Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 30th NOVEMBER 2022
BOARDROOM, 5th FLOOR, 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.

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11.05	8.	Committee Report – Quality	NHST (22)090	Assurance	Rani Thind
11.15	9.	Committee Report – Finance & Performance	NHST (22)091	Assurance	Jeff Kozer
11.25	10.	Committee Report – Strategic People	NHST (22)092	Assurance	Lisa Knight
11.30	11.	Committee Report - Audit	NHST(22) 093	Assurance	Ian Clayton

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.35	12.	Flu Vaccination Programme Self-Assessment Checklist	NHST (22) 094	Assurance	Anne-Marie Stretch
11.40	13.	Trust Objectives 2022-23 Mid-Year Review	NHST (22) 095	Assurance	Ann Marr
11.55	14.	Research & Development Annual Review and Capability Statement	NHST (22) 096	Approval	Dr Peter Williams
12.05	15.	Biennial Review of NHS Constitution	NHST (22) 097	Approval	Nicola Bunce
12.15	16.	Trust Board Meeting Arrangements 2023/24	NHST (22) 098	Approval	Nicola Bunce
12.20	17.	Charitable Funds – Annual Accounts 2021-22.	NHST (22) 099	Approval	Gareth Lawrence
12.30	18.	Digital Strategy – Review of Progress	NHST (22)100	Assurance	Christine Walters
Closing Business					
12.45	19.	Effectiveness of Meeting	Verbal	Assurance	Chair
	20.	Any Other Business		Information	
	21.	Date of Next Meeting – 25th January 2023		Information	

TRUST PUBLIC BOARD ACTION LOG – 30th November 2023

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~~. **Action closed**	SR	~~28.09.22~~ 26.10.22
50	28.09.22	~~GL to provide a breakdown of the non-NHS aged debt~~. **Action closed**	GL	26.10.22
51	28.09.22	~~AMS to clarify whether the volunteer awards will be reinstated this year with the Volunteer Manager~~ **Action closed**	AMS	26.10.22
52	26.10.22	End to end review of complaints process to improve response timeframes	SR	25.01.23
53	26.10.23	Review of initiative for “my name is” badges.	SR/ AMS	25.01.23
54	26.10.23	Explore recruitment of Ukrainian Doctors and Nurses.	SR	25.01.23
55	26.10.23	Discussion with Viki Hunt, Head of Therapy Services regarding therapy provision at weekends to improve discharge rate	SR	25.01.23

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)088
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 October 2022. (YTD = 1).

There were no MRSA cases in October 2022. (YTD = 1).

There were 2 C. Difficile (CDI) positive cases reported in October 2022 (2 hospital onset and 0 community onset). (YTD = 35). Of the 35 cases, 25 have been reviewed at RCA panel, 17 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 October 2022 was 92.3%. 2022-23 YTD rate is 93.5%.

During the month of September 2022 there were 3 falls resulting in severe harm or death category . (YTD severe harm or above category falls = 13).

There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in September 2022. (YTD = 1).

Community incident reporting levels have decreased to 66 in the month of September compared to 103 in August 2022. 54 incidents were related to pressure skin damage, 2 were classified as low harm, the remaining 52 incidents were classified as no harm.

YTD HSMR (April - June) for 2022-23 is 90.4

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: 30th November 2022

Operational Performance
Performance against the 62 day cancer standard was below the target of 85.0% in month (September 2022) at 78.4%. YTD 81.9%. The 31 day target was achieved in September 2022 with 96.3% performance in month against a target of 96%, YTD 97.6%. The 2 week rule target was not achieved in September 2022 with 56.8% in month and 74.7% 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 October 2022 was 45.1% and YTD 47.0%. The all type mapped STHK Trust footprint performance for October 22 was 69.1% and YTD 71.7%. The Trust saw average daily attendances of 318, which is up compared to September, at 313. Total attendances for October 2022 was 9,844.

Total ambulance turnaround time was not achieved in October 2022 with 43 mins on average. There were 2,101 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 2,080 in September 2022.

The UTC had 4,574 attendances in the month of September, compared to 4,961 in month of August, a decrease of 7.8%. Overall, 93% of patients were seen and treated within 4 hours

The average daily number of super stranded patients in October 2022 was 133 compared with 156 in September. 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 October 2022 with 67.3% compliance and YTD 67.3% (Target 92%). Performance in September 2022 was 65.9%. There were (2,408) 52+ week waiters. The 6 week diagnostic target was not achieved in October 22 with 76.8% compliance. (Target 99%). Performance in September 2022 was 74.3%.

There was a slight decrease in referrals received within the District Nursing Service in September however, the levels are still within average range (513 in September compared to 609 in August). The overall caseload size remains within normal range (1,258 in September compared to 1,262 in August). Community matron caseloads have decreased to 123 in September compared to 130 in August. 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 7 (October), the Trust is in line with plan at a £1.7m deficit.

Surplus/Deficit - At the end of Month 7, the Trust is reporting a deficit position of £1.7m, with £308.1m income and £309.8m 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 7, low risk schemes either delivered or at finalisation stage total £25.0m in year and £16.3m recurrently.

Cash - At the end of M7, the cash balance was £80.6m.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £4.8m. 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 not drawn down from DHSC.

Human Resources
In October 2022, there was an increase in the absence rate (6.3%) from September's figure of 5.9%. The rate for All Nursing and Midwifery staff group is 7.8%.

Appraisal compliance in October is 85%, an improvement from September (83.5%). Mandatory training compliance has improved slightly to 79.7% (September 78.7%).

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

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	Oct-22	2.6%	2.3%	No Target	2.6%		HSMR under expected values in all domains	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	▲	Jun-22	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Jun-22	95.7	90.4	100.0	96.9					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jun-22	102.9	98.4	100.0	105.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	May-22	94.7	95.6	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	Jun-22	84.7	80.4	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	Jun-22	94.6	99.3	100.0	103.9					
% Medical Outliers	F&P	T	Oct-22	1.8%	1.7%	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	Oct-22	34.4%	32.9%	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	▲	Sep-22	63.4%	62.3%	90.0%	74.3%		IP discharge summaries - remain challenging and detailed work has gone on to identify key areas of challenge. The IT team has been involved to find a sustainable solution particularly in A&E. OP attendance letters - deterioration reflects staff sickness, increased activity pressures and IT licensing issues which have 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 ongoing with admin team and IT to improve performance.	PW
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Sep-22	29.1%	28.9%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Sep-22	98.4%	98.0%	95.0%	97.2%					

Oct-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q2	87.4%	87.2%	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	▲ £	Oct-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	Oct-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	▲ £	Oct-22	0	1	0	2		There were no MRSA cases in October 2022. (YTD = 1). There were 2 C. Difficile (CDI) positive cases reported in October 2022 (2 hospital onset and 0 community onset). (YTD = 35). Of the 35 cases, 25 have been reviewed at RCA panel, 17 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	▲ £	Oct-22	2	35	56	32					
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Oct-22	6	20	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Sep-22	0	1	No Contract target	2		1 validated category 3 pressure ulcer with lapse in care YTD, reported from Ward 1A in August 2022.	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	▲	Sep-22	3	13	No Contract target	22		3 fall resulting in severe harm category in September 2022 (Ward A&E, 3D and 3 Alpha).	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		Oct-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	Oct-22	92.3%	93.5%	No Target	92.1%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Oct-22	1	12	No Target	30					

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CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Sep-22	56.8%	74.7%	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	▲ £	Sep-22	96.3%	97.6%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Sep-22	78.4%	81.9%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Oct-22	67.3%	67.3%	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	▲	Oct-22	76.8%	79.8%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Oct-22	2,408	2,408	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Oct-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	▲ £	Sep-22	100.0%	99.2%	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	▲	Oct-22	45.1%	47.0%	95.0%	55.8%		Accident and Emergency Type 1 performance for October 2022 was 45.1% and YTD 47.0%. The all type mapped STHK Trust footprint performance for October 22 was 69.1% and YTD 71.7%. The Trust saw average daily attendances of 318, which is up compared to September, at 313. Total attendances for October 2022 was 9,844. Total ambulance turnaround time was not achieved in October 2022 with 43 mins on average. There were 2,101 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 2,080 in September 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	▲	Oct-22	69.1%	71.7%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Oct-22	0	0	0	0					

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	▲ £	Oct-22	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Oct-22	13	115	No Target	254		Decrease in the number of new complaints received in month. % new (Stage 1) complaints resolved within agreed timescales remains below the target but improved slightly in October.	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	Oct-22	21	123	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Oct-22	85.7%	74.0%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to October 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	Oct-22	362	359		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Oct-22	133	135		108					
Friends and Family Test: % recommended - A&E	Q	▲	Oct-22	76.6%	79.3%	90.0%	79.0%		Recommendation rates remain above target for inpatients and postnatal community, but below target for the remaining areas. The rates remain fairly consistent with previous months.	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	▲	Oct-22	96.2%	95.0%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Oct-22	96.2%	94.4%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Oct-22	95.0%	92.9%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Oct-22	95.5%	94.6%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Oct-22	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Oct-22	93.6%	93.9%	95.0%	93.8%					

Oct-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Oct-22	6.3%	6.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In October 2022, there was an increase in the absence rate (6.3%) from September's figure of 5.9%. The rate for All Nursing and Midwifery staff group is 7.8%. 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.	There is a bi-weekly review of Trust absences by the HR Team and the Health, Work and Wellbeing Clinical Lead. Trends are monitored and management referrals analysed in order to provide targeted support to areas as needed 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.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Oct-22	7.8%	7.8%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Oct-22	85.0%	85.0%	85.0%	65.9%		Appraisal compliance in October is 85% which is an improvement from September (83.5%). Mandatory training compliance is 79.7% which has also improved from September (78.7%)	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Appraisal compliance has shown significant improvement in month and is now compliant. Mandatory training has also improved and remains just below the 85% target. 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	Oct-22	79.7%	79.7%	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.	Actions associated with the responses to the Q2 survey now incorporated into the Staff Survey action plan for 2022. 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	Oct-22	0.9%		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	Oct-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.	Non-recurrent benefits will impact the underlying position of the Trust going into next financial year.	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.	GL
Progress on delivery of CIP savings (000's)	F&P	T	Oct-22	13,670	13,670	28,100						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Oct-22	(1,706)	(1,706)	(4,949)						
Cash balances - Number of days to cover operating expenses	F&P	T	Oct-22	28	28	10						
Capital spend £ YTD (000's)	F&P	T	Oct-22	4,800	4,800	26,100			The capital plan includes external funding that has still not yet been received by the Trust.	Delays in the capital being received could impact the delivery of the capital programme.	The Trust continues to do all preparatory work to ensure there will be no slippage in the capital programme.	
Financial forecast outturn & performance against plan	F&P	T	Oct-22	(4,949)	(4,949)	(4,949)						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Oct-22	95.7%	95.7%	95.0%						

