NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26th OCTOBER 2022
BOARDROOM, WHISTON HOSPITAL

This meeting will be a hybrid meeting
All papers/policies have been distributed to members and are available on the Trust website. Joining instructions have been sent by Denise Baker in a diary invite.
If attendees require any accessibility adjustments or wish to advise of their preferred pronoun, please contact the chair in confidence prior the meeting.

AGENDA				Paper	Purpose	Presenter
09.30	1.	Employee of the Month Films - August 2022 - October 2022		Verbal	Information	Chair
09.50	2.	Apologies for Absence		Verbal	Assurance	Chair
09.55	3.	Declaration of Interests		Verbal		
10.00	4.	Minutes of the Board Meeting held on 28th September 2022		Attached		
		4.1	Correct Record and Matters Arising	Verbal		
		4.2	Action log			
Performance Reports						
10.10	5.	Integrated Performance Report		NHST (22) 076	Assurance	Anne-Marie Stretch
		5.1	Quality Indicators			Sue Redfern
		5.2	Operational Indicators			Dr Peter Williams obo Rob Cooper
		5.3	Financial Indicators			Gareth Lawrence
		5.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
10.30	6.	Committee Report – Executive		NHST (22) 077	Assurance	Ann Marr

10.40	7.	Committee Report – Quality	NHST (22) 078	Assurance	Rani Thind
10.50	8.	Committee Report – Finance & Performance	NHST (22) 079	Assurance	Jeff Kozer
11.00	9.	Committee Report - Charitable Funds	NHST (22) 080	Assurance	Paul Growney

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.10	10.	Corporate Risk Register	NHST (22) 081	Assurance	Nicola Bunce
11.15	11.	Board Assurance Framework	NHST (22) 082	Approval	Nicola Bunce
11.25	12.	Aggregated Incidents, Complaints and Claims	NHST (22) 083	Assurance	Sue Redfern
11.35	13.	Learning from Deaths Quarterly Report – Quarter 1(2022/23)	NHST (22) 084	Assurance	Dr Peter Williams
11.45	14.	Safeguarding Annual Report 2021/22 (Adults & Children)	NHST (22) 085	Approval	Sue Redfern
12.00	15.	EPRR Annual Self-Assessment	NHST (22) 086	Approval	Sue Redfern
12.15	16.	Safer Staffing – Nurse Establishment Review	NHST (22) 087	Assurance	Sue Redfern
Closing Business					
12.30	17.	Effectiveness of Meeting	Verbal	Assurance	Chair
	18.	Any Other Business		Information	
	19.	Date of Next Meeting – Wednesday 30th November 2022		Information	

Action Logs – October 2022

TRUST PUBLIC BOARD ACTION LOG – 26TH OCTOBER 2022

No	Date of Meeting (Minute)	Action	Lead	Date Due
47	27.07.22	SR to provide information on the criteria for reporting recurrent C.Diff infections.	SR	~~28.09.22~~ 26.10.22
48	27.07.22	~~PW to ask Elspeth Worthington about the inclusion of spot checks in relation to the revised Learning from Deaths process~~. **CLOSED**	PW	~~28.09.22~~
49	28.09.22	Contact to be made with the Halton Council to establish if they still wish to have a member attending the future Trust Board meetings.	NB	26.10.22
50	28.09.22	GL to provide a breakdown of the non-NHS aged debt.	GL	26.10.22
51	28.09.22	AMS to clarify whether the volunteer awards will be reinstated this year with the Volunteer Manager	AMS	26.10.22

St Helens and Knowsley Teaching Hospitals NHS Trust

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)076
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 September 2022. (YTD = 1).

There was 1 MRSA case in September 2022. (YTD = 1).

There were 2 C. Difficile (CDI) positive cases reported in September 2022 (1 hospital onset and 1 community onset). (YTD = 33). Of the 33 cases, 21 have been reviewed at RCA panel, 14 cases were deemed unavoidable as no lapses in care. Two of the cases had previously been C. Diff positive. The annual tolerance for CDI for 2022-23 is 56.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2022 was 93.7%. 2022-23 YTD rate is 93.7%.

During the month of August 2022 there was 1 fall resulting in severe harm or death category . (YTD severe harm or above category falls = 10).

There was 1 validated grade 3 hospital acquired pressure ulcer with lapse in care in August 2022. (YTD = 1).

Community Incident reporting levels have increased to 103 in the month of August 2022 Compared to 83 in July.
87 incidents were related to pressure skin damage, 5 were classified as low harm, the remaining 82 incidents were classified as no harm.

YTD HSMR (April - May) for 2022-23 is 88.2

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: 26th October 2022

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (August 2022) at 76.0%. YTD 82.4%. The 31 day target was achieved in August 2022 with 97.1% performance in month against a target of 96%, YTD 97.8%. The 2 week rule target was not achieved in August 2022 with 68.0% in month and 78.9% YTD against a target of 93%. 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 September 2022 was 47.3% and YTD 47.3%. The all type mapped STHK Trust footprint performance for September 22 was 70.6% and YTD 72.1%**.** The Trust saw average daily attendances of 313, which is up compared to August, at 300. Total attendances for September 2022 was 9,391.

Total ambulance turnaround time was not achieved in September 2022 with 57 mins on average. There were 2,080 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,032 in August 2022.

The UTC had 4,961 attendances in August 2022, compared to 5,246 in month of July 2022, an decrease of 5%,
Overall, 97% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in September 2022 was 156 compared with 147 in August. 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 August 2022 with 66.1% compliance and YTD 66.1% (Target 92%). Performance in July 2022 was 66.6%. There were (2,163) 52+ week waiters. The 6 week diagnostic target was not achieved in August 22 with 77.4% compliance. (Target 99%). Performance in July 2022 was 81.9%.

There was an increase in referrals received within the District Nursing Service in August however, the levels are still within average range (609 in August compared to 552 in July). The overall caseload size is within normal range (1,262 in August compared to 1,280 in July). Community matron caseloads have decreased to 130 in August compared to 134 in July. 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%). Included within the plan were agreed non recurrent savings to support the position. As at Month 6 (September), the Trust is in line with plan (£2.2m deficit).

Surplus/Deficit - At the end of Month 6, the Trust is reporting a deficit position of £2.2m, with £263.3m income and £265.4m expenditure year to date. This is in line with plan. Included within the financial position are non-recurrent benefits which are offsetting the non-achievement of National ERF, non-pay inflation pressures (excluding energy & PFI) and the pay award impact over and above funded levels.

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 agreed with C&M ICS. As at Month 6, low risk schemes either delivered or at finalisation stage total £24.5m in year and £16.0m recurrently.

Cash - At the end of Month 6, the cash balance was £41.0m.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £4.3m. Internally generated depreciation exceeds the 2022/23 capex plan. The plan has been agreed at ICS/ICB level, and includes PDC funding (£9.1m) which is agreed but not fully signed off nor drawn down from DHSC.

Human Resources

In September 2022, all staff sickness was 5.9%, a reduction of 0.2% from August (6.1%). The rate for Nursing and Midwifery staff group remains at 7.1%.

Appraisal compliance in September is 83.5%, a significant improvement from August (65.8%). Mandatory training compliance has dipped very slightly to 78.7% (August 79.1%).

St Helens and Knowsley Teaching Hospitals NHS Trust

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

Sep-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	Sep-22	2.1%	2.2%	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	▲	May-22	1.06		1.00						
Mortality: HSMR (HED)	Q	▲	May-22	81.6	88.2	100.0	96.9					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	May-22	84.5	96.6	100.0	105.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Apr-22	97.3	97.3	100.0	93.1		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	May-22	84.1	78.6	100.0	88.6		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	May-22	101.3	102.7	100.0	103.9					
% Medical Outliers	F&P	T	Sep-22	1.7%	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	Sep-22	26.7%	32.7%	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	▲	Aug-22	61.8%	62.2%	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.		Inpatients - 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. Outpatients - Work currently in process with admin team to review capacity to meet demand for outpatient clinic letters. Urgent letters are being prioritised but typing capacity is primary constraint in delivery of this target.	PW
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Aug-22	31.7%	28.9%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Aug-22	97.8%	97.9%	95.0%	97.2%					

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	▲	Q1	87.1%	87.1%	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	▲ £	Sep-22	0	1	0	1		One never event 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	Sep-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	▲ £	Sep-22	1	1	0	2		There was 1 MRSA cases in September 2022. (YTD = 1). There were 2 C. Difficile (CDI) positive cases reported in September 2022 (1 hospital onset and 1 community onset). (YTD = 33). Of the 33 cases, 21 have been reviewed at RCA panel, 14 cases were deemed unavoidable as no lapses in care. Two of the cases had previously been C. Diff positive. 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	▲ £	Sep-22	2	33	56	32					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-22	3	14	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Aug-22	1	1	No Contract target	2		1 validated category 3 pressure ulcer with lapse in care YTD, reported from Ward 1A.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from reported pressure ulcer incident and learning.	SR
Number of falls resulting in severe harm or death	Q	▲	Aug-22	1	10	No Contract target	22		1 fall resulting in severe harm category in August 2022 (Ward 5C).	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to ward.	SR
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-21			No Target	12			Quality and patient safety	We continue to emphasise the importance of thrombosis prevention. All cases reviewed. Appropriate prescribing and care identified. eVTE assessment tool currently now rolled out in ED as part of Electronic Medical Assessment Proforma.	PW
To achieve and maintain CQC registration	Q		Sep-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	Sep-22	93.7%	93.7%	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	Sep-22	1	11	No Target	30					

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 (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Aug-22	68.0%	78.9%	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	▲ £	Aug-22	97.1%	97.8%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-22	76.0%	82.4%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Aug-22	66.1%	66.1%	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	▲	Aug-22	77.4%	81.7%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Aug-22	2,163	2,163	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-22	1.1%	1.0%	0.8%	0.82%		Underperformance in cancelled ops has been due to staff sickness/absence and medical NEL pressures. The team is confident that this will recover going forward, although performance remains at risk.	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Aug-22	100.0%	99.0%	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	▲	Sep-22	47.3%	47.3%	95.0%	55.8%		Accident and Emergency Type 1 performance for September 2022 was 47.3% and YTD 47.3%. The all type mapped STHK Trust footprint performance for September 22 was 70.6% and YTD 72.1%. The Trust saw average daily attendances of 313, which is up compared to August, at 300. Total attendances for September 2022 was 9,391. Total ambulance turnaround time was not achieved in September 2022 with 57 mins on average. There were 2,080 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,032 in August 2022.	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. Flow through the Hospital 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	▲	Sep-22	70.6%	72.1%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Sep-22	0	0	0	0					

Sep-22

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	▲ £	Sep-22	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Sep-22	24	103	No Target	254		Slight increase in the number of new complaints received in month. % 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. The timescale for responding has been reduced to 100 days, as interim measure to reduce to 30 and 60 day response times in place pre-pandemic. Additional temporary resources remain in place to increase response rates within the Medical Care Group which has the largest number of open complaints.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-22	12	102	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-22	66.7%	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 September 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	Sep-22	379	359		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Sep-22	156	136		108					
Friends and Family Test: % recommended - A&E	Q	▲	Sep-22	79.7%	79.7%	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	▲	Sep-22	93.9%	94.8%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Sep-22	96.3%	94.3%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Sep-22	88.9%	92.7%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Sep-22	100.0%	94.4%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Sep-22	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Sep-22	94.2%	93.9%	95.0%	93.8%					

Sep-22

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
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Sep-22	5.9%	6.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In September 2022, all staff sickness was 5.9%, a reduction from August (6.1%). The rate for All Nursing and Midwifery staff group remains at 7.1%. N.B This includes normal sickness and COVID19 sickness reasons.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Employees who are absent from work due to sickness are contacted early to provide them with appropriate support and advice to aid their recovery and return to work. The support includes referral to occupational health and the implementation of reasonable adjustments, where applicable. Meaningful discussions take place between employees and managers during the absence and when employees return to work in the form of welfare, return-to-work, and attendance review meetings. There is a bi-weekly review of Trust absences. This is done by the HR Team and the Health, Work and Wellbeing 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	Sep-22	7.1%	7.8%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-22	83.5%	83.5%	85.0%	65.9%		Appraisal compliance in September is 83.5% which is an improvement from August (65.8%). Mandatory training compliance is 78.7% which has dipped from August (79.1%)	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Efforts to recover Appraisal compliance has shown significant improvement in performance in month. Mandatory training has dipped very slightly. Both remain just under the 85% target and recovery plans and actions to meet compliance continue to be delivered and monitored through People Council.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Sep-22	78.7%	78.7%	85.0%	74.7%					
NHS National Quarterly Pulse Survey : % recommended Care	Q	▲	Q2 2022-23	66.8%					Staff Friends and Family test superseded by the Quarterly staff survey in 2020-21.	Staff engagement, recruitment and retention.	Q2 survey results published at the end of August. All actions associated with the responses to the Q2 survey form a key component of the Staff Survey action plan for 2022, which continues to be monitored through the Executive Committee and People Council. Q3 survey is underway (Annual Staff Survey) this will close on the 25th November and results expected in early 2023.	AMS
NHS National Quarterly Pulse Survey : % recommended Work	Q	▲	Q2 2022-23	50.6%								
Staffing: Turnover rate	Q F&P UOR	T	Sep-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	Sep-22	Discontinued	Discontinued	N/A			The Trust financial position contains non-recurrent savings of £5.7m which are supporting delivery of the plan. The non recurrent savings are offsetting the non delivery of National ERF and increased inflation pressures (excluding energy and PFI) above funded levels. The capital plan includes external funding that has still not yet been received by the Trust.	Non-recurrent benefits will impact the underlying position of the Trust going into next financial year. Delays in the capital being received could impact the delivery of the capital programme.	The Trust will continue to liaise with the ICS so that they are fully aware of the non recurrent support within the Trust. The Trust is liaising with National supply chain who are working on plans to minimise inflation impacts. The Trust continues to do all preparatory work to ensure there will be no slippage in the capital programme.	GL
Progress on delivery of CIP savings (000's)	F&P	T	Sep-22	13,033	13,033	28,100						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Sep-22	(2,188)	(2,188)	(4,949)						
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-22	28	28	10						
Capital spend £ YTD (000's)	F&P	T	Sep-22	4,300	4,300	26,100						
Financial forecast outturn & performance against plan	F&P	T	Sep-22	(4,949)	(4,949)	(4,949)						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-22	96.0%	96.0%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-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	▲ £	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	100.0%	93.1%	83.3%	100.0%	100.0%	100.0%	94.8%	85.0%		96.0%		RC
	Total > 62 days		0.0	0.5	0.5	0.0	1.0	1.0	0.0	0.0	1.0	2.0	0.0	0.0	0.0	3.0			6.0		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.5		
Lower GI	% Within 62 days	▲ £	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	86.7%	90.5%	76.5%	79.3%	65.2%	83.3%	78.9%	85.0%		79.7%		
	Total > 62 days		2.5	0.0	3.0	4.0	3.0	2.0	1.0	1.0	1.0	2.0	3.0	4.0	2.0	12.0			24.5		
	Total > 104 days		1.5	0.0	0.0	1.5	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	1.0			4.0		
Upper GI	% Within 62 days	▲ £	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	36.4%	90.0%	84.6%	100.0%	85.7%	70.0%	84.3%	85.0%		83.2%		
	Total > 62 days		3.0	1.0	0.0	0.0	1.0	0.0	0.0	3.5	0.5	1.0	0.0	1.0	1.5	4.0			9.5		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.0	0.0	0.0	0.5	1.0			3.0		
Urological	% Within 62 days	▲ £	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	93.9%	90.0%	81.0%	79.2%	78.1%	85.0%	80.9%	85.0%		80.5%		
	Total > 62 days		4.5	2.0	1.0	3.5	0.5	8.5	1.5	1.0	1.5	4.0	2.5	3.5	1.5	13.0			32.5		
	Total > 104 days		0.5	2.0	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	0.5	1.5	0.5	2.5			4.0		
Head & Neck	% Within 62 days	▲ £	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	16.7%	0.0%	44.4%	0.0%	25.0%	20.7%	85.0%		24.4%		
	Total > 62 days		1.0	1.0	2.0	0.5	2.0	0.0	1.0	1.0	2.5	3.5	2.5	1.5	1.5	11.5			15.5		
	Total > 104 days		0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.5	0.0	0.5	3.0			2.0		
Sarcoma	% Within 62 days	▲ £									100.0%					100.0%	85.0%		100.0%		
	Total > 62 days										0.0					0.0			0.0		
	Total > 104 days										0.0					0.0			0.0		
Gynaecological	% Within 62 days	▲ £	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	60.0%	75.0%	66.7%	100.0%	45.5%	25.0%	53.3%	85.0%		67.3%		
	Total > 62 days		2.5	2.0	1.0	0.5	3.0	0.0	5.0	2.0	1.0	2.0	0.0	3.0	4.5	10.5			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.0	1.0	0.0	0.0	2.0	0.0	3.0			2.5		
Lung	% Within 62 days	▲ £	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	55.6%	50.0%	92.3%	69.6%	30.8%	64.7%	63.9%	85.0%		77.2%		
	Total > 62 days		0.0	2.5	3.0	1.5	1.0	2.5	1.5	2.0	1.5	0.5	3.5	4.5	3.0	13.0			18.0		
	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	1.0	0.0	1.0			1.5		
Haematological	% Within 62 days	▲ £	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	0.0%	100.0%	100.0%	75.0%	75.0%	69.2%	76.7%	85.0%		60.5%		
	Total > 62 days		0.0	0.0	0.0	1.0	1.0	0.0	0.0	2.0	0.0	0.0	1.0	2.0	2.0	5.0			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0	2.0			5.0		
Skin	% Within 62 days	▲ £	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	100.0%	97.7%	93.4%	95.5%	86.9%	79.7%	90.7%	85.0%		93.3%		
	Total > 62 days		1.0	3.5	4.0	4.5	3.0	3.0	2.0	0.0	1.0	2.5	1.5	5.5	7.5	18.0			29.5		
	Total > 104 days		0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	2.0	0.0	4.0			1.5		
Unknown	% Within 62 days	▲ £	100.0%		100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%	85.0%		88.2%		
	Total > 62 days		0.0		0.0	0.0		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	0.0			0.0		
All Tumour Sites	% Within 62 days	▲ £	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	86.3%	90.3%	83.2%	85.4%	77.6%	76.0%	82.4%	85.0%		85.2%		
	Total > 62 days		14.5	12.5	14.5	15.5	15.5	17.0	12.0	12.5	10.0	17.5	14.0	25.0	23.5	90.0			170.5		
	Total > 104 days		3.0	2.5	1.5	2.0	1.5	0.5	2.0	3.0	1.5	3.0	3.0	7.5	2.5	17.5			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%	66.7%	100.0%	100.0%			83.3%	85.0%		100.0%		
	Total > 31 days		0.0	0.0	0.0		0.0			0.0	1.0	0.0	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) 077
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 September 2022. There were five Executive Committee meetings held during this period. The new investment decisions made were: 1. Cardiology Consultant Business Case 2. Endoscopy Surveillance Recovery Business Case 3. Preceptorship Scheme – Business Case 4. Nurse - International Recruitment Business Case (subject to Board ratification) 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: Ann Marr, Chief Executive
Date of meeting: 26th October 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were five Executive Committee meetings in September 2022.

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

2. 1st September 2022

2.1 Safer Staffing Report – Month 4

The Director of Nursing, Midwifery and Governance presented the report on the high-level safer staffing figures for month 4 (July 2022) which were RN/M overall fill rate 93.58% and RCA overall fill rate 109.91%, and the deep dive analysis for month 3. The report now included additional information about nurse recruitment. It was noted that due to the business cases approved in July and August the nurse establishment had increased, but there was a pipeline of 86 newly qualified nurses due to join the Trust before the end of December and 63 additional international nurses.

2.2 Cardiology Consultant Business Case

The Director of Operations and Performance introduced the business case to increase the cardiology consultant establishment and support staff to respond to the increase in referrals and the waiting list. The case demonstrated that the current capacity was not sufficient to meet demand and that recruiting additional consultants represented the best value for money and was sustainable. The business case was approved.

2.3 Endoscopy Surveillance Recovery Business Case

The Director of Operations and Performance presented the business case for a time limited waiting list initiative plan to eliminate the backlog of overdue surveillance procedures. There was additional funding available from NHSE to support this initiative. The case demonstrated that this was the most cost effective option to increase short term capacity and was approved.

2.5 Additional Bed Capacity

The Director of Operations and Performance and Director of Corporate Services updated the committee on the impact of the current Whiston and St Helens Hospital site development plans on bed capacity and the timelines for these beds to be available. During 2020/21 the capital programme had yielded a net gain of 47 additional beds and the other schemes in progress or planned would create a further 36 additional beds on the Whiston Hospital site. Other opportunities for expanding the bed based within the current estate had also been identified and it was agreed these would be taken forward to feasibility stage so there was a pipeline of potential schemes ready to be progressed.

