 4 x 3 = 12	Continue collaboration across C&M to deliver transformational CIP contribution	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances	Seek all possible sources of capital funding including national bids to support capacity planning (Ongoing) Continue to monitor impact of COVID-19 on elective recovery plans and achievement of planned ERF income (revised to September 2022 as national ERF allocation criteria not published) Delivery of the agreed 2022/23 financial plan (March 2023)	4 x 2 = 8	GL

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit reps • ICB CEO Meetings • CQC System Reviews e.g. Halton, Liverpool • ~~COVID-19 EPRR operational command and control structure in place~~	4 x 5=20	Implementation of routine capacity and demand modelling	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow ~~for winter 2021/22 and beyond~~ COVID-19 and restoration escalation plans to release capacity and trigger mutual aid in place and operational. Assurance that there is sufficient system response to operational pressures and delayed discharges	Widnes UTC ICB Review (September 2022) Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) ~~Major Incident Escalation and Business Continuity Plans in response to COVID-19 Omicron surge (On going)~~ Optimise utilisation of the discharge lounge to support patient flow (September 2022) Develop capacity and escalation plans for winter 2022/23 & for future sustainability (September 2022) Deliver the 2022/23 waiting list reduction and recovery targets (March 2023) Maintain capability to respond to future waves of COVID with minimum disruption to other services (March 2023)	4 x 3 = 12	RC

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

Risk 5 – Failure to work effectively with stakeholders	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • CCG Representative attending StHK Board and Trust NED attending Governing Body • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSE/I Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M ICB leadership and programme boards • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care partnerships in these Boroughs • Annual staff engagement events programme • ~~COVID -19 Command and Control structure and Hospital Cell~~ • ED&I Steering ~~Delivery~~ Group	4 x 3 = 12	~~Work with the local Boroughs to develop plans for Place Based Partnerships (PBP) from July 2022~~ Effective working with the Shaping Care Together programme in Southport and Formby and West Lancashire	C&M Integrated Care System performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks Understanding of the performance monitoring systems that will be established under the new NHS Bill. ~~that comes into effect on 1st July 2022~~	~~Continue participation with the Collaboration at scale board and work streams (Suspended due to COVID-19)~~ Continued engagement with C&M ICB senior leadership as part of the system response to COVID-19 and restoration and recovery. Continue as a full partner of St Helens Place Based Partnership, contributing to the delivery of the improvement objectives Work with NHSE and other Providers to provide management support for S&O fragile services (March 2023) Work with NHSE/ICB and national colleagues to progress the formal transaction with S&O (April 2023)	4 x 2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management Strategy	To Board; • Strategic People Committee • People Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce operational plans • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • National Quarterly Pulse Surveys ~~Staff F&FT~~ snapshots • WRES , WDES and Gender Pay Gap reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Group Other • HR benchmarking • Nurse & Midwifery staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment	5 x 4 = 20	Equality Delivery System 2 – action plan (Next due 2024)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3 Capacity to deliver the recovery and restoration plans for activities suspended due to COVID-19 ~~Attendance management COVID-19 recovery plan~~ Establish diagnostic collaborative bank Develop sustainable COVID vaccination programme staffing arrangements for C&M (September 2022) ~~Mandatory training and appraisal compliance 85% recovery plans and detailed dashboards for managers~~	Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going) ~~C&M Lead Provider role for the COVID vaccination programme – including planned winter booster programme for staff and the school aged Children's vaccination programme (On going)~~ Restoration of appraisal and mandatory training compliance with the 85% target (March 2023) Refresh the ED&I operational plan and action plan (Revised to October 2022) Deliver the staff survey action plan (March 2023)	5 x 2 = 10	AMS

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

Risk 8 – Major and sustained failure of essential IT systems	Original Risk Score	Key Controls	Sources of Assurance	Current Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Careflow/DAP benefits realisation programme monitoring	4 x 4= 16	Annual Corporate Governance Structure review Technical Development	ISO27001 Service Improvement Plans IT Communications Strategy Digital Maturity Assessment	ISO27001 (revised to December 2022) Achieve HIMMS Level 5 (November 2023) Achieve minimum digital foundation standards (March 2025) Migration from end-of-life operating systems – PC replacements completed and Server Programme remaining (December 2022) Delivery of the EPR Digital Maturity Programme (revised to March 2025) Delivery of Community EPR (December 2022) Respond to cyber threat alerts (including Log4J and the war in the Ukraine) and update systems as required (on going) Test major incident and data recovery plans (January 2023)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)062

Title of paper: Corporate Risk Register Report – July

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

Summary:

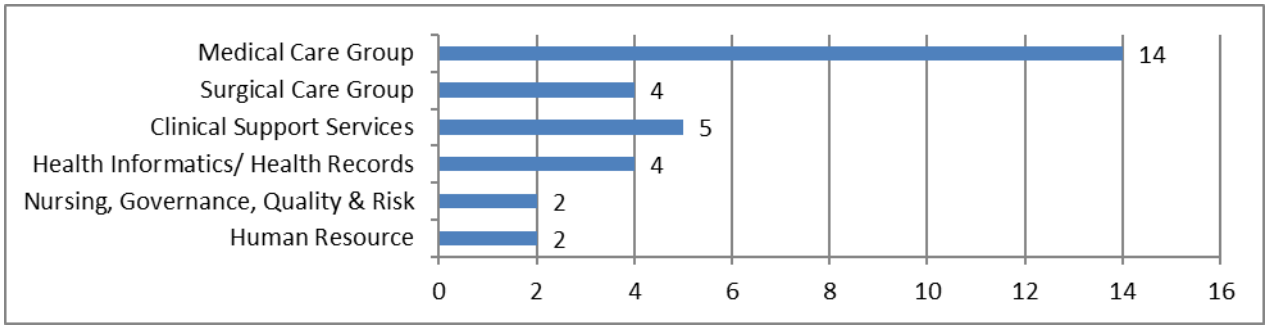
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

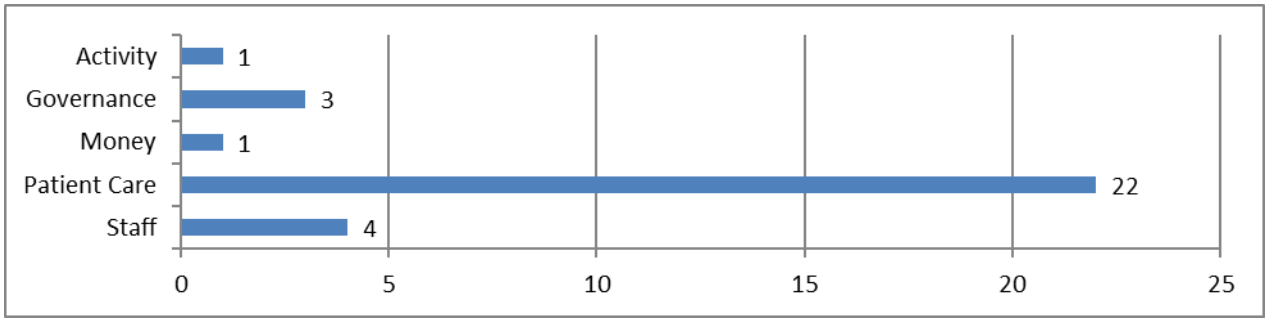
This report (appendix 1) is based on Datix information and covers the risks reported and reviewed during June 2022. The report shows;

- The total number of risks on the risk register was 811 compared to 806 in April. This includes the new 2022/23 CIP risks added to the risk register.
- 57.83% (465) of the Trusts reviewed risks are rated as moderate or high compared to 57.10% (450) in April.
- There are 31 high/extreme risks (appendix 2) that have been escalated to the CRR compared to 30 in April.

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



The risk categories of the CRR risks are;



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

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

Financial implications: None directly from this report.

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

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 27th July 2022

Appendix 1

CORPORATE RISK REGISTER REPORT – JULY 2022

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/07/2022	Previous Reporting Period 01/06/2022	Previous Reporting Period 03/05/2022
Number of new risks reported	22	27	31
Number of risks closed or removed	36	8	21
Number of increased risk scores	5	6	3
Number of decreased risk scores	10	25	7
Number of risks overdue for review	50	64	137
Total Number of Datix risks	**811***	**827**	**809**

** Includes 7 risks that have been reported but not yet scored or approved in DATIX as it is a live system*

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

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
29	**35**	**18**	**91**	**9**	**157**	**72**	**172**	**35**	**155**	**8**	**12**	**10**	**1**
82 = 10.20%			**257 = 31.97%**			**434 = 53.98%**				**31 = 3.86%**			

**Based on 804 scored risks*

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

2.1 Surgical Care Group – 168 risks reported 20.89% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**6**	**2**	**12**	**3**	**35**	**21**	**41**	**10**	**34**	**1**	**2**	**1**	**0**
8 = 4.76%			**50 = 29.76%**			**106 = 63.10%**				**4 = 2.38%**			

2.2 Medical Care Group – 126 risks reported 15.67% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**6**	**0**	**9**	**1**	**24**	**5**	**21**	**14**	**22**	**3**	**3**	**7**	**1**
16 = 12.70%			**34 = 26.98%**			**62 = 49.21%**				**14 = 11.11%**			

2.3 Clinical Support Care Group – 122 risks reported 15.17% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**5**	**3**	**16**	**0**	**24**	**11**	**24**	**5**	**23**	**3**	**1**	**1**	**0**
14 = 11.48%			**40 = 32.79%**			**63 = 51.64%**				**5 = 4.10%**			

2.4 Primary Care and Community Services Care Group – 54 risks reported 6.71% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
3	**0**	**0**	**6**	**0**	**7**	**5**	**12**	**3**	**18**	**0**	**0**	**0**	**0**
3 = 5.56%			**13 = 24.07%**			**38 = 70.37%**				**0**			

2.5 Corporate – 334 risks reported 41.54% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**18**	**13**	**48**	**5**	**67**	**30**	**74**	**3**	**58**	**1**	**6**	**1**	**0**
41 = 12.27%			**120 =**			**165 = 35.92%**				**8 = 2.39%**			

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

	High	Moderate	Low	Very low	**Total**
Health Informatics/ Health Records	4	17	19	4	**44**
Facilities (Medirest/TWFM)	0	11	15	7	**33**
Nursing, Governance, Quality & Risk	2	19	12	4	**37**
Finance	0	11	20	8	**39**
Medicines Management	0	26	30	5	**61**
Human Resource	2	81	24	13	**120**
Total	**8**	**165**	**120**	**41**	**334**

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

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

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

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies, **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	24/06/2022	4 x 2 = 8	✓	Strategic People Committee
2	Operational Risk	767	**If** ED are unable to recruit to nursing vacancies and maintain nursing establishment **then** there is a risk to patient safety	4 x 5 = 20	4 x 5 = 20	26/01/2022 Sue Redfern	13/06/2022	4 x 2 = 8	✓	Strategic People Committee
3	Patient Care	935	**If** the breast service experiences an increase in referrals that exceeds capacity, **then** the two week cancer referral target may not be achieved	3 x 5 = 15	4 x 4 = 16	05/11/2021 Rob Cooper	16/02/2022	3 x 4 = 12	✓	Finance & Performance Committee
4	Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 4 = 16	3 x 5 = 15	17/03/2020 Sue Redfern	20/05/2022	4 x 2 = 8	✓	Executive Committee
5	Money	1152	**If** there is an increase in bank and agency, **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	24/06/2022	4 x 3 = 8	✓	Finance & Performance Committee
6	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	13/06/2022	4 x 3 = 12	✓	Executive Committee
7	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance, **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	29/04/2022	4 x 2 = 8	✓	Finance & Performance Committee
8	Patient Care	1896	**If** the AMU and SDEC assessment bay spaces on 1B are utilised for overnight patient stays **then** there is a risk to maintaining patient flow through ED and 1B, patient safety and experience	3 x 3 = 9	3 x 5 = 15	16/05/2022 Rob Cooper	13/06/2022	3 x 2 = 6	✓	Quality Committee
9	Staff	1944	**If** the Dermatology Consultant workforce is not sufficient **then** there is a risk to patient safety, care and experience.	4 x 3 = 12	4 x 4 = 16	18/11/2021 Peter Williams	29/06/2022	4 x 2 = 8	✓	Strategic People Committee
10	Patient Care	2080	**If** the Emergency department is congested with lack of flow, **then** there is an increased likelihood of patients being cared for on the corridors which will affect Patient privacy and dignity, safety, quality of care, Patient experience, Staff morale, and Ambulance Turnaround compliance	5 x 4 = 20	4 x 5 = 20	03/11/2021 Rob Cooper	13/06/2022	3 x 2 = 6	✓	Executive Committee
11	Patient Care	2082	**If** there is no robust established daily process for review of all medical patients who remain in the ED/EAU due to the lack of an available bed on the ward, **then** this can result in patient safety and experience issues	4 x = 12	3 x 5 =15	27/05/2022 Peter Williams	13/06/2022	3 x 2 = 6	✓	Quality Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
12	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	13/06/2022	2 x 2 = 4	✓	Quality Committee
13	Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels, **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 3 = 12	4 x 5 = 20	09/12/2021 Rob Cooper	13/06/2022	2 x 4 = 8	✓	Executive Committee
14	Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts, **then** there will be a risk to the quality of patient care	4 x 4 = 16	5 x 5 = 25	30/03/2020 Rob Cooper	10/12/2021	3 x 2 = 6	✓	Strategic People Committee
15	Patient Care	2545	**If** the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, **then** there is a risk that compliance with this standard may not be maintained	4 x 4 = 16	4 x 4 = 16	21/07/2021 Sue Redfern	23/06/2022	4 x 2 = 8	✓	Quality Committee
16	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient for diagnostic imaging results	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	06/05/2022	5 x 2 = 10	✓	Quality Committee
17	Patient Care	2767	**If** inpatient maternity staffing shortfalls persist **then** there could be a negative impact on patient safety. It will also have an impact on patient experience. Inpatient maternity staffing shortfall	3 x 3 = 9	3 x 5 = 15	23/03/2022 Sue Redfern	23/06/2022	2 x 3 = 6	✓	Quality Committee
18	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.	5 x 4 = 20	5 x 4 = 20	21/10/2020 Rob Cooper	24/06/2022	5 x1= 5	✓	Quality Committee
19	Patient Care	2964	**If** there are not sufficient dieticians to meet the increased incidence of gastro-intestinal cancers, **then** this could impact on their treatment outcomes	3 x 5 = 15	3 x 5 = 15	13/10/2020 Sue Redfern	17/06/2022	3 x 1 = 3	✓	Strategic People Committee
20	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	27/06/2022	3 x 2 = 6	✓	Executive Committee
21	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas, **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	27/10/2020 Sue Redfern	14/06/2022	3 x 2 = 6	✓	Executive Committee
22	Staff	3178	**If** there are not sufficient staff in post in blood sciences, **then** there is a risk to service delivery	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	23/06/2022	4 x 2 = 8	✓	Strategic People Committee
23	Patient Care	3180	**If** the Trust cannot secure sufficient staff to undertake supplementary care for the patients who need it, **then** there is a risk to the quality and safety of care	4 X 5 = 20	4 x 4 = 16	21/07/2021 Sue Redfern	14/06/2022	4 x 2 = 8	✓	Strategic People Committee
24	Patient Care	3199	**If** medical patients are to 'forward wait' on a medical ward **then** there is a risk to patient safety, dignity, and experience	4 x 4 = 16	4 x 4 = 16	02/11/2021 Sue Redfern	13/06/2022	4 x 1 = 4	✓	Executive Committee
25	Patient Care	3251	**If** the current end of life solution for outpatient letter printing fails before a replacement system is implemented, **then** there is a risk that letters will be delayed or could impact other EPR functionality	4 X 5 = 20	4 X 5 = 20	21/10/2021 Christine Walters	25/04/2022	1 x 1 = 2	✓	Executive Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
26	Governance	3298	**If** the Trust is impacted by the cyber threat Apache Log4J, **then** Trust systems could be accessed and exploited.	4 x 4 = 16	4 x 4 = 16	14/12/2021 Christine Walters	25/04/2022	3 x 3 = 9	✓	Executive Committee
27	Governance	3302	**If** the Trust does not centralise the Subject Access Request process and ensure Information Governance is part of this process, **then** there is a risk data breaches will continue to occur, and the Information Commissioner's Office (ICO) will issue further warnings. Centralising the Subject Access Request Process due to ICO Infringement Order	4 x 4 = 16	4 x 4 = 6	15/12/2021 Christine Walters	23/06/2022	2 x 2 = 4	✓	Executive Committee
28	Patient Care	3349	**If** the stock of Olympus scopes is not maintained, **then** there is a risk to business continuity for the endoscopy service	4 x 5 = 20	4 x 5 = 20	29/04/2022 Rob Cooper	13/06/2022	4 x 2 = 8	✓	Executive Committee
29	Patient Care	3371	**If** medical wards are to accommodate an additional patient due to insufficient medical beds, **then** there is a risk to patient safety, dignity and patient experience.	4 4 =16	4 x 4= 16	29/04/2022 Sue Redfern	23/05/2022	2 x 2 = 4	✓	Executive Committee
30	Patient Care	3444	**If** there is no defined pathway/process/policy or sufficiently trained nursing staff each shift for patients admitted to the Trust with a tracheostomy/laryngectomy (not requiring critical care support) **then** there is a risk to patient safety, quality of care and experience.	4 x 5 = 20	4 x 5 = 20	30/05/2022 Rob Cooper	18/06/2022	4 x 1 = 4	✓	Quality Committee
31	Patient Care	3470	**If** there is reduced therapy capacity to support Bevan Court/Ambulatory Care/Frailty, **then** there will be more delayed discharges	3 x 5 = 15	3 x 5 = 15	28/06/2022 Rob Cooper	28/06/2022	2 x 3 = 6	✓	Executive Committee