APPENDIX A

Tumour site	Measure		Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-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	▲ £	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	100.0%	93.1%	83.3%	100.0%	100.0%	100.0%	88.0%	93.6%	85.0%		96.0%		RC
	Total > 62 days		0.5	0.5	0.0	1.0	1.0	0.0	0.0	1.0	2.0	0.0	0.0	0.0	1.5	4.5			6.0		
	Total > 104 days		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	0.0			0.5		
Lower GI	% Within 62 days	▲ £	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	86.7%	90.5%	76.5%	79.3%	65.2%	83.3%	42.9%	75.0%	85.0%		79.7%		
	Total > 62 days		0.0	3.0	4.0	3.0	2.0	1.0	1.0	1.0	2.0	3.0	4.0	2.0	4.0	16.0			24.5		
	Total > 104 days		0.0	0.0	1.5	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	3.0			4.0		
Upper GI	% Within 62 days	▲ £	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	36.4%	90.0%	84.6%	100.0%	85.7%	70.0%	75.0%	83.1%	85.0%		83.2%		
	Total > 62 days		1.0	0.0	0.0	1.0	0.0	0.0	3.5	0.5	1.0	0.0	1.0	1.5	1.0	5.0			9.5		
	Total > 104 days		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	2.0			3.0		
Urological	% Within 62 days	▲ £	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	93.9%	90.0%	81.0%	79.2%	78.1%	85.0%	73.1%	79.4%	85.0%		80.5%		
	Total > 62 days		2.0	1.0	3.5	0.5	8.5	1.5	1.0	1.5	4.0	2.5	3.5	1.5	3.5	16.5			32.5		
	Total > 104 days		2.0	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	0.5	1.5	0.5	1.5	4.0			4.0		
Head & Neck	% Within 62 days	▲ £	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	16.7%	0.0%	44.4%	0.0%	25.0%	0.0%	18.8%	85.0%		24.4%		
	Total > 62 days		1.0	2.0	0.5	2.0	0.0	1.0	1.0	2.5	3.5	2.5	1.5	1.5	1.5	13.0			15.5		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.5	0.0	0.5	1.0	4.0			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	▲ £	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	60.0%	75.0%	66.7%	100.0%	45.5%	25.0%	50.0%	53.1%	85.0%		67.3%		
	Total > 62 days		2.0	1.0	0.5	3.0	0.0	5.0	2.0	1.0	2.0	0.0	3.0	4.5	1.0	11.5			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.5	1.0	1.0	0.0	0.0	2.0	0.0	0.0	3.0			2.5		
Lung	% Within 62 days	▲ £	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	55.6%	50.0%	92.3%	69.6%	30.8%	64.7%	66.7%	64.2%	85.0%		77.2%		
	Total > 62 days		2.5	3.0	1.5	1.0	2.5	1.5	2.0	1.5	0.5	3.5	4.5	3.0	1.5	14.5			18.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.5	1.5			1.5		
Haematological	% Within 62 days	▲ £	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	0.0%	100.0%	100.0%	75.0%	75.0%	69.2%	0.0%	73.3%	85.0%		60.5%		
	Total > 62 days		0.0	0.0	1.0	1.0	0.0	0.0	2.0	0.0	0.0	1.0	2.0	2.0	1.0	6.0			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0	0.0	2.0			5.0		
Skin	% Within 62 days	▲ £	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	100.0%	97.7%	93.4%	95.5%	86.9%	79.7%	92.8%	91.0%	85.0%		93.3%		
	Total > 62 days		3.5	4.0	4.5	3.0	3.0	2.0	0.0	1.0	2.5	1.5	5.5	7.5	2.5	20.5			29.5		
	Total > 104 days		0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	2.0	0.0	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	▲ £	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	86.3%	90.3%	83.2%	85.4%	77.6%	76.0%	78.4%	81.9%	85.0%		85.2%		
	Total > 62 days		12.5	14.5	15.5	15.5	17.0	12.0	12.5	10.0	17.5	14.0	25.0	23.5	17.5	107.5			170.5		
	Total > 104 days		2.5	1.5	2.0	1.5	0.5	2.0	3.0	1.5	3.0	3.0	7.5	2.5	6.0	23.5			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%	66.7%	100.0%	100.0%			0.0%	71.4%	85.0%		100.0%		
	Total > 31 days		0.0	0.0		0.0			0.0	1.0	0.0	0.0			1.0	2.0			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																				

Trust Board

Paper No: NHST(22) 089
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 October 2022. There were three Executive Committee meetings held during this period. The 13th October coincided with Emergency Preparedness, Resilience and Response Training for the Executive Team. There were no new investment decisions made. 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: 30th November 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were three Executive Committee meetings in October 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. 6th October 2022

2.1 Robotic Process Automation (RPA) Business Case – Benefits Realisation Report

The Deputy CEO/Director of HR introduced the report which gave an update on the business case to develop RPA in HR and payroll, which had been approved in 2021. There were now 91 bots in use covering 8 processes. These had delivered the efficiency saving required to make the LUHFT payroll contract viable. Further bots were now being developed, including some for lead employer processes with potential identified for further productivity benefits and job enrichment, as staff were released from having to perform routine repetitive administrative tasks. There was now a network established to allow new bots to be shared across trusts to spread the development costs. The paper included a proposal to retain the in house development team on the basis that this would be self-funding from the efficiencies generated. The proposal was approved.

2.2 Public Health Strategy – St Helens

The Director of Integration presented a summary of the St Helens public health strategy and how this aligned to the St Helens Place objectives.

2.3 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agendas for October for review and agreement.

2.5 Southport and Ormskirk Hospital NHST (S&O)

The Director of Informatics provided a briefing on the recent IT outage at S&O and the work that had been commissioned to prevent this happening again.

The Director of Corporate Services provided an update on the Transaction Programme and confirmed that briefing sessions for Non-Executive Directors from both S&O and STHK had been arranged.

The committee also discussed the future organisational structure and proposals to create single service divisions.

It was agreed that governance arrangements were already very similar and could be replicated in the new Trust, post transaction.

2.6 COVID 19 Staff Vaccination Booster Programme

A discussion was held about the COVID vaccination offer to staff over the previous month and it was agreed that this needed to be extended to increase take up and should continue to run alongside the winter flu vaccination programme.

2.7 Potential Industrial Action

The Deputy CEO/Director of HR reported that many of the unions representing NHS staff were balloting for strike action over the government pay offer for 2022/23. The ballots would be taking place over the coming weeks, with the results likely to be known in November. If strike action went ahead there would be an impact on planned procedures and non-urgent care, but emergency and urgent services would be maintained.

3. 20th October 2022

3.1 CQUIN Progress Report

The Director of Nursing, Midwifery and Governance presented progress on achieving the 2022/23 CQUINs at the end of quarter 1. 13 of the national CQUINs are in scope for the Trust and 10 have been negotiated for inclusion in the local CQUIN sanction regime. Although the financial values for the CQUINs had not yet been agreed for Cheshire and Merseyside ICB, the Trust had achieved the agreed KPIs for all 10 measures during quarter 1 and will therefore receive the full amount for this period. There was also assurance that all 13 CQUIN areas were on track to continue to deliver to the agreed standard for the remainder of the financial year.

3.2 Appraisal and Mandatory Training Compliance - September

The Deputy CEO/Director of HR presented the appraisal and mandatory training performance for September. Appraisal compliance had increased to 84% with all care groups and staff groups demonstrating improvement. Mandatory training compliance remained the same at 79%, the medical staff group continued to have the lowest compliance levels and the Medical Director outlined the work that had been initiated to improve compliance levels. The operational pressures facing the Trust were acknowledged, but all Directors agreed to maintain efforts to ensure that staff had a regular check-in with their manager and were released wherever possible to refresh their skills and knowledge.

3.3 Emergency Preparedness, Resilience and Response (EPRR) – Core Standards

The Director of Nursing, Midwifery and Governance presented the 2022/23 self-assessment against the revised EPRR standards ahead of approval by the Trust Board. It was noted that the Trust was partially compliant against some standards but there were actions in place and the new Emergency Planning Manager had now taken up post and was leading the delivery of the action plan.

3.4 Risk Management Council (RMC) Chairs Assurance Report

The Director of Corporate Services presented the RMC chairs report and Corporate Risk Register (CRR). There were 831 risks on the risk register, 32 of which had been escalated to the CRR. The RMC had discussed the escalation process and the need for CRR risks being escalated with director approval. Committee discussed the new CRR risk related to the

provision of skin cancer services to North Wales and the increased demand. This had been raised with the North Wales Health Board.

3.5 Board Assurance Framework (BAF)

The Director of Corporate Services presented the draft BAF for review, ahead of presentation to the Board for approval.

3.6 Winter Bed Capacity – Update

The Managing Director/Director of Operations and Performance introduced an update on the options for additional bed capacity to support patient flow during the coming winter. Working with a local care home provider, 30 additional beds would be opened for Trust pathway 1 to 3 patients, from mid-December.

Options to reconfigure beds internally to promote flow and work with the Rehabilitation Network had also identified the potential to create additional capacity for adult medical patients. Committee also discussed longer term options including the opportunity to purchase a site that had been vacated by Mersey Care NHST, which could be developed.

3.7 Nurse Staffing Establishment Review

The Director of Nursing, Midwifery and Governance presented the review of the nursing establishment against national safety board standards and professional judgement. The review confirmed that the establishment, the approved budgets, and the ledger were aligned. The review had identified 2 wards where the establishment for Health Care Assistant (HCA) staff needed to be increased and a business case would be developed to support this. The report also detailed the actions being taken to fill vacant posts within the establishment, for both qualified and HCA positions. The reported was approved for presentation to the Trust Board.

3.8 Monthly Safer Staffing Report

The Director of Nursing, Midwifery and Governance presented the safer staffing report for month 6 (September). The overall RN/RM fill rate was 93.66% and the HCA overall fill rate was 109.22 (including supplementary care). The report also included a detailed analysis of month 5 comparing staffing levels with reported incidents, bank and agency fill rates and recruitment initiatives.

3.9 Maternity Digital Strategy

The Director of Informatics presented a paper explaining the requirement for every trust to have a Maternity Digital Strategy and submit this to the ICB to meet the 2022/23 CNST requirements. The paper also included the proposed strategy for STHK and S&O to jointly procure an electronic system to support maternity care. If approved, strategy implementation would be supported by a business case and benefits realisation plans.

The strategy would be presented for formal approval to the STHK Board and the S&O Strategy and Operations Committee.

3.10 Southport and Ormskirk Hospital NHST (S&O)

The Deputy CEO/Director of HR provided an update on the recent LMNS site visit.

Committee reviewed the draft Transaction Strategic Case and initial due diligence assessment. Comments and feedback were provided so that the Strategic Case could be finalised for presentation to the STHK Trust Board on the 26th October, the Transaction Board on the 28th October and the extraordinary meeting of the S&O Board on the 3rd November.

4. 27th October 2022

4.1 Southport and Ormskirk Hospital NHST (S&O)

The Deputy CEO/Director of HR reported on the feedback letter that had been received from the LMNS about the S&O maternity service and the response that was being prepared.

Committee reflected on the STHK Board discussion and approval of the Transaction Strategic Case and planned for the Transaction Board on 28th October, which included key stakeholders and NHSE Transformation Team representatives.

The Director of Corporate Services briefed the committee on the plans for the NHSE Transaction Team visit and interviews with Board members from both Trusts and key stakeholders which were planned for w/c 7th November. Formal feedback on the Strategic case was expected w/c 14th November.

ENDS

Trust Board

Paper No: NHST(22) 090
Reporting from: Quality Committee
Date of Committee Meeting: 22nd November 2022
Reporting to: Trust Board
Present: Gill Brown, Non-Executive Director (Chair) Rani Thind, 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 **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 Stephen Beckett, Head of Quality Tracy Greenwood, Head of Nursing and Quality **In attendance to present specific reports:** Sue Orchard, Head of Midwifery Simon Gelder, Head of Pharmacy Sean Brady, Senior Pharmacy Technician Quality & Safety Emma Graham, Corporate Matron **Observing** Julie Tunney, Deputy Director of Quality
Matters Discussed **Patient Experience Council report** The Council received a number of reports, including an update on dementia and delirium, noting the work to improve levels of training; a detailed patient experience report; feedback from Healthwatch Knowsley, noting four negative experiences, but extremely positive feedback from the relaunched face to face outreach at Whiston Hospital. The Council noted the improvement actions taken following the Cancer Patient Experience & Quality Assurance Group's meeting effectiveness review and the work being undertaken prior to the implementation of Liberty Protection Safeguards. **Integrated Performance Report** (IPR) highlighted:

- No Never Events, or MRSA bacteraemia reported in October and no category 3 hospital acquired pressure ulcers reported in September
- 2 cases of hospital onset C difficile reported in October
- 3 falls resulting in severe harm reported in September
- Safer staffing fill rate for registered nurses/midwives for October 2022 was 92.3% and year-to-date rate 93.5%
- HSMR for April – June 2022-23 was 90.4
- Continued achievement of 31-day target in September; 62-day target was below target in month at 78.4% and remains below target year to date, however it did increase in month and the Trust was the best acute performer in Cheshire and Merseyside
- 2-week rule target was not achieved in September
- Continued challenges in meeting emergency care access targets, with 93% of patients seen and treated within 4 hours at the Urgent Treatment Centre
- Ambulance turnaround times were not achieved, although improved performance was commended
- Average daily number of super stranded patients (length of stay over 21 days) decreased to 133 in October from 156 in September
- 18-week referral to treatment and 6-week diagnostic targets were not achieved, but both improved in October compared to the previous month
- Sickness absence increased to 6.3%, appraisals improved to 85% and mandatory training increased to 79.7% in October
- District nursing referrals decreased in September but remained in line with average figures

The Committee were informed of the work being undertaken by Place leads to reduce the number of super stranded patients, as well as the provision of increased capacity in general and acute/community beds to improve patient flow and reduce congestion in the Emergency Department. The Committee noted the actions being taken regarding long waiters and diagnostics with the potential for this to impact positively on the 28-day cancer target by end March 2023.