The committee also discussed opportunities for creating more capacity for winter 2022/23 working with care homes and Local Authorities to create step down facilities for patients who were fit for discharge.

2.6 Trust Board Agenda

The Director of Corporate Services presented the draft September Trust Board agendas and proposals for re-instating face to face meeting of the Board.

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

The Director of Informatics presented an options appraisal to provide support to the S&O Informatics service and it was agreed that a proposal should be made to both STHK and S&O Boards.

2.8 Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative – Governance proposals

The Director of Corporate Services presented the CMAST proposals to create a committee in common of all the member trusts to enable collective decision making. The proposals had to be approved by each Trust Board.

3. 8th September 2022

3.1 Preceptorship Scheme – Business Case

The Deputy CEO/Director of HR introduced the proposal to enhance the Trust preceptorship scheme to implement the new national preceptorship framework and quality standards. Preceptorship is an established programme for newly qualified nurses which is now being expanded to include Allied Health Professionals and International recruits undertaking the OSCE qualification. 12 months of funding had been provided by Health Education England to establish the new framework and it was proposed to recruit to fixed term positions to evaluate the effectiveness of the new framework in reducing the attrition rate of newly qualified staff. The proposal was approved.

3.2 Maternity Insight Visit Feedback

The Director of Nursing, Midwifery and Governance introduced the report of the formal feedback from the maternity insight visit that had taken place on 15th August to assess the Trust's progress in delivering the Ockenden Report recommendations. Good progress had been noted against the 47 key lines of enquiry (KLOE) with 41 rated as compliant, 5 as partially compliant and 1 as non-compliant. The non-compliant action related to the reporting arrangements for the Head of Midwifery. Committee reviewed the progress made against the partially compliant KLOEs and the timescales for completion.

4. 15th September 2022

4.1 Wagestream Instant Pay Trial Evaluation

The Deputy CEO/Director of HR introduced the report which presented the results of the trial of Wagestream which had taken place between January and April 2022 for staff in the Emergency Department and ICU, where the Trust had already been undertaking manual

weekly overtime payments. Wagestream enables staff to draw down overtime and enhancement payments earned outside of the payroll cycle. During the three month trial Wagestream was used by 71 staff members on 87 occasions. During the last year Wagestream had been adopted by 35 Trusts nationally and 4 in Cheshire and Merseyside and more were in the process of implementing the system. The system was also used by Patchwork for the Junior Doctors Collaborative Bank. The committee agreed that, although there had not been a high take up during the trail, this was a facility that should be available to staff via the Wagestream system and it should now be rolled out to all staff who worked overtime or additional hours.

4.2 Nurse - International Recruitment Business Case

The Director of Nursing, Midwifery and Governance introduced the paper which detailed the additional funding required to support the recruitment of 100 additional international nurses. The funding was required to support training and support costs in the first few months of employment with experience demonstrating that this investment was needed to help staff form overseas to settle in a new country and successfully obtain their OSCE qualification. The plans for the international recruitment alongside other planned recruitment into nursing vacancies would result in over recruitment against establishment if all posts were filled. The committee considered that it was a prudent investment to try and recruit and retain more nursing staff in the current labour market, and any additional posts could be used to offset bank and agency costs. The investment requested was over £0.5m and therefore required Board approval. It was agreed that a recommendation from the Committee would be made to the October Trust Board.

4.3 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

The Deputy CEO/Director of HR presented the annual WRES and WDES reports and proposed action plans. The committee discussed the proposed actions and the reported changes compared to 2020/21. The reports would be presented at the September Trust Board.

4.4 Appraisal Compliance - August

The Deputy CEO/Director of HR reported that appraisal compliance had increased but remained significantly below 85%. The report included a breakdown of compliance by staff group and by care group to allow Directors to address this with their teams. The information campaign promoting the appraisal “window” which closed on 30th September, continued.

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

The Director of Corporate Services provided an update on the transaction programme and the planned communication with staff, following the end of the official period of mourning for Queen Elizabeth II.

The Deputy CEO/Director of HR reported on the recent IT outage at S&O which had been resolved with support from STHK.

The S&O Annual General Meeting was taking place on 22nd September.

4.6 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for review and agreement of the commentary.

4.7 Risk Management Council Chair's Assurance Report

The Director of Corporate Services presented the report which included an update on the Corporate Risk Register (CRR). 2 risks had been removed from the CRR and 1 new risk had been escalated - risk of ambulance delays transporting stroke patients for neuro radiology. The RMC had also reviewed progress in implementing the recommendations from the internal audit review in April 2022.

4.8 National Digital Funding

The Director of Informatics briefed the committee on the recent digital funding announcements and the procurement requirements to access this funding. It was agreed that an option appraisal should be undertaken with expert procurement advice.

5. 22nd September 2022

5.1 Pension Policy

The Deputy CEO/Director of HR presented proposals in relation to the pension recycling, which were to be taken to the Remuneration Committee for approval.

5.2 Safer Staffing Report – Month 5

The report detailed the safer staffing figures in August (RN/M overall fill rate 93.22% and HCA overall fill rate 110.02%) and presented the deep dive analysis for the July. Committee discussed falls which had been reported in this period and how many of these patients had been assessed as needing 1 to 1 supplementary care. It was agreed that additional fill rate information would be provided in future reports for those wards which had been trialling long shifts, as this could be used as part of the consultation evaluation and feedback.

5.3 Southport and Ormskirk NHS Trust (S&O)

The Director of Informatics proposed commissioning an IT infrastructure review of S&O to understand the remedial works required and the level of risk. The suggestion was supported.

The Associate Medical Director of Planned Care vacancy at S&O had been filled by a STHK consultant.

6. 29th September 2022

6.1 Electronic Patient Record (EPR) Collaboration

The Director of Informatics presented 8 potential options to take forward the collaborative procurement of a new EPR with neighbouring Trusts to meet the NHS Digital requirements to access the national funding.

6.2 HFMA Financial Sustainability Self-Assessment

The Director of Finance and Information introduced the paper which detailed the Trusts self-assessment against the new mandatory HFMA financial sustainability checklist, which reflected best practice in financial systems and controls. The committee approved the self-assessment for submission to the ICB.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22) 078
Reporting from: Quality Committee
Date of Committee Meeting: 18th October 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 and Governance
Peter Williams, Medical Director
Rob Cooper, Director of Operations
Nicola Bunce, Director of Corporate Services
Gareth Lawrence, Director of Finance

In attendance:
Teresa Keyes, Deputy Director of Nursing and Quality
Rajesh Karimbath, Assistant Director of Patient Safety
Jacqui Scott, Head of Nursing and Quality
Anne Rosbotham-Williams, Deputy Director of Governance
Debbie Stanway, Head of Nursing and Quality
Stephen Beckett, Head of Quality
Su Hobbs, Associate Head of Nursing and Quality
Tracy Greenwood, Head of Nursing and Quality

Matters Discussed

Positive feedback received following the CQC inspection of Marshalls Cross Medical Centre, noting the significant progress made since the previous inspection in 2018.

Action Log
One action remains ongoing, with an update on the work taking place with theatres to be presented to January's Committee meeting.

Integrated Performance Report (IPR) highlighted:

- No Never Events, with one MRSA bacteraemia reported in September and one category 3 hospital acquired pressure ulcer reported in August, noting the ongoing actions being taken, including targeted training and support
- 2 cases of C difficile reported in September
- 1 fall resulting in severe harm reported in August
- Safer staffing fill rate for registered nurses/midwives for September 2022 was 93.7% and year-to-date rate 93.7%
- HSMR for April – May 2022-23 was 88.2

- Continued achievement of 31-day target in August, although 62-day target was below target in month at 76% and below target year to date
- 2-week rule target was not achieved in August
- Continued challenges in meeting emergency care access targets, however 97% of patients were seen and treated within 4 hours at the Urgent Treatment Centre
- Ambulance turnaround times were not achieved
- Average daily number of super stranded patients (length of stay over 21 days) increased to 156 in September
- 18-week referral to treatment and 6-week diagnostic targets were not achieved
- Improvements noted in sickness absence and appraisals with mandatory training falling slightly in September
- District nursing referrals increased in August but remained in line with average

The Committee asked for additional information relating to the increase in caesarean sections to be brought to the next meeting.

Clinical Effectiveness Council report
The Council received a presentation on Resuscitation Services, noting an increased compliance with NEWS2 (national early warning scores) and the targeted work to improve mandatory training for life support. The Medical Emergency Team (MET) audit highlighted that the majority of calls continue to be out of hours and for elevated NEWS. The Tendable presentation provided an overview of electronic audits and indicated that the action planning module will be rolled out shortly. The major trauma audit indicated that only one of the 16 indicators was not met (for CT scans completed within one hour for all head injuries) due to the volume of activity, with improvements sought. Additional funding has been secured to increase the number of non-medical prescribers across the Trust. A number of reports were received including maternity KPIs, Drug and Therapeutics Group and Quality Improvement and Clinical Audit update, showing 99% compliance with the audit plan. Two policies were approved with escalation of any overdue documents.

Patient Safety Council Report
A number of reports were received, including the patient safety report which noted 10 StEIS reportable incidents in August and a continued reduction in patient falls; there was a detailed discussion at the meeting relating to MRSA bacteraemia; the CAS report noted that all alerts were being actioned and the medicines safety group report highlighted monitoring of incidents; manual handling report noted low training compliance which needs to be addressed. The Tendable audit report highlighted areas that had improved in the latest round of audits. The Council received an update on the new Patient Safety Incident Response Framework, which will be implemented next year. Two procedural documents were approved.

Safeguarding Annual Report 2021-22
The Committee approved the annual report from last year and noted in particular the progress in delivering the actions outlined in the report, with a number to be carried forward into this year, including ongoing training, planning for the implementation of Liberty Protection Safeguards and recruiting into the posts approved in the recent business case. The Team continued to see an increase in activity, including Learning Disability and Deprivation of Liberty Safeguard referrals.

The Committee noted the steps being taken to improve services across the system for CAMHS patients and in completing the health assessments for looked after

children. The funding secured for Mersey Care to support the administration of Mental Health Act was also noted.

Safeguarding Quarterly Report
The quarter 2 report highlighted the significant activity within the service, which will be supported by the recruitment of additional staff. Training remains a key focus for improvement with support provided to managers. There has been an improvement in the number of looked after children receiving health assessments within the 20-working day target, noting that a high number of delays were beyond the control of the team. The final code of practice for the Liberty Protection Safeguards is awaited.

Nurse Safer Staffing Monthly Report
The overall fill rate for registered nurses/midwives was 93.33% in August and 110.02% for health care assistants, although there was a shortfall noted for the total number of supplementary care requests. The number of wards below the fill rate of 90% in July was 11 for registered staff and 6 for health care assistants, a slight increase on the previous month. A small number of incident red flags were reported when staffing rates were below 85%, including no harm drug incidents and there was one maternity divert reported, however no women needed to be diverted during that time. The report included additional detail relating to vacancies and recruitment activity. The Committee were informed of the support and training that is now in place to increase retention of health care assistants and plans for further international recruits.

Patient Experience Council report
The Council received a number of reports, including the actions being taken to continue to improve patient discharges and the action plans following the latest national patient surveys for Marshalls Cross Medical Centre, Urgent and Emergency Care and Children and Young People. Complaints and PALS activity was noted at the Council, including lessons learned and actions taken. Positive comments were received from Healthwatch Knowsley and St Helens, with any areas of concern addressed where possible. No procedural documents were overdue.

Complaints, PALS, Claims and Friends and Family Test Quarter 2 2022-23
The number of new complaints has increased, following a decrease in the previous quarter, leading to a slight increase in overall open complaints. It was pleasing to note that the number of complaints received by the Emergency Department has decreased, potentially due to the actions taken following previous complaints. There was an increase in complaints relating to Theatres, which will be reviewed fully following the investigations currently underway.

The number of claims remains fairly consistent with previous quarters, with slightly more NHS Resolution instructed claims than the last two quarters, reflecting a return to pre-pandemic levels. Lessons learned from both complaints and claims were shared to highlight actions taken.

The number of inquests has increased slightly, although the Coroner is requesting less staff to attend in person, reflecting the quality of the information and evidence submitted in advance.

PALS continue to receive a similar number of concerns as in previous quarters and have maintained a low level of conversions to formal complaints.

Friends and Family Test recommendation rates remain above target for inpatients, postnatal and postnatal community, but below target for all other areas, with ongoing work with departments to address any negative feedback. Over 18,000 comments were received in Q2, with the vast majority being positive.

Assurance provided:

- Continued decrease in rate of falls
- Increased number of patients being deflected from Emergency Department to Urgent Treatment Centre
- Low cardiac arrest rate (0.25 per 1000 hospital admissions) compared to other trusts
- Review of all paediatric patients attending the Emergency Department by the Paediatric Liaison Team to ensure no issues of safeguarding concern are overlooked
- Robust support and training in place for new health care assistants and registered nursing staff to increase retention rates
- Conversion of informal PALS concerns to formal complaints remains low

Decisions taken:

- No formal approvals required

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

- Continued focus on recovery of mandatory training

Matters for escalation:

- Ongoing challenges being met to reduce waiting times across a number of services and pathways, including referral to treatment times and access to diagnostics

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: 26th October, 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)079
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 20th October 2022

Summary

Meeting attended by:

J Kozer – NED & Chair
P Growney – NED
P Williams – Medical Director
A Bassi – Divisional Medical Director
G Lawrence – Director of Finance & Information
N Bunce – Director of Corporate Services
A Matson – Assistant Director of Finance – Financial Management
T Truong – Assistant Director of Finance – Corporate
P Nee – Assistant Director of Operations – Surgical Care
K Lythgoe – Assistant Director of Finance – Surgical Care

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was below the 85% target in August, at 76.0%.
- Target 31 day performance was met in August, at 97.1% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in August, at 68.0% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 47.3% in September and 47.3% year to date. All type mapped STHK Trust footprint performance was 70.6% in September and is 72.1% year to date. The Trust saw average daily attendances of 313, which is an increase compared to August at 300. Total attendances for September were 9,391.
- The ambulance turnaround time target was not achieved in September, at 57 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- In September, overall sickness had reduced to 5.9%, from 6.1% in August.

B) Finance Report Month 6

- At Month 6, the Trust is reporting a year to date deficit of £2.2m and forecast outturn deficit of £4.9m, in line with plan.
- Included within the financial position are non-recurrent benefits of £7.7m which are offsetting pressures in relation to underachievement of national Elective Recovery Fund (ERF) income, non-pay inflation and the 22/23 pay award impact above funded levels. These underlying pressures will be highlighted during the 23/24 finanical planning process.
- Further risk to delivery of the forecast position relates to the inclusion of full local ERF and CQUIN income, assuming no clawback by NHSE.
- Capital expenditure for the year to date (excluding PFI lifecycle maintenance) totals £4.3m.
- At the end of Month 6, the Trust has a cash balance of £41.0m.

- Agency expenditure of £6.2m is included in the year to date position, compared to £4.6m year to date at Month 6 of 21/22. Premium Payment Scrutiny Council meetings have been reintroduced.
- The Better Payment Practice Code (BPPC) requirement has been achieved for non-NHS invoices by value at 97.1% against a target of 95%.

For Approval

N/A

For Information

CIP Council Update – Update noted by the committee

Risks noted/items to be raised at Board

N/A

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members

Recommendation(s): Members are asked to note the contents of the report

Presenting officer: J Kozer, Non-Executive Director

Date of meeting: 26th October 2022

TRUST BOARD

Paper No: NHST(22) 080
Title of paper: Committee Report – Charitable Funds
Purpose: To report to the Trust Board on the Charitable Funds Committee, 19th Oct 2022

Summary

Meeting attended by:

P Growney – NED & Chair
L Knight - NED
C Oakley – Deputy Director of Finance & Information
D Littler – Charity
D Pye – Financial Accountant
J Turner – Charitable Funds Officer

Agenda Items

For Assurance

- YTD I&E Summary: Income £28,196 Expenditure £29,549 Commitment £58,177
- Details of in year donations presented and options to increase these discussed.
- Significant items of expenditure noted including £12,896 expenditure for post operative bra's for breast reconstruction patients.

For Information

- Strategy for the Charity to be worked up and discussed at the next meeting
- Agreement for funds to be released for Christmas gifts for patients
- Annual accounts & Annual report for 2021-22 approved by Chair and committee.

For Approval

- Annual accounts & Annual report for 2021-22 approved by Chair and committee.

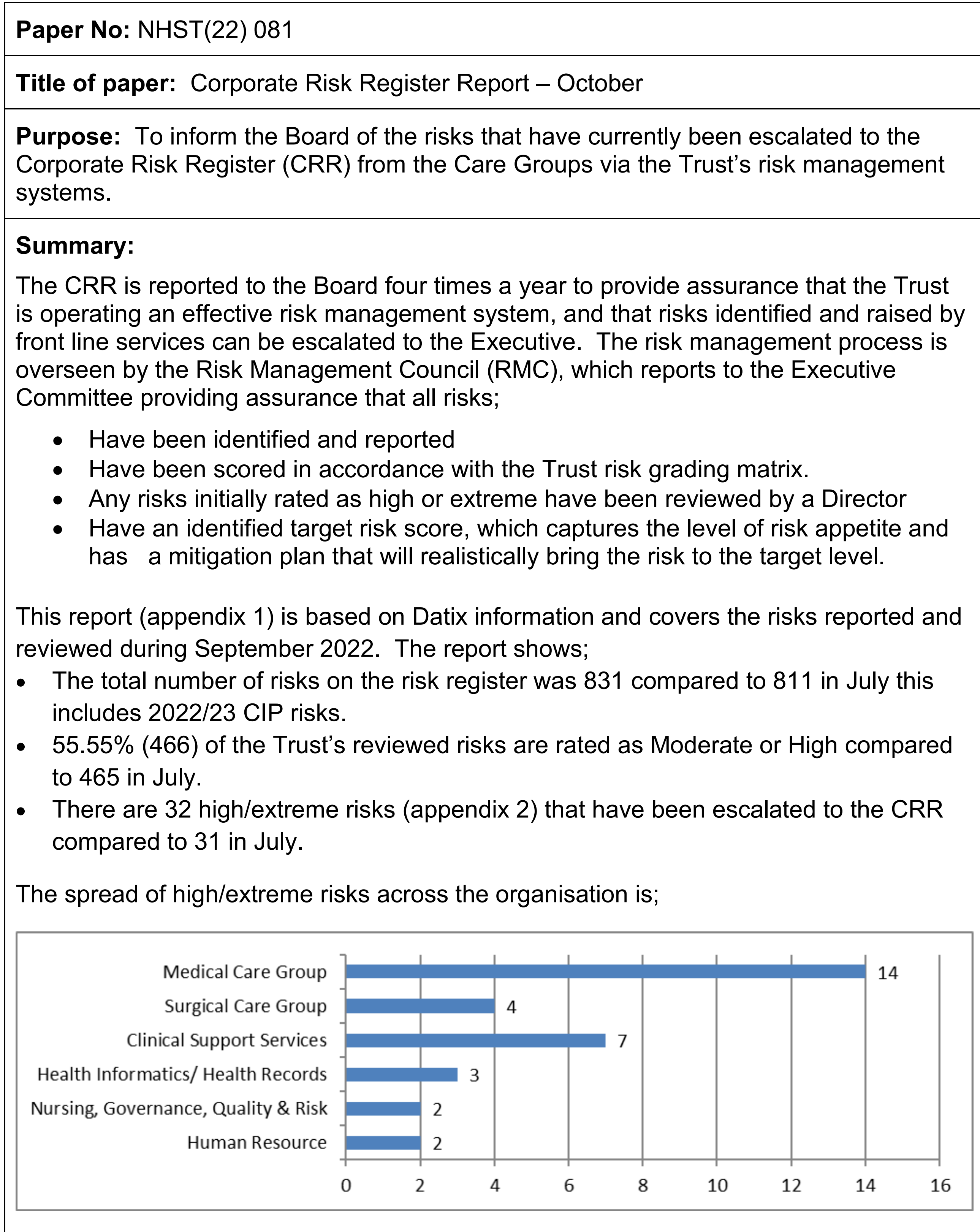
Risks noted/items to be raised at Board

None

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: Paul Growney
Date of meeting: 26th October 2022

NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

Trust Board



Paper No: NHST(22) 081
Title of paper: Corporate Risk Register Report – October
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;

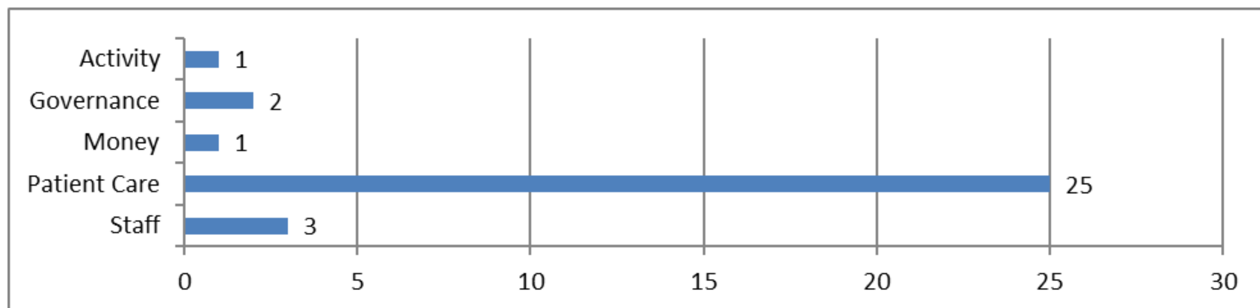
- Have been identified and reported
- Have been scored in accordance with the Trust risk grading matrix.
- Any risks initially rated as high or extreme have been reviewed by a Director
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will 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 September 2022. The report shows;

- The total number of risks on the risk register was 831 compared to 811 in July this includes 2022/23 CIP risks.
- 55.55% (466) of the Trust's reviewed risks are rated as Moderate or High compared to 465 in July.
- There are 32 high/extreme risks (appendix 2) that have been escalated to the CRR compared to 31 in July.