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

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

Risk Category	Datix Reference	Risk Description
Patient Care	2523	If the delivery suite staffing is not adequate, then there is a risk for patient safety.
Patient Care	3166	If Bevan Court 2 is unable to provide appropriate Registered Nurse & HCA levels for patient care then there is a risk to patient safety, quality of care and experience
Patient Care	3046	If Cardio-Respiratory is unable to provide sufficient staff to cover ECG provision throughout the whole of the Trust, then there is a risk to patient safety as ECG's are not undertaken in a timely manner.
Patient Care	1492	If the number of dermatology referrals for the 2ww cancer access target continue then there is a risk to patient, safety, experience and clinical effectiveness
Patient Care	3057	If the stroke service does not have 8 consultants in post, then there is a risk to the level of service provision based on predicted activity

Patient Care	3354	If the Trust cannot successfully introduce personalised supported self-management for high-risk skin cancer patients, then there is a risk that some patients will be lost to follow up

Trust Risk Profile – April 2022

Comparison of the Trust risk profile in the last Board Report

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

Trust Risk Profile – July 2021

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

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
13	**22**	**16**	**70**	**8**	**122**	**57**	**185**	**35**	**140**	**9**	**6**	**7**	**0**
51 = 7.39%			**200 = 28.99%**			**417 = 60.43%**				**22 = 3.19%**			

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)063

Title of paper: Learning from Deaths Quarterly Report Q3 & Q4 2021-2022

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

Summary:

	No. of reviews	*Green*	*Green with Learning*	*Green with positive feedback*	*Amber*	*Red*
October 2021	*39*	*14*	*5*	*5*	*0*	*0*
November 2021	*46*	*17*	*3*	*2*	*1*	*0*
December 2021	*46*	*17*	*3*	*3*	*0*	*0*
January 2022	*25*	*13*	*2*	*3*	*0*	*0*
February 2022	*17*	*9*	*3*	*0*	*0*	*0*
March 2022	*8**	*5*	*2*	*0*	*0*	*0*

**not yet reported in full*

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

Financial implications: None arising from this report

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

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

Presenting officer: Dr Elspeth Worthington – Assistant Medical Director

Date of meeting: 27th July 2022

1 EXECUTIVE SUMMARY

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

In Quarter 3 2021/22 a total of 131 SJRs were requested, to date 70 have been completed 69 of the reviews had an outcome of no concerns (Green, Green with learning/positive). 1 of the reviews had an amber outcome (a complex presentation involving a multifactorial delay in ECG in ED which led to cardiac arrest before all treatments had been initiated: local action is underway to address this).

In Quarter 4 2021/22 a total of 50 SJRs have been requested so far. All of those completed (37) and received an outcome of no concerns (Green, Green with learning/positive).

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

1.1. Shared learning for Q4

Alerts	**Recognition of the deteriorating patient**
The alert status for COVID risk and shielding is to be removed from the electronic records. This reiterates the need to check the alert status in every clinical interaction when highlighted to be aware of any additional needs / risks.	This starts at the patient's bedside, adhering to the NEWS2 policy and escalating accordingly. Everyone plays a role from the speciality teams – in hours and out of hours, from FY1 through to consultants, further supported by Medical Emergency Team and ICU.

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

1.2 Sharing and embedding learning

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

2. ANALYSIS

2.1 Total number of reviews completed for Q3 2021/22

	No. of reviews	Green	Green with Learning	*Green with positive feedback	Amber	Red
October 2021	*39*	*14*	*5*	*5*	*0*	*0*
November 2021	*46*	*17*	*3*	*2*	*1**	*0*
December 2021	*46*	*17*	*3*	*3*	*0*	*0*

2.1.1 Total number of reviews completed for Q4 2021/22

	No. of reviews	Green	Green with Learning	Green with positive feedback	Amber	Red
January 2022	*25*	*13*	*2*	*3*	*0*	*0*
February 2022	*17*	*9*	*3*	*0*	*0*	*0*
March 2022	*8**	*5*	*2*	*0*	*0*	*0*

**not yet reported in full*

2.2 Specified Groups breakdown for Q3 & Q4 2021/22 (See Appendix 1)

	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
Cardiac Arrest Death	4	2	7	4	4	1	22
Concern Death	1	0	0	0	0	0	1
CRAB Mortality Triggers	1	6	5	9	0	1	22
Diagnosis Group Death	9	0	6	0	0	1	16
Internal request (not included in any other category)	0	1	0	0	0	0	1
Learning Disabilities Death	3	3	3	1	1	1	12
Medical Examiner Referral	1	3	3	2	2	3	14
Post operative death	7	5	8	3	6	0	29
Random Selection Death	10	21	13	1	0	0	45
Severe Mental Illness Death	2	4	1	3	3	0	13
Total	38	45	46	23	16	7	175

2.3 Deteriorating patient project

There has been a successful appointment into the role of Deteriorating Patient Quality Improvement Lead (12 months secondment) - Julie White (currently a senior MET Nurse). It is hoped that she will start by mid-September 2022 and early initiatives will include building the wider governance structure with representation from all of the relevant specialist teams and extending the NEWS2 pilot work carried out on ward 2B, into all other wards. In addition, the clinical leads for both sepsis and MET are currently available for appointment. These roles are currently being amended to incorporate the deteriorating patient role and infection control respectively.

2.4 Projected changes to Learning from Deaths process

The current model of Trust Mortality Review at STHK was started in 2017 and is now fully embedded both as a stand-alone system and within the bigger Patient Safety and Serious Incidents process.

The learning now forms a regular part of the Trust communications system for wider distribution to clinical teams and can be evidenced in changes of practice and culture. The overall trajectory is of fewer serious issues identified through Mortality Governance; this reflects a combination of the learning and process changes already adapted and the improved recognition of concerns at or near the time of event, then being managed under the Patient Safety Framework.

The Structed Judgement Review (SJR) taken from the RCP guidance has formed the cornerstone of the mortality review process. However, each report is time consuming even when there are no gaps or lapses in care identified. Ongoing intense clinical pressures for the team of reviewers is unyielding with a negative effect on additional roles such as this. A strategy is afoot to modify the report by using 12 initial key questions and only then continuing to a full report if concern has been identified from these. By this system, a standard GREEN review should take approximately 10-15 minutes to complete, versus the current 40 minutes.

The questions are primarily taken from previous verified national mortality or harm review systems with an additional few relevant to specific patterns identified over earlier reviews at STHK since the outset of the process. As a pilot we have commenced using the system with 2 other reviewers in July / August 2022 and once ratified the remaining reviewers will transfer to this system in September / October 2022.

3 CONCLUSION AND RECOMMENDATIONS

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

- SJR process is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised. (Appendix 2)
- Where concerns have been identified these have received further peer review and escalated as appropriate.
- Improvements are to be made in the efficiency of the review process to ensure valued time can be spent on cases which identify concern without losing the safety of the review process.

Appendix 1

Total Deaths in Scope[1]

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

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

Appendix 2

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

Paper No: NHST(22)064
Subject: HR Indicators Report.
Purpose: This paper provides Trust Board with details of achievement of the delivery of the Trusts Workforce Strategy over the last four months April 2022 – July 2022 and provides an update for, and assurance on, the management of workforce matters during the Covid-19 pandemic and subsequent Covid-19 recovery plans.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce in line with our Trust objectives and in particular the commitments the Trust has made in terms of the NHS People Plan. This paper provides an update on workforce activity and achievements since Board received a HR Indicators Report in March 2022. In particular the report focusses on how the Trust has ensured the importance of the People Plan agenda and the actions the Trust has taken to ensure supply of an appropriately skilled workforce whose health, safety and wellbeing has continued to be a priority during the pandemic. The paper is aligned with the four pillars: 1. Looking after our people – with quality health and wellbeing support for everyone; 2. Belonging in the NHS – with a particular focus on the discrimination that some staff face; 3. New ways of working and delivering care – capturing innovation, much of it led by our NHS people 4. Growing for the future – how we recruit, train and keep our people, and welcome back colleagues who want to return Overall the paper summarises achievements/progress to date.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: None at this time
Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues
Recommendation(s): The Trust Board is requested to note the content of this paper and that actions are in place to ensure continued delivery of the Trusts Workforce Strategy
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Trust Board: 27 July 2022

HR Indicators Summary

1. Looking after our people

The Trust continues to prioritise the mental, physical and financial wellbeing of the workforce through; the ongoing delivery of wellbeing conversations, the production of a financial support booklet, signposting to financial support services, targeted face to face events and a continual focus on improving attendance rates.

The Absence Improvement Programme actively manage all sickness absence with; bi-weekly meetings, the introduction of a Long Covid steering group and manager guidance and improving access to Health work and wellbeing by reducing DNA rates from 18.9% to 14.9%. There has been an overall improvement in sickness absence this quarter (6.18%) however sickness due to Stress (29%), Chest & respiratory problems (23%) and MSK (9%) does continue to be a challenge.

Further planned support and interventions will continued to be monitored including the winter vaccination campaign and the wellbeing hub activity.

2. Belonging in the NHS

A business case for workforce investment into the Equality Diversity & Inclusion function was approved in June 2022. This will enable the Trust to deliver on its strategic ambitions, ensuring it remains well-led and at pace with the equality, diversity and inclusion agenda. As part of this investment a broad programme of training is being developed which will cover employment matters, HR policies and procedures.

In order to tackle disparities identified in the WDES the Trust has been consulting on a new Adjustments Passport to help staff and managers ensure the support needs of staff with disabilities and long-term health conditions are met. In addition, the Trust has partnered with the Business Disability Forum to develop bespoke training on reasonable adjustments for all clinical and non-clinical line managers.

A review of performance against the key indicators within the WRES identified a priority area of low to mid-grade nursing career progression. The Trust has invested in 18 places on the Royal College of Nursing's Cultural Ambassador Programme. This training will provide advocates for cultural and inclusion competence and provide independent perspective to formal procedures and recruitment processes.

3. New ways of working & delivering care

There are several workstreams which seek to bring about new ways of working and delivering care through the exploration of new roles and the upskilling of our existing workforce.

The Trust continues to expand the number of Advanced Clinical Practitioners (16) and a recent bid for funding has been submitted for 2 Anaesthetic Associates to begin study in January 2023.

A “new look” induction programme for Healthcare Support Workers who join the Trust has been developed in partnership with the senior nursing teams. This programme utilises the National Care Certificate and the Trust’s current training provision. The new programme will allow new to care Healthcare Support Workers to be ward ready at the time of deployment but will also ensure continued support is in place.