The Committee also noted that benchmarking information will be provided in the revised IPR going forward.

Mersey Internal Audit Agency (MIAA) report
The findings of the latest quality spot checks undertaken by MIAA were reported, noting the actions that have been completed and those that are being taken following the limited assurance level given for two wards and the moderate assurance level for two community nursing teams. This includes local actions in relation to supporting new ward managers/junior staff and reauditing areas where improvements have been made to provide assurance that the issues identified have been effectively addressed. Several Trust-wide actions have also been implemented, including re-establishing peer audits. The Committee discussed the findings in detail and requested a further report to come to the next meeting to confirm the steps being taken to prepare and support ward managers and future leaders for these challenging roles, to ensure earlier identification of areas of concern and to ensure an effective feedback loop is in place for providing robust assurance.

Patient Safety Council report
A number of papers were received, including:

- Medical Care Group quarter 2 report which highlighted increased referrals to the Safeguarding Team and the actions taken to improve diabetes management
- Clinical Support Services 6 monthly report highlighted the actions being taken following two serious incidents
- Claims and inquest report, noting lessons learned
- Obstetrics and Gynaecology, noting reduction in new-born screening incidents and the increased reporting of any staffing deficits in line with policy
- Primary and Community Care report
- Infection prevention report
- EPMA update highlighting lessons learned following the recent system upgrade

The Committee noted the actions that need to be taken to improve training levels in Safeguarding level 3 and Prevent, including increased staff within the team and in infection prevention and control, noting mandatory training by department is now a standard item on the Clinical Directors' forum agenda.

Maternity report
A comprehensive report was provided noting progress in delivering the Ockenden recommendations, with only one outstanding from the initial report in relation to consultant-led night handover for which a business case is being developed to ensure full compliance. Of the four outstanding essential actions from the final report one is complete and plans are in place for the remaining three.

The report also outlined the delivery of the latest Maternity Incentive Scheme following its relaunch earlier this year, noting the submission deadline is February 2023. There have been no never events and two maternity diverts in the first 6 months of the financial year, significantly less than the previous year. All Healthcare Safety Investigation Branch (HSIB) reports have been completed bar one, which is in hand. The Trust is compliant with Saving Baby Lives bundle. Rolling recruitment has seen a number of new midwives appointed, which will support the plan to ensure 2 midwives are available in the maternity triage area.

The Committee also noted that the latest Birth Rate Plus report will be presented to the Quality Committee and Trust Board in January.

Freedom to speak up report
The bi-annual report confirmed the processes in place for staff to raise concerns, noting there had been 17 reported in quarters 1&2 via different routes, including anonymous concerns. It was noted that the majority were from nurses, but there were others from admin and therapies for example. Key themes identified included raising awareness to support staff with mental health issues and preceptorship for junior staff, with actions in place to address these. The results of the latest staff survey (2021-22) relating to raising concerns highlighted that the four relevant questions had positive scores that were significantly better than other trusts.

The Committee sought assurance that feedback is given to staff where concerns are raised on the actions taken to address these.

Medicines Management Audit report
The findings from the latest audits were presented, noting overall improvement in July, with slight deterioration in the October audits; quarterly controlled drugs audit will be combined with medicines safety audit from next year. The Committee were

informed that further work is being undertaken to incorporate areas that are not currently included, for example St Helens UTC.

Quality Care Assessment Tool (QCAT)
An update on progress with QCAT noted the results are aligned to the CQC domains (responsive, well led, safe, caring and effective) and key lines of enquiry. The initial self-assessment results found 11 wards achieved gold, 21 wards silver and 2 wards are yet to be analysed (3F & 4F). Peer review QCATs are currently being arranged.

Clinical Effectiveness Council report
The Council received 5 policies for approval, 2 presentations and several reports, including National Emergency Laparotomy Audit (NELA); ICNARC reported discharge delays have now been added to the Risk Register; Learning from Deaths are piloting a new Structured Judgement Review model; staffing issues were highlighted in Histopathology which is also a national pressure and in Anaesthetics, some of which are due to staff retiring.

Assurance provided:

- Work of the Cancer Support Workers in improving the overall experience of cancer patients
- Cancer Services Team won the Nursing Times' Cancer Nursing Award for the implementation of the brain cancer pathway
- Continued reduction in number of falls per 1000 bed days
- Good progress in delivering the recommendations from both Ockenden reports and compliance with Saving Babies' Lives in Maternity Services
- All risks are monitored through the Risk Management Council

Decisions taken:

- No formal approvals required

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

- Paper to be presented to January's Quality Committee following the MIAA report to outline support for ward managers, process for identifying areas of concern at an early stage and reviewing the feedback loop for providing assurance to the Committee
- Update on mandatory training to be provided to January's meeting
- Ongoing staffing challenges within histopathology with report to be provided to February's meeting

Matters for escalation:

- Continued focus on achieving mandatory training in key areas including safeguarding level 3, Prevent and infection prevention

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

Committee Chair: Gill Brown, Non-Executive Director

Date of Meeting: 30th November, 2022

St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST BOARD

Paper No: NHST (22) 091
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 24th Nov

Summary

Meeting attended by:

J Kozer – NED & Chair
P Growney – NED
I Clayton – NED
G Appleton - NED
A Stretch – Deputy Chief Executive/Managing Director S&O
R Cooper – Managing Director STHK
G Lawrence – Director of Finance & Information
Dr P Williams – Medical Director
C Oakley – Deputy Director of Finance & Information
P Williams – Medical Director
A Bassi – Divisional Medical Director
J McCabe – Divisional Medical Director
N Bunce – Director of Corporate Services
A Matson – Assistant Director of Finance – Financial Management
T Truong – Assistant Director of Finance – Corporate

Agenda Items

For Assurance

A) Integrated Performance Report
- 62 day performance was below the 85% target in September, at 78.4%.
- Target 31 day performance was met in September, at 96.3% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in September, at 56.8% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 45.1% in October and 47.0% year to date. All type mapped STHK Trust footprint performance was 69.1% in October and is 71.7% year to date. The Trust saw average daily attendances of 318, which is an increase compared to September at 313. Total attendances for October were 9,844.
- The ambulance turnaround time target was not achieved in October, at 43 minutes on average. The Trust was the second busiest in C&M and fourth busiest across the North West.
- In October, overall sickness had increased to 6.3%, from 5.9% in September.

B) Finance Report Month 7
- At Month 7, the Trust is reporting a year to date deficit of £1.7m and forecast outturn deficit of £4.9m, in line with plan.
- Included within the financial position are non-recurrent benefits of approximately £8m 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 financial planning process.
- 22/23 forecast outturn may improve ahead of M8 reporting as a result of increases in interest rates.
- Risk to be captured as part of 23/24 planning process in relation to impact of RPI increases on PFI contract. Currently estimating pressure at £6.7m – this will be updated in January based on the December RPI figure.
- Capital expenditure for the year to date (excluding PFI lifecycle maintenance) totals £4.8m.
- At the end of Month 7, the Trust has a cash balance of £80.6m, with an increase seen in relation to Lead Employer contracts.
- Agency expenditure of £6.4m is included in the year to date position, compared to £5.6m year to date at Month 7 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 97.3% against a target of 95%.

C) 2023/24 Budget Setting Process
- The 2023/24 budget setting process is now underway, with an initial draft plan to be reviewed in January.
- NHSE planning guidance has not yet been received. Assumptions will be revisited when this is available.

D) Update on Estates Returns Information Collection (ERIC) 2021/22
- The committee noted the update and key changes since the 2020/21 return.

E) Commercial Finance Report Month 7 2022/23
- The committee noted the update on commercial HR services provided by the Trust.
- The committee noted risk around varying contribution levels from these services, but were assured that actions are being taken to mitigate this risk, including ensuring that new Lead Employer contracts allow for charges to be increased in line with pay inflation.

For Approval

N/A

For Information

- **CIP Council Update** – Update noted by the committee
- **Procurement Steering Council Update** – Update noted by the committee
- **Implied Efficency** – The committee noted the results from the audited HFMA checklist and acknowledged the positive outcome of the audit.
- **Improving Financial sustainability checklist** – The committee were updated with the current implied efficiency score of the Trust. While this was positive compared to peers there was still work to do on tunring the score positive. The committee noted that this performance would correlate with the underlying position of the Trust.

- **Social Care Fund** – The committee noted the additional investment for social care that would support faster discharges for patients.

Risks noted/items to be raised at Board

A) Clinical review of ED performance metrics
- It has been indicated that the implemtation of the new ED metrics will now not go ahead. The Trust awaits official confirmation which will then be communicated with clinical leads who were engaged with the new metrics.

B) NHSE Protocol for changes to in-year revenue financial forecast
- An update was provided on the conditions that will be applied to provider organisations reporting a forecast deterioration against their financial plan. This includes a requirement for any revenue investments above £50,000 to be signed off by the provider and the ICB as part of a ‘double-lock’ approval process.
- The committee raised concerns with this requirement and the potential impact on patient care should this process cause delays in approval of new developments.

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: 30th November 2022

Trust Board

Paper No: **NHST (22)092**
Reporting from: Strategic People Committee
Date of Committee Meeting: 10.10.22
Reporting to: Trust Board

Attendance:

Lisa Knight	(LK) Non-Executive Director (Chair)
Gill Brown	(GB) Non-Executive Director
Claire Scrafton	(CS) Deputy Director of HR & Governance
Gareth Lawrence	(GL) Director of Finance and Information
Rob Cooper	(RC) Managing Director
Ian Clayton	(IC) Non-Executive Director

Apologies:

Anne-Marie Stretch	(AMS)Deputy CEO/Director of HR
Malise Szpakowska	(MS) Deputy Director of HR
Sue Redfern	SR) Director of Nursing Midwifery & Governance
Nicola Bunce	(NB) Director of Corporate Services

In Attendance:

Teresa Keyes	(TK) Deputy Director of Nursing and Quality
Kelly Stephenson	(KS) Head of HR Governance and Performance
Adam Rudduck	(AR) Assistant Director of OD
Paul Maskell	(PM) Head of Learning & OD
Hayley McCann	(HM) Minutes

Matters Discussed:

6.0 - Organisational Development – Operational Plan

AR presented the Operational Development Operational plan which was approved at People Council.