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 (July 2022) and against the same period last year – October 2021 (Appendix 3).

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

Financial implications: None directly from this report.

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

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 26th October 2022

Appendix 1

CORPORATE RISK REGISTER REPORT – OCTBER 2022

1. Risk Register Summary for the Reporting Period

RISK REGISTER	October 2022	September 2022	August 2022
Number of new risks reported	31	24	11
Number of risks closed or removed	20	17	9
Number of increased risk scores	4	6	3
Number of decreased risk scores	12	13	15
Number of risks overdue for review	61	87	62
Total Number of Datix risks	**831***	**822**	**816**

** Includes 7 risks that have been reported but not yet scored or approved in DATIX as it is a live system, remainder of the report is based on the 824 scored risks.*

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 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
33	**34**	**15**	**92**	**10**	**174**	**67**	**174**	**30**	**163**	**10**	**11**	**11**	**0**
82 = 9.95%			**276 = 33.50%**			**434 = 52.67%**				**32 = 3.88%**			

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

2.1 Surgical Care Group – 180 risks reported 21.84% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**6**	**2**	**14**	**3**	**41**	**20**	**44**	**10**	**34**	**1**	**1**	**2**	**0**
10 = 5.56%			**58 = 32.22%**			**108 = 60%**				**4 = 2.22%**			

2.2 Medical Care Group – 128 risks reported 15.53% 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
13	**6**	**0**	**9**	**2**	**22**	**5**	**20**	**11**	**26**	**3**	**4**	**7**	**0**
19 = 14.84%			**33 = 25.78%**			**62 = 48.44%**				**14 = 10.94%**			

2.3 Clinical Support Care Group – 122 risks reported 14.80% 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	**4**	**0**	**16**	**0**	**26**	**9**	**24**	**5**	**25**	**5**	**1**	**1**	**0**
10 = 8.20%			**42 = 34.43%**			**63 = 51.64%**				**7 = 5.74%**			

2.4 Primary Care and Community Services Care Group – 59 risks reported 7.16% 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**	**7**	**0**	**9**	**6**	**13**	**3**	**18**	**0**	**0**	**0**	**0**
3 = 5.08%			**16 = 27.12%**			**40 = 67.80%**				**0**			

2.5 Corporate – 335 risks reported 40.65% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**18**	**13**	**46**	**5**	**76**	**27**	**73**	**1**	**60**	**1**	**5**	**1**	**0**
40			**127**			**161**				**7**			

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	3	17	14	4	38
Facilities (Medirest/TWFM)	0	10	15	7	32
Nursing, Governance, Quality & Risk	2	18	13	4	37
Finance	0	11	24	8	43
Medicines Management	0	25	31	5	61
Human Resource	2	80	30	12	124
Total	7	161	127	40	335

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 – October 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	23/09/2022	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	28/09/2022	4 x 2 = 8	✓	Strategic People Committee
3	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	25/05/2022	4 x 2 = 8	✓	Executive Committee
4	Money	1152	**If** there is an increase in bank and agency, **then** there is a risk 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	23/09/2022	4 x 3 = 8	✓	Finance & Performance Committee
5	Patient Care	1263	**If** the Trust cannot achieve the required numbers of patient discharges and transfers, **then** there is a risk to operational performance	3 x 3 = 9	3 x 5 = 15	18/07/2022 Rob Cooper	15/09/2022	3 x 2 = 6	✓	Executive 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	21/07/2022	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	01/09/2022	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	12/09/2022	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	26/09/2022	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	28/09/2022	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	26/09/2022	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	26/09/2022	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	26/09/2022	2 x 4 = 8	✓	Executive Committee
14	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	30/09/2022	4 x 2 = 8	✓	Quality Committee
15	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	20/09/2022	5 x 2 = 10	✓	Quality Committee
16	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	31/08/2022	2 x 3 = 6	✓	Quality Committee
17	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	21/09/2022	5 x1= 5	✓	Quality Committee
18	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
19	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	22/09/2022	3 x 2 = 6	✓	Executive Committee
20	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	31/08/2022	4 x 2 = 8	✓	Strategic People Committee
21	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	22/08/2022	4 x 2 = 8	✓	Strategic People Committee
22	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	12/09/2022	4 x 1 = 4	✓	Executive Committee
23	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	20/09/2022	1 x 1 = 2	✓	Executive Committee
24	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	16/09/2022	2 x 2 = 4	✓	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
25	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	22/09/2022	4 x 2 = 8	✓	Executive Committee
26	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	26/09/2022	2 x 2 = 4	✓	Executive Committee
27	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	05/09/2022	2 x 3 = 6	✓	Executive Committee
28	Patient Care	3475	**If** there is a delay in NWAS transferring patients who have had a stroke for neuro radiology intervention(thrombectomy), **then** this can make a significant difference to patient outcomes.	4 x 5 = 20	4 x 4 = 16	09/08/2022 Rob Cooper	13/09/2022	4 x 1 = 4	✓	Executive Committee
29	Patient Care	3513	**If** there is insufficient capacity due to staff vacancies and sickness absence, **then** there is a risk of delay in booking appointment slots for urgent referrals	3 x 5 = 15	3 x 5 = 15	01/09/2022 Rob Cooper	14/09/2022	3 x 3 = 9	✓	Executive Committee
30	Patient Care	3514	**If** there are delays in actioning requests to change clinics (cancel or reduce capacity), due to lack of capacity to respond to the volume of requests **then** there is a risk that patients will not been seen in a timely manner	3 x 5 = 15	3 x 5 = 15	01/09/2022 Rob Cooper	14/09/2022	3 x 3 = 9	✓	Executive Committee
31	Patient Care	3525	**If** there is not sufficient capacity, **then** there is a risk that the target for 72 hour urgent ultrasound scans will not be performed within the recommended timescales	3 x 5 = 15	3 x 5 = 15	14/09/2022 Rob Cooper	14/09/2022	3 x 2 = 6	✓	Executive Committee
32	Patient Care	3527	**If** there is not sufficient plastic surgery capacity commissioned **then** non urgent patients in North Wales may face extended waits to be seen, and there will be a reduction in follow up appointments for cancer patients	4 x 5 = 20	4 x 5 = 20	21/09/2022 Rob Cooper	21/09/2022	4 x 1 = 4	✓	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 July 2022 are;

Risk Category	Datix Reference	Risk Description
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.
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
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
Governance	3298	If the Trust is impacted by the cyber threat Apache Log4J, then Trust systems could be accessed and exploited.

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.

Appendix 3

Trust Risk Profile – July 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
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%**			

Trust Risk Profile – October 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
25	**25**	**14**	**81**	**8**	**139**	**64**	**169**	**35**	**145**	**8**	**7**	**7**	**0**
64 = 8.80%			**228 = 31.36%**			**413 = 56.81%**				**22 = 3.03%**			

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)082
Title of paper: Review of the Board Assurance Framework (BAF) – October 2022
Purpose: For the Executive Committee to review and agree any proposed 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 July 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** There were no proposed changes to risk scores this quarter.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE/I, CQC, ICB
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 20th October 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 (Revised to November 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 Revise the maternity performance dashboard in line with Ockenden recommendations (Revised to November 2022)	~~Delivery of never event improvement plans and human factors training (Revised to September 2022)~~ Deteriorating patient improvement project (Project scope reviewed and refreshed revised to March 2023) Birth Rate Plus review of maternity staffing (report not yet finalised – rescheduled for November 2022) Improve mandatory and core skills training compliance (Revised to March 2023) Delivery of the 2022/23 CNST Maternity Safety Bundle (March 2023) Undertake a deep dive in to falls and the impact of the falls action plan (January 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 • 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 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 3 = 12~~ 4 x 4 = 16	Continue collaboration across C&M to deliver transformational CIP contribution 2022/23 contracts remain unsigned for the C&M ICB (December 2022)	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 Reduction in bank and agency spend compared to 2021/22 (March 2023)	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 December 2022 as national ERF allocation criteria not published) Delivery of the agreed 2022/23 financial plan (March 2023) Complete financial modelling and scenario planning to support the S&O/STHK transaction business case (November 2022) Develop financial and activity plans for 2023/24 when national planning guidance is published – including baselining of activity values (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	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 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 Phase 2 – Discharge Lounge improvement work to optimise capacity (January 2023)	Widnes UTC ICB Review (September 2022) Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) ~~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 and/or flu with minimum disruption to other services (March 2023) Assess the impact on activity of the opening of the new Royal Liverpool Hospital (December 2022)	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 • 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 • ED&I Steering Group 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 • Place Director 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 Place Directors to develop plans for PBPs in these Boroughs • Annual staff engagement events programme • ED&I Steering Group • Member of CMAST Provider Collaborative	4 x 3 = 12	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.	Continued engagement with C&M ICB and CMAST 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) Work with Place system partners to coordinate responses to UEC pressures and maintain patient flow (March 2023)	4 x 2 = 8	AMS/RC

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, EDS3 pilot 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 • ~~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 Establish diagnostic collaborative bank (March 2023) Develop sustainable COVID vaccination programme staffing arrangements for C&M (Revised to March 2023) Review of staff incident reporting and monitoring (March 2023)	Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (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 November 2022) Deliver the staff survey action plan (March 2023) Refreshed People Strategy 2023 – 25 (January 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 • Green Plan	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 Develop energy security strategy (December 2022)	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 (Revised to March 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 Development of management agreement for the leadership and management of S&O IT (November 2022)	Review benefits of ISO27001 – if not superseded plan for implementation July 2023 Achieve HIMMS Level 5 2022 standards (November 2025) 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 (March 2025) Delivery of Community EPR (Completion revised to March 2023) 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) 083
Title of paper: Incidents, Complaints, Concerns & Claims – Quarters 1 & 2 2022-23
Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarters 1 & 2 2022-23

Summary

Incidents

- Total incidents reported in Q1 = 4654 (5.80% increase on Q4 2021-22 = 4399)
- Total incidents reported in Q2 = 4624 (0.64% decrease on Q1 2022-23)
- Total patient incidents in Q1 = 3781 (4.16% increase on Q4 2021-22 = 3630)
- Total patient incidents in Q2 = 3681 (2.64% decrease on Q1 2022-23)
- Total patient incidents graded as moderate or above in Q1 = 32 (25.58% decrease on Q4 2021-22 = 43)
- Total patient incidents graded as moderate/severe/death in Q2 = 28 (12.5% decrease on Q1 2022-23 = 32)
- The highest number of incidents reported relate to:
    - Pressure ulcers = 806 in Q1 and 753 in Q2 (which include pressure ulcers acquired prior to admission to Trust services)
    - Patient slips, trips or falls = 514 in Q1 and 558 in Q2

Complaints

- 44 first stage complaints were received in Q1 and 64 in Q2
- Clinical treatment was the main reason for complaints, in line with previous quarters
- ED remained the main department to receive complaints, although numbers have reduced
- The Trust closed 67 1st stage complaints in Q1 and 39 in Q2 2022-23

Claims

- 48 new claims in Q1 and 47 in Q2; 20 of these were NHSR instructed claims
- In addition, 19 pre-action claims converted to NHSR instructed claims in Q1 and Q2
- Failure/delay in diagnosis remained the main cause of new claims
- 11 new inquests were received in Q1 and 16 in Q2
- 16 inquests were closed in Q1 and 12 in Q2

PALS

- 1137 contacts were received in Q1 2022-23 and 1118 in Q2; Q2 showed a 1.61% decrease from Q1.

• Q1 2022-23, 95.58% of enquires were resolved (4.42% % conversation rate to complaints); Q2 94.40% of enquiries were resolved (5.60% conversation rate to complaints) • Top 5 themes remain consistent with previous quarters, with a decrease in PALS enquiries relating to communication throughout 2022-23 compared to 2021-22.
Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 26th October 2022

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarters 1 and 2 2022-23, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

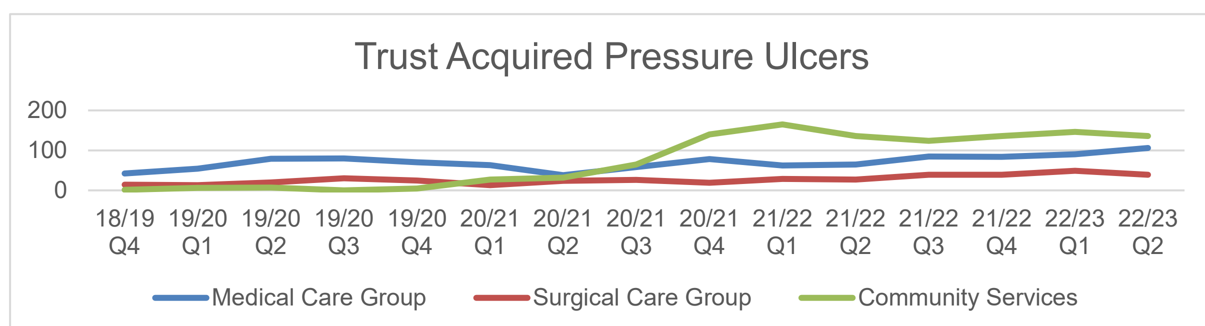
During Q1, 4654 incidents were reported, of which 81.24% (3781) were patient safety incidents. This is a 5.80% increase from Q4 2021-22 in all incidents and 4.16% increase in patient incidents. During Q2 4624 incidents were reported, of which 79.61% (3681) were patient safety incidents. This represents a decrease from Q1 2022-23 of 0.64% in all incidents and 2.64% decrease in patient incidents.

Incident type	2022-23	
	Q1	Q2
Incidents affecting Patients	3781	3681
Incidents affecting Staff	385	427
Incidents affecting the Trust or other organisation	462	488
Incidents affecting Visitors, Contractors or Members of the Public	26	28
Total	4654	4624

Q1 had 12 and Q2 had 23 incidents reported to StEIS, compared to 22 in Q4 2021-22. During Q1 2022-23, there were 32 patient safety incidents categorised as moderate harm, severe harm or death and there were 28 during Q2. In comparison in Q4 2021-22 there were 43 incidents reported moderate or above, showing a marked decrease.

StEIS reported incidents						
	21-22 Q1	21-22 Q2	21-22 Q3	21-22 Q4	22-23 Q1	22-23 Q2
Moderate	24	30	27	26	22	18
Severe	7	6	11	15	8	9
Death	2	2	4	2	2	1

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories during Q1 and Q2 were pressure ulcers (806 in Q1 and 753 in Q2), which includes all patients who are admitted with pre-existing pressure ulcers. The second highest reported category is slips, trips and falls (514 in Q1 and 558 in Q2). These are consistently the highest reported incidents in previous quarters.

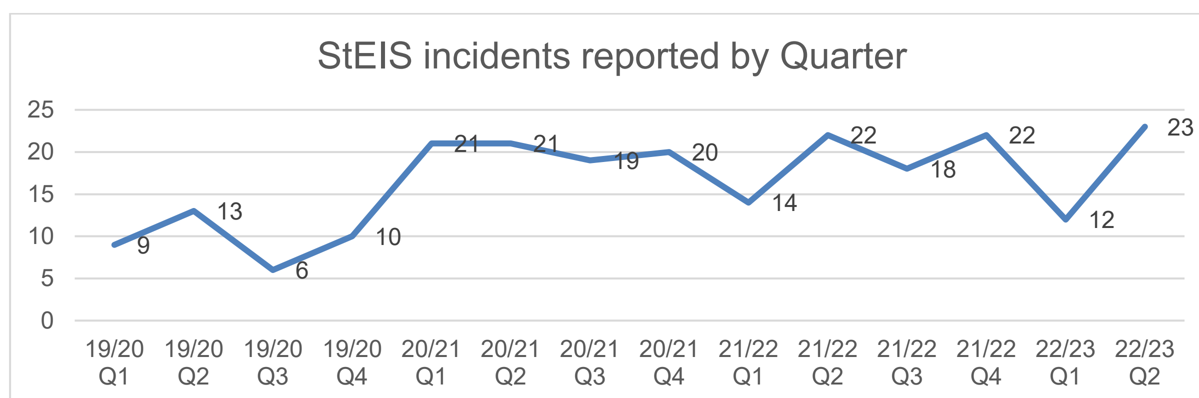


No severe harm Trust acquired pressure ulcers, with lapses in care were identified in Q1 or Q2 2022-23.

STHK Acquired PU	2019-20				2020-21				2021-22				2022-23	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
None	9	17	7	3	7	8	15	77	100	82	113	145	198	165
Low	58	85	97	97	94	86	134	157	155	137	124	105	77	95
Moderate	6	4	5	0	2	0	0	1	0	0	0	0	1	1
Severe	0	0	1	0	0	0	0	0	1	0	1	0	0	0
Ungraded to date	0	0	0	0	0	0	0	2	0	9	10	9	9	20
Total	73	106	110	100	103	94	149	237	256	228	248	259	285	281

2.1. Review of incidents reported to StEIS in Q1 and Q2 2022-23

During Quarter 1 2022-23 the Trust had 12 incidents which were reported to StEIS and 23 incidents in Q2. In comparison, the Trust reported 22 incidents during Q4 2021-22. These incidents met the serious incident reporting criteria.



During Q1 there were 31 StEIS reports submitted to the CCG and 16 submitted in Q2. 3 reports submitted during Q1 were shared after the agreed timeframe. A plan was put in place during Q1 to ensure all breached RCA were submitted with new timeframes as agreed with the CCG. All of the remaining 44 reports were submitted within the agreed timeframes. Actions taken and lessons learned are shared both internally and with the CCG.

2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q1 and Q2. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm incidents and Level 1 incidents are monitored within the Care Groups.

2.3. Benchmarking

The table below shows the most recent data (September 2021) provided by NHS England comparing patient safety incidents reported to the NRLS by the Trust to the

national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe harm or death vary due to the relatively small numbers. National figures are published every September.

% of all reported incidents	April 20 to March 21		April 21 to March 22	
	National %	**Trust %**	**National %**	**Trust %**
No harm	72.7%	82.4%	70.6%	79.0%
Low	24.6%	17.0%	26.0%	20.2%
Moderate	2.2%	0.4%	2.9%	0.5%
Severe	0.3%	0.1%	0.3%	0.3%
Death	0.2%	0.02%	0.2%	0.1%

2.4. Dissemination of learning

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

3. Complaints

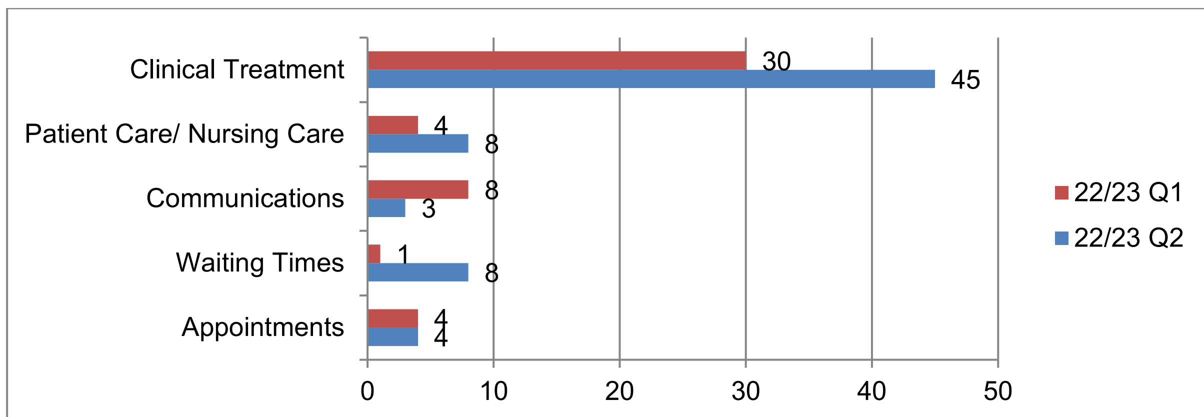
The table below shows the number of received and opened first stage complaints by quarter. The Trust experienced a decrease in complaints in the first two quarters of 2022-23, compared to 2021-22; if this trend continues then the Trust will have less complaints than any of the previous 4 years. There have been 20 2nd stage complaints so far this year, which is an increase on the previous 4 years. The main reasons for complainants submitting a second stage complaint are for further information or if they do not agree with the findings.