4. Growing for the future

The Strategic People Committee in June ratified the Recruitment and Retention Operational Delivery Plan which identified 4 key priorities to address the ongoing workforce challenges facing the health service; retention, recruitment processes, routes into healthcare and attraction.

Retention of our existing workforce remains a number one priority. This includes creating an employer brand and a better staff engagement infrastructure. Similarly maximising system capacity in recruitment process through automation, simpler recruitment processes and more inclusive interview assessments are also areas of focus.

Priorities		We will…
1	• Retention	Seek to understand why people leave STHK and support the organisation to reduce turnover
2	• Recruitment	Maintain safe and effective recruitment and innovate through new technology
3	• Routes into Healthcare	Improve our accessibility as an employer within our local community
4	• Attraction	We will create an employer brand that showcases STHK as the best place to work

In June the Trust is reporting an overall 15% turnover with the two highest reasons being resignation and retirement. Exit interview data shows that 73% of leavers would recommend the Trust as a place to work and it is a lack of job satisfaction and a feeling valued were the two reasons that influenced the individual’s decision to leave. A targeted piece of work is underway to gain feedback from staff members who have recently retired and returned to better streamline this process along with one-to-one retirement conversations to discuss career options.

The Trust has had recent success with targeted recruitment events and careers fairs providing opportunities for offers of employment on the day (156 offers). Monthly recruitment events will continue to take place throughout the year with the next one planned for August.

Finally, the Trust will welcome a further 20 International Nurses in July, who will join the 17 that have already arrived. Two further cohorts are due to join the Trust in September and November 2022.

END

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

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

This report outlines workforce data, action plans and progress to date. Typically, Trust Board receives this information on a six monthly basis, however due to operational pressures in the Trust the last report was presented in March covered an extended period (July 2021 – February 2022). This report covers the period **April 2022 – July 2022.**

Pillar 1 – Looking after our people

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

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

Pillar 1 – Looking after our people

Areas of focus

- **Financial wellbeing**– Dedicated communication and support available through: staff extranet, engagement app, hard copy printed book and events/sessions designed to support staff with all aspects of important and relevant financial wellbeing advice
- **Supporting our people through their health and wellbeing** continues to be an area of sustained activity and demand – with the department carrying out pre- employment checks (499), HWWB appointments (1,901) and management referrals (212) during this period.
- **Reducing DNA's in HWWB** is an ongoing particular area of focus. DNA performance has improved by 4.17% compared to the last reporting period, now at 14.8% as a direct result of sustained management of DNA activity and proactive scheduling.
- **The Wellbeing Hub** have delivered 58 sessions/events with 650 people attending, equating to an average of 11 staff per session. Our counsellors/MHN and Psychologists have seen 278 staff.
- **Improving attendance** - sickness overall has reduced to 6.18% compared to 8.47% in the last quarter. Stress (29%) remains the main cause of sickness absence with chest/respiratory related absence increasing at the height of the pandemic to 25%. HR and HWWB continue to meet bi-weekly to review absence matters to ensure that the wellbeing of staff remains a priority. Staff members who are absent due to sickness are being supported with welfare meetings and HWWB guidance. A Long COVID Steering Group have developed a guidance document for the management of staff with Long COVID.
- **Withdrawal of staff terms and conditions section of COVID-19 workforce –** as a result, from 1st September 2022; normal contractual sick pay arrangements will be reinstated for all staff regardless of sickness absence, covid-19 sick pay for covid-19 related absences and covid-19 special leave for self-isolation will be removed

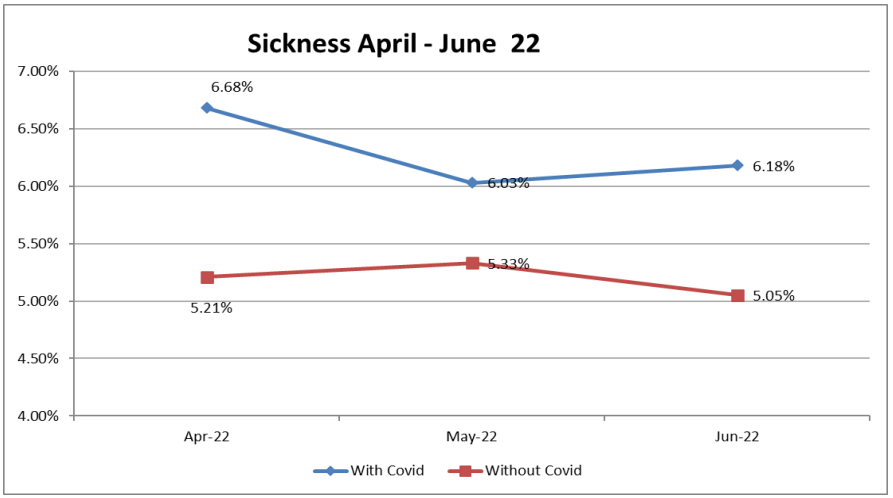
Progress To date

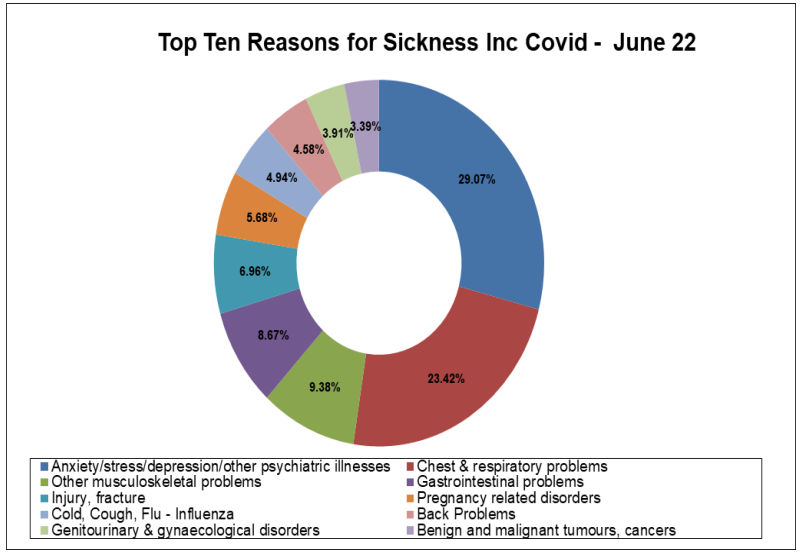
- **Wellbeing Dashboard** is in development as part of the newly devised NHSE framework and will form part of the Wellbeing Guardian role to present to trust executives on a bi-annual basis most, first completed report (1st April to 30th Sept 2022) to be reported by Oct/Nov 2022.
- **Wellbeing conversations** are continually being offered or accepted by staff via the appraisal totalling 273, these are also being offered throughout the wellbeing network
- **Covid-19 vaccination reporting** has ceased. The Trust is no longer mandated to provide data to PHE. Overall covid-19 vaccination status as at the end of April 2022 remained high at 93.80% first dose, 91.25% second dose, 76.49% third dose.
- **Flu vaccination campaign** 21/22 final result 72.06%. CQUIN Target re-introduced for 22/23, target range of 70-90%, current operational planning taking place with final plans to be submitted to Trust executives by the end of July 22.
- **Covid-19 Self isolation Hub** The Self-Isolation Hub had received a total of 561 staff referrals in this period with an average of approx. 69% positive rate.
    - Staff testing measures have reduced, PCR testing no longer required (with exception of high risk patients groups), LFD testing now the preferred method in self-testing. All communications have been updated and no current supply chain issues with regards to LFD's
- **HWWB SEQOHS** annual re-accreditation window commenced in June 2022 to Nov 2022, with the final outcome will be known by December 2022.

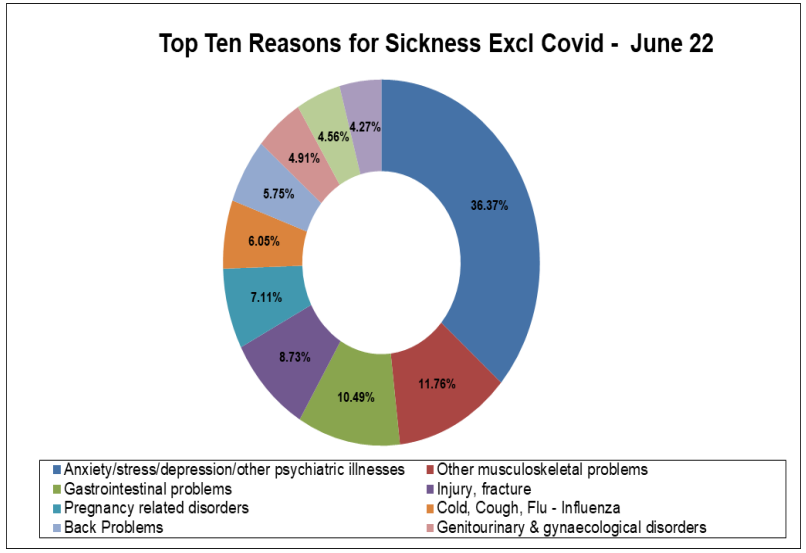
Areas of risk and mitigation

- **Sickness.** The efforts of the Absence Improvement Programme continue to reduce levels of sickness absence across all areas, challenging times remain due to the impact of Covid-19.

Pillar 1 – Looking after our people – Metrics and Activity







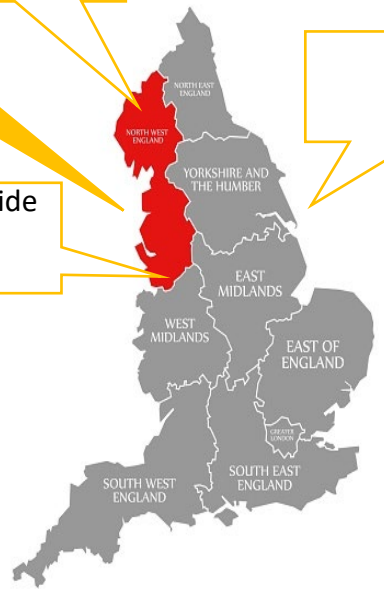
Regional sickness Including Covid
June 2022

North West
5.9%

STHK
6.18%
(with COVID)

National
4.8%

Cheshire & Merseyside Acute Trusts
5.4%

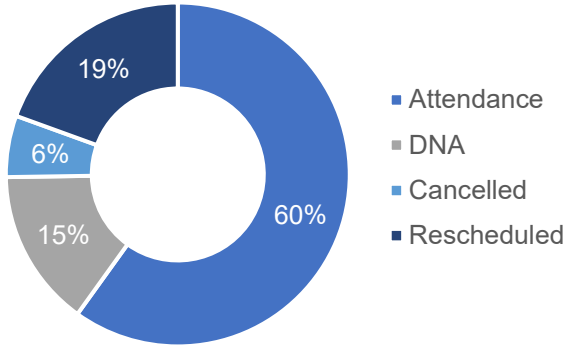


520
Pre-Employment Assessments

867
Appointments e.g. blood tests, dermatology, MMR vaccination

505
Management Referrals

Attendance Performance (StHK)



428
OH Advisor

77
OH Physician

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

Pillar 2 – Belonging in the NHS

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

- Trust Workforce Profile
- Data on Employee Relations Cases including the rise in the number of Employment Tribunal cases
- WRES and WDES update

Pillar 2 – Belonging in the NHS

Areas of Focus

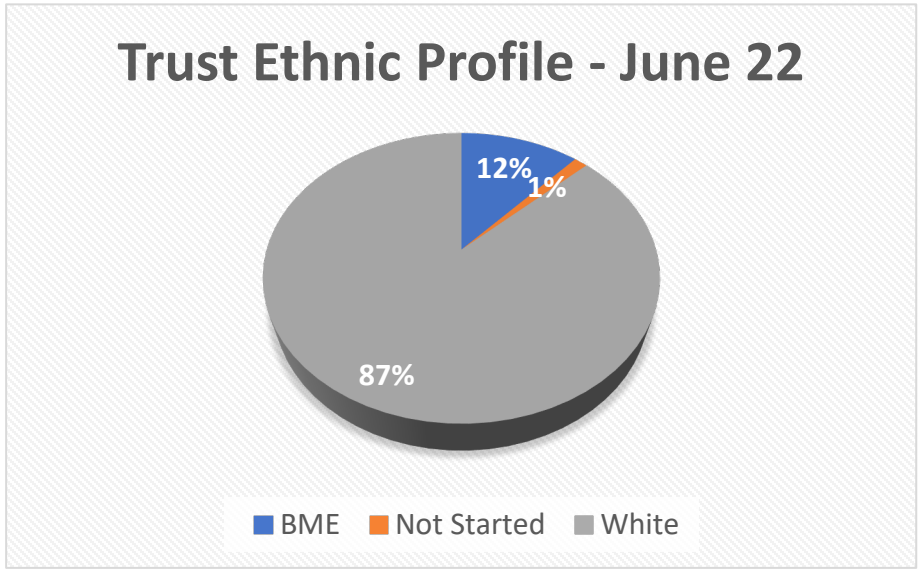
- **Compassionate and inclusive** leadership at all levels, through promotion of refreshed values and behaviours and bespoke training on how to support ED&I and an inclusive workforce..
- **Staff Survey** –Activity to improve workforce morale with a key focus on supporting Maternity, Theatres ITU and ED.
- As well as reviewing HR policies and introducing the 72 hour pause process (Just Culture), work is underway to develop and deliver an **education programme** to managers and employees with the aim of reducing the number of cases referred for formal investigation.
- **WDES:** Continued priority on meeting the needs of disabled staff across the WRES metrics including overall staff declaration of disability (2.95% against national target of 4%), proportion of staff having adequate adjustments in place (68% versus 75.5% for sector in 2021 Staff Survey), pressure to come to work unwell and equipping managers to support staff appropriately.
- **WRES –** activity to refresh objectives as new Bank and Medical WRESs coming.