- The key focus from 2022 – 25 is Leadership and Management Development, staff experience and capability and partnership working
- The ACE behaviours and the refreshed infographic will support communication to staff about how they link to the Trust Values, and this will be communicated out to the rest of the Trust
- Action for RC to share frameworks with AR to support OD plan

7.0 Belonging in the NHS - Equality, Diversity & Inclusion Update, WRES & WDES (Internal) Reports

- CS reported that the Trust is expecting some new national guidance on ED&I which will include a national ED&I Strategy that can then be incorporated into the Trusts local ED&I Operational Plan
- The Trust has been accredited with the NHS Rainbow Badge Bronze award by the LGBT Foundation and confirmed that an action plan would be developed to implement the foundations recommendations.
- A business case to invest in resources to create a workforce ED&I team has been approved by the Trusts Executive Committee and that the recruitment process will be completed by the 31st December 2022
- The ED&I team are continuing to work on reporting for protected characteristics so that cases can be tracked via Datix
- MS will share the dashboard with NED's ahead of January SPC, following re-alignment with the new IPR Trust template

8.0 - Overarching People Strategy – Consultation

- CS confirmed that the People Strategy was being presented for consultation with the SPC and following feedback it would be brought to SPC for approval in January 2023 prior to ratification by the Trust Board
- The People Strategy aims to bring together the themes and priorities of all the supporting Operational Plans that have been approved earlier in 2022/23 and there will be more information added to this when the ED&I operational is approved later in October 2022

9.0 - Trust Objectives/People Plan Strategy - action plan update - Q1/Q2 - 2022/23

- The actions delivered in Q1 and Q2 were detailed in this report using a BRAG status
- By Q3 there will be more tangible measurements on the report to give assurance about the progress that is being made

14.0 – Any other business

- Debbie Livesey, Head of HR & Stakeholder Engagement, Lead Employer and Ngozi Anya, Head of HR Operations, Trust will attend SPC in January 2023 to give an update on some case trends over the last 12 months to give assurance.
- Staff stories will be a new standing agenda item for future meetings and someone who has recently completed an apprenticeship will be invited to January SPC

Assurance Provided:

- Organisational Development – Operational plan
- Overarching People Strategy – Consultation process in progress
- Belonging in the NHS - Equality, Diversity & Inclusion Update, WRES & WDES (Internal) Reports

• Trust objectives/People Plan Strategy - action plan update - Q1/Q2 - 2022/23
Decisions Taken: 1. There were no decisions from the committee
Risks identified and action taken: • There were no risks identified.
Matters for escalation: None
Recommendation(s): Members are asked to note the content of the report, including assurances provided and actions taken to address areas of concern.
Committee Chair: Lisa Knight, Non-Executive Director
Date of Meeting: 10th October 2022

TRUST BOARD

Paper No: NHST (22) 093
Title of paper: Committee Report – Audit
Purpose: To report to the Trust Board on the Audit Committee, 9th November 2022

Summary

Meeting attended by:

I Clayton – NED & Chair
J Kozer – NED
G Brown – NED
G Lawrence – Director of Finance & Information
S Redfern – Director of Nursing
N Bunce – Director of Corporate Services
K Jenkinson – Assistant Director of Finance
J Farrar - Engagement Lead, Grant Thornton UK LLP
G Baines – MIAA, Senior Manager
A Poll - Senior Audit Manager, MIAA
R Barker - MIAA Anti-Fraud Specialist

Agenda Items

For Assurance

A) External Audit
- The committee noted the report from external audit

B) Internal Audit
- The Qulaity Spt Check review has been completed since the last Audit committee.
- The committee noted the limited assurance on the review and sought assurances around the remedial plan.
- The committee noted that progress was ongoing on the following reviews:
  - HFMA Financial sustainability
  - Payroll

C) MIAA Anti-Fraud Services
- The committee noted the appointment of the Trusts new Fraud Champion (C Oakley).
- The committee reviewed the progress of the antif fraud activity

D) Audit log
- The committee noted progress against actions from previous audits and where assured that progress was being made in clearing the actions.
- It was noted that external audit actions are now being monitored within the log.

E) Losses and Special Payments

- £108k losses and special payments registered ytd 2022/23, 37% of 2021/22 full year total of £289k.

F) Aged Debt
- Total NHS invoiced debt: £23.6m of which £6.7m has been due for more than 30 days.
- Total Non NHS invoiced debt: £5.3m of which £3.9m has been due for more than 30 days.

G) Tender and Quotation Waivers
- The committee noted the number of waivers.

For Approval

Risks noted/items to be raised at Board

Corporate objectives met or risks addressed: Finance and Performance

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members

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

Presenting officer: Ian Clayton, Non-Executive Director

Date of meeting: 30th November 2022

TRUST BOARD

Paper No: NHST(22) 094
Title of paper: Influenza Campaign 2022-2023 Board Assurance Checklist
Purpose: To ensure that the Trust Board is cited on the Healthcare Worker Influenza Vaccination best practice management checklist and the Trust's performance
Summary: As per the national and seasonal influenza campaign, directed by DHSC, NHS England and UKHSA. The Trust is required to complete a Healthcare worker influenza vaccination best practice management checklist and seek Trust Board approval of the action taken to date.
Corporate objective met or risk addressed: Developing organisational culture and supporting our workforce
Financial implications: None
Stakeholders: All
Recommendation(s): The Trust Board is asked to approve the completed Healthcare worker influenza vaccination best practice management checklist.
Presenting officer: Anne-Marie Stretch, Deputy Chief Executive / Director of Human Resources
Date of meeting: 29th November 2022

Trust Self-Assessment: Healthcare worker flu vaccination best practice management checklist

Item	Leadership	BRAG
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers (Both clinical and non-clinical staff who have contact with patients)	Completed
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Completed
A3	Board receives an evaluation of the flu programme 2020 to 2021, including data, successes, challenges, and lessons learnt	Completed
A4	Agree on a board champion for flu campaign	Completed
A5	All board members receive flu vaccination and publicise this	Completed
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Completed
A7	Flu team to meet regularly from September 2022	On-going

Item	Communication Strategy	BRAG
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	On-going
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	On-going
B3	Board and senior managers having their vaccinations to be publicised	Completed
B4	Flu vaccination programme and access to vaccination on induction programmes	On-Going
B5	Programme to be publicised on screensavers, posters, and social media etc.	On-going
B6	Weekly feedback on percentage uptake for directorates, teams, and professional groups	On-going

Item	Service Delivery Model's	BRAG
C1	Schedule for easy access drop-in clinics agreed	On-going
C2	Schedule for roving vaccinations to be agreed	On-going
C3	Flu Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate, and empowered	Completed

Item	Incentives	BRAG
D1	Board to agree on incentives and how to publicise this	Completed
D2	Success to be celebrated weekly	Ongoing

- **END -**

Trust Board

Paper No: NHST(22) 095

Title of paper: Trust Objectives 2022/23 – Mid Year Review

Purpose: To note the progress in achieving the 2022/23 Trust Objectives.

Summary:

1. The Trust Board agreed thirty-one Trust objectives for 2022/23 in March, incorporating the quality improvement objectives.
2. The objectives will be split into 9 categories: 5 representing the Trust's Five Star Patient Care criteria of care, safety, pathways, communication, and systems. There are then 4 categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency and productivity; and strategic plans.
3. This report summarises progress in achieving the objectives halfway through the year based on the following criteria.

Definition	Rating
Fully achieved	**1 (4%)**
Good progress being made and on track to be fully achieved by 31st March 2023	**22 (71%)**
Progress made but may not be fully achieved by 31st March 2023	**6 (19%)**
Lack of progress and at risk of not being achieved by 31st March 2023	**2 (6%)**

The review demonstrates solid progress in a challenging operating environment

Two objectives have been reported as red (at risk of not being delivered in this financial year). These objectives relate to delivery of performance or recovery standards and the impact of congestion, capacity and challenges with patient flow and consequential impact on optimal hospital capacity and throughput. Objectives which are dependent upon staffing and patient flow have been impacted by the complexity and capacity constraints currently being experienced within our local system. The Trust performance challenges in these areas are being experienced by all acute providers.

Notwithstanding these challenges, there are mitigations in place to promote recovery. Ambulance triage times reduce from 23 to 19 minutes over the reporting period and we have secured temporary funding for additional community beds which will support capacity through the winter.

Trust objective met or risk addressed: provides assurance to the Board that the Trust is making sufficient progress in delivering its annual Trust objectives after the first 6 months of the year.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff, patients and all stakeholders.
Recommendation(s): The Board notes the progress made in achieving the 2022/23 Trust objectives
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 30th November 2022.

2022/23 Trust Objectives – Mid Year Review

Objective	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
1. 5 STAR PATIENT CARE – Care We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families					
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of hospital-acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee	October audit – 90% of identified patients had red jugs and 91% with completed fluid balance charts. Standard Mortality Ratio (SMRs) have reduced to 103 for AKI, CRAB – both the number of triggers and the % of triggers with admissions for AKI have reduced.	
1.2 Continue to ensure the timely and effective	DoOp	• Patients triaged within 15 minutes of arrival			

Objective	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
assessment and care of patients in the emergency department (QA)			Quality Committee	Delivery of this objective has proven to be extremely challenging within our current operating environment and wider health and care context. However, through targeted focus and delivery of mitigations we have begun to achieve recovery seeing ambulance triage times reduce from 23 to 19 minutes over the reporting period. Following investment and winter resources our focus is, now, on consolidating these gains to continue to enhance performance on triage, first clinical assessment and treatment within 12 hours Our performance over the reporting period has been: **Triage**	

Objective	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• First clinical assessment median time of <2 hours over each 24 hour period • Implement the new national ED standards to; see and treat 98% of patients within 12 hours and "clinically ready to proceed" • Implement revised safety checklist documentation which includes National Early Warning Score (NEWS) and sepsis screening and undertake regular audits to demonstrate effective		Ambulance triage times are now 19 minutes (23 mins in 2019/20). The ratio of walk-in / Ambulance arrivals has changed since 2019, with the number of walk-in presentations increasing by 4%. Front door streaming has been introduced which means there may be a longer average wait time but the most poorly patients are seen faster. The Department is also trialling a new triage model; which has been shown to reduce the triage time and support the front door streaming model. **First Clinical Assessment** The median time to first clinical assessment was **145** mins (m1-6 2022/23), compared to 105 mins in 2019/20. Departmental congestion is the biggest predictor of performance. Service improvement work is being undertaken. Our focus is on ○ Front door streaming ○ Departmental efficiency inc. SDEC ○ Corridor Improvement inc. handover times. **12-Hour from arrival performance** Against the new metric of <12 hours from time of arrival, 8.7% of patients have waited longer than 12 hours (M 1-6). This is compared to 6.7% in the same period 2019. The additional bed capacity being brought online from 1st December will help to decongest ED, and improve flow into specialty areas. **NEWS and Sepsis** The patient pathways are that all patients should have an Early Warning Score documented at Triage and be screened for	

Objective	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		monitoring and appropriate escalation		Sepsis if there are sepsis triggers. The new ED Quality Lead Nurse is responsible for auditing compliance. As at the end of the reported period performance recorded in audits for Sepsis and NEWS was at 100%	
1.3. Increase capacity at the Trust and improve clinical	DoOp/	• Continue to progress the strategic site development plans for the Trust and the	Executive Committee	All planned schemes for the 2022/23 capital programme are progressing to plan, with the Paediatric ED due for completion in spring 2023.	

Objective	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
adjacencies to optimise patient flow	DoCS	capital schemes planned for 2022/23 to improve patient facilities and increase capacity; • Paediatric Emergency Department and Children's Observation Ward • Additional Theatre capacity at Whiston Hospital • Implement the accommodation strategy to create space in the main hospital buildings for clinical services • Deliver increased diagnostic capacity in support of the elective recovery plans		The accommodation strategy is also progressing to plan and IT, HR, Lead Employer, Finance and Procurement have now moved to new offsite offices, vacating off site accommodation that was no longer fit for purpose and allowing decant space on site to facilitate the theatres scheme. The Community Diagnostic Centre at St Helens is operational and additional national funding has been secured to create further capacity.	

2. STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**					
2.1 Reduce avoidable harm by preventing falls (QA)	DoN	• Reduction in the number of inpatient falls per 1000 bed days by at least 10% compared to 2021/22 (stretch target remains less than 7.2 inpatient falls per 1000 bed days)	Quality Committee	A reduction in total falls per 1000 bed days for Q1 and Q2 (cumulative) to 7.46, decreasing from 8.56 in 2021-22.	
		• 95% of patients to have a documented falls risk assessment within 6 hours of admission measured through quarterly audit of sample of patients		For Q1-Q2 (cumulative), 89% of patients had falls risk assessment completed within 6 hours of admission (Tendable audit)	
		• When falls do occur the subsequent investigation will identify the root cause so these can be monitored and analysed		All moderate harm and above category falls have an RCA level 1 or 2 as appropriate. Biannual thematic review of all serious harm falls is undertaken, and findings are presented to Patient Safety Council. The findings then feed into the Trust falls prevention strategy and action plan.	
		• Audit demonstrating that patients at risk of falling have a completed falls prevention care plan in place that has been reviewed as per hospital policy		98% of patients audited in Q2 had a completed falls prevention care plan and appropriate interventions in place.	
2.2 Evaluate best practice and develop proposals for improving the Trust wide safety culture	DoN	• Commission an independent diagnostic and cultural survey to inform the development of the “Safe	Executive Committee	The Trust is working with AQUA in relation to the falls strategy and is sourcing external advice to undertake an assessment of the ward environment, cultural survey and observations of care delivery	

		and Sound" strategy and action plan • Launch and publicise the agreed strategy and the ways that staff can contribute • Celebrate achievements and successes with regular bulletins and dissemination across all clinical and patient facing staff		A patient safety panel has been established. This meets weekly to discuss all incidents graded moderate or above. This results in learning bulletins monthly and direct feedback to teams involved, to reinforce the Trust aims The Deteriorating Patients project has held quarterly workshops (May and November). A lead nurse and clinical lead have been appointed, to take this forward. Safety culture: • Have an implementation plan to introduce the new National Patient Safety Incident Response Framework (PSIRF) in 2023, • TVN trained to conduct monofilament testing to check arterial blood pressure for use in managing diabetic foot and venous leg ulcers • Listening events have been held with a number of wards • Safety day planned for Patient Safety Awareness Week March 2023 Resources: • Assistant Directors Safety x2 in post and leading on care groups safety and incident reviews • Experienced interim Deputy Director of Nursing has been appointed I to focus on safety culture including clinical and safety audits and listening events	
2.3 Implement the recommendations of the Ockenden Report into the safety of Maternity Services	DoN	• Delivery of the year two action plan to implement the recommendations of the Ockenden Report	Quality Committee	Fully compliant with all the elements of Saving babies lives care bundle (SBL). Annual audits were completed in 2021 and on track to be repeated in 2022.	

		• Achievement of the CNST maternity safety bundle for 2022/23		The Northwest Coast SBL quarterly bundle survey has been implemented and submitted in May 22. Ockenden 1, one year review against compliance completed. Insight visit undertaken by the regional team on 15.08.22 to assess against the 7 immediate and essential actions (IEA) of Ockenden 1 and positive feedback was received. Ockenden 2 gap analysis completed and action plan in progress aligned to the further 15 overarching EIAs. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4 submission timeframes were suspended but continued work from the maternity service on the 10 safety actions has been maintained as much as practicable. This will support submissions by the revised date of 05.01.23. Maternity safety champions include NED and DON who report to maternity incidents to the Trust board. Fortnightly CNST task and finish group established to monitor progress.	

<table>
<tr><td colspan="6">3. 5 STAR PATIENT CARE – Pathways
As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient</td></tr>
<tr>
<td>3.1 Improve the effectiveness of the discharge process for patients and carers (QA)</td>
<td>DoOp</td>
<td>Continue to improve inpatient survey satisfaction rates for receiving discharge information
In regular audits achieve a minimum 75% of patients who receive the discharge from hospital booklet
Achievement of the 20% target for patients to be discharged before noon during the week and 85% by 5.00pm, consistently across all wards
Achievement of 85% of the weekday average discharges to be achieved at the weekends, consistently across all wards
Implementation of standardised patient equipment ordering process for aides required at home.</td>
<td>Quality Committee</td>
<td>For the annual In-Patient Survey the Trust is rated in the top 10 for 14 questions, with an improvement in score for 10 questions. Hospital discharge remains a challenging part of people's experiences of care. In the survey we ranked second for discussing with patients if they may need any further health or social care services after leaving hospital and for patients knowing what would happen next before leaving hospital and ranked third for receiving enough support from health and social care services and understanding care after leaving hospital.

Daily monitoring and weekly/ monthly trend analysis of noon discharges ongoing. Strong performance against this target and processes in place to identify discharges for next day.

<table>
<tr><td>Discharges before midday</td><td>Q1 2022-23</td><td>Q2 2022-23</td></tr>
<tr><td>Medicine only</td><td>28%</td><td>24%</td></tr>
<tr><td>Medicine/ surgery combined</td><td>28%</td><td>26%</td></tr>
</table>

Weekend discharges continues to be challenging with minimal alternative care settings able to accept safe discharges during this period.

Equipment ordering process in place with clear instructions on intranet.</td>
<td></td>
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<tr>
<td>3.2 Implement the multidisciplinary Community Crisis Response Service for St Helens</td>
<td>DoOp</td>
<td>Respond to 80% of calls within 2 hours by Quarter 3, increasing to 90% by April 2023</td>
<td>Finance and Performance Committee</td>
<td>In September 2022 we went live in St Helens with our integrated Urgent Community Response (UCR) service with St Helens Council.

By October the service had 295 referrals, 92% were responded to within 2 hours.</td>
<td></td>
</tr>
</table>

		• Reduce ambulance conveyances to the ED • Reduce unnecessary emergency admissions to hospital		Service KPIs have been developed to monitor admissions avoided and appropriateness of referrals. Next step is planning for the Frailty Virtual Ward using UCR as the vehicle; with additional capacity to support this initiative funded.	
3.3 Improve acute care pathways to ensure optimal configuration of services	DoOp	Agree the optimal configuration of surgery, medical specialities and paediatrics within the Trust to; • Reduced number of patient ward moves • Reduced number of FCEs • Implement direct to specialty pathways • Improve patient satisfaction and experience ratings	Executive Committee	Bed modelling exercise undertaken. Ongoing work to ensure specialty bed bases are right sized, to include appropriate work force e.g.Cardiology G&A bed increase required – investment in consultant workforce approved. Direct to specialty pathways in place for Medicine, Surgery, Paediatrics, Frailty as well as other specialist pathways including Plastics Trauma. The Trust has worked to reduce the number of finished FCE and the number of ward moves. Within an extremely challenged environment these have remained on the right trajectory. Ward spells were 1.53 and total FCEs down 5% in September 2022 from two years previously. A programme of work has commenced between the Trust, NWAS, 111, Primary care and community services to ensure that patients are directed to the most appropriate service. See also statements and progress update provided on In Patient survey November 2021 reported under 3.1 and plans to better align beds though moves and supported by increased capacity from winter monies.	
3.4 Continue to redesign outpatient pathways through transformation and modernisation	DoI/DoOp	• Introduce an electronic room-booking service, so that the capacity in the outpatient departments are optimised to accommodate additional clinics	Executive Committee	• Work is ongoing to find a suitable solution. Supplier demonstration scheduled for 15/11/22. Interim solution in place for main outpatients to facilitate improved room management • Data gathering process in place to begin to populate Careflow with contact information, choosing letter or email, in advance of the pilot of Careflow letters, which is aligned to the clinic reconfiguration project. More advanced capability	

		• Reduce DNAs by enabling patients to choose their preferred method of communication for appointments and appointment reminders • Implement electronic requesting for clinicians in outpatient settings e.g. prescribing, request for follow up appointments, diagnostic tests • Reduce the number of cancelled and rearranged appointments by 20% by revising the current clinic structures and piloting shortened booking horizons		around preferred method of contact will be available with the implementation of the patient portal which is planned for Therapies by March 2023 • Electronic requesting is available in outpatient areas for prescribing and for placing diagnostic orders. Work is in progress to identify, train and resolve any issues from areas not placing electronic diagnostic orders. Histology, Cardiorespiratory and Urology specialised ordering has recently been developed and deployed. • The plan to complete the clinic reconfiguration and booking horizon reduction is in place. Awaiting approval of resourcing plans to commence the work.	
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1 Improve communications for relatives who need to contact our wards	DoN/DoI	• Develop innovative solutions to enable relatives to be able to contact the clinical team on each ward and be regularly up dated about their loved one • Reduce PALs contacts and complaints relating to communication with wards • Reduce the number of abandoned calls to wards	Quality Committee	• We are exploring the use of Vocera, an IT solution already in place at the Trust, which will enable clinical staff on the ward to be contacted more easily. Pilot to be in place by January 2023. • There were 3 formal complaints involving poor communication with relatives in Q1&2 2022-23 compared to the same number in 2021-22, however there were 333 PALS concerns where communication with relative was noted as a concern in Q1&2 2021 compared to 115 in 2022, a reduction of 65.5% • There has been a 30% reduction in calls not answered on the wards when comparing Q1&2 2021-22 to Q1&2 2022-23	

4.2 Introduction of digital letters and "real time chat" alongside telehealth appointments to support patients in having a choice about how they communicate with the Trust	DoI	• Digital letters that meet the accessibility standards and can easily be shared with other carers or relatives • Improved digital information supported by "messaging" to enable patients to ask questions about their care or condition directly and easily with the clinical team looking after them	Executive Committee	• The trust has contracted with a 3rd party print and mail provider who can meet the accessibility standard and will be applied to appointment letters by March 2023. A further development (in conjunction with Southport and Ormskirk) will create a patient portal where digital letters can be viewed and shared. A pilot to be in place by March 2023. • Messaging capability to be provided as part of the new patient portal and virtual appointment solutions which will be introduced by March 2023	
4.3 Improve internal processes and communication systems with patients and relatives about patient property	DoN	• Reduction in incidents relating to lost patient property • Reduction in PALs contacts and formal complaints received about patient property	Quality Committee	• There were 12 incidents relating to inpatient lost property in Q1&2 2022/23 compared to 13 in Q1&2 2021/22 [*Incidents reported where the lost items were located have not been included in the numbers] • The lost property task and finish group continues to progress with actions to further reduce lost property including review of Patient Property Policy, development of flow chart to remind staff of correct process and reiteration of impact of any loss on patients/carers. A pilot is taking place of new property boxes for small items in ED which will be reviewed with a view to rolling out across other areas by quarter 4 2022-23	

5. 5 STAR PATIENT CARE – Systems We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes					
5.1 Deliver the 2022/23 Digital Strategy Objectives and achieve HIMSS Level 5 or greater by Autumn 2023	DoI	• Reduce the amount of paper in nursing and therapies documentation produced, as part of the paper based medical record by 90% • Reduce the amount of paper in medical documentation by 50%, aided by in-built clinical decision support • During Careflow downtime ensure clinicians have access to patient allergies, problem/diagnostic lists, medications and lab results	Executive Committee	• Pilot area Ward 3C has achieved 90% reduction in Nursing and AHP paper documentation. Rollout now taking place across the hospitals. • Medical documentation has been reduced by 20% to date. • Careflow Connect BCP (cloud based) displays patient allergies from the EPR, Problem/Diagnostic lists in the SBAR. EPMA BCP provides medication information. Lab results available on ICE system in the event of a Careflow downtime. Complete	
5.2 Implement and electronic bed management and discharge planning system across inpatient wards at Whiston Hospital.	DoI	• Help ensure that the sickest patients are seen soonest by the use of Early Warning Scores (EWS). These are available via the clinical modules within Careflow EPR, specifically Vitals on desktops and handheld devices, Careflow Connect, and Patient Flow, which displays the EWS in a colour coded format. • Roll out electronic whiteboards across Whiston Hospital wards	Executive Committee	• Informatics have been working with the Deteriorating Patient Team and Training Team to improve Vitals compliance by supporting and retraining staff. The desktop version of Patient Flow shows the latest EWS score. • The desktop version of Patient Flow has been deployed to all wards and includes indicators on risk assessment compliance. Touch screen whiteboards are being installed at every nursing station on inpatient wards. Medical wards are expected to be complete by the end of December 2022 and surgical wards by March 2023. • All areas have access to Workspace and staff training is in progress. “Narrative” will be implemented in March 2023.	