The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved in 2019-20, 2020-21 and 2021-22. The Trust's response time to first stage complaints has decreased in both Q1 and Q2. The Trust has resolved 106 1st stage complaints in the first 2 quarters of 2022-23, of which 76 were in time and 30 were out of time.

*data correct as a 14 October 2022. There may be some subsequent changes if complaints are discontinued or reclassified.

Indicator	2018-19	2019-20	2020-21	2021-22	2022-23	
					Q1	Q2
Total number of new complaints including community services	273	325	251	266	44	64
Total number of new complaints received (excluding community services)	267	320	242	254	42	63
Acknowledged within 3 days – target 100%	99.3%	100%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	92.1%	93.4%	94%	80%	71.6%	71.7%
Number of overdue complaints	1	1	4	7	6	6
Second stage complaints	36	36	23	32	7	13

3.1. Top five reasons for complaints Q1 and Q2 2022-23

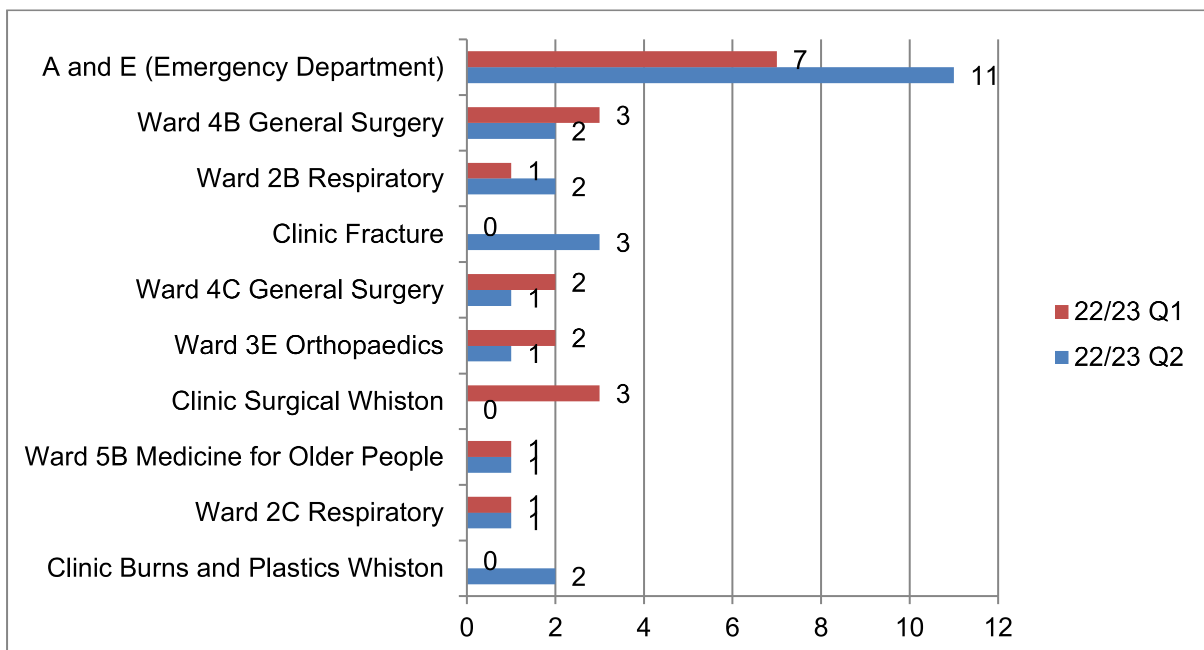


Clinical treatment remained the main reason for complaints with both Q1 and Q2 higher than the previous 2 quarters. Complaints about communications have reduced from the last quarters of the previous year down to 3 in Q2. Waiting times and patient/nursing care both received 8 complaints in Q2.

3.2. Complaints by top location

The Emergency Department received the highest number of complaints in Q1 and Q2, which is consistent with previous quarters, although overall the number of ED complaints has declined across the last year and by way of comparison in Q2 of 2021-22 the Trust received 24 ED complaints.

Ward 4B received the next highest combined number of complaints across Q1 and Q2, with 5. These complaints are generally quite complex and related to a number of factors, including communication and delays in receiving test results/treatment. The complaint investigations are still ongoing and the final outcomes will be reviewed to identify any themes.



3.3. Comparison of written complaints received with neighbouring trusts

NHS Digital has recently indicated its intention to move back to a model of annual reporting for complaints data, therefore, there is now no quarterly data to use as a comparison with other local trusts. The summary paper on written complaints for 2021-22 is due to be published on 24 November 2022.

3.4. Closed complaints

During Q1, 67 first stage complaints were closed, with 71.6% closed within the timescales agreed with the complainant. In Q2 the Trust closed 39 first stage complaints, of which 71.7% were responded to within agreed timescales.

Overall the Trust responded to 89 complaints in Q1 and 51 in Q2.

It should be noted that the majority of the complaints are not upheld. Additional information on complaints is contained in Appendix 1.

3.5. Dissemination of learning

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

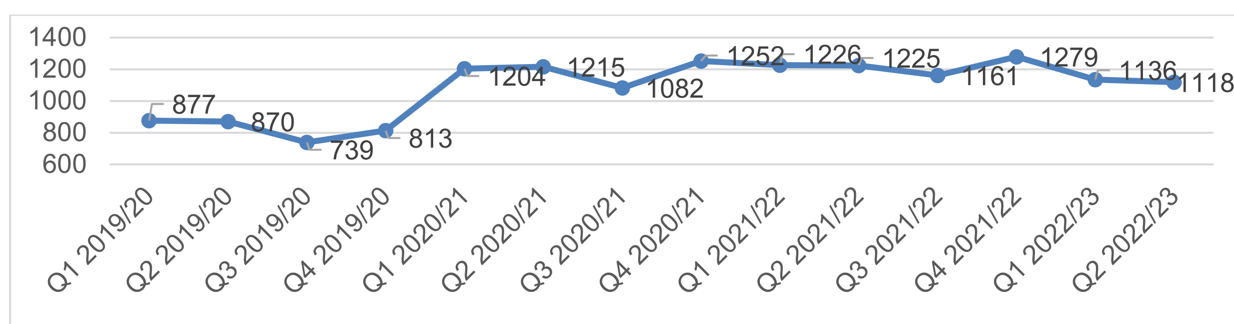
3.6. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

In Q1 and Q2 the Trust received 1 request for a copy of the complaint response and was notified of one preliminary/primary case review in Q1 and one in Q2. There was one notification of intention to investigate in Q1 and one in Q2. 1 preliminary investigation was closed in Q1 and no investigations were concluded in Q2.

4. PALS

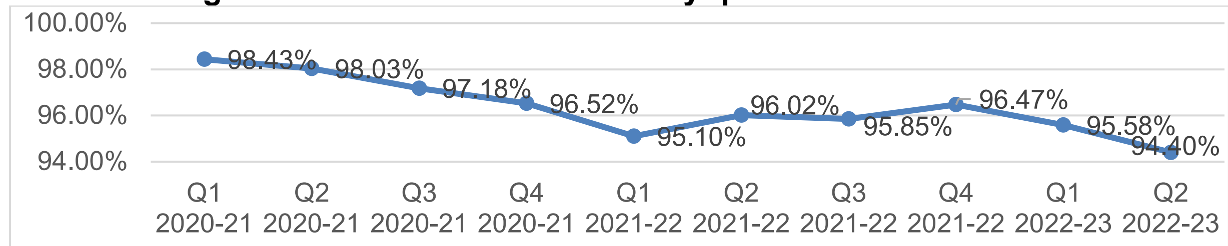
1137 contacts were received in Q1 2022-23 and 1118 in Q2. Q2 showed a 1.61% decrease from Q1. In total for both quarters there were 2255 contacts which is a 8.69% decrease from Q1 and Q2 2021-22 (2451 contacts)

4.1. Total contacts by quarter



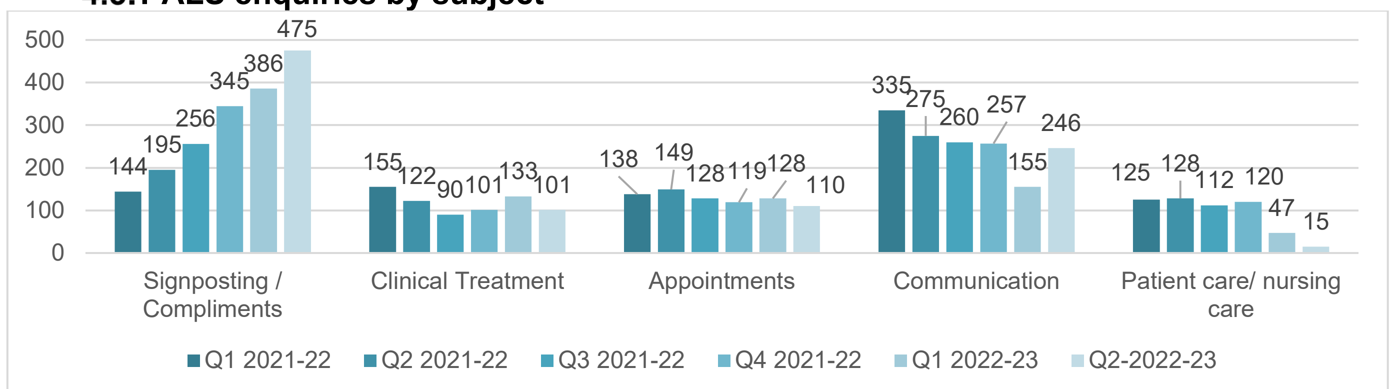
In Q1 2022-23, 95.58% of enquires were resolved, with 62 PALS enquiries being converted to formal complaints, a 4.42% conversion rate, this was a decrease from 3.53% in Q4 2021-22. In Q2, 94.40% of enquiries were resolved, with 36 PALS enquiries being converted to formal complaints, a 5.60% conversion rate. This was a decrease from 4.42% in Q1.

4.2. Percentage of PALS contacts resolved by quarter



The top 5 themes remain consistent with previous reports. There has been a decrease in PALS enquiries relating to communication throughout 2022-23 compared to 2021-22.

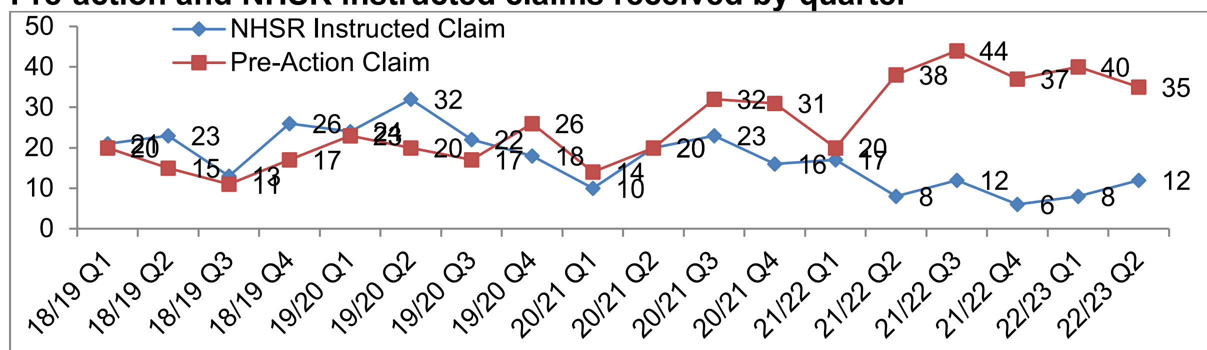
4.3. PALS enquiries by subject



5. Clinical Negligence Claims

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

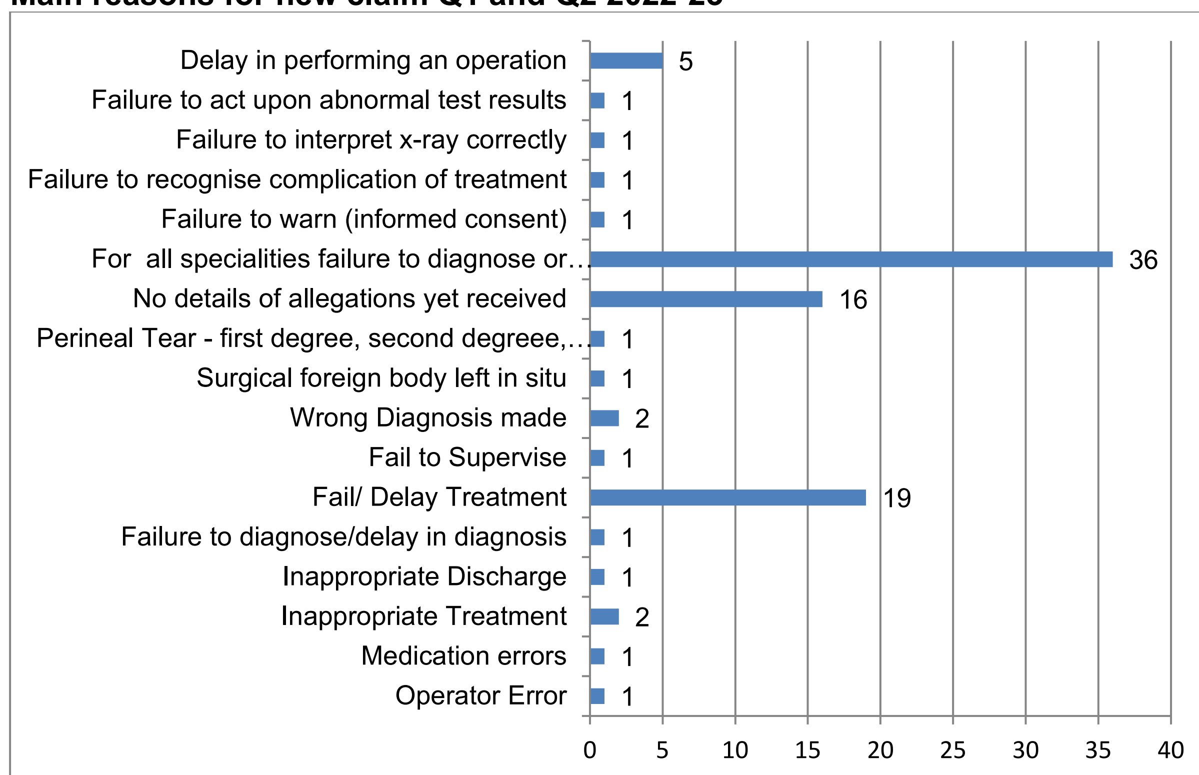
Pre-action and NHSR instructed claims received by quarter



8 new NHSR instructed claims were received in Q1 and 12 in Q2. In addition 19 claims that were previously pre-action claims have become NHSR instructed claims in the first 2 quarters of this financial year.

Failure/delay in diagnosis was the main reason for claims. This is consistent across both Q1 and Q2. Failure/delay in treatment was the second highest cause of claims.

Main reasons for new claim Q1 and Q2 2022-23



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

6. Inquests

11 inquest notifications were received in Q1 of 2022-23, a decrease of 7 from Q4 of 2021-22. This increased to 16 in Q2, but still significantly less than the 34 received in Q2 of 2021-22.

16 inquests were closed in Q1 of 2022-23; 12 were closed in Q2. There were no Prevention of Future Deaths (PFD) Orders this quarter. The last PFD received by the Trust was in March 2021.

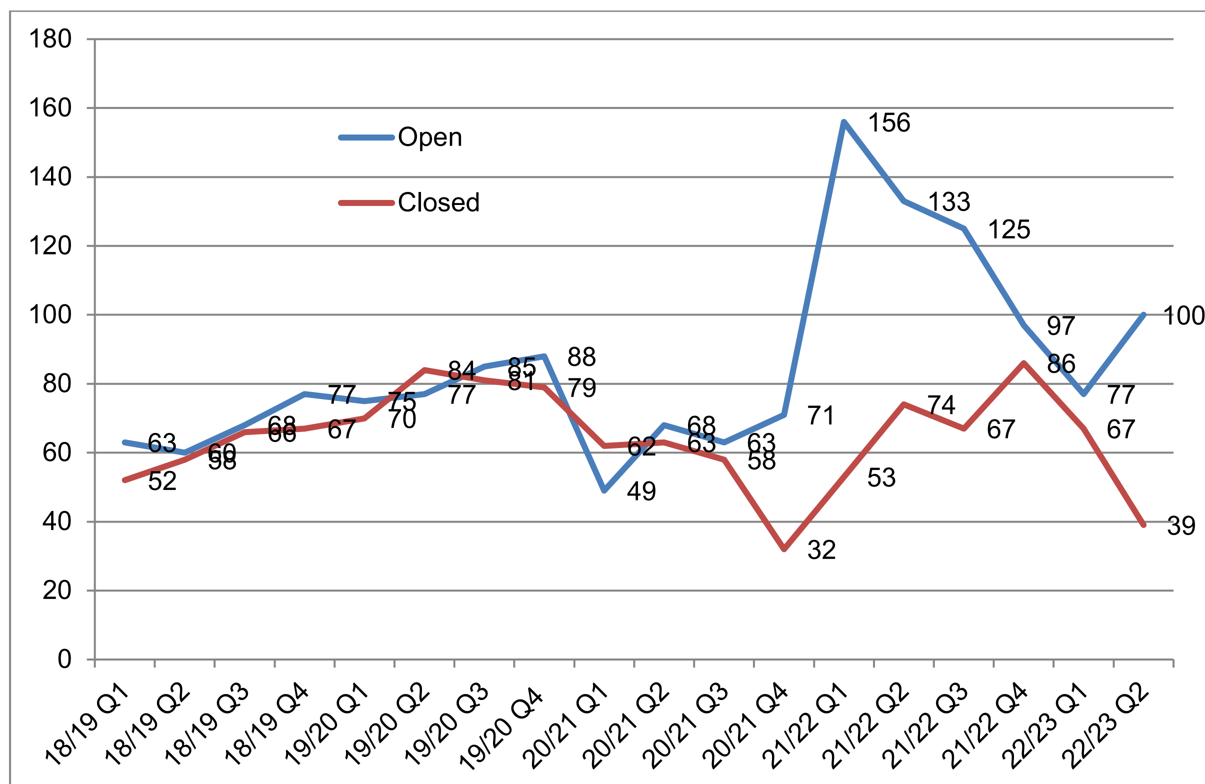
7. Recommendations

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

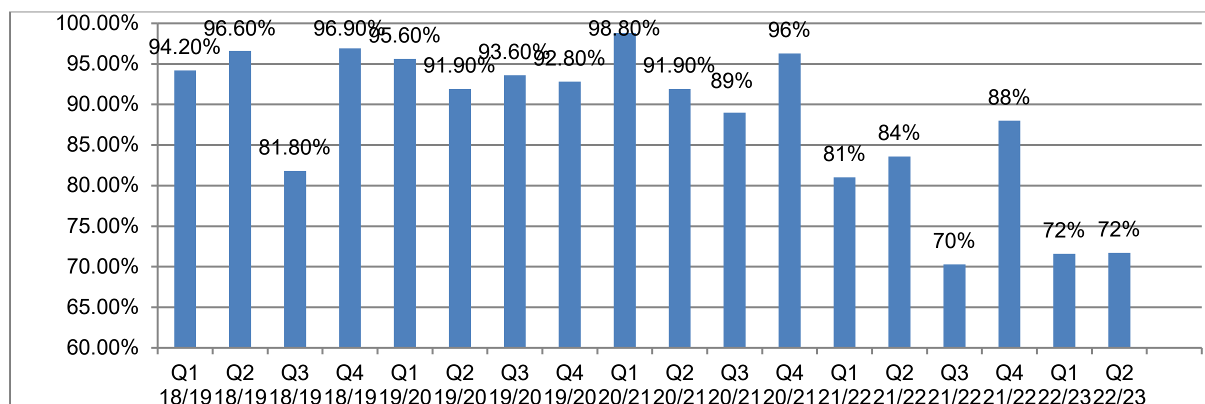
ENDS

Appendix 1 – summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in 2021-22

	22-23 Q1	22-23 Q2	Total
Not Upheld Locally	21	16	37
Partially Upheld Locally	35	18	53
Upheld Locally	12	5	17
Total	68	39	107

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST BOARD

Paper No: NHST(22) 084

Title of paper: Learning from Deaths Quarterly Report Q1 2022/23

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*
January 2022	27	17	4	3	0	0
February 2022	17	9	1	5	0	0
March 2022	28	15	5	2	0	0
*April 2022**	26	3	1	0	0	0
*May 2022**	36	2	1	0	0	0
*June 2022**	Not yet reported					

**delayed reporting and distribution to reviewers whilst we trial the new SJR process*

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 Peter Williams – Medical Director

Date of meeting: 26th October 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 1 2022/23

There have been 62 SJRs reported, however due to a period of catching up on old cases, only a small amount have been allocated to reviewers. 7 cases have been reviewed in total, with 5 having an outcome of GREEN and 2 having an outcome of GREEN WITH LEARNING.