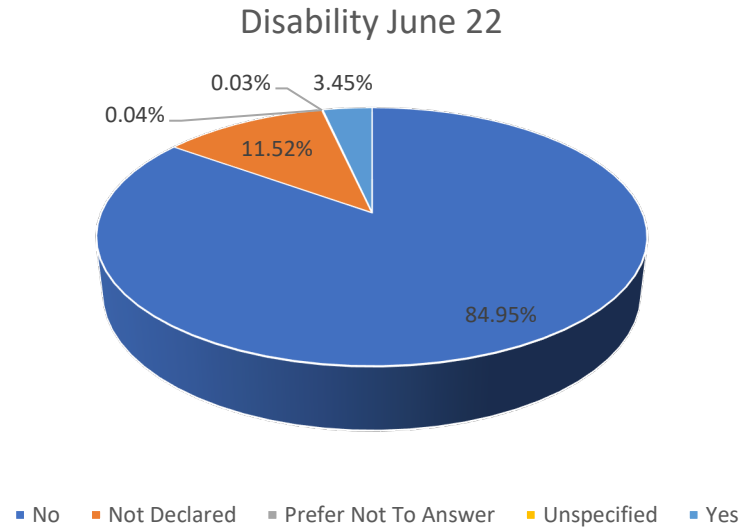
Areas of risk and mitigation

- **Developing Organisational Competency –** as a result of reviews of HR cases, staff surveys and actions from ED&I standards in relation to ED&I, a programme of action and intervention is being implemented to support clinical and non-clinical managers with updated policies and templates and a newly developed blended training programme to support compassionate and inclusive leadership.
- **Closing Disability Gaps –** the WDES Innovation Fund in-depth engagement project has been ongoing to identify barriers, needs and new approaches to best address the support needs of staff with disabilities. This has been supplemented by updated staff survey results for 2021 and will form part of an ongoing strategy.
- **Tackling the Disciplinary Gap** – a review of HR policies including the Grievance Procedure, 72 Hour Pause Process and participation in advocacy programmes.

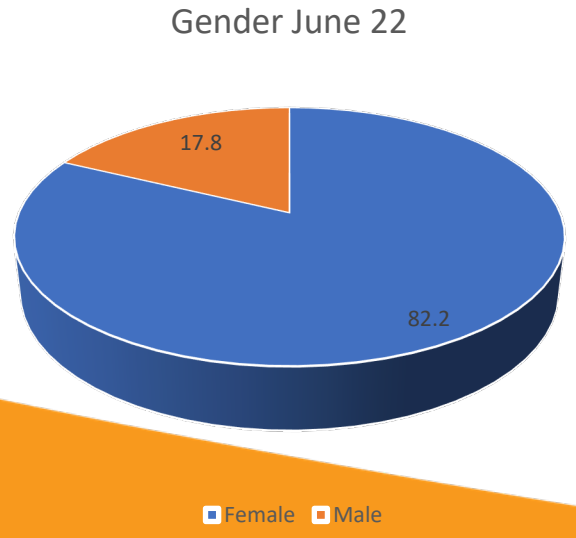
Progress to date

- The Trust has recognised that increased operational capacity is required to deliver the Trust's strategic ambitions and ensure that it keeps pace and remains well-led with regards to Equality, Diversity and Inclusion. A decision was made by the Executive Committee in June to make an **investment in resources** for the workforce EDI function to support this work.
- To support managers in meeting the requirements of a Well Led organisation and contribute to improving organisational performance and effectiveness **a broad programme of training covering employment matters** is being developed in partnership with the Trust solicitors.
- **WDES** – to tackle disparities identified in the WDES indicators and 2021 Staff Survey, consultation has been taking place on a new Adjustments Passport to support staff and managers in ensuring the support needs of staff with disabilities and long term health conditions are met, the Trust has partnered with **the Business Disability Forum** to develop bespoke training on reasonable adjustments for all clinical and non-clinical line managers from July to support the Passport, and staff are being encouraged to update their personal information in a rolling programme of popups on ESR.
- **WRES** – a review of performance against the key indicators is underway, supported by new local analytics from the WRES national team. Action toward addressing priority area of low to mid-grade career progression includes the Trust investing in 18 places on the Royal College of Nursing's **Cultural Ambassador (CA) Programme,** aimed at training advocates for cultural and inclusion competence to provide independent perspective for formal procedures and recruitment processes.
- **HR Policies** – As well as reviewing the current status of all HR policies, a tracker has been created in order to monitor the review timelines with the aim reviewing all policies by March 2023. Most recently the Personal Relationships at Work Policy has been through the governance process and approved at People Council in June.

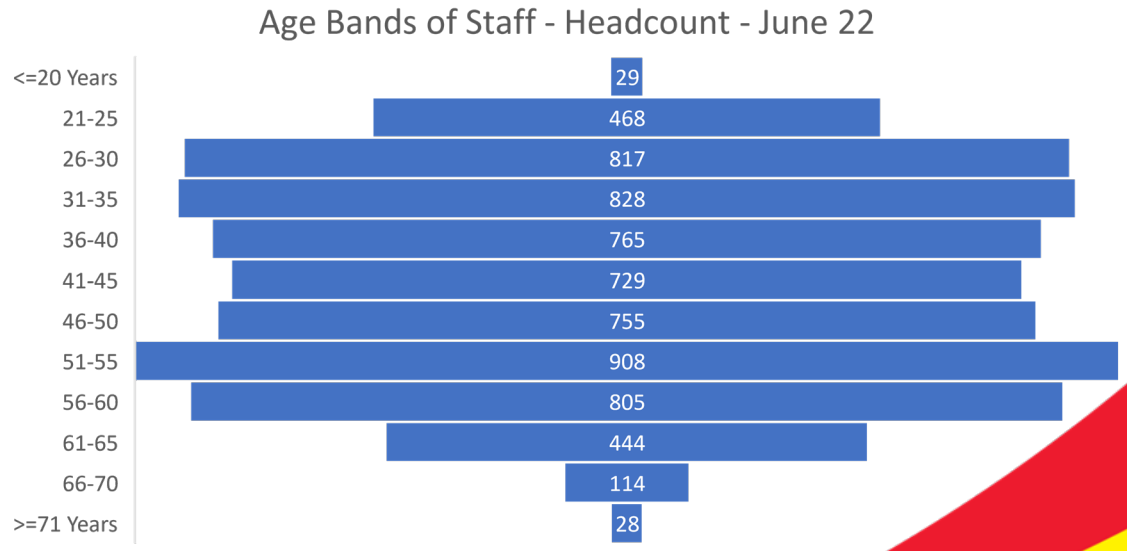




Disability Flag	Headcount	%
No	5,683	84.95%
Not Declared	771	11.52%
Prefer Not To Answer	3	0.04%
Unspecified	2	0.03%
Yes	231	3.45%



Gender	Headcount	%	FTE
Female	5,497	82.2	4721.06
Male	1,193	17.8	1125.79
Grand Total	**6,690**	**100.0**	**5846.85**



Pillar 2 – Belonging in the NHS – Employee Relations Metrics

PILLAR 2 IN ACTION…

Mediations and **facilitated conversations** are being used as restorative practices with the aim of reducing the number of cases which progress to the formal stages. The restorative practices undertaken within this period resulted in the closure of 8 cases. The department will be monitoring the overall impact of these within a 12-month period.

Current Cases on 27th June 2022

Case Category	Medical Care Group (FTE 1399)	Surgical Care Group (FTE 1319)	C & PC (FTE 463)	Corp, (FTE 816) CSSG, (FTE 1046) Medirest ROE (FTE 237)	Medical (FTE 538)	Total
Disciplinary	1	4	0	0	0	5
ET	0	1	0	0	2	3
Fast Tracks	2	0	0	4	0	6
Grievances	1	0	3	7	1	12
Investigations	11	2	0	6	5	24
Respect and Dignity at Work	4	0	0	0	1	5
Overall Total	19	7	3	17	9	55

Case Categories: for the purpose of clarity:

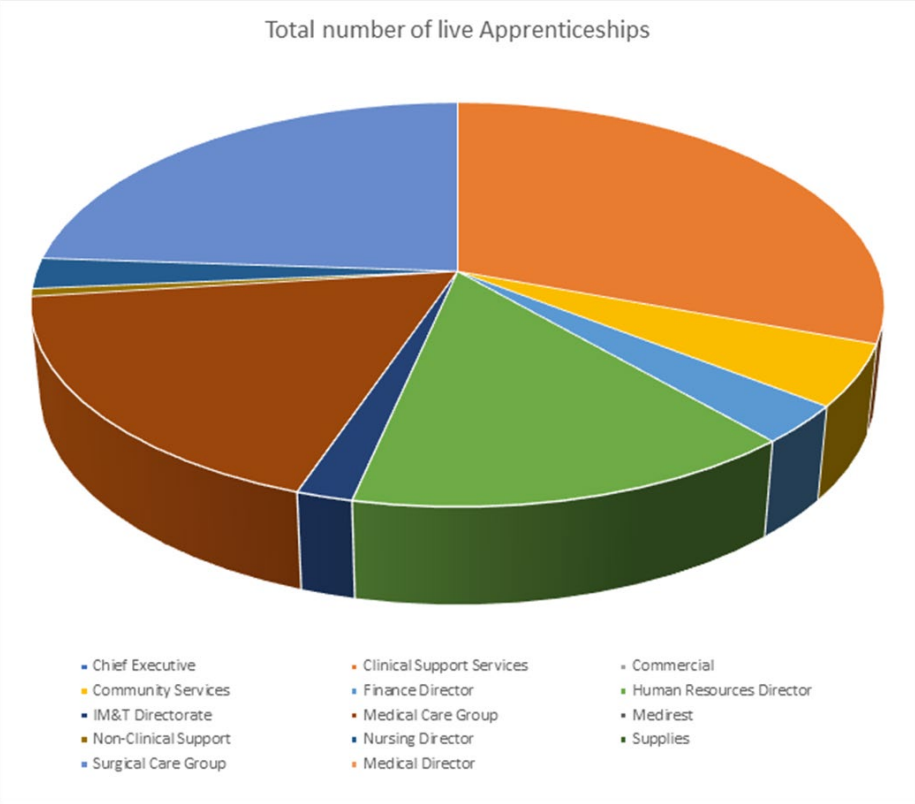
- **Grievances** are the complaints which employees raise.
- **Disciplinaries** are mainly about conduct and when it has been decided that a hearing is required.
- Investigations do not include grievances - they vary and could be linked to potential conduct issues.

Closed Cases - March to June 2022

Activity	Number
County Court Cases	0
Disciplinary	9
Employment Tribunals	2
Fast Tracks	6
Grievances	4
Investigations	8
Long Term Sick Terminations	10
Respect and Dignity at Work	1
Total	40

- The **Just and Learning culture** continues to be embedded into policies and practice. This includes ensuring that people who raise concerns are listened to and that cases are looked into openly, fairly and thoroughly. We will also be monitoring outcomes and lessons learned as a way to improve processes for the future.
- **Employment law training sessions** are being organised for managers to support people practice.

Apprenticeships



Apprenticeship Activity

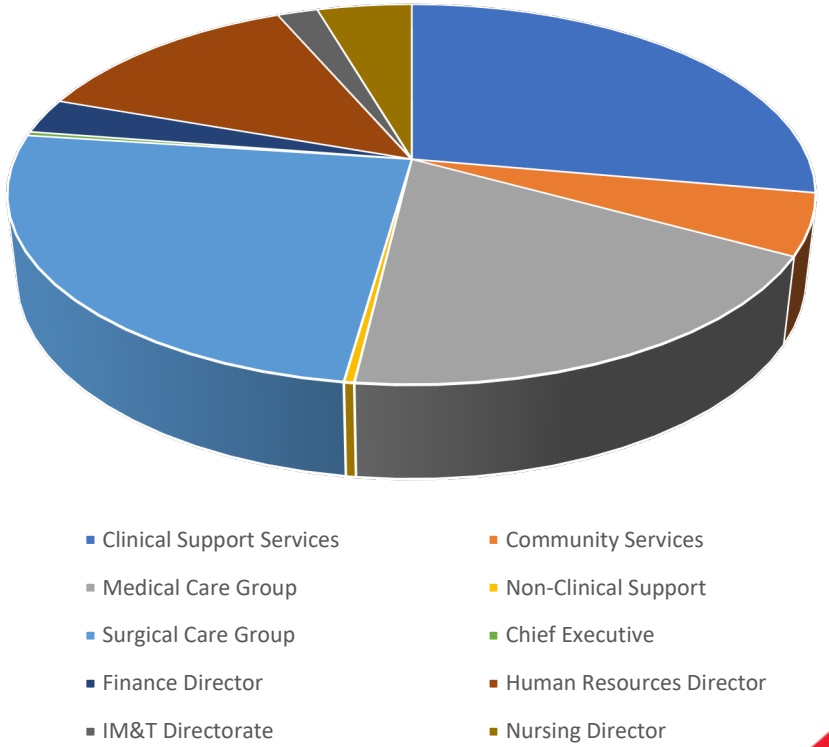
Live apprenticeships – **180**

Levy Spend Q1 - **£202,961** **(total pot £1.18m)**

No. different apprenticeships (live/complete) **- 43**

Most popular apprenticeships	No. live/ complete
Nursing Associate L5	44
Senior Healthcare Support Worker L3	33
Senior Leader L7	27
Healthcare Science Practitioner	23
Business Administration L3	19
Registered Nurse L6	17
Payroll Administration L3	11
Team Leader / Supervisor L3	10

Levy Spend Q1 Apr – Jun 2022



Pillar 2 – Belonging in the NHS

Staff Survey and National Quarterly Pulse Survey(NQPS)

- Actions are progressing in line with the agreed plan for the national survey
- Meetings with all senior teams from all care groups are now completed with follow up meetings and specific action planning to complete in June
- 'Teams Talks' programme dates in discussion with an expanded programme planned to launch in July involving other representatives from the executive team
- NQPS survey period completed in Q1 with the results presented to the Executive Committee in May, with any findings to be included into the Staff Survey action plan.

- Appraisal window now open for all staff on A4C contracts and will close 30th September by which time all staff in scope will have had an appraisal within the window and entered onto ESR.
- It is anticipated that with regular review and support to managers, the Trust will achieve full compliance by close of the window and the L&OD team providing on going support to managers including, activity tracking data, guidance on effective appraisals and data entry onto ESR.