		• Improve access to patient information by the implementation and roll out of Workspace and Narrative digital clinical documentation • Reduction in patient LOS by supporting achievement of the national discharge targets • Patient information to be entered electronically only once and used many times.		• By deploying Patient Flow on mobile devices and touch screens on inpatient wards, ward and operational staff will have access to real time bed management and patient flow information in one place, ensuring patients are discharged as soon as possible and highlighting outstanding tasks that prevent early discharge sooner. • The new clinical notes have been designed to record information once and once only. The About Me – SHADL is a good example of one form where information is entered once and used multiple times by Nurses, Medics, AHPs, Discharge Coordinators, Specialist Nurses etc.	
5.3 Implement new Community Electronic Patient Record (EPR) solution	DoI/Do Op	• To improve the management of patients in the community • Reducing the amount of paper that clinicians have to complete , releasing more time to care • Improving the ability to share information in real time with primary and secondary care colleagues. Supporting joined up care.	Executive Committee	• The first stage of the system implementation was completed in August 2022, with a small number of services live on the EMIS solution. This has been well received by the services, and some operational improvements are being made to leverage maximum benefits from the new solution. Most community services will migrate to EMIS by March 2023. • Those services currently on an alternative EPR systems are also using them in varying degrees and data migration has required further planning. i.e., Developmental paediatrics will require full data migration to support safeguarding records. • GP's can now see UCR records, and we intend to build on this as we roll out to the other services, strengthening communication and improved ways of working.	

6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.					
People Plan Pillars – Looking After our People					
6.1 Enhance health and wellbeing support services for staff and promote attendance	DoHR	• Comply with NICE guidance and the NHS People Plan and provide an extended range of support services to improve the health, well-being, and resilience of our staff , including supporting staff who have been impacted by the COVID-19 pandemic • Implement a new person-centred well-being and attendance management policy framework that supports staff to return to work • Develop a leadership development training programme that supports managers deliver the new approach	Strategic People Committee	• The Wellbeing Hub continues to offer a wide range of support services to support staff with their health and wellbeing needs. Additional bespoke sessions and events have been created specially in response to cost-of-living crisis, Winter Wellbeing, Menopause Café. • Autumn Covid-19 booster campaign commenced w/c 12/09/22. Seasonal influenza campaign commenced w/c 19/09/22. Wellbeing conversations continue to be offered as part of the annual appraisal. Evaluation of the wellbeing conversations is taking place in Q3. • The new NW draft Wellbeing Policy which focuses on a person-centred wellbeing approach is under review. • In readiness for the new Wellbeing Policy the Operational HR Team have reviewed all template letters to fit with our compassion leadership approach. • The Leadership Development Training programme is underway with an initial focus on disability awareness training, employment law, along with staff group/ departmental specific leadership programmes such as a Estates & Facilitates Leadership programme and Clinical Director Leadership Programme.	
People Plan Pillars - Belonging to the NHS					
6.2 Continue to listen to our staff to ensure we remain an employer of choice	DoHR	• Agree the priority actions from the 2021 staff survey and deliver them in 2022/23	Executive Committee	• Staff Survey Action Plan in progress and monitored by People Council and reported to the Strategic People Committee • 'You said, we did' produced and published in advance of the 2022 survey. Newsletter circulated to all areas of the Trust highlighting actions taken. Actions continue to be monitored through newly established Staff Survey Operational Group.	

6.3. Improve the methods of delivery and ease of access of mandatory training to increase compliance rate recovery	DoHR	• Achieve the COVID-19 recovery improvement trajectory of 85% compliance with mandatory training across all staff groups • Continue to innovate with the subject matter experts to create alternative delivery methods to support staff access to mandatory training	Strategic People Committee	• Actions continue to move Mandatory Training compliance in a positive direction, however this is still slightly below target • Development and deployment of e-learning package for Safeguarding Level 2 completed to replace workbooks.	
6.4 Respond to feedback from staff to improve appraisals and appraisal compliance to support staff to deliver high quality patient care.	DoHR	• Continue to embed the new Trust appraisals process and evaluate the impact with staff	Strategic People Committee	• New online appraisal and personal development system to support staff in their development and career planning throughout the year has been implemented.	
People Plan Pillar – New Ways of Working					
6.5 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimal design of the workforce and the right number and skill mix of staff	DoHR	• Undertake a benefits realisation review for e-rostering and e–job planning to improve levels of compliance • Improve the management and governance processes that support e-rostering and reduce errors • Restart the specialist nursing job planning project	Executive Committee	• Better Rostering Steering Group established chaired by the Deputy Director of Nursing to ensure benefits realisation from e-rostering solutions and sharing of best practice • Almost all clinical staff are now rostered. Previous quarter was at 97% we are now at 98%. Final teams are being approached and supported to ensure they are rostered by Q3. Roster KPI's are reported on a regular basis at local roster utilisation groups, roster oversight group and People council and include safe care. • Specialist nursing job planning project re-started and to be completed by March 2023 • Ongoing work on band 2-6 nursing review with the support of Service Improvement and the Information Team	

		with the aim of having 50% of this staff group with refreshed job descriptions • With the Director of Nursing review opportunities for the development and deployment of the band 2-6 nursing workforce to ensure effective use of resources aligned to patient acuity and the delivery of safe and effective care.			
People Plan Pillar – Growing for the Future					
6.6 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Recruit 180 additional new permanent nurses • Recruit 80 of the new nurses and 20 medical and dental staff via international recruitment programmes • In partnership with the Medical Director and Director of Nursing, Midwifery & Governance develop workforce development plans to achieve a strong pipeline of new clinical roles including 15 TNAs, 6 ACPs and 6 PAs • Support registered nurses to adopt a flexible approach to working, offering all those eligible retire and return conversation	Strategic People Committee	• Since 1st April 2022, 70 externally recruited Band 5 to Band 7 registered nurses have commenced with STHK. A further 52 Newly qualified Band 5 nurses will join between September and December 2022. • 67 international nurses have now been appointed into the organisation, with the remaining 30 planned to arrive in November. 36 international medics have commenced in post since April 2022. • 9 x TNAs recruited to start training September 2022. Funding secured for 2 x AAs to start January 2023. Work has started with operations and finance colleagues to review workforce needs ahead of the ACP funding window opening for bids. • As part of the Retire and Return process, conversations are being held with staff. Pre-retirement workshops are available for staff to book on. • HCSW's are being supported to transfer earlier during their induction period to support their requirements rather than see them leave. The introduction of an amended 5 day training programme with support from a dedicated education lead is also reaping benefits in terms of early career retention interventions. • Reviewed and amended the induction, training, and development pathway for new to care HCSWs in	

		• Increase the Healthcare Support Worker use of the internal transfer scheme by 10% and improve staff retention rates for this group of staff by 15% through meeting career aspirations and development opportunities within the Trust • Create opportunities for people who are "new to care" offering the care certificate and apprenticeship programmes • Support more staff to undertake further training in Advanced Clinical Practice and Leadership Development, utilising the apprenticeship levy		collaboration with HR and Nursing colleagues. Action has already been taken to ensure that all HCSWs complete the Care Certificate during their first 12 weeks at the Trust with the intention to add Level 2 and 3 apprenticeships followed by opportunities to train to become Nursing Associates where applicable. • Medical leadership development now in consultation following additional changes and addition of Mentorship Scheme	
7 OPERATIONAL PERFORMANCE We will meet and sustain national and local performance standards					
7.1 Deliver the elective recovery activity targets to reduce waiting lists	DoOp	• Deliver at least 104% of 2019/20 elective activity levels • By July 2022 no one to have waited longer than two years • Eliminate waits of over 18 months by April 2023	Finance and Performance Committee	Delivery to October was to a rate of 99% Elective Activity - Non Adjusted and at a rate of 101.7% when working day adjusted. We eliminated 104 week waits by the national deadline, as did all of C&M when recognising nationally agreed exceptions such as patient choice The Trust is currently around trajectory to achieve the 78ww objective within the relevant timeframe. Regional mutual aid is actively considered to maximise opportunities for all C&M patients	

		• Provide mutual aid in specific specialities to support the delivery of system recovery targets		Mutual aid for skin, colorectal and urological cancer was provided to the wider region during COVID-19. Any further requests for mutual aid are now provided on an individual, case by case basis due to capacity constraints. We continue to assist S&O with pressures in Ophthalmology. Overall delivery against this objective is considered to be solid and within reach for delivery at year end. This delivery has taken place within an extremely challenging operating environment, of delayed discharge, congested wards and heightened attendances and acuity.	
7.2 Implement recovery plans to consistently achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including the new 12 hour see and treat targets • 62-day cancer treatment standard • Diagnostic tests completed within 6 weeks • Ambulance handover times (under 30 minutes)	Finance and Performance Committee	Delivery against this objective is challenging within a congested operating environment, of delayed discharge, high bed occupancy and heightened attendances and acuity. There is an improvement programme, which alongside the additional community beds will support improvement in the later months of the year. **12-Hour from arrival performance** • 8.7% of patients have waited longer than 12 hours (M 1-6). This is compared to 6.7% in the same period 2019. **62 day cancer standard** • 78.4% and YTD 81.9% against a target of 85%. This is the best performance of an acute trust in C&M.	

		• Working with system partners reduce the % of medically optimised patients with delayed discharges		**Diagnostic tests completed within 6 weeks** • 77.4% and YTD 81.7%, against a target of 99%. **Ambulance handover times** • September average for ambulance turnaround time was 57 minutes. **Delayed discharges** Discharge trajectories have been set per PLACE, with the PLACE Directors being accountable for delivery. In addition to the ongoing work with system partners, the introduction of additional community beds, will support the reduction of this number. The average daily number of super stranded patient in September was 153.	
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g. GiRFT to ensure that all services meet best practice standards	DoOp	• Continued participation in national programme of GiRFT and other reviews and delivery of the resulting action plans • Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery and sustainability of the changes	Finance and Performance Committee	The Trust actively participates in the GiRFT programme, which has now recommenced with a series of specialty webinars for organisation to join.	

8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money					
8.1 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaboration at scale to increase efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration at scale with system partners	Executive Committee	The Trust has committed to and is signed up to - Cheshire and Merseyside Acute and Specialist Trust Collaborative (CMAST). The CEO of the Trust Chairs the Collaborative and the Trust hosts its Managing Director. The Trust also signed up to the Joint Working Agreement and established a Committees in Common approach to decision making, in October 2022. CMAST is re-establishing the Collaboration at Scale programme to be led by a CMAST CEO and sponsored by the ICB. STHK is a contributor to all ICS / ICB financial discussions and leads the ICS wide finance ledger programme which reports to the CAS Board. We also host networks for the system which drive pathway innovation, efficiency, and enhanced performance. DOFs, through CMAST, have also agreed to procure once where this fits with strategy to deliver and achieve efficiencies – Imaging being a recent example.	
8.2 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2022/23 • Delivery of the agreed Cost Improvement Programme • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.	Finance and Performance Committee	All of these metrics are regularly reported and discussed at the Finance and Performance Committee and the Trust Board. Aged debt, specifically is reported to the Trust Audit Committee The Trust agreed a final 22/23 financial plan at a deficit of £4.9m in June 2022. The plan included a CIP target of £28.1m (5%) including non- recurrent savings. At Month 6 (September), the Trust was in line with plan (£2.2m deficit), with £263.3m income and £265.4m expenditure year to date. The financial position includes non-recurrent benefits offsetting the non-achievement of national ERF, non-pay inflation pressures (excluding energy & PFI) and the pay award impact over and above funded levels.	