Now that the new SJR tool has been approved and we are making headway into the old cases, Q1 & Q2 SJR's will be allocated for review over the next few weeks.

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

1.1. Shared learning for Q4

Abnormal results	**Recognition of new confusion with Sepsis**
When checking a patient's results, please be aware once reviewed, it may not appear on someone else's check list and therefore go unmanaged. It is therefore vital that anything abnormal is duly actioned or escalated according to need.	New confusion (or a worsening confusion from a patient's baseline) may be a first sign of sepsis at initial presentation or as in-patient with an early opportunity to treat and reverse. Please be suspicious, think sepsis and arrange appropriate investigations to evaluate further.

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 Q4 2021/22

	No. of reviews	Green	Green with Learning	Green with positive feedback	Amber	Red
January 2022	27	17	4	3	0	0
February 2022	17	9	1	5	0	0

March 2022	28	15	5	2	0	0

2.1.1 Total number of reviews completed for Q1 2022/23

	No. of reviews	Green	Green with Learning	Green with positive feedback	Amber	Red
*April 2022**	26	3	1	0	0	0
*May 2022**	36	2	1	0	0	0
*June 2022**	Not yet reported					

**delayed reporting and distribution to reviewers whilst we trial the new SJR process – the few cases that have been done have come to us via Medical Examiner Referrals.*

2.2 Specified Groups breakdown for Q1 2022/23 & Q4 2021/22

	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Total
Cardiac Arrest Death	4	4	3	0	1	0	12
Concern Death	2	0	0	0	0	0	2
CRAB Mortality Triggers	9	1	4	0	2	0	16
Diagnosis Group Death	1	0	6	0	2	0	9
Learning Disabilities Death	1	1	2	0	0	0	4
Medical Examiner Referral	3	2	3	4	0	1	13
Post operative death	3	6	5	1	1	0	16
Random Selection Death	1	0	8	1	1	0	11
Severe Mental Illness Death	3	3	4	1	0	0	11
Total	27	17	35	7	7	1	94

2.4 Projected changes to Learning from Deaths process

There has been a delay in reporting Q1 2022/23 SJR's whilst efforts have concentrated on catching up on outstanding cases from previous months, alongside trialling and introducing the new SJR model. The new model focuses the reviewer towards recurrent themes from previous case reviews with drop down boxes but still supports free text in narrative around concerns when found. The trial has confirmed

the improved efficiency of case reviews without concern, without losing the sensitivity in further interrogation when concern in care is seen.
This is now being rolled out to all reviewers with the distribution of latest 2022-23 cases.

The implementation of the Patient Safety Panel (PSP) every Monday morning has led to timelier case review and direction along the Serious Incident route for cases when concerns have been raised e.g. through Datix; deaths are included in this process. Thus these may not make it to the SJR process, reinforcing the capacity for mortality reviewers to focus on deaths that aren't reviewed elsewhere.
The few more recent SJRs in the above tables have come via alternative routes i.e., Medical Examiner requests.

3 CONCLUSION AND RECOMMENDATIONS

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

- Learning from Deaths 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.
- After a 3-month trial the new SJR process has now been distributed to all reviewers. We will continue to monitor its reliability and provide the appropriate assurance.

Appendix 1

Total Deaths in Scope[1]

Check	Review
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	Rani Thind	Joanne Newton
Finance & Performance	Jeff Kozer	Laura Hart
Clinical Effectiveness Council	Peter Williams	Helen Burton
Patient Safety Council	Rajesh Karimbath	Jill Prescott
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	Sam Barr
ED Teaching	Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Brenda Longworth	
Grand Rounds	Brenda Longworth	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22) 085

Title of paper: Safeguarding Annual Report 2021/22 (Adults & Children)

Purpose:

St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguard children, young people and adults at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business; to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly with children, young people and parents or carers.

The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2021 – March 2022), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

Summary:

The report provides information and assurance for all aspects of safeguarding during the financial year 2021/22.

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

Financial implications: None directly because of this report

Stakeholders: Patients, the public, Regulators and Commissioners

Recommendation(s): Board members are asked to approve the report and agree the recommendations for future development and the work to be undertaken to gain a significant assurance rating.

Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance and Executive Lead for Safeguarding.

Date of meeting: 26th October 2022

Safeguarding Annual Report
April 2021 – March 2022

Author:

Anne Monteith Assistant Director of Safeguarding

Contents

Item	Page

1. Introduction 4
2. Safeguarding Team Update 4
3. Key Achievements 5
4. Governance and Reporting Arrangements (See Appendix 2) 7
5. Safeguarding Activity....8
6. Safeguarding Training 9
7. Safeguarding Team Training and Development....10
8. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) 11
9. Liberty Protection Safeguards 11
10. Learning Disability....12
11. Mental Health....13
12. Children and Adolescent Mental Health Services (CAMHS)....14
13. PREVENT 15
14. Domestic Abuse cases / Multi Agency Risk Assessment Conference (MARAC) 2021/22 15
15. Community Contract 15
16. Community Paediatrics 16
17. Allegations / Staffing Issues 16
18. Partnership Work 17
19. External Reviews 17
20. Audits....18
21. Next Steps 2022/23 19
22. Glossary....20
Appendix 1 21
Appendix 2....22
Appendix 3 Safeguarding Adults Partnership Work 23
Appendix 4 Safeguarding Children Team Partnership Work 24

1. Introduction

1.1 St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguard children, young people and adults at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business; to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly with children, young people and parents or carers.

1.2 Safeguarding activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG), as well as the Local Safeguarding Children Partnership Boards and Safeguarding Adults Boards.

1.3 The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2021 – March 2022), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

2. Safeguarding Team Update

2.1 After 2 years of the teams being separated due the office capacity and ongoing Covid restrictions, a new office was allocated and the Safeguarding Adult, Children and Paediatric Liaison Teams were relocated in March 2022. This is a positive move which will support the provision of joint working, this is further strengthened as the Psychiatric Liaison Team are also located in the same office. This will support information sharing, risk assessments, and strengthen information sharing particularly relating to patients detained under the Mental Health Act.

2.2 The Trust acquired the majority of the Bridgewater Community Midwifery Service in November 2021, this include the transfer of a 0.6 WTE Band 7 Named Midwife Safeguarding Children; this was welcomed by the Safeguarding Team to support the additional activity brought with the additional contract.

2.3 Susan Norbury retired from the post of Assistant Director Safeguarding in March 2022 and was replaced by Anne Monteith who previously held the post of Named Nurse Safeguarding Children.

2.4 It has been recognised that the staffing levels in the Team are not sufficient to manage the workload; therefore, a business case has been completed to support funding to increase capacity.

3. Key Achievements

3.1 The Next Steps referred to in last year's annual report are listed below with progress marked against them. It is very pleasing to note the progression made, in view of the difficulties caused by the Covid 19 and ongoing capacity issues across the Trust. Key updates will also be included further on in the annual report.

3.2 Progress on next steps identified last year

Identified next steps 20/21	Update	Status
Support the Trust to regain Safeguarding Training Compliance	The Safeguarding Team have continued to support the Trust in the improvement of safeguarding training compliance, although there has been improvement KPI compliance has not been achieved due to the ongoing impact of COVID and capacity issues.	Ongoing
Increased LD flagging / tracing / Care flow connect	There has been a significant increase in the number or patients who have a flag to identify team as having and LD or autism diagnosis. This has been delivered through the liaison and partnership working with community learning disability teams and through identification when a patient is admitted an referred to the Trust Specialist Nurse.	Complete
Consider /Progress the local LD improvement plan recommendations for the Trust to include champions role with a view to gaining local kite mark recognition when implemented	Due to the ongoing impact of COVID and continuing pressures within the Trust. This will be further discussed with the Equality and Diversity Team to enquire if LD can be added to the current Diversity Champions already identified.	Ongoing
Electronic records for Mental Health patients	There has been no progression with this but it will continue to be discussed with mental health colleagues at the Mental Health and Law Forum.	Ongoing
Liberty Protection Safeguards preparedness and readiness	The Draft LPS Code of Conduct was published in March 2022, the Safeguarding Team will review this and submit relevant comments, attendance at local health forums continue. There is no date for publication of the final Code currently.	Ongoing

Clarity and capture regarding Early Help offer / input from Trust staff	The Safeguarding Children Team continues to work with the Designated Nurse and St Helens Partnership Board to identify Early Help support offered to children and families. There is a plan to deliver a revised Early Help Strategy which will support this process.	Ongoing
Ensure timely acceptance of referrals for unborn by Children's Social Care referrals	The Named Nurse has worked with 2 neighbouring local authorities to review the pre birth protocol; changes have been made to ensure that Level 4 (Child Protection) referrals are accepted following booking appointment rather than awaiting completion of the dating scan.	Complete
Develop and implement a Rapid Review Risk Assessment Tool to identify and communicate any essential risks identified for individual patients requiring reasonable adjustments: Personal Safety, Communication, Swallowing Nutrition & Hydration, Mental Capacity to Consent, Pain, Safe Discharge Coordination.	Risk assessment completed and implemented. This is used for any LD patient with a planned admission or for those who do not have a Health Passport.	Complete
Improve Coding of Learning Disability patients / Autism & Acquired Brain Injury	Coding processes have been amended to provide clarity as to whether a patient has a Learning Disability, Autism or an acquired brain injury via Careflow connect.	Complete
Review TNA and training delivery	The TNA was reviewed in 2021; the main focus was to ensure all staff were allocated the required competency. Funding was also granted to source an E learning package for the delivery of Level 2 Safeguarding Children and Adult training.	Complete
Look at restraint in the organisation and what is required for	The Safeguarding Team have worked with the people Protection Manager to share the availability of training for staff	Ongoing

patients especially those under DOLS/CAMHS	in key areas. This is an ongoing piece of work.	
Review of team structures	Due to concerns regarding the increased workload a Business Case had been drafted to source additional funding, this will be used to recruit more Safeguarding Specialist Nurses into the Team.	Ongoing
Electronic forms that populate automatically with patient data for DoLS referrals to reduce burden on staff	This option has been explored with the Digital Nursing Team but unfortunately is not currently available. This can hopefully be reconsidered in the future when the digital platform is upgraded.	Ongoing
Support the external safeguarding Partnerships and Boards in delivering Board priorities	Both the Safeguarding Adult and Children Teams have maintained attendance at key Partnership Meetings ensuring contributions to the planning and delivery of priorities.	Complete

4. Governance and Reporting Arrangements (See Appendix 2)

4.1 Quarterly reports are submitted to the Patient Safety Council, Patient Experience Council and Quality Committee which feeds into the Trust Board. The reporting governance structure is demonstrated in Appendix 1.

4.2 Safeguarding KPI's are completed on a quarterly basis; these are scrutinised and reported on by St Helens CCG Designated nurses. Feedback is captured in Quarterly reports and within the Safeguarding Assurance Team agendas.

4.3 An annual Section 11 audit is completed to provide assurance to the Children's Partnership Board in relation to the Trust compliance with Statutory Safeguarding Children responsibility.

4.4 The Trust has the following governance arrangements in place to support the Safeguarding Agenda:

- Robust internal governance processes to safeguard children and adults including an Executive lead, a Named Doctor, Named Nurse for Safeguarding Children, Named Nurse Safeguarding Adults and Named Midwife in post.
- Quarterly Trust Safeguarding Assurance Group meetings with invitations to Healthwatch and local CCGs for external, additional scrutiny. Meetings

continue to be held virtually as this is seen to improve attendance. One meeting was cancelled in July 2021 due to extreme Trust pressures.

- Safer recruitment processes.
- Training of all staff as appropriate for role.
- A suite of Safeguarding policies, providing guidance for staff dealing with any safeguarding issue, concerns regarding mental capacity, allegations against staff and management of domestic abuse (patients and staff).
- Effective supervision arrangements.
- Close partnership working with all key agencies.

4.5 There are excellent links with the Complaints Team and Patient Safety Manager where advice will be requested from the Safeguarding Team in relation to cases that may meet the safeguarding threshold. This also includes reviews of responses following further information gathering.

4.6 The Assistant Director of Safeguarding continues to attend the Serious Incident Review Panel at St Helens CCG to support the Patient Safety Manager with additional information, when required, to provide assurance regarding safeguarding process.

4.7 Safeguarding Key Performance Indicators are completed on a quarterly basis and quality assured by St Helens CCG. The areas scrutinised relate to:

- Partnership Working
- Policies and Procedures
- Commissioning standards
- Safeguarding Training
- Looked After Children

Overall compliance during 2021 /22 has provided a rag rating of Amber, this is due to the training compliance and breaches in LAC Initial Health Assessments.

4.8 There have been no external scrutiny visits during this year.

5. Safeguarding Activity

5.1 The table below shows key activity by the Safeguarding Team. In addition to activity in the table below there are multiple other meetings across the Organisation which the Safeguarding Team attend, submit information to or support other staff in attending. All MDT meetings have been conducted via teams and this appears set to continue, this is seen as a positive as it increases efficiency and enables attendance at more meetings as no travel time required.

5.2 Safeguarding Key Activity Table

Activity	19/20	20/21	21/22

Children			
Safeguarding Strategy Meetings	93	137	139
Safeguarding Referrals	309	531	416
CAMHS	525	517	602
Adults			
Safeguarding Referrals	126	280	291
Strategy meetings	10	30	11

5.3 The Safeguarding Team support Hospital Acquired Pressure Ulcer (HAPU) meetings and the Community weekly Patient Safety Panel (PSP) meetings. The Safeguarding Team now also attend the fractured Neck of Femur panel meetings to review the cases and required learning and will refer to Local Authority as required if lapses of care are identified or care cannot be evidenced due to poor documentation.

5.4 The Assistant Director of Safeguarding attends the monthly Trust Mortality Surveillance Group. During the year there have been increased requests for safeguarding reviews and opinions following the Structured Judgement Review process undertaken by senior Medical staff. It is positive that medical staff are considering safeguarding and DoLS as part of their reviews.

6. Safeguarding Training

6.1 At the start of the Covid 19 pandemic all safeguarding training was reviewed to support staff maintaining compliance, managing social distancing requirements and the reduced number of staff in work due to shielding / sickness. Level 1 safeguarding children and adults e-learning training packages were agreed with additional Trust information of how to access the team added to the package.

6.2 Level 2 training for adults and children is currently completed via workbook, however the Trust have commissioned Virtual College to design a bespoke E Learning package which should be available to staff from October 2022, this will be a more accessible option for staff and the administration process will be reduced.

6.3 Level 3 safeguarding children training continues to be delivered via E Learning, the initial technical difficulties have been resolved and this is training is now easily accessible to staff.

6.4 Level 3 safeguarding adults training remains face to face, with an option for virtual delivery if required; during significant periods of pressure caused by the pandemic staff have likely not been able to leave clinical areas for training.

6.5 Prevent training for both levels are delivered via E-learning.

6.6 The table below demonstrates the ongoing issues with safeguarding training compliance; the CCG has acknowledged the pressures the Trust have been under following the pandemic and continuous staffing pressures. The compliance target for CCG's is 90% across all safeguarding subjects. The Safeguarding Team is actively following staff up regarding this and highlighting area of low compliance to Directorate Managers, Clinical Leads and Heads of Nursing and Quality.

6.7 Overall Safeguarding Training Trust Compliance 2021/22

	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Safeguarding Children Level 1	84.1%	85.9%	84.3%	83.4%	85.8%	85.8%
Safeguarding Children Level 2	74.2%	74.2%	76.5%	75.9%	73.4%	77.3%
Safeguarding Children Level 3	64.1%	71.8%	75.4%	72.2%	72.4%	77.7%
Safeguarding Children Level 4	100%	100%	100%	100%	100%	100%
Safeguarding Adults Level 1	78.1%	83.4%	85.6%	85.8%	87.1%	87.3%
Safeguarding Adults Level 2	72.7%	71.2%	75.8%	75.9%	77.0%	77.7%
Safeguarding Adults Level 3	53.4%	58.4%	79.8%	80.0%	75.6%	79.5%
Prevent Awareness	84.1%	84.6%	86.3%	84.4%	85.8%	86.3%
Prevent Level 3	86.7%	82.1%	82.8%	81.8%	76.1%	76.5%

6.8 *MCA training was previously included in safeguarding adult training and captured within that data, however this has been transferred to a stand-alone session to ensure the staff receive adequate training in preparation for the implementation of Liberty Protection Safeguards.

7. Safeguarding Team Training and Development

7.1 As the specialists for safeguarding and the wider safeguarding agenda it is important that the Safeguarding Team maintain their knowledge and skills. Where it is has been available to the Trust, via the Local Partnership Boards or NHS England, the Safeguarding Team has attended sessions to

improve leadership skills and knowledge in their specialist fields. This additional training is completed alongside the Trust Mandatory Training, all staff have achieved compliance in allocated subjects.

7.2 All staff have had an annual appraisal where additional learning or development has been identified. All efforts have been made to achieve additional training identified by the staff member or manager.

8. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

8.1 DoLS referrals have continued to increase year on year as seen in the tables below; there has been a 616% increase over a 5-year period. This is a testament to the Safeguarding Team who quality assures the applications, amend as required, submit to the Local Authority and pursue follow up when an urgent authorisation expires.

8.2 Table: 5 Year history of DoLS applications

Year	DoLS Applications to Trust Team
2017/18	162
2018/19	232
2019/20	373
2020/21	706
2021/22	1160

8.3 Table: DoLS referrals submitted 2020 – 21

	Q1	Q2	Q3	Q4	Total
19/20	**91**	**77**	**116**	**89**	373
20/21	**126**	**157**	**197**	**212**	692*
21/22	**270**	**297**	**301**	**292**	1160

9. Liberty Protection Safeguards

9.1 The implementation Liberty Protection Safeguards expected in April 2022 has been further delayed; the Draft Code of Practice was published in March 2022, the Safeguarding Team are reviewing this and will submit relevant comments in conjunction with other providers within the Cheshire and Mersey Network. There is no date for implementation yet, but this is likely to be 2023.

9.2 The Trust will become the Responsible Body when LPS is implemented and will need to ensure the following:

- That Schedule AA1 applies to the arrangements (Schedule AA1 provides for the new administrative scheme for the authorisation of arrangements enabling care or treatment of a person who lacks capacity to consent to the arrangements, which give rise to a

deprivation of that person's liberty. The scheme will apply in relation to all those aged 16 and above (the Bill as introduced only applied to those over 18, but the position changed during the course of its passage; the Supreme Court confirmed in September 2019 that the concept of deprivation of liberty applies to 16/17 year olds in exactly the same way as it does to those aged 18 and above).

- Determination has been made that the authorisation conditions are met
- Consultations have been carried out with all relevant parties, which will include relatives
- Cared-for person has an appropriate person/IMCA appointed where necessary
- A pre-authorisation review has been completed determining that the authorisation conditions are met
- A draft authorisation record has been prepared
- Authorisation record
- Publish information about the authorisation arrangements which are accessible and understandable to the cared for person and the appropriate person

9.3 There is no anticipated additional funding to implement the changes, however it is likely given the need to ensure the independence of the initial assessments and the additional administrative burden, that there will need to be assessors and administrators appointed to the role as this could not be undertaken as part of current clinical roles and without training on the legal requirements.

10. Learning Disability

10.1 Patients who attend the Trust with a diagnosis of a Learning Disability or Autism should be able to expect high quality, personalised and safe care. The NHSE/I improvement standards for Acute Trusts cover

- Respecting and protecting rights of those with a Learning Disability, ensuring the Trust meets the Equality Act requirements, provides reasonable adjustments and flagging to identify patients and support the additional care required

- Inclusion and engagement ensuring the patient, family and carers are all empowered and included in the care provided as a partnership

- Ensuring the workforce is resourced and skilled to care for those with a Learning Disability

10.2 The Learning Disability Specialist Nurse (LDSN) continues to maintain clear communication pathways between Community LD teams and the Safeguarding Team.

10.3 Support for patients admitted to the Trust includes an initial visit by the LDSN to assess the level of the learning disability and the likely support

required from the Learning Disability Specialist Nurse; there will be a review of the records and care plan ensuring that any reasonable adjustments required are in place. Reasonable adjustments are also included in the STHK Health Passport. The LDSN will ensure there is communication with the family/ care providers regarding the patient and that they are involved with issues such as DoLS applications or DNA CPR decisions.

10.4 There have been 21 deaths of patients with a diagnosed Learning Disability, all of which were referred for consideration of a LeDeR review, this is the learning from deaths review programme which aims to identify gaps in health care for patients with a Learning Disability with a view to improving health outcomes.

10.5 Learning Disability and Autism training will become a mandatory requirement for all health and social care staff in 2022; STHK already have an E Learning package in place as well as face to face training delivered by the LDSN. Over 2000 staff have completed the training which puts the Trust in a positive position when training is mandated via the Health and Social Care Bill.