	All Agenda For Change Staff			
Care Group/ Corporate Services	Number of staff requiring an appraisal by 30 September 2022	Number of appraisals required to date	Actual number of appraisals completed to date	% Completed appraisals to date
Clinical Support Services	1041	442	270	26%
Community Services	486	207	144	30%
Medical Care Group	1379	586	346	25%
Medirest	318	135	154	48%
Non-Clinical Support	37	16	6	16%
Surgical Care Group	1402	596	326	23%
Corporate Services/Finance & Information Director	162	69	43	27%
Corporate Services/ Nursing Director	87	37	15	17%
Corporate Services/Chief Executive	5	2	0	0%
Corporate Services/ Human Resources Director	292	124	83	28%
Corporate Services/ IM+T Director	185	79	49	26%
Corporate Services/ Medical Director	15	6	9	60%
Trust Total	5409	2298	1445	27%

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

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

- Effective use of our workforce skills, learning and experiences, enabling us to work differently in the future
- Innovation and horizon scanning - planning for the future in our service areas
- Developing the skills and knowledge of our people for the future
- Ensuring our people practice safely

Pillar 3 – New ways of working and delivering care

Areas of Focus

- **Nursing Clinical Workforce Review Project** – supporting corporate nursing to undertake a clinical model review in collaboration with Finance, Service Improvement and Information Teams.
- **Advanced Clinical Practitioners** – expanding the number of ACPs within the Trust. We currently have 16 at various stages of training across the organisation.
- **New Roles** – exploring the new roles available to the Trust and understanding the deployment capability of those roles. We are currently working with our anaesthetics colleagues to look at the Anaesthetic Associate role.
- **Widening Participation –** equipping HCAs with the skills and knowledge required to be "ward ready" prior to deployment.
- **Workforce Planning** – Clinical Diagnostic Centre business case submission, AHP 18 month Workforce Plan, 22-23 Operational Planning submissions.
- **Mandatory training and e-learning** which supports a growing and changing workforce .
- **Preceptorship** provision for Nurses and AHPs
- **Use of simulation** for clinical teams to develop clinical skills in a safe environment

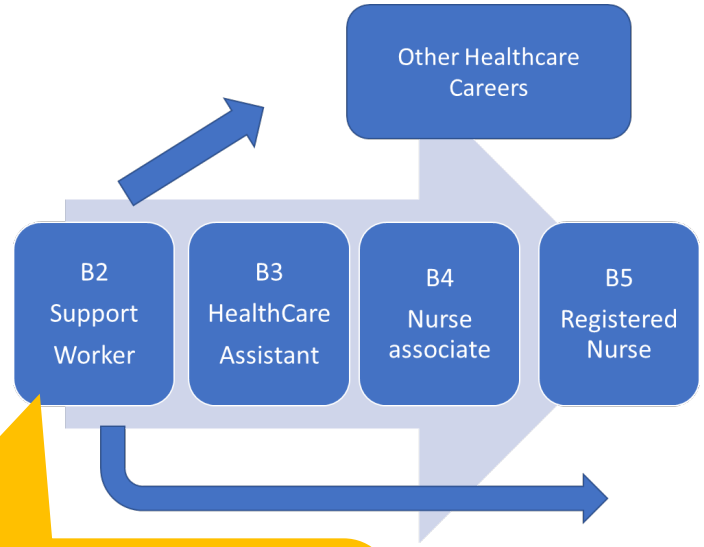
Progress to date

- The **Nursing Clinical Workforce Review Project** is well underway. The Project Board has been formed and a project overview has been created. The first engagement workshop to look at the activities undertaken on the wards has been undertaken.
- **Wagestream pilot update** - Executive paper is currently being drafted with recommendations.
- Funding from HEE was granted for 3 **ACP** roles. 1 in Paediatric Community Continence and 2 in Paediatric Emergency Department.
- Discussions have been ongoing with the Directorate Manager for Anaesthetics regarding the deployment of **Anaesthetic Associates** and a bid has been submitted for funding for 2 AA's to begin study in January 2023**.**
- **"Creating Coordinated Care Utilising the National Care Certificate"** delivered through the STHK Health Care Academy. Work has been undertaken to scope out the induction programme for HCAs that join the Trust, this is being developed in collaboration with Matrons.
- Continue to collaborate with finance and operations colleagues to undertake workforce planning for the **CDC business case** which will support us to articulate the workforce gap and the real cost of filling it including growing the workforce of the future through training posts and backfilling to cover activity demand. This business case has now been submitted to NHSE/I.

Risk and Mitigation

- The Nursing Clinical Workforce Review Project has a small window of funding to be undertaken and there is a risk that this will not be completed in the timeframe allotted. Executive sponsors of the project are aware and are receiving updates on the progress of the project for review and decision making.
- The Trust is not currently meeting the roster publication 8 week target overall with March 2022 performance being 5.1 weeks. There were 13 out of 83 roster areas that met the 8 week target. This has been affected by management days being cancelled to increase clinical capacity in the hospital. Between March and May 2022 106 out of 257 management days were cancelled. The roster team continue to provide support to operational colleagues in creating their rosters and providing advice and training where required.

Pillar 3 – New ways of working

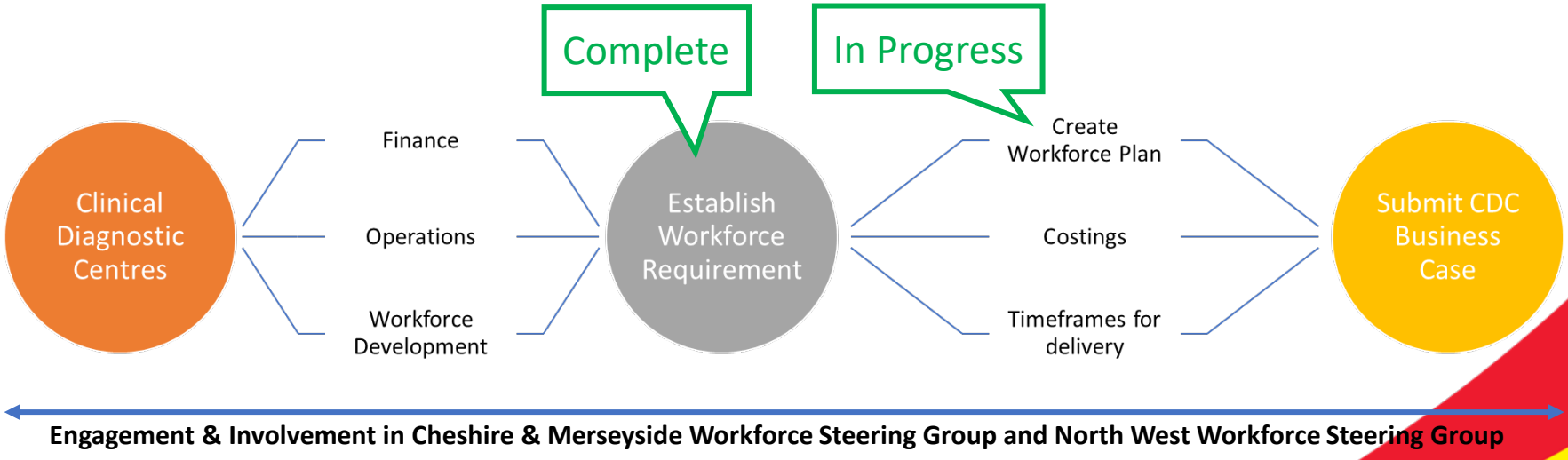


Scoping of the skills, support, investment and training as well as the mechanisms for spotting talent and succession planning

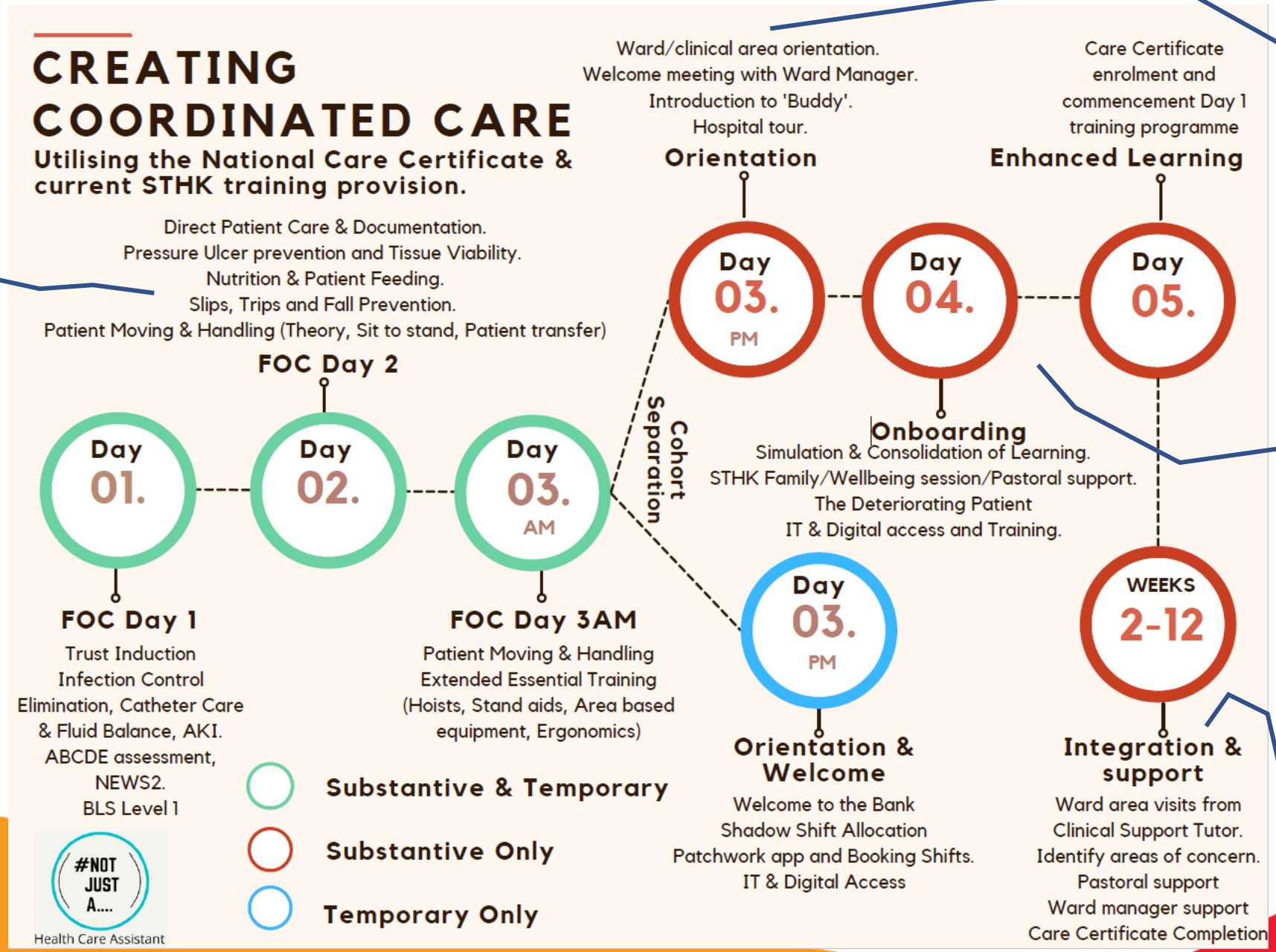
PILLAR 3 IN ACTION…

Matron Forum at the end of May had dedicated time to engage about the Entry to Health Care Careers pathways for Nursing.
Agreement reached with those in attendance on the content of a proposed 5 day induction for new starters – further review taking place with colleagues who were unable to attend.

Clinical Diagnostic Centre Workforce Plan in progress to support draft business case by the end of June 2022.



Pillar 3 – New ways of working



2 ½ days of training covering fundamental training requirements for HCAs

Ward orientation and "meet and greet" to provide a contact point and familiar face for new starters

2 additional days covering topics highlighted as a "Day 1" requirement by new starters and Matrons

Long term development and engagement to support retention and career planning

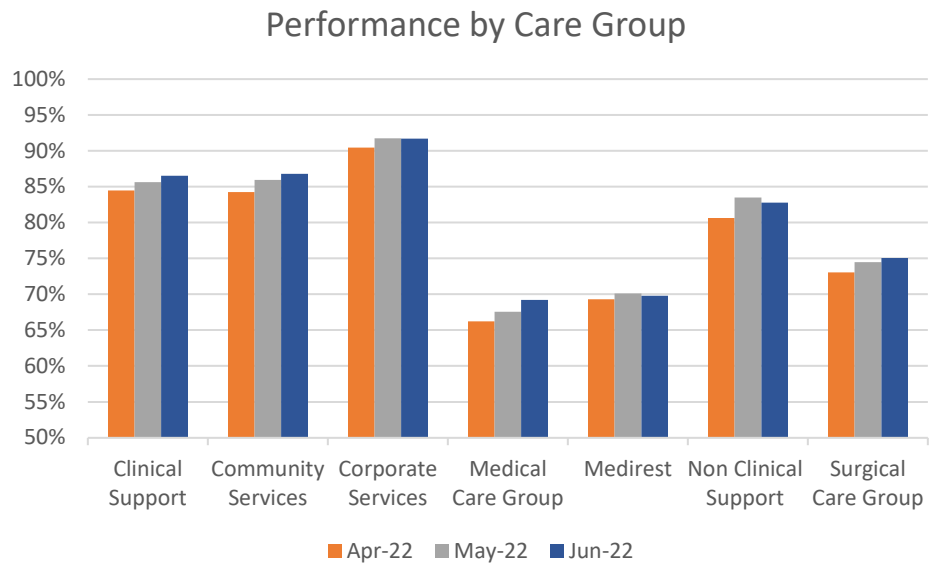
Pillar 3 – New ways of working and delivering care – making the most of the skills we have