				The Trust's final CIP target is £28.1m to a profile agreed with the ICS. At month 6, low risk schemes either delivered or are at finalisation stage and have realised £24.5m in year, £16.0m recurrently. At the end of Month 6, the cash balance was £41.0m. The cash balance at the end of the reporting period was better than tolerance at 18 days and the aged debt position vs income was 0.008% 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.	
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve system success	DoCS	• Meet statutory and regulatory responsibilities • Implement the new performance and accountability frameworks when the ICBs are created in July 2022.	Trust Board	No regulatory action has been taken against the Trust and it remains at SOF 2 for monitoring. ICB performance, and quality monitoring processes are becoming embedded via Place.	
9.2 Working with health and care system partners implement Place Based Partnerships to improve the health of the local population	DoInt	• Support our local boroughs to establish Place Based Partnership Boards (PBPBs) • Position the Trust as a key partner and anchor institution in each Place	Trust Board	The ICB hold regular review meetings: St Helens Place Partnership continues to be held as an exemplar for C&M. Halton and Knowsley Place reviews are also taking place in November/December. STHK gained accreditation for the Social Value Award in July 2022 and is currently pursuing the Prevention Pledge which focuses on reducing inequalities.	

9.3 Provide leadership and direction as part of the C&M ICB to achieve clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations • Support the development of effective Provider Collaboratives that enhance collaboration and integration of acute services and coordinates the delivery of the elective recovery plans to maximise the capacity available to the system	Trust Board	CMAST governance and shared decision framework has been agreed by all partner trusts. CMAST lead is a member of the C&M ICB CMAST continues to coordinate elective recovery plans, brokering mutual aid where appropriate and ensuring optimisation of available capacity and targeted investment to increase capacity for specific areas that are under pressure.	
9.4 Progress the Agreement for Long Term Collaboration (ALTC) with Southport and Ormskirk Hospital NHS Trust	All	• Continue to provide management support to S&O • Continue to develop plans to address the fragile clinical services working with clinicians across both Trusts and other providers as necessary • Develop a plan, with the Shaping Care Together programme that will deliver sustainable clinical services	Trust Board	Both Boards have now agreed to move forward and bring the two trusts together as a single entity. A transaction programme has been established and a Strategic Case submitted to NHSE NW and the NHSE Transformation Team. The objective is to complete the transaction on 1st April 2023. The final Transaction Business Case includes the plans to integrate services and maximise patient benefits, including the stabilisation of the remaining fragile services. Discussions continue in relation to the timetable for strategic service reconfiguration options to be put forward for public consultation	

END

NIHR Guideline B01
RDI Operational Capability Statement

May 2011

Note: This spreadsheet is protected to help avoid inadvertent changes. However there is no password set so that users can unlock the sheet and edit their own content if required.

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
Statement 001					
Statement 002	01/11/2013	01/11/2014	27/11/2013	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 003	18/11/2014	18/11/2015	18/11/2014	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 004	31/12/2015	31/12/2016	27/01/2016	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 005			12/01/2017	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 006	01/12/2017	01/12/2018	29/11/2017	Trust Board	Mrs Jeanette Anders
Statement 007	01/12/2018	01/12/2019	28/11/2018	Trust Board	Mrs Jeanette Anders
Statement 008	01/12/2019	01/12/2020	27/11/2019	Trust Board	Mrs Jeanette Anders
Statement 009	01/12/2020	01/12/2021	25/11/2020	Trust Board	Mrs Jeanette Anders
Statement 010	01/12/2021	01/12/2022	24/11/2021	Trust Board	Mrs Jeanette Anders
Statement 011	01/12/2022	01/12/2023			Mrs Jeanette Anders

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Organisation RDI management arrangements

Information on key contacts.

Organisation details	
Name of organisation	St Helens and Knowsley Teaching Hospitals NHS Trust (STHK)
Role:	Research Development and Innovation Executive Lead (Medical Director)
Name:	Dr Peter Williams
Contact number:	Contact by email
Contact email	Peter.Williams3@sthk.nhs.uk
Role:	Clinical Director of Research
Name:	Dr Ascanio Tridente
Contact number:	Contact by email
Contact email	Ascanio.Tridente@sthk.nhs.uk
RDI office details:	
Name:	Research Development and Innovation Department
Address:	The Research Hub, Whiston Hospital, Ground Floor , Yellow Zone, Warrington Road, Prescot, Merseyside, L35 5DR
Contact number:	0151 430 2334 / 1218
Contact email:	research@sthk.nhs.uk
Key contact details e.g. Feasibility, confirmation of capacity and capability to conduct research at STHK	
Contact 1:	
Role:	Research Development and Innovation Department Manager (RDI)
Name:	Jeanette Anders
Contact number:	0151 478 7850
Contact email:	jeanette.anders@sthk.nhs.uk
Contact 2:	

Role:	Research Development and Innovation Co-ordinator
Name:	Paula Scott
Contact number:	0151 430 1218
Contact email:	paula.scott@sthk.nhs.uk
Contact 3:	
Role:	Research Development and Innovation Research Support Officer
Name:	Vacancy TBC
Contact number:	0151 430 4898
Contact email:	TBC

Information on staffing of the RDI office.

RDI team		
RDI office roles (e.g. Governance, contracts, etc.)	Whole time equivalent	Comments indicate if shared/joint/week days in office etc.
Research Development and Innovation Manager	1.0 WTE	
Research Development and Innovation Co-ordinator	1.0 WTE	
Research Development and Innovation Support Officer	1.0 WTE	

Information on reporting structure in organisation (include information on any relevant committees, for example, a clinical research board / research committee / steering committee).

Reporting structures		
Trust Board		The Medical Director reports to the Trust Board.
The Medical Director reports to the Quality Committee.		The Quality Committee advises the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Manager report to the Clinical Effectiveness Council (CEC)		The CEC Council investigates any issue that sits within it terms of reference. Its aim is to seek and receive from any department or service assurance on the maintenance and improvement of clinical effectiveness. The Council is authorised by the Quality Committee to investigate any issue that may pose a risk to Clinical Effectiveness. The Committee shall advise the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Manager report to the Research Development & Innovation Group (RDIG)		The RDI Group reports to the Quality Committee to provide assurance about all aspects of RDIG activity within and involving the Trust. The Chair of the RDI Group is the Clinical Director for Research Development and Innovation. The RDI Group is responsible for: Review and approval of the RDI strategy consistent and compliant with contemporary (inter)national guidance Review and approval of the Annual RDI Report (written by the RDI Manager) Review and approval of the Research Capability and Capacity Statement Review and approval of the Research Standard Operating Procedures Oversee operational delivery of the RDI strategy via updates received from the RDI Manager Review of research studies deemed high risk or with identified issues/concerns will be referred to RDIG for consideration (by the RDI Manager). Any risk or safety issues relating to research activity will be reported to the RDI Group for discussion and action plan. The Core membership of the RDI Group oversees the reinvestment (in research) of the commercial and non-commercial funding and the income distribution plan.
The Research Practitioner Group (RPG)		The Research Practitioner Group (RPG) has delegated responsibility from the Research Development & Innovation Group (RDIG) to ensure that the trust has robust processes and systems in place for Research Development & Innovation (RDI). The RPG is responsible for: Review Research Standard Operating Procedures (SOPs) prior to submission to RDIG for approval. Ensure that the Trust is prepared for a Research MHRA (Medicines and Healthcare Products Regulatory Agency) inspection through the review and discussion of regular action plans Report to the RDIG quarterly (through the RDI Manager who sits on both groups) Support the aim to embed a positive research culture throughout the organisation Ensure that lessons are learned from research audits/issues and that effective improvement is implemented Ensure that on a day to day basis RDI activities are conducted according to RDI Standard Operating Procedures (SOPs) Support the training programme for Research Nurses to ensure that they are fully complaint in accordance with nursing/trust requirements.

Information on research networks supporting/working with the organisation.
Information on how the organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research networks	
Research network (name/location)	Role/relationship of the research network e.g. host organisation

St Helens and Knowlsey Teaching Hospitals NHS Trust	Research Development and Innovation Manager
St Helens and Knowlsey Teaching Hospitals NHS Trust	Nursing and Midwifery, Senior Research Nurse
St Helens and Knowlsey Teaching Hospitals NHS Trust	Research Development and Innovation Co-ordinator
St Helens and Knowlsey Teaching Hospitals NHS Trust	Research Development and Innovation Support Officer
St Helens and Knowlsey Teaching Hospitals NHS Trust	Project Support Officer
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Senior Research Nurse
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurses x 7
Clinical Research Network, North West Coast (CRN NWC)	Research Midwife x1
Clinical Research Network, North West Coast (CRN NWC)	Data Managers x2
Clinical Research Network, North West Coast (CRN NWC)	Project Support Officer x2

Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, other NHS organisations, higher education institutes, industry).

Organisation name	Details of collaboration / partnership (e.g. university/organisation joint office, external provider of pathology services to organisation, etc., effective dates)	Contact name	Email address	Contact number
Liverpool and Edge Hill Universities	Professor Rowan Pritchard Jones, Consultant Plastic Surgeon at STHK is an Honorary Clinical Professor at Edge Hill University, and an Honorary Clinical Associate Professor at the University of Liverpool. STHK are involved in a number of research projects with Liverpool and Edge Hill University Professor Rowan Prtcaihrd Jones is also the Medical Director of the Cheshire and Merseyside Integrated Care Board.	Professor Rowan Pritchard Jones	rowan.pritchardjones@sthk.nhs.uk	By email only
Manchester Metropolitan University	The Trust is involved in a number of research projects with Manchester Metropolitan University, involving collaborations with Critical care (Dr A Tridente, CD and Visiting Professor, Manchester Metropolitan University) and Burns and Plastics (Mr K Shokrollahi, Clinical Lead, Mersey Regional Burns Service)	For details of studies please contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk Kayvan.Shokrollahi@sthk.nhs.uk ascanio.tridente@sthk.nhs.uk	0151 478 7850

Liverpool School of Tropical Medicine	The Trust has established links with the Liverpool School of Tropical Medicine and is following up patients on a COVID vaccine trial.	Angela Hyder-Wright Accelerator Research Clinic (ARC) Manager/ Senior Research Nurse Liverpool School of Tropical Medicine	adwright@liverpool.ac.uk	By email only
St Helens Primary care	The Trust has links to Primary Care through the Marshall Cross . These links are vital and offer us the potential to collaborate on joint research projects as well as recruiting from the primary care sector.	Dr Greg Irvine GP and Consultant in Primary Care St.Helens CCG Governing Body Member	Greg.Irving3@sthk.nhs.uk	01744 627596
Clinical Research Network, North West Coast	STHK are a partner organisation of The Clinical Research Network in the North West Coast (CRN NWC).	Dr Chris Smith, Chief Operating Officer.	chris.smith@nihr.ac.uk	0151 331 5124
Liverpool Health Partners	STHK have links with Liverpool Health Partners (LHP). LHP work together with Academic and NHS partners to develop groundbreaking research by encouraging conversations across the region, and sharing expertise to improve population health outcomes and economic productivity for the better.	Professor Eliot Forster Chair of LHP Board	lhpadmin@lhch.nhs.uk	0151 482 9386
UK Research and Innovation	STHK have links UKRI. UKRI organisation brings together the seven disciplinary research councils, Research England, which is responsible for supporting research and knowledge exchange at higher education institutions in England, and the UK's innovation agency, Innovate UK.	Professor Dame Ottoline Leyser ,Chief Executive	communications@ukri.org	communications@ukri.org
NIHR Research Design Service -North West	The Research Design Service in the North West is part of the NIHR infrastructure and exists to provide support and advice for people preparing NIHR grant applications.	Dr P Dolby, Communications and information Manager	www.rds-nw.nihr.ac.uk	
Clatterbridge Centre for Oncology (CCC)	STHK & CCC work collaboratively with CCC. There is an agreement in place whereby patients have access to Systemic Anti-Cancer Therapy (SACT) trials at STHK through the availability of CCC employed staff working to CCC governance arrangements.	Dr Maria McGuire	Maria.Maguire@clatterbridgecc.nhs.uk	By email only
Innovation Agency (Academic Health Science Network, North West Coast)	The Trust is a partner of the AHSN, we work together to embed innovation as a core part of the business within STHK .	Chief Executive,Dr Phil Jennings	info@innovationagencynwc.nhs.uk	0151 254 3400

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation study capabilities

Information on the types of studies that can be supported by the organisation to the relevant regulatory standards.