10.6 Learning Disability Data

The table below highlights the number of patients supported by the LDSN during the reporting period

	Inpatients	Outpatients	Information sharing only	Total
Q1 21/22	76	56	17	149
Q2	102	40	26	168
Q3	120	37	8	165
Q4	120	37	7	164

11. Mental Health

11.1 Mental Health Detentions 21/22

As per the table below the number of patients detained to the Trust has increased only slightly this year.

April – March 2017/18	50
April – March 2018/19	66
April – March 2019/20	109

April – March 2020/21	111
April – March 2021/22	118

11.2 The Safeguarding Team currently carry out the Mental Health Act administration process for all patients detained to the Trust. As this is a specialist role and takes significant resource from the Team a request for funding was made by the Assistant Director of Safeguarding to support a SLA with Mersey Care to provide this role. Funding has been granted and this request will be taken forward.

11.3 There have been two formal requests for a tribunal by patients detained to the Trust, however the sections were rescinded before the process was initiated.

12. Children and Adolescent Mental Health Services (CAMHS)

12.1 There has been increased attendances for children under the age of 18 seeking help for mental health with a total of 602 referrals this year, attendances for the previous year recorded as 517.

12.2 CAMHS attendances 2021/22

	Q1	Q2	Q3	Q4	Total
CAMHS Attendances	155	121	179	147	602

12.3 The Paediatric Department has continued to face challenges when Looked After Children, admitted with mental health problems, are unable to return to placement as the providers feel unable to keep them safe. This situation often leads to significant delays in discharge, an escalation of challenging behaviour and a significant impact on staff and other patients and families. The Director of Nursing and Named Nurse Safeguarding Children continue to raise these concerns with local and regional commissioners, local authorities and Partnership Boards.

12.4 There is a plan to improve CAMHS provision in 2022/23. Additional resource has been allocated to target services in the Community to provide increase support for children and prevent admission to hospital. There will also be an increase on the CAMHS Response provision for children and young people attending vie the Emergency Department. The response time will be reduced from 24 hours to 4 hours and a 24-hour service will be provided. This should result in a significant reduction in admissions.

13. PREVENT

13.1 There have been no referrals made this year under the PREVENT agenda (preventing radicalisation / terrorism). The Safeguarding Team attend the monthly Knowsley and monthly St Helens Channel panel where those at risk of radicalisation are discussed. The Trust shares information as required for those being discussed as a concern.

14. Domestic Abuse cases / Multi Agency Risk Assessment Conference (MARAC) 2021/22

14.1 Yearly MERIT /MARAC data
A MERIT risk assessment is completed when a patient or staff member discloses a history / incident of domestic abuse. A referral is made to MARAC when the risk is scored as high, and a multi-agency response is required. For those cases assessed as lower risk, relevant advice and support is offered to the victim.

	18/19	19/20	20/21	21/22
Total Number of MARAC referrals	**76**	**89**	**96**	**96**
Total Number of MERIT risk assessments completed	**168**	**173**	**189**	**173**

14.2 The number of MERIT risk assessments and referrals to MARAC has decreased this year, however, there has been no concerns raised that would suggest domestic abuse is not being recognised or appropriate action taken

14.3 Support has also been given to Trust staff and / or Managers where domestic abuse is a feature of personal relationships.

14.4 The Safeguarding Team attend MARAC meetings within 2 of the adjoining authorities, St Helens and Knowsley, as well as submitting information to meetings held in Halton and Warrington. Alerts are added to records of any victim known to the Trust highlighting the fact that they are deemed to be high risk.

15. Community Contract

15.1 It has been pleasing to see the continuing engagement with Community Nurses, Urgent Treatment Centre (UTC) and Sexual Health Services. This has given additional assurance to the CCG’s regarding safeguarding activity. There has been an increase in referrals to adult and children’s

social care as well as in the number of MERIT risk assessment and referrals to Local MARAC.
Safeguarding Children supervision is provided to the UTC and Sexual Health Services on a quarterly basis to ensure that staff have the opportunity to discuss any concerns re process or case management.

15.2 The Named Nurse Safeguarding Adults attends the weekly Patient Safety Panel where community staff review incidents and pressure ulcers from the community. There has also been opportunity to address patients who cross between community and the acute.

16. Community Paediatrics

16.1 Looked After Children

STHK is commissioned to complete the Initial Health Assessments (IHA) for St Helens children new into care or children from other boroughs placed in St Helens. IHAs are a statutory requirement and should be completed within 20 days of a child entering the care system. During 2021/22 only 48% of assessments were completed within timescales; the majority of breaches were due to delays in notification from the Local Authority, lack of information provided, or children not brought for appointments. However, there were some issues within the STHK service due to lack of appointments due to gaps in Community Paediatrician provision and within the administration team leading to delays in completing reports. Meetings are held regularly with the Designated LAC Nurse to monitor progress and monthly reporting has been requested until compliance is improved.

16.1.1 LAC activity 2021/22

Activity	Contacts
Initial Health Assessments – completed when a child is taken into care of the local authority.	133
Adult health Assessments – completed to support the recruitment process for foster carers	117
Adoption medicals – completed as part of the adoption process	45

17. Allegations / Staffing Issues

17.1 The Safeguarding Team continue to support the Trust with management of allegations. These cases maybe allegations in relation to abuse or neglect of a patient or concerns raised in relation to a staff member and

their suitability to work with children and / or vulnerable adult; this could include criminal activity, drug and alcohol issues or concerns of abuse to a child / family member.

During this reporting period 16 concerns were raised from Lead Employer, 9 of which required referral to the LADO, 9 concerns from the Acute Trust, all of which were referred to the LADO, 2 referred to the Local Authority adult Safeguarding Team as per the Care Act guidance. The Safeguarding Team attend all LADO meeting along with HR colleagues, as well as offering advice and support with what can be very complex cases requiring extensive investigation. All cases are assessed as a matter of urgency to consider any immediate restrictions that may be required to ensure patient safety.

17.2 The Safeguarding Team also support the staff and managers with management of domestic abuse concerns, 10 cases were brought to the attention of the Team. Support includes consideration for a risk assessment, safety of the victim and any children, relevant referrals for ongoing support and safety planning within the workplace.

18. Partnership Work

18.1 The Safeguarding Team has worked hard to maintain all case specific meeting attendances including strategy meetings, MARAC meetings, MDT's, Channel meetings and Core Groups. Meetings continue to be held via TEAMS which is a positive for the Team.

18.2 As an identified key agency, the Safeguarding Team represent the Trust at Children and Adult Partnership Board meetings and several subgroups within St Helens, Knowsley and Halton (see Appendix 3 & 4).

19. External Reviews

19.1 Child Safeguarding Partnership Review

The Safeguarding Team have completed 2 rapid reviews chronologies for the Local Safeguarding Children Partnerships to inform the decision-making process in relation to completion of a Safeguarding Children Practice Review.

One case progressed to a Local Multi-agency review but there was no significant involvement for the Trust.

19.2 Safeguarding Adult Reviews (SAR)

There has been one SAR completed by St Helens Adults Board, there was some learning identified in relation to the phlebotomy service and non

- attendance, subsequent actions have been put in place following the review.

19.3 Domestic Homicide Reviews (DHR)

The Safeguarding Team have submitted 4 information requests for cases considered for a DHR. However, information has been minimal with no requirement for Trust representation within the review panels and, to date, no lessons learnt have been identified.

19.4 Serious Incident Review

The Assistant Director of Safeguarding has continued to attend the CCG Serious Incident Review Group (SIRG), where Trust reports are scrutinised. Safeguarding referrals are submitted for those patients who have come to moderate or severe harm caused by lapses in care. Predominantly the referrals relate to fractured neck of femur's where there have been lapses in the care provided, or a lack of documented evidence that the right controls were in place Safeguarding representation at SIRG provides assurance that safeguarding process has been followed and gives the opportunity for any concerns from the panel to be discussed.

20. Audits

Audit finding 2021/2022		
	Findings	**Actions**
ADULTS		
Safeguarding Adult Referrals	Good evidence of staff having the ability to recognise safeguarding concerns and contact the Safeguarding Team appropriately. Some concern highlighted regarding follow of E Mails sent to the team, unable to determine if the concerns was acted on appropriately.	Safeguarding Team to add all responses to the patient record via Careflow or document directly into the written record.
Children		
Referrals to Children's Social Care	The findings were positive in respect of the appropriateness of referrals and the quality of information. The areas for improvement were highlighted as the need for staff to consider and record contact details for	Findings shared at the trust Safeguarding Steering Group, staff training and supervision.

	parents who do not live in the family home, and for the inclusion of the analysis of risk.	
Emergency Department Paediatric Safeguarding Compliance	The audit identified that medical staff were not consistently completing the safeguarding section of the ED paperwork, this should be completed for all children / young people to identify concerns or document that there are none. The child exploitation screening tool was not completed in all cases when indicators were highlighted. It was identified that not having the tool within the document was a potentially a barrier. Flags identified via CPIS for children in care or subject to a Child Protection Plan were not recorded consistently in the records.	Further training to be provided to staff regarding completion of the safeguarding documentation. CE screening tool to be incorporated into the ED paperwork.

21. Next Steps 2022/23

The following actions will form the basis of the Safeguarding activity in the coming year:

- Review and increase the staffing within the Safeguarding Team
- Prepare for implementation of LPS including improved compliance with the Mental Capacity Act and quality and Timeliness of DoLS applications.
- Continue to improve Training Compliance
- Review Training Needs Analysis to include mandatory Leaning Disability Training
- Implement E Learning for Adult and Children Safeguarding Training
- Review Management of Allegations Process to ensure all concerns are dealt with in a timely way using a consistent process.
- Pursue a Service level Agreement to outsource Mental Health Act Administration to Mersey Care Mental Health Trust.

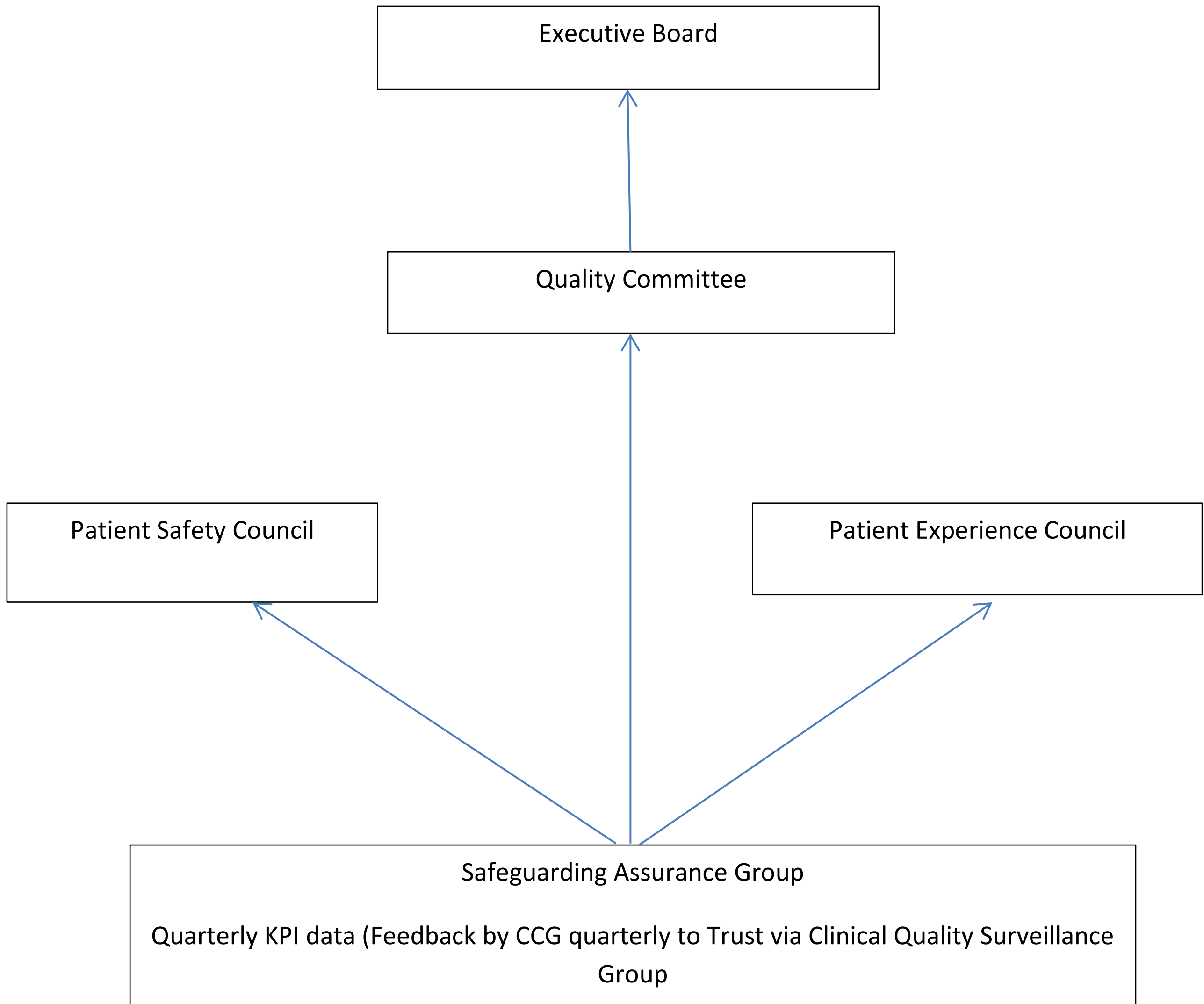
- Continue to work with CCG colleagues, particularly with the transition to the Integrated Care Board model.

22. Glossary

Acronym	Meaning
CAMHS	Children and Adolescents Mental Health Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CYPMHS	Children and Young People Mental Health Services
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DOLS	Deprivation of Liberty Safeguards
ED	Emergency Department
HAPU	Hospital Acquired Pressure Ulcer
KPI	Key Performance Indicators
LADO	Local Authority Designated Officer
LD	Learning Disability
LDSN	Learning Disability Specialist Nurse
MACE	Multi Agency Child Exploitation meeting
MARAC	Multi Agency Risk Assessment Conference – for high risk / gold domestic abuse cases.
MeRIT	Merseyside Risk Identification Tool – for domestic abuse cases, indicates whether support services are required or referral to MARAC, although professional judgement can overrule scoring to make a referral to MARAC .
MSP	Making Safeguarding Personal
NHSE	National Health Service England
NSPCC	National Society for the Prevention of Cruelty to Children
PSP	Patient Safety Panel (Community)
RAG	Red / Amber /Green rating
Section 11	Section 11 audit - places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children
StHK	St Helens and Knowsley Teaching Hospital NHS Trust
TNA	Training Needs Analysis
UTC	Urgent Treatment Centre