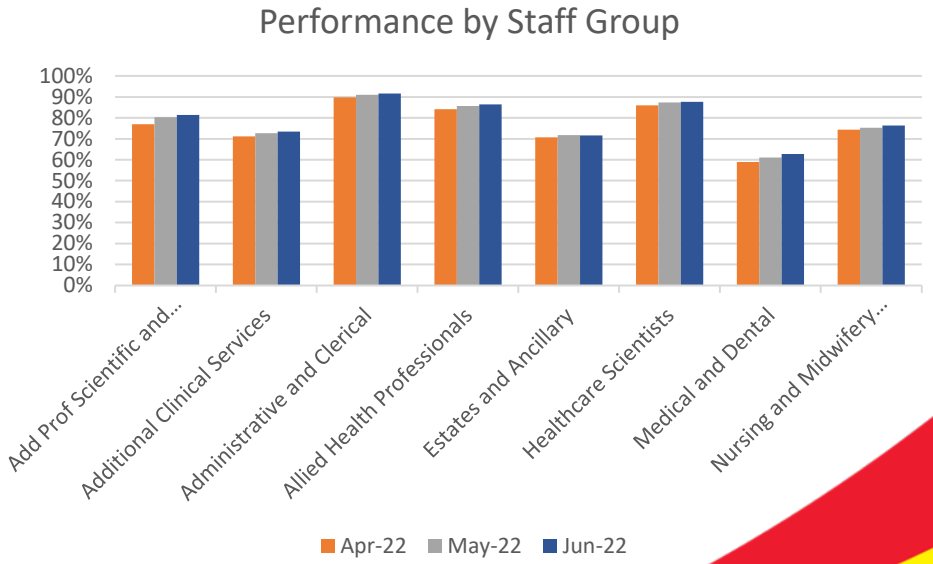
Mandatory Training

- **Compliance** – Overall, compliance continues to improve but is still below the 85% target. Feedback from managers is the challenge of accessing the 'face to face' subjects of Clinical Fire Safety, Patient Handling and Infection control/ANTT. Work with the Subject Matter Experts (SMEs) of these subjects is ongoing to look for alternative ways to simplify access for staff.
- **L&OD, and ESR** continue to perform an on-going review of application of training requirements to roles to ensure only those that require the training for safe practice are required to undertake it.
- e learning materials are under review to increase flexibility of access and minimise time commitment for all staff groups.
- **Robust monitoring and escalation processes** are in place to tackle areas and subjects of sub optimal performance in collaboration with Subject Matter Experts and service managers.
- **Manager Induction** – Staff joining the Trust to roles with a supervisory or management responsibility will be directed to participate in basic training on the systems and processes they will need to use in their roles e.g. SBS/e Roster/ ESR plus relevant policies
- **STEP project**: by allowing sharing of mandatory training compliance data for Trainee Doctors not directly employed by the Trust, the use of this passporting product assists in ensuring trainees both don't duplicate training and remain compliant as they rotate through the Trust.

Risk and Mitigation

- All subjects mandated for staff must follow a strict process to ensure only essential/ critical subjects are approved.
- A current focus on professions with high levels of non compliance, in particular Medical and Estates workforces.
- Although during the reporting period compliance has improved, when challenged, mangers of clinical areas commonly cite high levels of activity impacting the ability to release staff to complete training.





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

The relevant HR Indicators for this pillar focus on:

- Staff retention – including turnover, workforce stability and leavers
- Staff movement – including the Internal Transfer Scheme and planning for potential retirements
- Temporary workforce – including recruitment of bank staff
- Recruitment Activity – including international recruitment

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

Areas of Focus

- **AHP 18 Month Workforce Plan** – development and submission of the Trusts intended plans regarding the AHP workforce.
- **Staff turnover** – turnover continues on an upward trend with the team focussing on Band 5 RN and Band 2 HCA workforce in collaboration with Matrons and Corporate Nursing colleagues
- **Staff retention** – increased focus for online exit questionnaire is reaping richer data which is helping us to better understand people's reasons for leaving. This is being supplemented by the offer of a verbal interview should individuals want it. (slide 20).
- **Fast track pre-employment checks remain in place** using risk assessments where necessary to expedite time to hire. Time to hire also remains static at 82% with plans to introduce tighter KPI's where possible to help speed up the process.
- **Retirements** – the age profile of the workforce is such that there are 34% of our staff age 50 and over. This is highest in HCA and Registered Nurse staff groups. We are currently seeking feedback from staff who have recently retired and returned to ensure that the process is efficient, effective and 'pain free' to access. Following this we will be working with managers to ensure that retirement conversations take place so that we can better understand the intentions of our workforce.
- **Access to Apprenticeships** - Continuing communications across the Trust promoting apprentices with managers and how this can be embedded within their workforce planning.
- **Targeted recruitment events –** are having success with a recent HCA event resulting in 62 offers and a ED RGN event resulting in 16 offers of employment.

Risk and Mitigation

- The trust continues to use bank and agency to fill **temporary workforce**. Recruitment events have proved successful as per the numbers shared in progress to date and further events are planned as ongoing activity throughout 2022. In the meantime, escalated rates remain in place for ED.
- The increase in international nurses for 2022/23 will require **additional resource** across recruitment, education and estates, in the meantime Pan Mersey funding has been secured to allow us to begin the recruitment process.

Progress to date

- Workforce Development Strategy was presented to Strategic People Committee in July for ratification.
- Draft 18 month AHP workforce plan in circulation for consultation and sign off.
- Recruitment and Retention Strategy was presented to Strategic People Committee in July for ratification
- 100 international nurses have been secured for 2022. 17 of these have arrived, 20 are due at the end of July and the remaining 63 will be joining in two cohorts in September and November this year.
- We are increasing our attendance at local recruitment events which allow us to promote the Trust as an employer of choice across our community and encourage 'new to care' people into our workforce. We have also amended the Pensions workshop offered to our employees to promote the option of flexible retirement.
- **Careers fairs are proving fruitful in improving our opportunity to make more job offers.**
    - **13th March Admin and Clerical event** **Offers = 47**
    - **9th April Manchester Healthcare Jobs** **Offers = 2**
    - **23rd April Theatres event** **Offers – 15**
    - **11th June HCA event** **Offers – 62**
    - **25th June ED event** **Offers – 16**
    - **9th July RN event** **Offers - 14**
- Attendance at Matron forum in May 2022 to discuss our Band 5 RN and Band 2 HCA workforce regarding the following:
    - Existing workforce age profile
    - New Starter / Leaver Numbers for 2021/22
    - Vacancy Numbers

  The session was focussed on collaborative approaches to addressing the workforce pressures, supporting new colleagues to be ward ready and initiatives to improve retention through supporting all colleagues
- Work is continuing with St Helens CCG, Council, Primary Care, St Helens Chamber and St. Helens College to establish a **St Helens Health and Social Care ''Hub'** to attract local community to careers in health and social care providing the health and social care workforce of the future. Bid worked up for submission to St Helens Town fund for submission in August.

PILLAR 4 IN ACTION…

#teamSTHK: promoting recruitment through a targeted approach

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

We have focussed activity on hosting and attending large scale events over recent months and have made an additional 220 substantive offers as a result of this.

The recruitment team managed 588 adverts between 1st March and 30th June; this is an increase of 187 compared to the period 1st December to 28th February. Offers made have also increased.

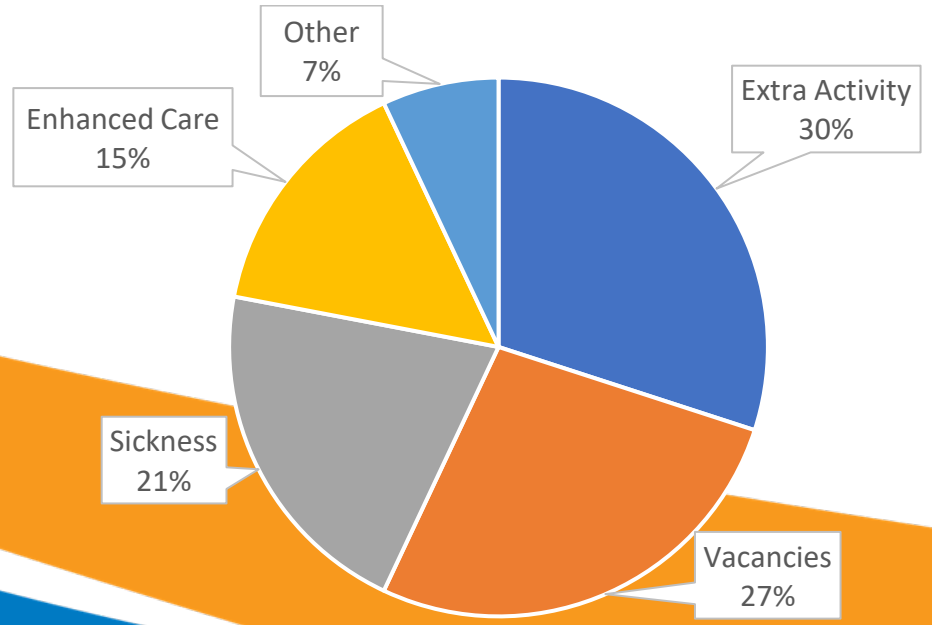
Pillar 4 – Growing for the future, recruiting, retaining and attracting people

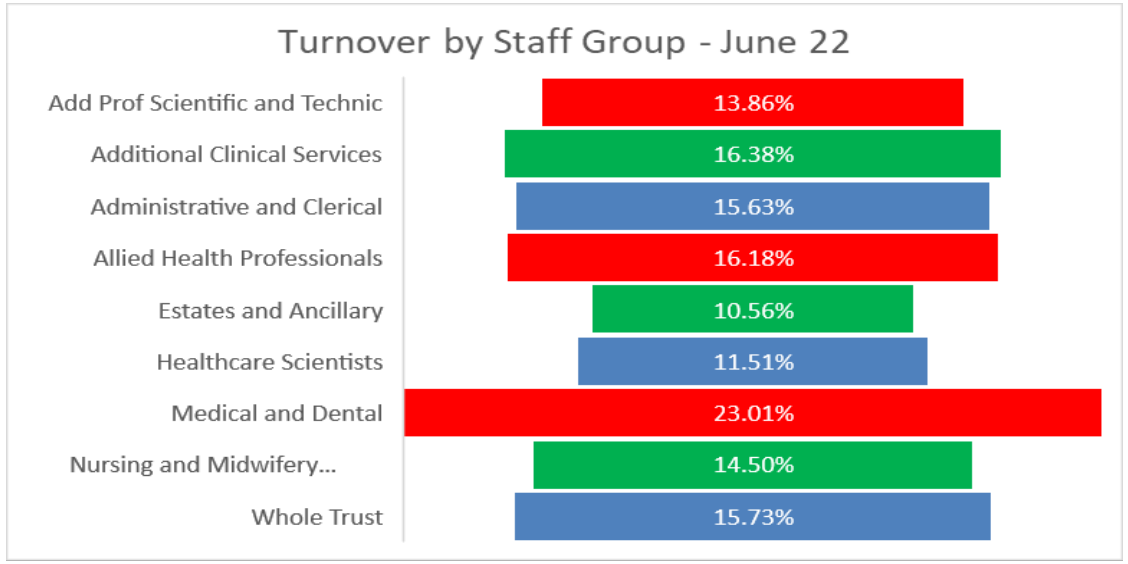
Temporary workforce Average Figures per month March 22 – June 22

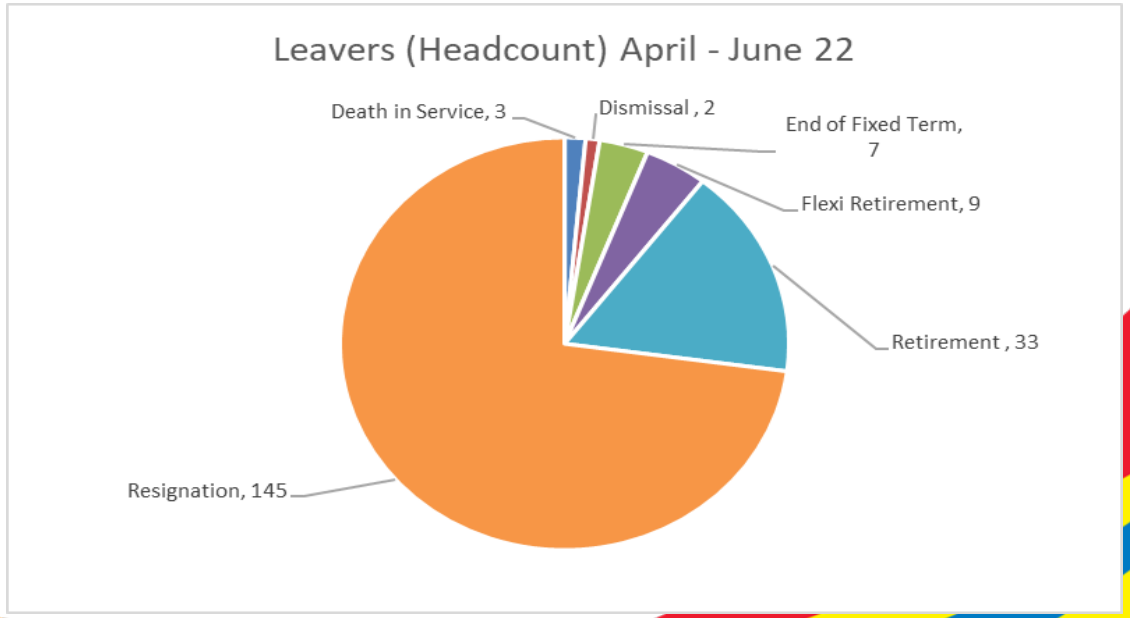
	Shifts requested	Shifts filled	% Fill rate	Bank fill	Agency fill	Unfilled
Mar-22	14,694	9,429	64%	7,166	2,263	5,265
Apr-22	12,555	8,069	64%	5,977	2,092	4,486
May-22	12,977	8,568	66%	6,461	2,107	4,409
Jun-22	12,981	8,765	68%	6,655	2,110	4,216
Total	**53,207**	**34,831**	**65%**	**26,259**	**8,572**	**18,376**

The fill rate has increased between March and June with an average fill rate of 65% during the period. Of those shifts filled the average split between bank and agency was 75% (bank) and 25% (agency).