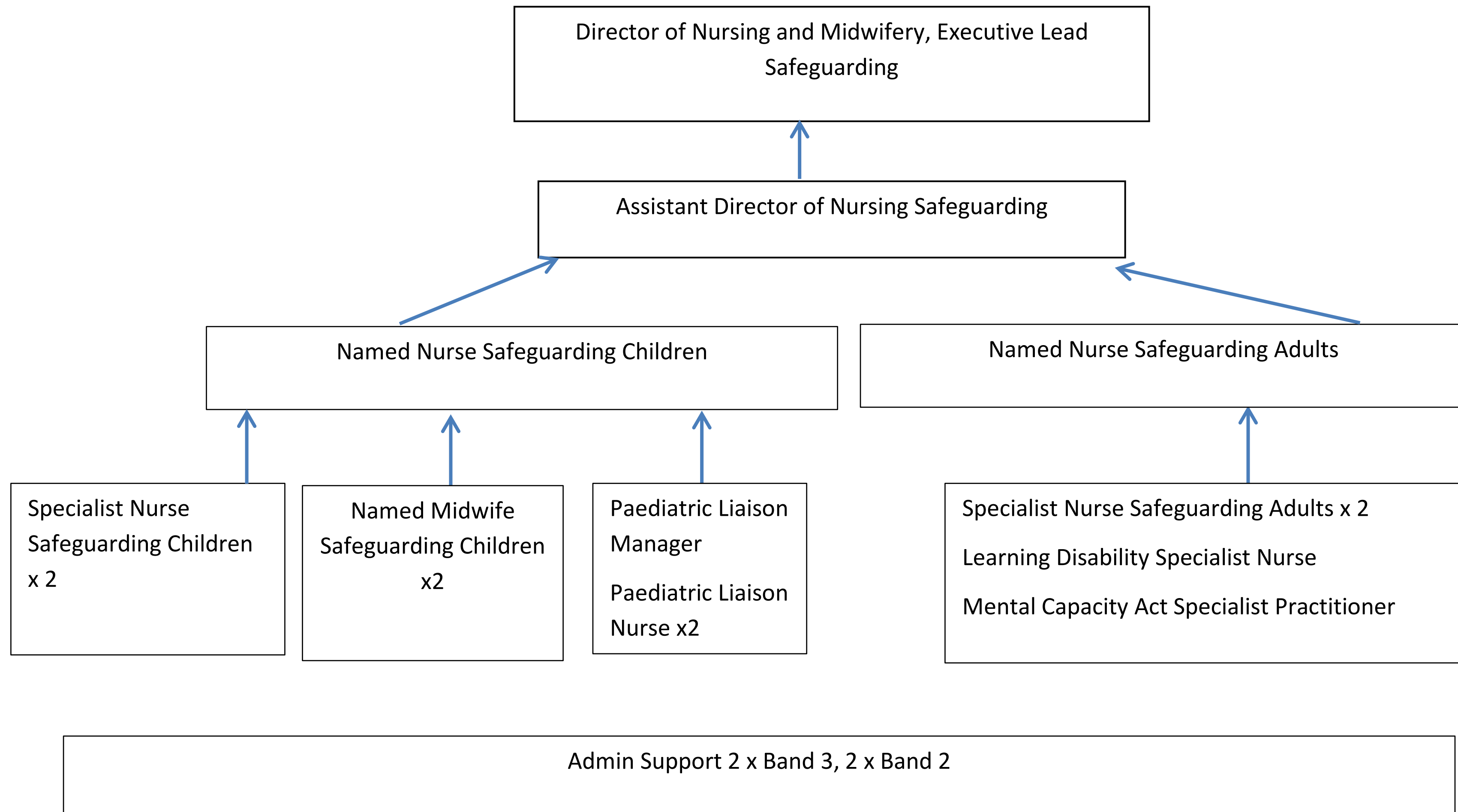
Appendix 1

Safeguarding Governance Structure



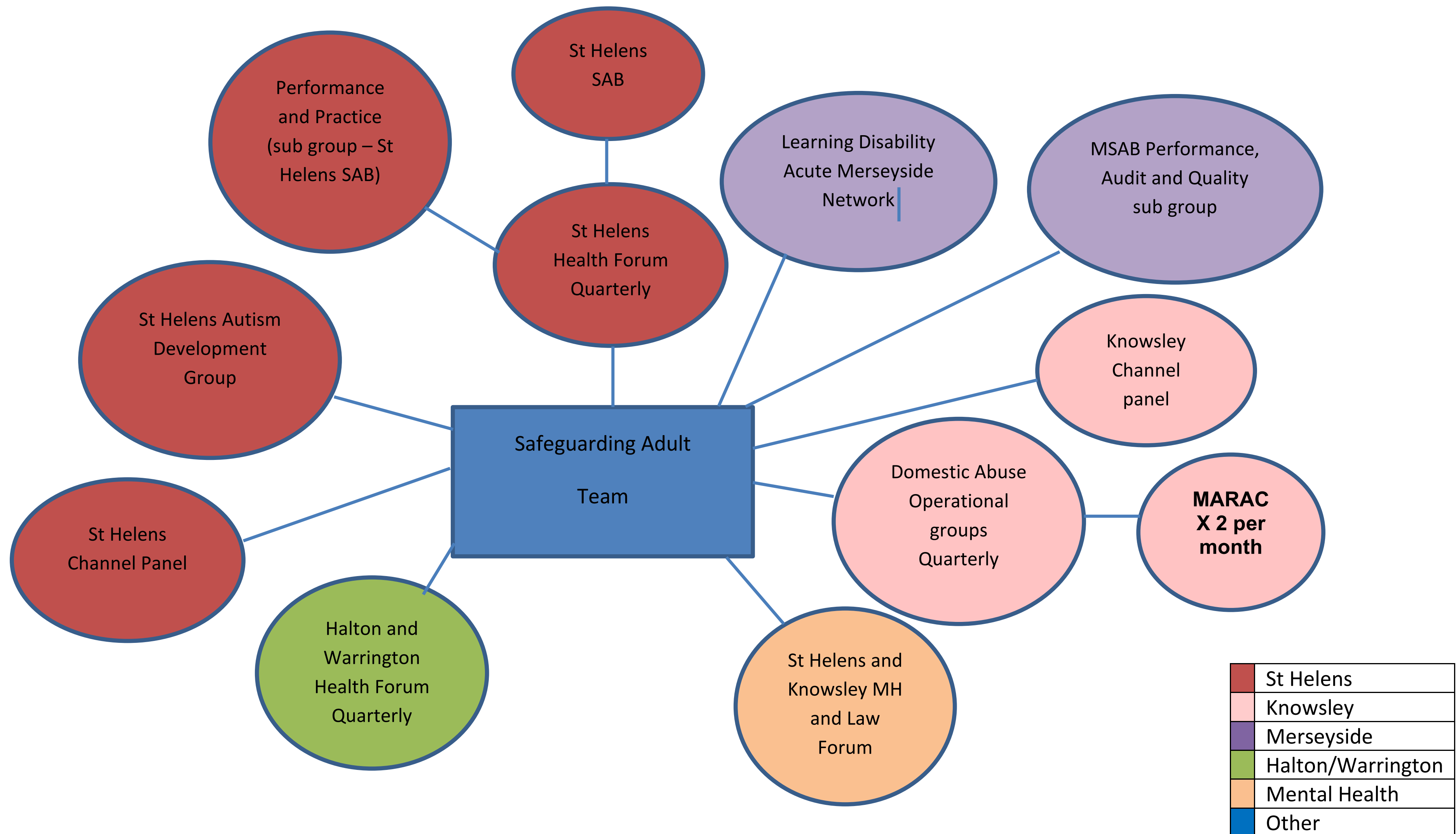
Appendix 2

Safeguarding Roles and Structure at the end of March 2022

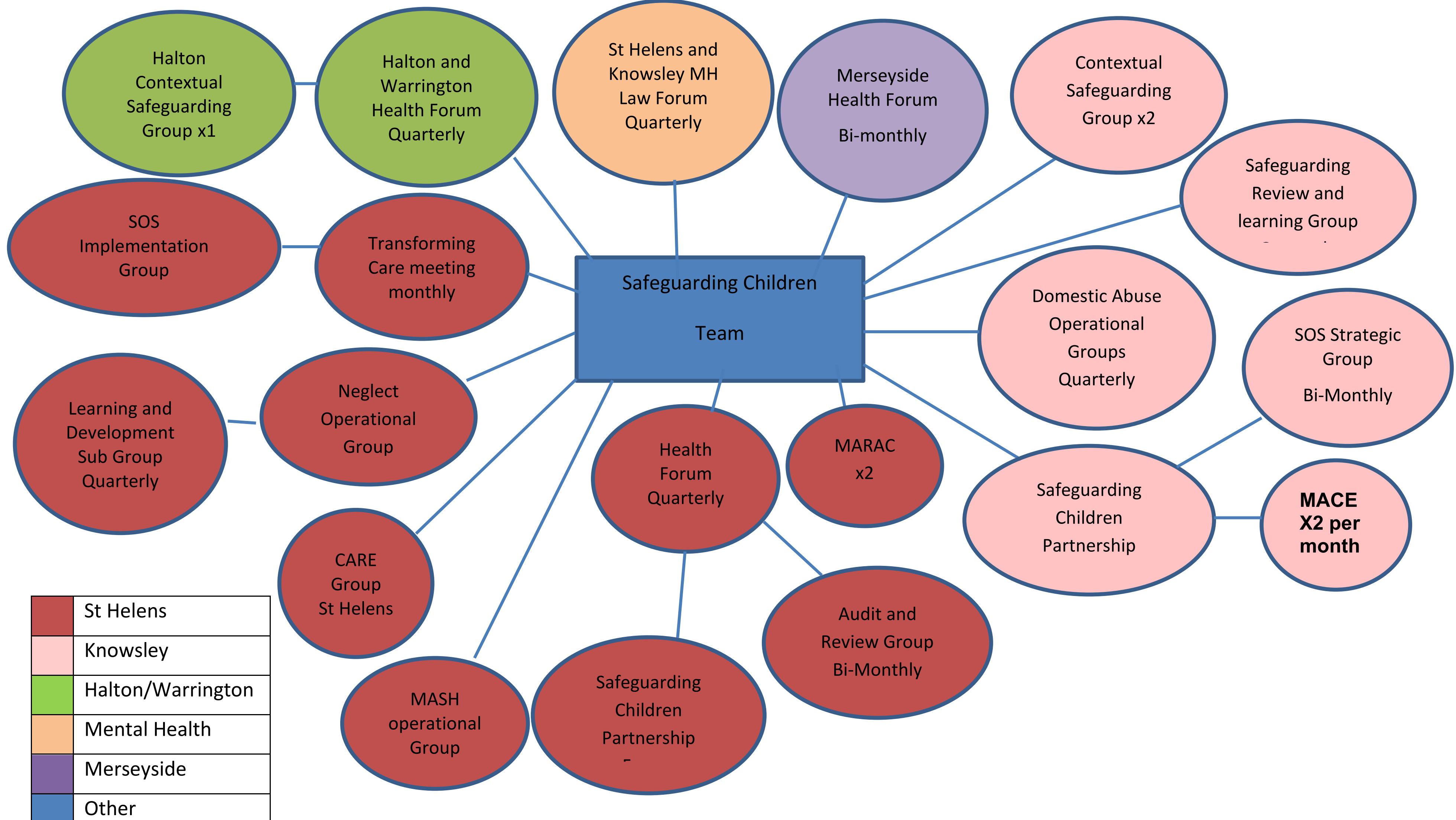


St Helens and Knowsley Teaching Hospitals NHS Trust

Appendix 3 Safeguarding Adults Partnership Work



Appendix 4 Safeguarding Children Team Partnership Work



St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)087
Title of paper: Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2022/23
Purpose: The Trust's annual statement of compliance with EPRR national core standards to be approved by Trust Board, prior to submission to the Integrated Care Board (ICB).

Summary:
Under the Civil Contingencies Act 2004 NHS Acute Providers are Category 1 responders, subject to the full set of civil protection duties. To demonstrate compliance with these duties, Acute Providers must meet the NHSE Core Standards for EPRR and, in line with contractual requirements, the Trust is required to provide to NHS England (by submission to the Integrated Care Board) an annual assurance of compliance with the Core Standards, with a 2022-23 submission deadline of 28/10/2022 comprising key documents of:

a) Statement of compliance.
b) EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.
c) Associated action plan

In 2021/22 the Trust achieved substantial compliance with a score of 95.6%.
For the 2022/23 submission, the Trust has achieved partial compliance with a score of 77%. This is due to three main reasons:

1. The number of EPRR Core Standards applicable to Acute Trust is increased this year to 64 (last year they were only 46).

2. Following the retirement of the Head of Emergency Preparedness, a new experienced person was appointed in the role and commenced in post in September 2022. Although several staff members have cooperated to maintain the EPRR workstream under the direction of the AEO, the absence of a subject matter expert made it not possible to complete all the key actions (namely: the review and testing of incident response plans).

3. Operational pressures and lack of external training related to HAZMAT/CBRN training trainers – previously trained staff were required to attend the National Ambulance Resilience Unit (NARU) 'train the trainer' training. This training is provided by NWAS and has limited places. The Trust has requested places on the next available course and has secured support from the Cheshire and Merseyside EPRR lead to be able to deliver this training in- house.

The full statement of compliance has been provided in Appendix A.
A summary of the Trust position against each standard is attached in Appendix B.

A comprehensive EPRR workplan for the period 2022/23 has been developed to address and mitigate all the Core Standards which are currently marked as "partially compliant" and to maintain the status of full compliance where this has been achieved.

The 2022/23 EPRR workplan is attached in Appendix C.

Corporate objectives met or risks addressed: To achieve high standards of quality care and safety for both patients and staff across the Trust, validated through EPRR compliance.

Financial implications: No new financial implications as a direct result of this paper

Stakeholders: Staff, patients, commissioners, regulators, partner agencies, Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) partners

Recommendation(s): The Trust's statement of compliance with EPRR national core standards is attached for approval by the Executive team and, subsequentially, by the Trust Board.

Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance and Trust EPRR Lead Director, supported by Maria Brancard (Head of Emergency Preparedness).

Date of meeting: 20th October 2022

2022-23 STHK EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE CORE STANDARDS SELF-ASSESSMENT

1. INTRODUCTION

The purpose of this report is to provide the STHK self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2022-23.

2. CONTEXT

The Civil Contingencies Act 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2022 underpin EPRR within health. Both Acts place EPRR duties on NHS England. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with NHS England EPRR guidance.

Under the CCA 2004 Acute Providers are Category 1 responders, which are recognised as being at the core of emergency response and are subject to the full set of civil protection duties including: risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

The minimum requirements Acute Providers must meet are set out in the NHSE Core Standards for EPRR, which are in accordance with the above-mentioned Acts. In line with contractual requirements the Trust is required to provide an annual assurance of compliance with the Core Standards, with a 2022-23 submission deadline of 28/10/2022 comprising key documents of:

a) Statement of compliance.
b) EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.
c) Associated action plan.

This year, following the publication of new guidance relating to EPRR in July 2022, there are a total of 64 standards applicable to Acute Providers, and additionally each year a ‘deep dive’ is conducted to gain additional assurance into a specific area. In 2022 the ‘deep dive’ topic is evacuation and shelter, and a deep dive was undertaken against the 13 core standards although these do not contribute towards the overall Trust compliance level.

3. COMPLIANCE

Based on STHK’s self-assessment; 49 out of 64 Core Standards were declared as ‘fully compliant’, resulting in STHK receiving an overall EPRR assurance rating of ‘Partial’ for 2022/2023. STHK receiving a rating of ‘Partial’ should prompt mitigating actions to be implemented in order to address areas of concern, and this has been included in the EPRR Workplan 2022/23. It is to be noted that most of the areas of improvement are linked to the staffing issues that have impacted the EPRR function in the course of the last year in terms of review, update and test of plans and policies currently in use.

It is to be noted that, due to the COVID pandemic, NHS England had decreased the level of scrutiny required in terms of compliance with the EPRR Core-Standards: this was due to the recognition of the extreme pressures all Trusts were under in relation to the response to the

pandemic. Only this year the full self-assessment has been resumed against all the 64 core standards (these were 46 for 2021/22 and was significantly reduced to cover only three domains in 2020/21). For these reasons and considering the ongoing efforts the Trust is undergoing to recover from the pandemic response, while dealing with significant operational pressures, it should not be perceived as a poor assurance for what the Trust is delivering against each NHS Core Standards for EPRR.

The full statement of compliance has been provided in Appendixes A and B.

Actions to address all the partially compliant standards are in place as outlined in Appendix C. The work plan will be overseen by the STHK EPRR Working Group to ensure delivery, with assurance to the Risk Management Council being provided regularly by the Head of EPRR. Cascade of actions will be undertaken through the STHK EPRR governance structure, as appropriate. In addition, external oversight and peer review of provider EPRR self-assessments and associated action plans, will be provided through the Local Health Resilience Partnership.

4. RECOMENDATIONS

The Trust Board are asked to note and approve the STHK EPRR statement of compliance for 2022-23 and support its presentation to the Trust Board for final approval, with assurance of delivery of actions and future improved compliance through the STHK EPRR governance structure.

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

St Helens and Knowsley Teaching Hospitals NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, STHK will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

____

Signed by the organisation's Accountable Emergency Officer

____

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Please choose your

Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	6	5	0	0
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	7	5	2	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	5	5	0	1
CBRN	14	11	2	1	0
Total	**64**	**49**	**14**	**1**	**4**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	3	10	0	0
Total	**13**	**3**	**10**	**0**	**0**

Percentage Compliance	77%
Overall Assessment	Partially Compliant

Assurance Rating Thresholds

- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Notes

Please do not delete rows or columns from any sheet as this will stop the calculations
Please ensure you have the correct Organisation Type selected
The Overall Assessment excludes the Deep Dive questions
Please do not copy and paste into the Self Assessment Column (*Column T*)

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	AEO appointed (Sue Red Fern, Director of Nursing)	Fully Compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy approved October 2022	Fully Compliant
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	Process is in place as per EPRR Policy	Fully Compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	EPRR Workplan for 2022/23 produced and approved by AEO. Reporting process outlined in the EPRR Policy	Fully Compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR roles included in EPRR policy. Budget assigned to EPRR for 2022/23.	Fully Compliant
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Process is in place as per EPRR Policy and reports regurarly submitted to the Board by the AEO.	Fully Compliant
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are considered as part of the Risk Management Council Agenda.	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR risks are considered as part of the Risk Management Council Agenda.	Fully Compliant
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Process is in place as per EPRR Policy, however since this is a new process it still need to be implemented	Partially Compliant
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	MIP has been recently (Oct 2022) updated, however departmental procedures still need integration and testing still need to take place.	Partially Compliant
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire	Heatwave plan reviewed Jul 2022 and Cold Weather Plan reviewed Oct 2022	Fully Compliant
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles	Reviewed Oct 2022	Fully Compliant
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Reviewed Oct 2022	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident	Reviewed Oct 2022	Fully Compliant
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Included in MIP	Fully Compliant
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Local evacuation plans are in place for each ward and evacuation routes for the whole site have been scoped during a targetted exercise in Jan 2022. A structured plan needs to be implemented.	Partially Compliant
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Policy is present, but is currently under review	Partially Compliant
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plan to be developed in cooperation with ED	Partially Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Appropriate provisions are in place, as per Regional Excess Fatality Plan.	Fully Compliant
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Rotas in place to cover Strategic and Tactical Command 24/7. Operational coordination covered by staff on site 24/7. EPRR policy outlines expectations for staff on-call.	Fully Compliant
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	EPRR Policy outlines expectations for staff on-call. Training needs analysis and training/exercising schedule in place for 2022/23	Fully Compliant
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Process outlined in EPRR Policy and training needs analysis carried out and relative training scheduled accordingly. Training record started Sep-22	Fully Compliant
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Exercise and training programme set for 2022/23. Lessons identified will be implemented and relative actions monitored via the EPRR Working Group, as per EPRR Policy	Fully Compliant
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training records created and records started systematically from Sept 2022.	Fully Compliant
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Reports reguraly submitted submitted to Board by AEO. Process included in EPRR Policy	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	ICC locations clearly identified in MIP. Testing and training schedule are in place. Resilience is obtained by having multiple ICC locations identifed.	Fully Compliant
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	All plans are available to all staff via Trust intranet and paper copies are kept in the ICCs	Fully Compliant
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	BC Plans are in place in key departments. Escalation processes need to be reviewed and tested.	Partially Compliant
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Training record created for loggists (Oct 22) and loggist training scheduled.	Partially Compliant
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Process and templates included to MIP. Sit Reps have been submitted via agreed routes until March 2022 as part of the COVID response	Fully Compliant
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Guidance present on the Trust intranet and as part of the ICCs documentation	Fully Compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Guidance present on the Trust intranet and as part of the ICCs documentation	Fully Compliant
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Included in MIP and local processes managed by the Communications Team	Fully Compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Included in MIP and local processes managed by the Communications Team	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Included in MIP and local processes managed by the Communications Team	Fully Compliant
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Included in MIP and local processes managed by the Communications Team	Fully Compliant
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	LHRP reguaraly attended by Trust representative both the Practitioners and Strategic meetings	Fully Compliant
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	LHRP reguaraly attended by Trust representative both the Practitioners and Strategic meetings	Fully Compliant
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Process to request Mutual Aid outlined in MIP	Fully Compliant
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	The Trust has published standards met and received significant assurance from MIAA when our evidence was audited . https://www.dsptoolkit.nhs.uk/OrganisationSearch/RBN	Fully Compliant
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	BC Policy approved Oct 2022	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	All details covered as part of the BC Policy	Fully Compliant
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Process in place as per BC Policy, however since this is a newly established provision is still to be implemented. This is included in the EPRR workplan	Partially Compliant
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCP checklist established, but departmental plans still need to be assessed to obtain assurance	Partially Compliant
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	No evidence of BC exercises been carried out in 2022. Included in EPRR workplan 2023	Partially Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The Trust has published standards met and received significant assurance from MIAA when our evidence was audited . https://www.dsptoolkit.nhs.uk/OrganisationSearch/RBN	Fully Compliant
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Process in place as per BC Policy.	Fully Compliant
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Process in place as per BC Policy, however since this is a newly established provision is still to be implemented. This is included in the EPRR workplan	Partially Compliant
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Process in place as per BC Policy, however since this is a newly established provision is still to be implemented. This is included in the EPRR workplan	Partially Compliant
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Assurance on commisisoned providers' BC provisions is held locally by the relevant departments. This is outlined in BC Policy	Fully Compliant
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Information included to the CBRN plan and present in ED	Fully Compliant
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Plan in place and reguarly tested/exercised in ED (records held locally). The CBRN plan needs updating	Partially Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	Not present. Included in EPRR workplan 2023	Partially Compliant
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7	ED staff reguarly trained and CBRN-trained staff on duty at all time: this is ensured by ED siter in charge of rotas	Fully Compliant
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Completed equipment inventories; including completion date	Equipment reguarly checked and inventory completed by ED CBRN lead.	Fully Compliant
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Completed equipment inventories; including completion date	Equipment reguarly checked and inventory completed by ED CBRN lead.	Fully Compliant
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Record of equipment checks, including date completed and by whom.	Equipment reguarly checked and inventory completed by ED CBRN lead. Some items (RAM GENE and disrobe/rerobe structures) currently under revision	Fully Compliant
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Completed PPM, including date completed, and by whom	PPM program in place with Respirex.	Fully Compliant
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Organisational policy	Policy to be developed. Included in EPRR workplan 2023	Fully Compliant
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Maintenance of CPD records	Training lead identified (Claire Fraser, ED Sister) and CPD training records held locally by ED.	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Training lead identified (Claire Fraser, ED Sister) and CPD training records held locally by ED.	Fully Compliant
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Maintenance of CPD records	The Trust has some trainers, however addiotnal number is needed but can't be achieved due to lack of training provided by NWAS.	Not Compliant
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Training lead identified (Claire Fraser, ED Sister) and CPD training records held locally by ED. Training sessions held reguarly in ED.	Fully Compliant
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		All Substantive staff are Fit tested on current Trust supplies of FFP3 or equivalent stock (inclusive of Respirator Masks)	Fully Compliant

TASK NAME	Related Core Standards	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	COMMENTS
Mainteinance of policies, governance meetings and reports	1-2-3-4-5-6-7-8-37-38-43-44-45-49-53	START											END	As described in EPRR Policy and Business Continuity Policy
Major Incident Plan integration and review	9-10-15-19-20-21-29-30-33-34-35-36-39	START								END				Includes: planning, consultation (internal and external), validation and review
Adverse Weather Plans review	11						START		END					Includes: planning, consultation (internal) and validation
Infectious disease Plan review (including emerging pandemics and contermeasures)	9-12-13-14										START		END	Includes: planning, consultation (internal and external) and validation and review
Evacuation and shelter Plan	9-16		START						END					Includes: planning, consultation (internal and external), validation and review
Protected individuals Plan	18		START		END									Includes: planning, consultation (internal) and validation
Burns Plan	9-10	START			END									Includes: planning, consultation (internal and external), validation and review
HAZMAT / CBRN planning review	9-10-31-32-55-56-57-58-68										START		END	Includes: planning, consultation (internal and external), validation and review
Incident Coordination Centres (ICCs) maintanance	26-27-29-30-39	START											END	Includes: ICC SOP review, ICC equipment review and maintenance
Business Impact Analysis (BIA)	46	START			END									Implemented for the whole Trust at Directorate level. Specific services may get included if deemed appropriate by the EPRR Working Group.
Business Continuity & Critical Incident Plan	10-28-29-30-52	START								END				Includes: planning, consultation (internal and external), validation and review
Service-Level Business Continuity Plans review	28-30-47-51-52		START						END					Includes: review, consultation (internal with specific staff groups) and validation
Equipment Preventative Programme of Maintenance update	59-60-61-62-63		START						END					Includes regualr equipment checks and appropriate testing.
Deliver training & exercise program 2022/23	22-23-24-25-26-27-48-67	START											END	Refer to "STHK Training & Exercising Programme 2023"

Please note *: Core Standards not quoted in the above table are either not relevant to the Trust or dependant on workstreams that, although related to EPRR, are owned by other departments within the Trust.*

TRUST BOARD

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST (22)088

Title of paper: Nurse Staffing Establishment Review paper

Purpose: To present to the Trust board, the latest findings of the nursing workforce inpatient ward establishment review which was undertaken in July 2022 (data collection completed prior to the reviews).
Nurse establishment reviews must be undertaken by Trusts twice a year and reported to Board annually to comply with the National Institute for Clinical Excellence (NICE) Safe Staffing, National Quality Board (NQB) Standards and the RCN Nursing Workforce Standards.

The review will provide the Trust Board with the assurance that the Trust has a nursing workforce with appropriately planned safe staffing resources to meet the patient care requirements. This paper will make recommendations to current staffing establishments accordingly for consideration.

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

- Background to the nationally mandated review and latest staffing guidance for inpatient adult wards from NICE guidance, NHSi guidance (Developing Workforce Safeguards 2018) and the RCN nursing workforce standards (2021).
- Nursing and Midwifery financial budgets compared to workforce position.
- Establishment and Shelford key findings summarised in Appendix 1
- The review confirmed that the funded establishment, the nurse staffing budgets, and financial ledger were all aligned. It was identified that 7 wards, Duffy, 3A, 3C, 3EGynae, 4A, 4C and 4D currently staff above their funded establishment. Work is underway within the care groups to correct this.
- The comprehensive review and triangulation of data indicated that 2 wards, 2B and 2C if funding is made available, require an additional HCA on the night shift to enhance the patient HCA ratio they currently have 1 HCA for 17 patients. This equates to 4.66 WTE HCA.
- Duffy ward professional judgement is that an extra HCA is required for the early and late shift and an RN bleep holder is needed for each night and weekend shifts. The area has been invited to produce evidence to support this case, which has not been made available during this review process, but can be considered in future establishment review processes, if produced.

- Ward 1B requires an additional HCA on the night shift when extra patients remain on the ward overnight. It was agreed that this staffing requirement is ad hoc and

so permanent funding is not needed, this should be overstaffed using the bank staffing system when required.

- In July the RN vacancies were 140.87 WTE and HCA vacancies were 83.01 WTE (including ED and Theatres). This includes staff in post versus the budgeted establishment. This is monitored monthly and is now reported in the Safe Staffing Paper to Executive Committee.

The staffing establishment reviews were undertaken in July 2022 and all data analysed to provide the assurance of the staffing levels in place meet the national recommendations.

Review key findings include:

- 24 of 33 wards nursing establishments currently meet the nurse, patient, and skill mix requirements. This has been agreed by the review team and the ward matrons as part of the process
- 7 wards are currently staff above their funded establishment. Work is underway within the care groups and Directorate Accountant to correct this within the next 3 months
- 2 wards, 2B and 2C, have been identified as requiring additional HCAs on the night shift due to the dependency and acuity of their patients
- Ward 1B identified the need for an additional HCA on the night shift when extra patients remain on the ward overnight. It was agreed that this staffing requirement is ad hoc and so permanent funding is not needed, this should be overstaffed when required via staffing solutions.

All identified areas require business cases to obtain funding for additional staffing.

- Paediatrics (3F, 4F and NNU) are required to complete a business case for additional staffing requirements outside of this review in line with Bapen standards and CNST requirements.

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

- Since the Covid -19 pandemic, it has been noted that Trust wide we continue to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements, this is currently under review and data will be available to share at the next establishment review. Information on the acuity and dependency of our patients, including any enhanced care needs is available via the ‘Safe Care’ functionality in health roster and is used in real time as part of our daily staffing meetings. A local pool of staff is used to deploy to support enhanced care needs as the numbers remain unpredictable and are therefore managed in real-time as part of overall considerations around safe staffing.

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

- As key action of the Nursing and Midwifery Strategy (2022- 2025) is the development of the nursing workforce including expansion of roles e.g., Nurse Associates (NA's) who will support the workforce development and skill mix. The Trust currently has 16 NA's who qualified in 21/22 with a further 13 due to qualify in October. In addition, 20 NAs are in training (as of 26/09/22)

- The Trust continues with the OCSE nurse programme with 67 international nurses appointed with a further 33 scheduled to arrive in November 22.

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

Financial implications: if approved for 4.66 WTE HCA the cost is £134,920 (average) – this money may be authorised following care group business cases

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

Recommendation(s):
1.The Trust Board are asked to note the continued improvement in nursing workforce and the actions taken in relation to recruitment.
2.The Executive committee will consider the business case to support the increase in staffing equating to 4.66 WTE in the 2 wards areas.

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

Date of meeting: 26th October 2022

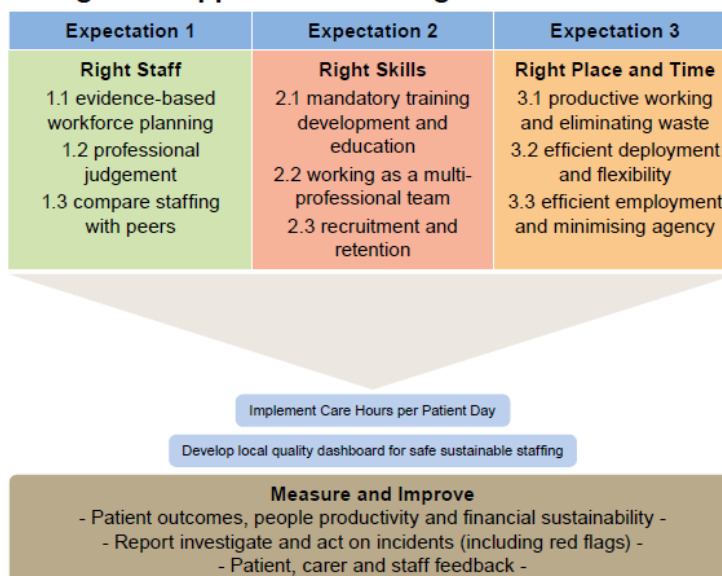
Introduction

1.0 Background

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

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

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



1.1 National context in relation to Nursing and Midwifery staffing

Nationally, nursing and midwifery workforce supply remains challenging with the shortfall in registered nurses being well documented as the biggest and most urgent need to address for all NHS providers. The NHS People Plan 2020-21 compliments the NHS Long Term Plan (2019) identifying recruitment and retention as a key priority for nursing and midwifery workforce.

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

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

Following the NQB (2016) expectations, implementation of NHSi Guidance 2018 (Developing Workforce Safeguards) and the System Oversight Framework (SOF) 2021 a full review is now undertaken annually (with a light touch review at 6 months) reporting to Executive Committee and Trust boards. This is to ensure ongoing quality with annual reporting to Trust Board. An establishment review was conducted in July 2022; the results from this review will be included in this paper for review.

NQB methodology 2016 / 2018

1.2 The Safer Nursing Care Tool (SNCT)

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

1.3 Care Hours Per Patient Day (CHPPD) guidance explained

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

As a result of this:

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

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

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

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

The average overall Trust CHPPD for the May - July period during the review was 7 which is comparative with the national benchmark of 7.
A full breakdown of RN and HCA CHPPD per ward for July can be seen in appendix 3

1.4 Nursing/Midwifery skill mix / ratio guidance

The Royal College of Nursing and NICE published guidance for safe staffing in general and elderly wards in 2021. The RCN guidance continues to recommend a 1:8 ratio of registered nursing staff to patients on days, 1:11 ratio of registered nursing staff to patients on nights, and a 60/40 skill mix for Registered Nurses (RN) and Health Care Assistants (HCA).
The Trust inpatient ward nurse establishments remain compliant with this. However, it is important to note different specialisms of nursing require differing bespoke skill sets to meet the core care needs of their patients.
This must, therefore, be reviewed and agreed when local templates for each ward staffing establishment is agreed and follows the recent advice from the CQC which suggest that when looking at staffing levels, there is no prescribed level and the correct staffing numbers for the ward consider the knowledge of the service you are providing focusing on the quality of care, patient safety and efficiency rather than just numbers and ratios of staff. The skill mix can be adjusted based on the levels of patient care, nursing intervention such as. intermediate / rehabilitation care.

1.6 Safer Staffing Submission

It is a national requirement of all Trusts to publish their monthly nursing and midwifery staffing levels to the NHS website. Safer staffing levels are the total planned number of hours worked by registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate calculated as a percentage for nights and days on each ward. A deep dive is conducted monthly into wards below 85% compliant, which provides triangulation of the staffing fill rate against quality metrics for the area. This is reported to the Executive Committee and Quality Committee and Trust board via the Integrated performance report.
Safer Staffing breakdown for the month of July can be seen in appendix 3.

2.0 STHK Nursing and Midwifery establishment methodology

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

- Use of national SNCT
- Care Hours Per Patient Day
- Professional Judgement
- Peer group validation (Daily Staffing Meeting)
- Review of E-Rostering data
- Review of ward quality metrics: Nurse to bed ratio and red flag indicators including pressure ulcers, falls and medication errors.

3.0 Nursing/Midwifery establishment review process July 2022

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

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

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

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

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

4.0 Results of the Establishment review

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

- 7 wards are currently staff above their funded establishment. Work is underway within the care groups and Directorate Accountant's to correct this within the next 3 months. This review is due by week commencing 5Th December 2022
- 2 ward areas, 2B and 2C have been identified as requiring additional HCAs on the night shift due to the ongoing dependency and acuity of their patients

4.1 .Analysis of the 2 wards

Ward 2B and 2C – Recommended uplift 2.33 WTE HCA per ward

Both wards 2B and 2C were originally 32 bedded wards however over the past 2 years the number of beds has increased to support operational pressures and referrals to the speciality including NIV. Ward 2B now has 35 beds and ward 2C has 34 beds, both wards are currently staffed to 2 HCAs on the night shift. It is considered by the ward managers and matron that this is not sufficient to needs of the patients as the HCA to patient ratio is 1 HCA to 17/ 17.5 patients.
The request for additional HCA on nights is based on,

- Increasing frailty and dependency of patients admitted to 2B and 2C
- Increase in numbers of patients admitted with additional oxygen requirements including high flow that require more frequent monitoring and supplementary care
- Increase in numbers of patients who are fully dependant on all of their care needs similar to DMOP wards
- Support for end of life care
- PPE requirements for patients in isolation (covid)
- Recent audits completed over the July. august and September identified on average per week 21 patients admitted to 2B and 2C who required supplementary care

Below are the current staffing levels on all 2 wards.

Ward	Early	Late	Night	Beds
2B	5+4	4+3	3+2	35
2C	5+4	4+3	3+2	34

4.2. Paediatrics and Special Care Baby Unit.

In 2022 the Neonatal Critical Care Review (NCCR) allocated £79,878 to the Trust which was utilised to fund 0.6WTE band 6 and 1.0 WTE band 5 neonatal nurses.

A review of the RCN and Bapen standards for paediatrics identified a gap analysis of the recommendations in the guidance, this includes the proposal that in addition to the full time supervisory ward manager there is an extra RN on each shift to allow all babies to be cared for by a registered nurse on each shift. We do not meet these standards; this is consistent across other paediatric units in District General hospitals. The senior nursing team recommend a business case be produced to secure funding for these posts and any additional requirements for transitional care.

It should also be noted that there is currently a national shortage of neonatal nurses.

4.3. Emergency Department Review

The Shelford Acuity Tool is not suitable for use in the Emergency Department. A specific tool has been recently released by Shelford and will be trialled in September by the senior nursing team, followed by full use of the tool during the next establishment review.
An accurate ED review requires staffing levels and designations, operational flow and consideration of additional corridor patients.

Temporary staffing arrangements to manage patient safety risks in ED due to overcrowding have been in place since 2019.
It was recently agreed to substantively fund these additional posts, based on the prolonged period of requirement, the low fill rates through Bank and Agencies and in certain areas of the Department, demonstrating an insufficient staff to patient ratio irrespective of overcrowding.

Posts approved on a recurent basis:

	WTE	Band	Total Cost	
Corridor	11.97	5	543,768	Conversion of temporary funding
Zones	11.67	2	337,298	Conversion of temporary funding
SDEC Co-ordinators	5.98	6	323,415	Newly requested funding
Total	**35.60**		**1,431,696**	

Including the newly approved funding for additaional staff (35.60 WTE) this results in ED current staffing establishment, including vacancies as:

Staffing Establishment	Funded WTE (including posts approved above)	Vacancy WTE (July 22)
Nurse band 2	45.87	18.98
Nurse band 4	0.8	
Nurse band 5	112.48	47.84
Nurse band 6	23.54	3.31
Nurse band 7	10.38	1.78
Grand Total	**195.07**	**71.91**

4.4. Maternity staffing review.

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

The Maternity service is required to undertake a 6 monthly staffing review or more regularly if required to determine safe and appropriate midwifery staffing establishment and to ensure it meets CNST's minimal evidential requirement relating to Safety Action 5 regarding effective midwifery workforce planning.
A midwife to birth ratio is included and monitored monthly on the local and regional maternity dashboard monthly. The current mechanism of calculating this ratio is under review and the ratios will be reflected accordingly once approved. Following the Maternity service insight visit in August 2022 the recommendation was to work towards a revised ratio of 1:24.

Birth-rate Plus® has developed a method of assessing and analysing the required numbers of Midwives in relation to activity and acuity utilising a well-established workforce planning methodology and is the only nationally endorsed tool for calculating maternity staffing levels. The Birth-rate Plus® methodology is based on an assessment of clinical risk, acuity and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period and the postpartum period within the hospital and in the community setting whilst utilising the accepted standard of 1 midwife to 1 woman in labour.

Currently the Maternity service is funded to the previous Birth-rate+ assessment and is currently at 1:28 however, this predated the introduction of the Continuity of carer(CoC team, the Midwifery Led Unit (MLU) and the maternity triage alongside clinical changes that has increased the dependency of women including an increase in Inductions of labour in line with the National recommendations of, 'Saving babies lives'.
The maternity service has completed a full Birth-rate plus assessment with all data submitted in 2021. A report is in preparation to provide the findings of the report to the Board detailing the recommendations of required staffing establishment across the entire maternity service.

5. Actual staffing versus funded establishment

The review confirmed that the funded establishment, the nurse staffing budgets, and financial ledger were all aligned. It was identified that 7 wards, Duffy, 3A, 3C, 3EGynae, 4A, 4C and 4D currently staff above their funded establishment. Work is underway within the care groups to correct this, with the anomalies on ward 3C and Duffy being immediately corrected.

The surgical care group are currently undertaking an urgent 3-month review to identify the source of the discrepancies below and from this, to determine next steps to ensure that actual staffing aligns with the funded establishment.

Ward	Role	Funded to (E, L, N)	Rostering to (E, L, N)	Ward WTE pressure
3A (Mon - Fri)	HCA	4, 3, 2	4, 4, 2	
3A (Sat / Sun)	HCA	3, 2, 1	3,3,2	2.4
3E (Mon-Fri)	RN	4, 3, 2	4, 4, 2	
3E (Sat/ Sun)	RN	2, 2, 2,	3, 3, 2	2.56
3E (Mon-Fri)	HCA	2, 1, 1	3, 3, 1	
3E (Sat/ Sun)	HCA	2, 2, 1	3, 3, 1	4.4
4A	RN	5, 4, 3	5, 5, 3	2.31
	HCA	3, 3, 2	3, 3, 3	1.91
4C	RN	5, 4, 3	5, 5, 3	2.31
4D	HCA	2, 2, 0	2, 2, 2	3.99

6. Costings

The table identifies the 2 wards for consideration of an uplift in establishment

	RN	HCA	Cost (average)
	WTE	WTE	£
2B		2.33	67,460
2C		2.33	67,460
Total		4.66	134,920 (average)

7. Ongoing Developments

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

- Support for staff through health work and wellbeing services
- Development of an internal staff transfer process
- Flexible working/retire and return scheme
- Promoting listening events and engagement sessions to listen to and address staff concerns
- Increase availability of apprenticeship courses available to invest in and upskill existing workforce

- In house education and training programmes available for nursing and midwifery workforce to support succession planning into senior roles within the organisation
- Speciality specific preceptorship programmes for staff working in Maternity, ICU and the Emergency Department
- Roll out of a 12.5hr shift pattern working to meet staff request for home/work life balance, folllowing consultation
- Development of Ward Managers to manage the demands of daily staffing work pressures
- Staffing review to be undertaken for Band 2-6 to ensure staff are delivering care compliant with their job descriptions and competence
- Delivery of OSCE programme for International Nurses
- Continued delivery of the Nurse Associate Programme.

Appendix 1. Establishment review findings and professional judgement recommendations

Establishment Review June 22- Sur

Appendix 2. July 2022 RN/M and HCA vacancies

Table 1 - Staffing Gaps*

Band	Budget	Staffing gaps Wards	Staffing gaps Theatres	Staffing gaps ED	Total staffing gap	Total % staffing gap
Band 2	602.23 WTE	66.11 WTE	3.79 WTE	13.11 WTE	83.01 WTE	13.78%
Band 5	892.86 WTE	79.05 WTE	12.10 WTE	35.87 WTE	127.02 WTE	14.23%
Band 6	287.81 WTE	9.42 WTE	4.96 WTE	-2.67 WTE	11.71 WTE	4.07%
Band 7	76.54 WTE	-0.80 WTE	0.16 WTE	2.78 WTE	2.14 WTE	2.80%
Total	1859.44 WTE	153.78 WTE	21.01WTE	49.09 WTE	223.88WTE	12.04%

**staffing gap is defined as staff in post verses budgeted establishment*

Appendix 3. Safe Staffing and CHPPD fill rates July 22

		Day		Night		Overall Fill rate %'s		CHPPD		
		RN fill rate	HCA fill rate	RN fill rate	HCA fill rate	RN fill rate	HCA fill rate	RN	HCA	Overall
Wards with an overall fill rate above 90% fill rate for RN or HCA	1ANew	90.6%	134.4%	91.1%	199.8%	90.8%	156.3%	2.5	3.3	5.8
	Bevan Court 1	96.1%	113.3%	106.5%	135.6%	99.3%	120.8%	4.0	6.8	10.8
	1C	99.1%	95.3%	93.2%	114.5%	96.9%	100.1%	5.0	2.5	7.5
	2A	102.3%	100.8%	98.8%	188.7%	100.7%	129.4%	3.7	2.1	5.8
	2C	106.2%	106.3%	95.1%	119.4%	102.1%	109.9%	3.3	2.4	5.7
	2D	96.9%	104.3%	96.3%	142.1%	96.7%	115.9%	3.0	2.8	5.8
	2E	109.2%	89.4%	98.1%	168.8%	105.8%	121.1%	5.1	1.1	6.2
	3Alpha	111.5%	129.1%	94.2%	154.6%	104.6%	140.2%	3.9	4.8	8.6
	3B	102.7%	101.7%	96.6%	124.6%	100.2%	112.0%	2.8	2.8	5.6
	3C	102.8%	122.5%	93.9%	134.9%	99.3%	128.1%	2.7	3.0	5.6
	3D	97.4%	106.2%	93.9%	101.6%	96.0%	104.6%	2.6	2.1	4.7
	3F	89.5%	129.0%	95.6%	135.2%	91.6%	131.5%	8.2	2.5	10.7
	4B	129.5%	153.2%	90.6%	120.6%	111.3%	143.5%	3.4	2.0	5.4
	4C	91.5%	91.1%	98.9%	98.5%	94.2%	94.6%	2.9	2.2	5.1
	5A	96.1%	117.2%	99.6%	168.5%	97.4%	131.8%	2.5	4.3	6.8
	5B	89.9%	101.6%	96.7%	133.3%	92.4%	110.7%	2.4	3.6	6.0
	5C	94.1%	109.6%	89.2%	104.7%	91.9%	107.2%	4.6	3.2	7.8
	Duffy Ward	107.7%	89.5%	100.0%	98.9%	104.6%	93.2%	2.2	3.0	5.2
	Seddon	108.5%	84.7%	100.8%	137.1%	106.1%	99.1%	4.0	4.2	8.2
	Newton Ward	91.2%	84.6%	96.9%	151.6%	92.8%	103.7%	2.6	3.7	6.4
	SCBU	110.1%	130.6%	86.0%	93.8%	98.0%	112.2%	7.9	2.3	10.1
Wards with an overall fill rate below 90% fill rate for RN	Bevan Court 2	87.2%	121.6%	85.0%	178.9%	86.4%	138.0%	2.4	4.8	7.2
	1D	86.9%	109.0%	94.0%	156.5%	89.1%	122.1%	2.6	2.7	5.3
	1E	86.5%	95.8%	96.0%		89.8%	108.7%	6.9	2.2	9.1
	4A	84.1%	110.3%	96.1%	115.8%	87.8%	112.5%	2.7	2.7	5.4
	5D	87.3%	85.3%	93.1%	92.7%	89.4%	87.3%	2.9	3.9	6.9
	Delivery Suite	102.5%	88.4%	127.6%	84.0%	112.5%	86.6%	22.2	4.9	27.1
Wards with an overall fill rate of 85% or less for HCA or RN	1B	80.2%	95.0%	89.7%	102.9%	83.7%	97.7%	3.8	2.4	6.2
	2B	77.3%	95.2%	95.9%	132.8%	83.0%	105.6%	2.5	2.3	4.8
	3A	76.2%	86.0%	88.5%	100.1%	79.4%	89.5%	3.5	3.1	6.7
	3E Gynae	73.4%	156.1%	100.0%	82.3%	81.6%	133.4%	3.0	2.4	5.4
	3E Ortho	93.3%	26.6%	95.1%	38.7%	94.0%	29.6%	4.2	1.1	5.3
	4D	116.6%	55.6%	87.2%	64.0%	105.5%	59.8%	10.8	4.6	15.5
	4E	74.3%	90.0%	81.1%	71.0%	77.0%	82.4%	18.6	3.3	21.9
	4F	85.1%	161.4%	65.8%	117.3%	79.5%	143.7%	9.3	4.0	13.3

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