The request reasons for bank and agency have been roughly the same each month as follows:



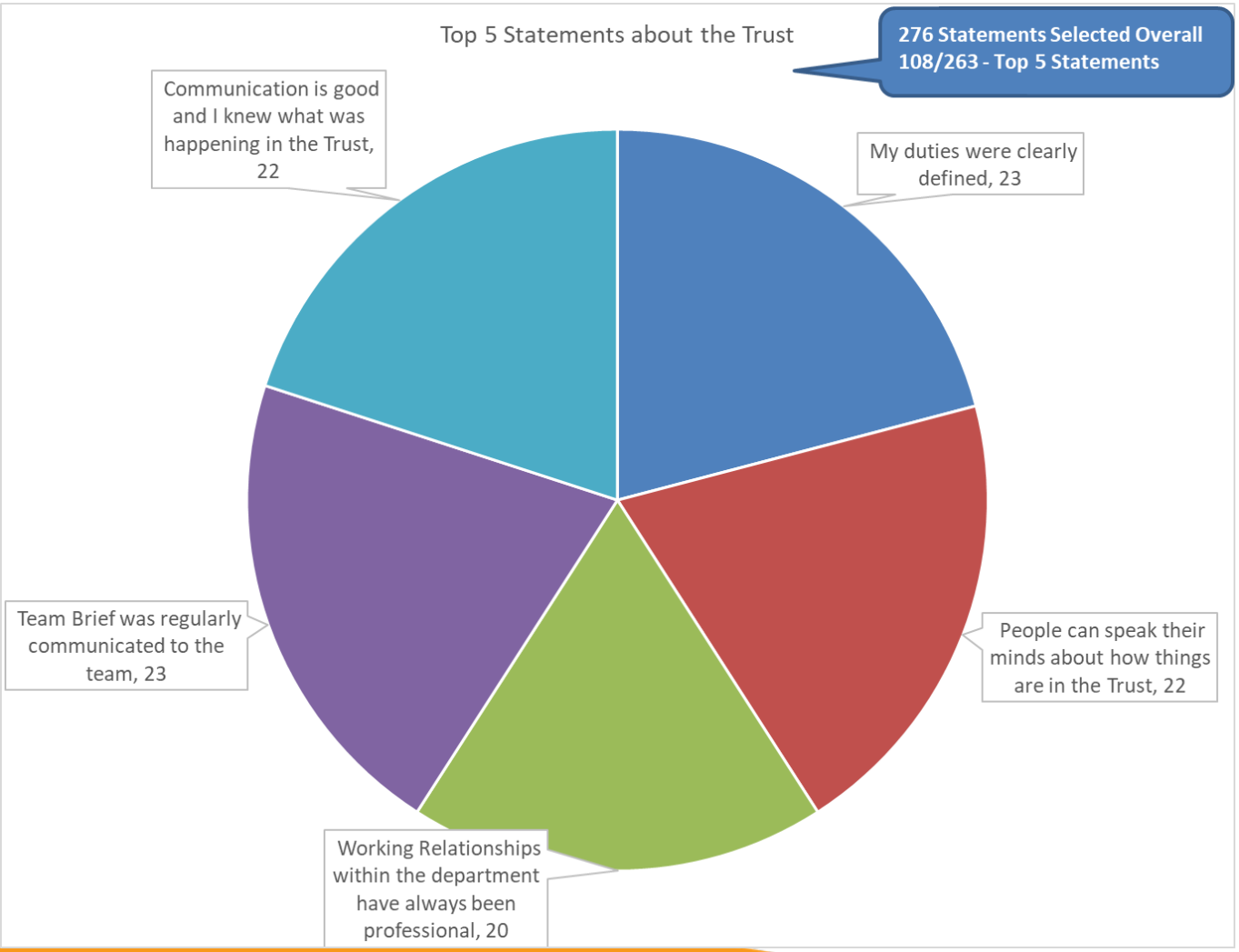


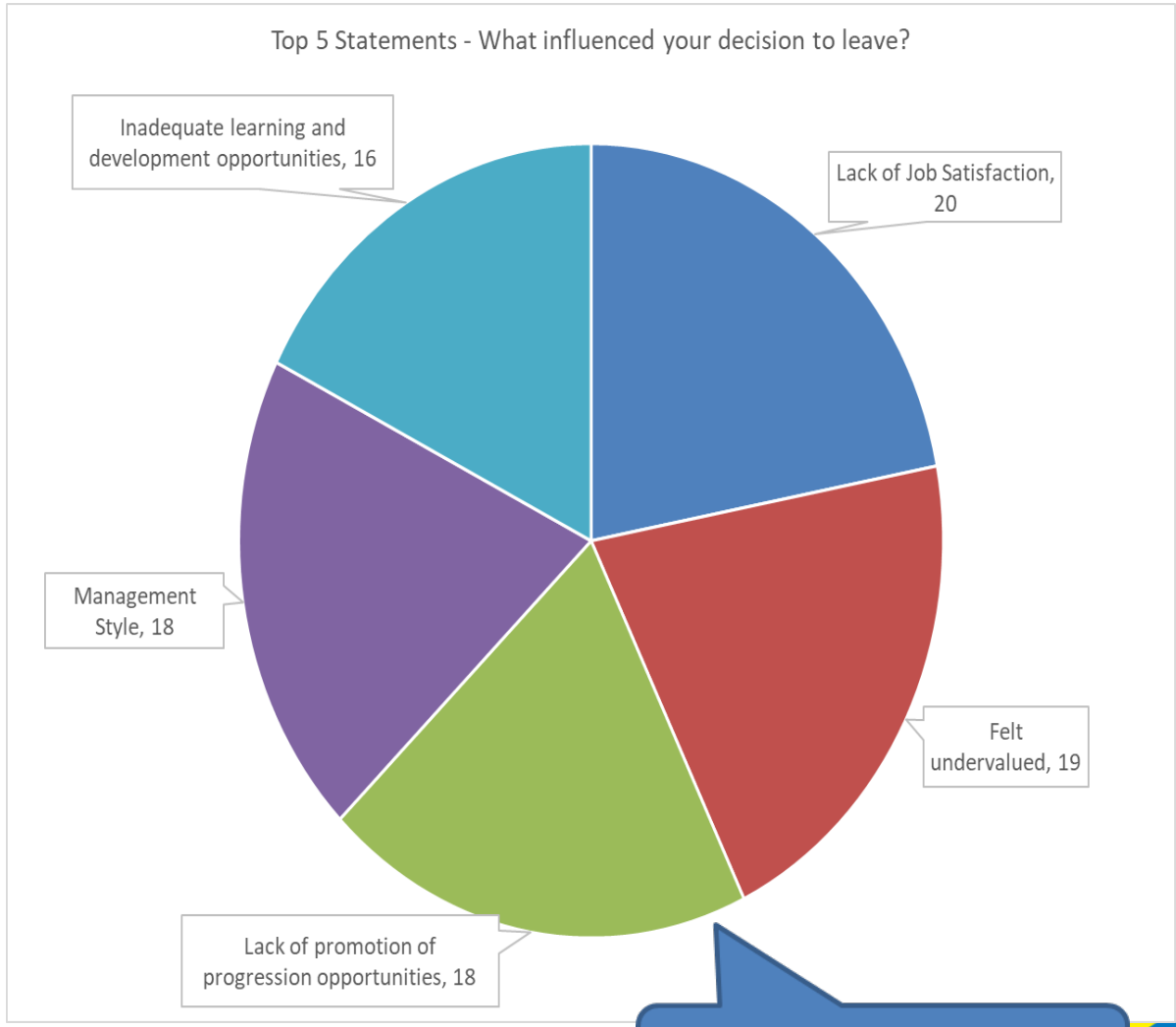


Pillar 4 – Growing for the future, recruiting, retaining and attracting people

59 Exit Questionnaires returned between March and June 2022

Would you recommend the Trust as a place to work to a friend or colleague?	
Yes - 73%	No - 27%





St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)065
Title of paper: Information Governance Annual Report (including Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Teaching Hospitals Trust has an effective Information Governance Agenda and Framework in place
Summary: This Report is designed to inform and give assurance to the Board of progress made against the Information Governance (IG) work programme for 2021-22. IG is a framework that not only provides a consistent way for staff to deal with the many different information handling requirements but brings together all of the requirements, standards and best practice that apply to the handling of information, specifically information that contains personal confidential information, now referred to as personal data. IG has four fundamental aims: • To support the provision of high-quality care by promoting the effective and appropriate use of information in a secure manner • To encourage staff to work closely together, preventing duplication of effort and enabling more efficient use of resources • To develop an information management structure to provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards • To enable organisations to understand their own performance and manage improvement in a systematic and effective way The Trust must ensure that it complies with its legal and regulatory obligations, for IG this is data protection legislation, more specifically the UK GDPR and Data Protection Act 2018. The Trust is therefore committed to conducting frequent reviews and improvements of its services; this includes Information Governance (IG). This report details the progress that has been made against the Information Governance work programme for 2021-22 and provides a 'year ahead' programme of work on areas that are necessary to remain IG compliant and to further embed IG within the Trust.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: *None directly from this report.*
Stakeholders: *Staff, Patients, Executive Committee, Trust Board and Commissioners.*
Recommendation(s): • The Board to note and approve the content of this paper. • Be assured that robust arrangements are in place to effectively manage the Information Governance Agenda within the Trust.

Presenting officer Christine Walters, Director of Informatics/SIRO
Date of meeting: 27th July 2022

Introduction

The NHS Information Governance Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. This Framework allows the Trust to ensure that all personal, sensitive and confidential data is handled legally, securely, efficiently and effectively. Information Governance (IG) is an ongoing process which covers many different areas including records management, data quality, legislative compliance, risk management and information security.

The Trust has a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), the Freedom of Information Act 2000 (FOIA 2000), and to meet Information Governance (IG) / Information Security / NHS specifications and requirements mainly relating to the National Data Guardians Data Security Standards and other related legislation, guidance and contractual responsibilities to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

The Trust has its own IG strategy which sets out the approach it takes in developing and implementing a robust Information Governance Framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further support IG work including the Records Management Policy and Procedure, Confidentiality Code of Conduct Policy, Data Security & Protection Breaches / Incident Reporting Policy and Procedure, Freedom of Information Policy, Data Protection Impact Procedure, Data Quality Policy. All of which are made available to staff via the intranet.

The Trust complete and submit the Data Security and Protection Toolkit (DSPT) on an annual basis which enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. To provide assurance that the Trust's DSPT is of a good standard it has been audited by Mersey Internal Audit Agency. For 2021-22 the Trust has received the rating of Substantial Assurance.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2021-22.

This section will provide assurance, from the SIRO, that the Trust:

- Have a sufficient framework in place to ensure compliance with all elements of the Information Governance Agenda
- Have an active and effective Information Governance Steering Group forum, meeting regularly
- Manage and investigate any Information Governance / Confidentiality incidents and issues

Roles and Responsibilities

The Role of the SIRO

Christine Walters, Director of Informatics, is the Trust's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

The SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to the Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the Trust's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust**.**

The SIRO has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The focus of DSPT is on setting standards and providing tools to achieve them. The SIRO authorises the DSPT Self-Assessment annual submissions once the relevant assurances have been provided by the Information Governance and IT Security teams. The data security standards provide assurance across ten areas.

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

The Role of the Caldicott Guardian

Mr Alex Benson is the Trust's registered Caldicott Guardian. Mr Benson is tasked with ensuring that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. Mr Benson provides leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader information governance agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance, to the Trust Board, that the Caldicott Guardian function within the Trust is operating at a satisfactory level and that it is appropriately supported within the existing Information Governance structure.

The Trust Caldicott Guardian is supported by the Director of Informatics in her role as Senior Information Risk Owner (SIRO) and the Head of Information Governance & Data Protection Officer and her team.

Data Protection Officer

Camilla Bhondoo is the Trust's Data Protection Officer. New to Data Protection legislation under the UK General Data Protection Regulation 2018 (UK GDPR) are Data Protection Officers (DPO's).

DPO's are at the heart of this legal framework for many organisations, facilitating compliance with the provisions of the UK GDPR. It is therefore mandatory for certain Data Controllers and Processors to designate a DPO (Article 37, UK GDPR).

This will be the case for all public authorities and bodies (irrespective of what data they process). The Trust is therefore required to appoint a DPO.

The named DPO must be:

- Independent
- An expert in data protection
- Adequately resourced
- Report to the highest management level

As per Article 39 of the UK GDPR the DPO tasks are to:

- inform and advise you and your employees about your obligations to comply with the UK GDPR and other data protection laws
- monitor compliance with the GDPR and other data protection laws, and with your data protection polices, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits

- advise on, and to monitor, Data Protection Impact Assessments
- cooperate with the supervisory authority and
- be the first point of contact for supervisory authorities and for individuals whose data is processed (employees, customers etc).

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee accountable to the Trust Risk Management Council and ultimately the Trust Board. The Group, which has been operational since January 2008, oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader Information Governance Agenda and provide the Trust Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust.

The IGSG is chaired by the Trust Caldicott Guardian Mr Alex Benson, with the Trust SIRO as Deputy Chair. Core membership includes Trust Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG has also seen the Group address the following topics in addition to achieving DSPT compliance –

- Implementing the new Data Security and Protection Breaches / Incident Reporting Policy and Procedure, which has seen high scoring data breaches being effectively managed and escalated.

- Review of key policies and procedures, such as; Information Governance Policy, Information Governance Strategy, Code of Confidentiality Policy, Records Management Policy and Procedure, Back Up Policy, Remote Access Policy, FOI Policy.

- New Privacy Notices for both patients and staff, made available on the internet and intranet, detailing the Trust's processing of personal data.

- The introduction of the Data Protection Impact Assessment (DPIA) Procedure which documents the Trust's approach to securely implementing new projects / systems / initiatives that require personal data to be processed. The dissemination of this procedure will help continue to embed the DPIA process across the Trust (which is mandatory under the UK GDPR) and will hopefully see a rise in the completion and approval of DPIAs.

- Reviewing a number of projects related to information sharing as part of the Covid Pandemic response and moving into business as usual processing activities where necessary or 'retired' as no longer required.

- Continued to build on a closer working relationship with IT security team.

- Approving the Backup Policy with a plan to work with Trust staff to educate on email 'house-keeping' / retention.

- Carried out supplier due diligence checks on new and existing suppliers.
- Streamlining the FOI process which has seen a rise in compliance.

Reportable Incidents

The Trust has a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2021/22 there were four incidents. None of the incidents reported required the Trust to take further action.

A breakdown of those incidents that have been reported to the ICO is below:

September 2021	A patient informed the Trust on 2 occasions that they had moved address but the system was not updated. A response letter from the Trust (complaints department) regarding a complaint sent to the patient's 'old' address. New occupant opened the letter, which contained confidential personal data to find out who to send the letter back to (there was no return to sender address on the envelope), Patient informed and unhappy. Additionally, an appointment letter was sent to patient's 'old' address, Trust resent out appointment letter to new address. Envelopes now include PO Box stamp, so that letters can be returned without the envelope having to be opened to identify the sender.
October 2021	5 sheets of double-sided paper stapled together containing information on 30 patients was found in a car park outside Trust premises. Contained patient's name, DOB, NHS number, admission dates, ward, nurse and doctor information, current situation, background and diagnosis, assessment and recommendations. Some of these boxes contain relatives' details and contact numbers. Information handed back into the Trust.
October 2021	Subject Access Request information that should have been redacted relating to another individual was not. The recipient therefore was exposed to information they should not have seen. The individual made aware of the incident.
March 2022	A camera (a hospital device) which was used to take photographs of a patient, in particular parts of their face as it was for a surgical procedure, was stolen. The camera was not encrypted and was in transit in a car when the camera was stolen. The clinician was taking the camera from one hospital site to another. The camera contained photos of 1 patient and also a label confirming the patient's name.

There have been no fines issued by the ICO to the Trust in 2021-22. However, due to a number of complaints made directly to the ICO concerning the processing of Subject Access Requests (SARs) the Trust has been notified that they are on an ICO Infringement list and should further concerns arise, a review will occur and the ICO will decide whether further action against the Trust is required.

In order to try and reduce further similar breaches, all SAR processing across the Trust will come under Information Governance management going forward. This will ensure the relevant IG checks can be made before release. A business case is due to be presented to the Executive Committee for approval shortly. The team will also process the other Individual Rights that sit under the UK GDPR, for example Right to Rectification, Right to Erasure. The ICO have been notified of the plan, demonstrating we are aware of data protection responsibilities and obligations.

Reporting & Monitoring

Progress against the DSPT and compliance with relevant legislation is monitored by the Head of Risk Assurance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports are presented to the IG Steering Group and subsequently to the Risk Management Council, then ultimately to the Trust Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met required action plans were prepared and were monitored to ensure improvement and compliance.

The Year Ahead

The next 12 months will continue to see the Trust continue to embed its Information Governance strategy and ensure it remains compliant with the DSPT, data protection legislation and its own IG framework. Maintaining compliance with occur through planning and day to day activities which will need to be balanced against the needs of the organisation.

It is important that key IG processes are monitored, revisited and updated where necessary. This ensures that they remain relevant and work in line with other Trust policies.

In 2021-22 an Information Governance Workplan was introduced which was monitored by the IGSG and highlighted the progress in each area, required to ensure the Trust adheres to not only the DSPT but Data Protection law as a whole. It was presented at the IGSG in July to show the final status of each area for 2021-22 – all complete. The IG Workplan details what work the hospital will need to carry out during the course of this financial year to ensure it remains on track with its compliancy. A new IG Workplan for 2022-23 is now in place.

This year the following areas will be of primary focus:

- **IAO (Information Asset Owner) engagement and complying with responsibilities** – specific IAO training has now been developed and will be delivered to all IAOs (and Information Asset Managers, who will have this delegated responsibility) to ensure they understand their IG responsibilities and how an IAO provides support to the SIRO, the IG team and the Trust's IG agenda. This aligns with a requirement in the DSPT.

- **Continued roll out of Information Asset Registers (IARs)** - an IAR has been developed incorporating ICO and data protection legislation requirements. There is a

need to understand where in the Trust personal data is being processed and to ensure this data can be processed legally, is being held as securely as possible and to identify any risks. The IAR template was approved by the IGSG. Work needs to continue this year to collate robust IARs for each area with the support of the IAOs. Any high risks will be highlighted to the SIRO. Required by the DSPT and UK GDPR Article 30.

- **Continued use of the Data Breach Investigation Report** – when a data breach occurs, whether that is a serious near miss or an actual breach, it is important that a full report is carried out with lessons learned and an action plan. This report will be able to provide the SIRO and Caldicott Guardian (and any relevant parties) with assurance that the breach was fully investigated. This report template was approved by IGSG last year and will be used in conjunction with Trust teams going forward. Required by the DSPT and UK GDPR Article 33.

- **Implementation of the new DPIA procedure and review of DPIA template –** there is a need to communicate to the Trust when DPIAs are required and why. Now the DPIA procedure has been approved (May's IGSG) and the process has been documented the team will continue to inform the Trust on the importance of DPIAs; this should see an uptake in completion of DPIAs. Focus this year will also be to make the DPIA template user friendly so that staff are aware of who should complete which sections (this is an IG risk assessment form whereby all staff involved in the project should input, rarely it is a document that can be completed by one person). Once updated there will be a drive to communicate what DPIAs are, when they should be completed and by whom. Required by the DSPT and UK GDPR Article 35.

- **Annual review of data processing** – the IG Team keep a log of all DPIAs and there is a need to review these on an annual basis with the IAO / project lead to check whether this processing is still occurring. This will also create an opportunity to update the DPIA if any changes have been made (and the IG Team have not been made aware) or make the DPIA redundant if the process is no longer happening. The team will also check the associated documents, i.e. contracts, data sharing agreements, data processing agreements to ensure their validity. This aligns with a requirement in the DSPT.

- **Allocate a Training Resource** – IG training is a mandatory requirement for the DPST, the IG agenda and the Trust's training agenda. The DSPT requires that the Trust achieve 95% compliance on an annual basis. The Head of the Risk Assurance and DPO has allocated resource from within the IG Team to focus on delivering IG Training (80% of their working week). This should allow for all Trust staff to have greater access to training sessions and the types of training the team offer. Working continually throughout the year to maintain a 95% compliance should reduce the 'last minute' race we see the Trust go through each year (when the DSPT submission is required). This aligns with a requirement in the DSPT.

- **The set up 'Email Working Groups'** – the Backup Policy was approved at IGSG with a plan to work with Trust staff to educate on email 'housekeeping' / retention. Key working groups need to be established across the Trust in order to educate users on what emails are for, not to be used as a file store, to save any key documents on the

network and to delete emails. This will align with the retention period set in the Backup Policy. This aligns with a requirement in the DSPT and Principle (e): Storage limitation of the UK GDPR.

- **Continue to work with the IT Security Team** – the DSPT will continue to want IT evidence and it is important that the IG Team work with the IT Security Team to ensure actions that are produced due to the audit are completed, continue to collate evidence for the new version on the DSPT. Required to ensure completion of the DSPT.

Conclusion

The Trust continues to build and improve on the Information Governance foundations which have been embedded. This is demonstrated by the completion of the Data Security and Protection Toolkit and the robust processes it has in place in terms of reporting data breaches, the completion of DPIAs, data sharing agreements, data processor agreements, delivering training and awareness, providing advice and guidance on a range of data protection queries.

This year will continue to see new systems and processes being implemented that will involve the use of the personal data not only for use at the Trust but wider across the Cheshire and Mersey Health Care Partnership and the North West. This is welcomed and required for cross organisational and collaborative working. It is therefore important that the IG Steering Group continue to monitor the progress of the Information Governance Agenda within the Trust, to ensure the IG team receive full support, so that compliance is maintained, processes are improved upon and proactive involvement occurs.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No:

Title of paper: Freedom of Information Act Annual Report 2021/22

Purpose: To provide the Trust Board assurance that St Helens and Knowsley Teaching Hospitals NHS Trust strives to comply with the Freedom of Information Act.

Summary: This report is designed to give the Trust Board assurances that the Trust is compliant with the Freedom of Information Act. This report summarises the key points of FOI compliance for 2021-22.

For the 2020/21 financial year the Trust received 623 requests, at the time of writing the report 95% of the requests received were completed, of those completed requests 63% were completed within the 20 working day time frame.

	2019/20	2020/21
Requests received	486	623
Requests completed	89%	95%
20 working day compliance	35%	63%

The number of requests received compared to the previous year has increased by 137 requests, despite this increase the Trust's compliance has increased both in terms of the number of completed requests which has increased 6% on the previous year and the compliance with the 20 working days timescale which has increased by 28%.

Corporate objectives met or risks addressed: Systems, Communications

Financial implications: None directly from this report.

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

Recommendation(s): The Trust Board to note and approve the content of this report

Presenting officer: Christine Walters Director of Informatics/SIRO

Date of meeting: 27th July, 2022

Introduction

As a public authority the Trust is required to action and respond to Freedom of Information (FOI) Requests under the legislation 'the Freedom of Information Act 2000.' The public are able to request non personal information about the Trust and its activities.

Anyone can make an FOI request and the Trust must respond to the request within 20 working days. Failure to do so could result in a fine, warning from the Information Commissioners Office.

The Chief Executive who has overall responsibility in the Trust for the FOI Act has delegated the responsibility for the implementation and monitoring of the Act to Anne-Marie Stretch, the Deputy Chief Executive and Director of Human Resources (also known as the Executive FOI lead). The Executive FOI Lead ensures that the Trust is complying with the legislation and takes overall ownership of the Trust's FOI Policy making sure systems and procedures are established and reviewed to support the FOI process.

The Information Governance team through dedicated resources, process, coordinate, monitor and report all FOI requests. This includes following all administration procedures and record keeping in line with the Trust's FOI policy and the FOI Act.

This report is designed to provide the Trust Board with assurance that the Trust is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for 2021-22 will be shown here, with comparisons to previous years where relevant.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

Performance

- The overall compliance figure shows an improvement on the previous year's compliance levels both in terms of compliance with the 20-working day timescale and the overall response rate.

- 623 requests received in total; this is an increase from last year's total of 486.

- The areas of the Trust that received the most requests to answer were HR (93) Information (59) Finance (54) Informatics (50).

- 63% of requests were answered within the 20-working day timescale, this is an increase on previous year's 35%.

- January 2022 saw the highest rate of compliance with 75% of requests responded to within 20 working days.

- 95.5% of all requests received in the financial year have been responded to.

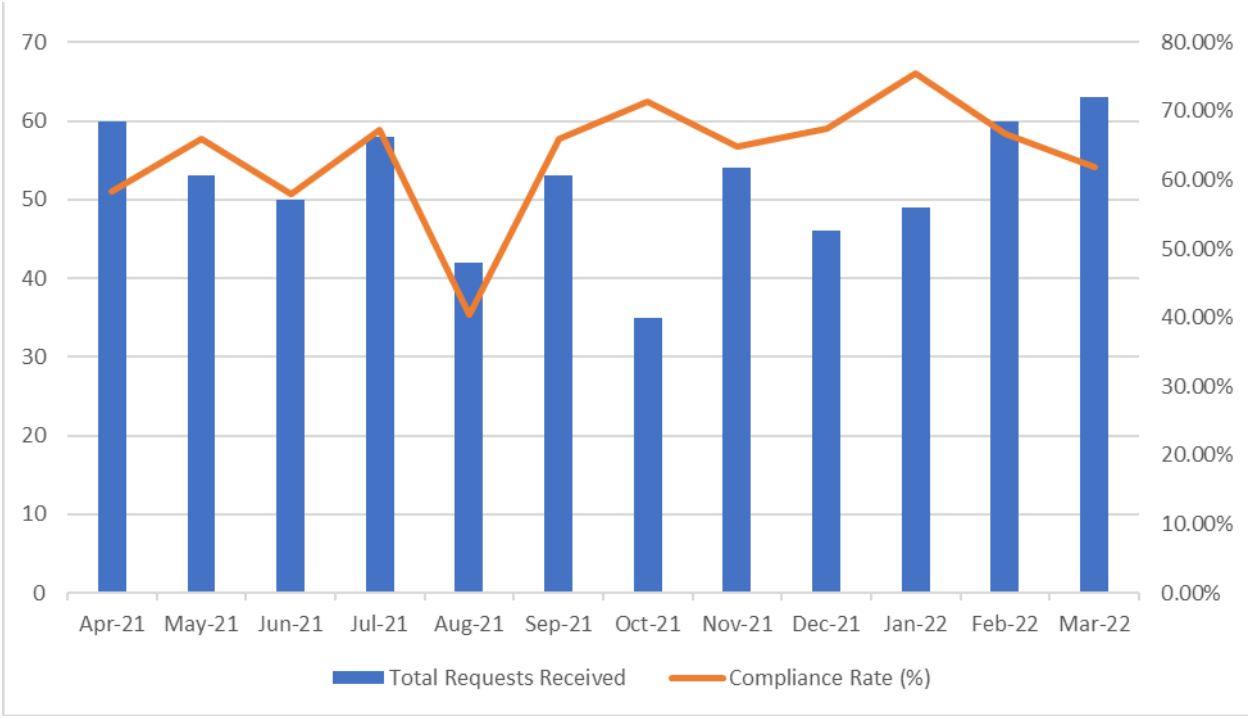
- Requests from the Commercial sector accounted for 293 of all the requests received

- The top 3 categories of requests that were received were: Lists & Registers, Our Services and About the Trust this remains the same as previous years.

- A bespoke system is under development for processing FOI requests, this is being created in house as an additional module to the IT helpdesk system to automate some of the FOI processes.

Table 1 below shows the improvements made throughout the year.

Table 1 – 2021 -22



Areas of Improvement in 2021-22

- A full review took place to monitor compliance with all areas of the FOIA and not just the mandatory timescales, compliance is monitored at the Trust's Risk Management Committee. The process has been revised with escalation procedures in place which includes increased weekly reports to each Executive Lead.

- The Executive Team have received FOI training and are now responsible for reviewing and approving FOIs that relate to each of their areas of responsibility before being sent to the requestor.

- Training within the IG Team has taken place which has seen that each team member can cross-cover and every team member can process FOIs; FOIs are now processed on a daily basis.

- The Trust's website has been updated and the FOI Disclosure Log (a log of responses to previous requests made) is now searchable using key words, this will help requesters find the information they require if it has already been answered and will help reduce requests relating to the same subject area.

- The FOI publication scheme has been reviewed and is currently being updated.

Conclusion

Significant changes which include additional resource to the IG Team, ensuring cross covering and each Executive Lead reviewing and approving FOIs for their respective areas has resulted in the process becoming streamlined and the Trust has therefore seen substantial progress, it is expected that this progress will continue throughout the new financial year.

Report Ends.