Types of studies organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate phases)	Clinical trial of a medical device	Other clinical studies	Human tissue: Tissue samples studies	Study administering questionnaires	Qualitative study	OTHER
As sponsoring organisation			√	√	√	√	
As participating organisation	√ (Phase, II, III, IV,)	√	√	√	√	√	
As participant identification centre	√ (Phase, II, III, IV,)	√	√	√	√	√	

Information on any licences held by the organisation which may be relevant to research.

Organisation licences			
Licence name Example: Human Tissue Authority licence	Licence details	Licence start date (if applicable)	Licence end date (if applicable)
Human Tissue Act 2004	Licence number 12043		On-going

For organisations with responsibilities for GPs: Information on the practices which are able to conduct research.

Number/notes on General Practitioner (GP) practices
Marshalls Cross Surgery, sits within St Helens Hospital and is currently conducting a number of research studies.

Organisation services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting RDI governance decisions across the organisation.

Clinical service departments					
Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Desingated Research Clinics located within the Research Hub at Whiston Hosptilal		Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 478 7850	
Pathology	Minus 20, 30 and 80 freezers	Kevin McLachlan	Kevin.McLachlan@sthk.nhs.uk	0151 290 4122	
Pharmacy	Designated Research Pharmacist	Jodie Kirk	jodie.kirk@sthk.nhs.uk	0151 430 1537 Bleep 7435	
Pharmacy	Pharmacy Technician	Olive Reilly	olive.reilly@sthk.nhs.uk	TBC	
Pharmacy	Pharmacy Technician	Gafar Baruwa	gafar.baruwa@sthk.nhs.uk	TBC	
Radiology	Clinical Radiation Expert	Dr Andrea Howes	andrea.howes@sthk.nhs.uk	0151 426 1600	Clinical Director for Radiology
Radiology	Medical Physics Expert	Paul Connolly	paulconnolly@irs-limited.com	0151 709 6296	Paul Connolly from IRS Ltd is one of the Medical Physics experts for the Trust his
Radiology	2x 1.5 GE MRI 1 x 3.0T MRI 5 X GE128 slice CT scanners	Sue Conroy	Sue.Conroy@sthk.nhs.uk		
Radiology	2x Digital Mammography including tomosynthesis	Sue Conroy	Sue.Conroy@sthk.nhs.uk		
Radiology	1x Digital dental including cephalometry Cone Beam CT 1 x Digital dental including cephalometry	Sue Conroy	Sue.Conroy@sthk.nhs.uk		
Radiology	2x Fluoroscopy /1 x interventional	Sue Conroy	Sue.Conroy@sthk.nhs.uk		
Radiology	30X Ultrasound including Cardiac	Sue Conroy	Sue.Conroy@sthk.nhs.uk		
Radiology	10x Digital radiography including tomosynthesis	Sue Conroy	Sue.Conroy@sthk.nhs.uk		

Cardio-Respiratory Department	24 hour ambulatory electrocardiography Extended ambulatory electrocardiography Event Recording Ambulatory blood pressure monitoring Electrocardiograms: 12 lead ECGs Transthoracic echocardiography Transoesophageal echocardiography Stress echocardiography Exercise electrocardiography Spirometry Measurement of maximum expiratory and inspiratory flow volume loop Oximetry assessment Carbon monoxide transfer factor test Simple lung function exercise test Measurement of static lung volume Measurement of respiratory muscle strength Measurement of maximum expiratory and inspiratory flow volume loop Bronchial Reactivity Overnight oximetry (Includes: Measurement of oxygen desaturation index FENO testing	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	
Cardio-Respiratory Department	Assessment for fitness to fly (hypoxic challenge) - flight assessment Pacemaker Implantation - single / dual [plus Box Changes] Implant/Removal of electrocardiography loop recorders ILRs Remote Follow-up inc. Pacemakers /ICDs Coronary Angiography	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	

Information on key management contacts for supporting RDI governance decisions across the organisation.

Management Support e.g. Finance, legal services, archiving					
Department	Specialist services that may be provided	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Archiving	Archiving arrangements are part of the Trust approval process and are detailed in the Clinical Trial Agreement for each study. The Trust also holds a Standard Operating Procedure for archiving.	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	
Contracts (study related)	Advice and support - See comments	Jeanette Anders and Paula Scott	research@sthk.nhs.uk	0151 478 7850 and 430 2334	The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust

Contracts (study related)	Sign off of clinical trial agreements	Dr Peter Williams	Peter.Williams3@sthk.nhs.uk		The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Contracts (study related)	Review and completion of the Organisational Information Document (OID)	Jeanette Anders and Paula Scott	research@sthk.nhs.uk	0151 430 2334	The Organisation Information Document is to be used as the Agreement between the Sponsor and participating NHS organisation, this document forms a formal legal contract between the Parties.
Finance	Corporate Accountant	Mary Jockins	Mary.Jockins@sthk.nhs.uk	0151 426 1600	The RDI Department has links with finance and are fully supported in all areas relating to research.
Information Technology	Director of Informatics	Christine Walters	christine.walters@sthk.nhs.uk	0151 430 1134	RDI Department is fully supported by the Director of ICT. IT training, IT system set up, hardware and software configuration set up, firewall configuration and connection to external servers.
Legal	Head of Complaints & Legal Services	Tom Briggs	Tom.Briggs@sthk.nhs.uk	0151 426 1600	Support and advice with the legal aspects of research is provided when necessary.
HR	Research Passports, Letters of Access	Employment Services	Employment.Services@sthk.nhs.uk	0151 290 4185	
Training	Essential In house Standard Operating Procedure Training	Jeanette Anders, Senior Research Nurses	research@sthk.nhs.uk	0151 430 2334/ 2315	In house training on essential Standard Operating Procedures is provided for new starters or as updates if required.
Training	Good Clinical Practice (GCP) training. Principal Investigator Essentials training. The RDI Manager is a Facilitator for the above NIHR training courses.	Jeanette Anders	research@sthk.nhs.uk	0151 430 2334/ 2315	Courses are delivered either Face to Face or virtally.
Performance Management of studies	Audit and on-going review of studies.	Contact via RDI Department	research@sthk.nhs.uk	0151 430 2334/ 2315	During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department remain a point of contact, reviewing the progress of each study. A yearly audit is conducted and when a need is identified ad hoc audits will be completed.

Organisation RDI interests

Information on the research areas of interest to the organisation (provide detailed or summary information as appropriate).

Organisation RDI areas of interest				
Area of interest	Details	Contact name		Contact number
Acute Medical Unit		Dr Thiru Desa	Thiru.Desa@sthk.nhs.uk	
Anaesthetics	Anaesthetist for Obs & Gynae	Dr P Yoxall	peter.yoxall@sthk.nhs.uk	
Anaesthetics		Dr K Mukhtar	karim.mukhtar@sthk.nhs.uk	
Anaesthetics		Dr S Miller	Scott.Miller@sthk.nhs.uk	
Anaesthetics		Dr Goel	Vandana.Goel@sthk.nhs.uk	
Anaesthetics		Dr Atherton	Paul.Atherton@sthk.nhs.uk	
Anaesthetics		Dr Kingston	Elizabeth.Kingston@sthk.nhs.uk	
Anaesthetics		Dr Narayanaswamy	Satishkar.Narayanaswamy@sthk.nhs.uk	
Anaesthetics / ICU		Dr Hanamanthu	Ganesh.Hanumanthu@sthk.nhs.uk	
Burns and Plastics		Professor Rowan Pritchard-Jones	rowan.pritchardjones@sthk.nhs.uk	
Burns and Plastics		Mr P Brackley	philip.brackley@sthk.nhs.uk	0151 430 1664
Burns and Plastics		Professor K Shokrollahi	kayvan.shokrollahi@sthk.nhs.uk	
Burns and Plastics		Mr A Benson	Alex.Benson@sthk.nhs.uk	
Burns and Plastics		Mr S Liew	Sehwang.Liew@sthk.nhs.uk	
Burns and Plastics		Ms A Harper	Aenone.Harper@sthk.nhs.uk	
Burns and Plastics		Mr H Shabban	Hassan.Shaaban2@sthk.nhs.uk	
Burns and Plastics		Mr Hosain	Mohammad.Hosain2@sthk.nhs.uk	
Burns and Plastics		Mr D Gurusinghe	Dilnath.Gurusinghe@sthk.nhs.uk	
Lung Cancer (Radiology)		Dr Meenal Abhyankar	Meenal.Abhyankar@sthk.nhs.uk	
Cancer		Dr Puneet Malhotra	Puneet.Malhotra@sthk.nhs.uk	
Cancer		Ms Leena Chagla	leena.chagla@sthk.nhs.uk	
Cancer		Dr T Nicholson	toby.nicholson@sthk.nhs.uk	
Cancer		Dr E Hindle	elaine.hindle@sthk.nhs.uk	
Cancer		Dr Z Khan	zahed.khan@nhs.net	
Cancer		Dr R Lord	rosemary.lord@nhs.net	
Cancer		Dr H Innes	helen.innes@nhs.net	
Cancer		Miss T Kiernan	Tamara.Kiernan@sthk.nhs.uk	
Cancer		Mr A Khattak	Altaf.Khattak@sthk.nhs.uk	
Cancer		Dr Taylor	David.Taylor4@sthk.nhs.uk	
Cancer		Mr R Pritchard-Jones	rowan.pritchardjones@sthk.nhs.uk	
Cancer		Mr P Brackley	philip.brackley@sthk.nhs.uk	
Cancer		Mr Samad	Ajai.Samad@sthk.nhs.uk	
Cancer		Mr J McCabe	John.mccabe@sthk.nhs.uk	
Cancer		Dr Eleana Loizou	Eleana.Loizou@sthk.nhs.uk	
Cancer		Dr N Hamnett	Nathan.Hamnett@sthk.nhs.uk	
Cancer		Miss Sonia Bathla	Sonia.Bathla@sthk.nhs.uk	
Cancer		Dr Shien Chow	Shien.chow@nhs.net	
Cancer		Dr S Evans	Sally.Evans@sthk.nhs.uk	
Cancer		Dr K Moss	Kat.Moss@sthk.nhs.uk	
Cardiology		Dr R Katira	Ravish. Katira@sthk.nhs.uk	0151 430 1041
Cardiology		Dr AlChaghouri	Samir.AlChaghouri@sthk.nhs.uk	
Care of the Elderly		Aude.Gatignol	Aude.Gatignol2@sthk.nhs.uk	
Critical Care		Dr A Cochrane	Anthony.Cochrane@sthk.nhs.uk	
Critical Care		Dr A Tridente	Ascanio.Tridente@sthk.nhs.uk	
Critical Care		Dr Murray	Diane.Murray2@sthk.nhs.uk	
Dermatology		Dr J Ellison	judith.ellison@sthk.nhs.uk	01744 646584
Dermatology		Dr E Pang	evelyn.pang@sthk.nhs.uk	01744 646614
Dermatology		Dr M Walsh	Maeve.Walsh@sthk.nhs.uk	
Dermatology		Dr K Eustace	Karen.Eustace@sthk.nhs.uk	
Dermatology		Dr Ngan	Kok.Ngan@sthk.nhs.uk	
Dermatology		Dr Layla Hanna-Bashara	Layla.HannaBashara@sthk.nhs.uk	
Diabetes		Dr N Furlong	naill.furlong@sthk.nhs.uk	01744 646496
Diabetes		Dr P Narayanan	Prakash.Narayanan@sthk.nhs.uk	
Diabetes		Dr H Sullivan	Heather.Sullivan@sthk.nhs.uk	
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Emergency Medicine		Dr M Hedley	Mike.Hedley@sthk.nhs.uk	
Emergency Medicine		Dr C O'Leary	Clare.OLeary@sthk.nhs.uk	
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Gastro		Dr K Clarke	Katie.Clark2@sthk.nhs.u	
Haematology		Dr E Loizou	Eleana.Loizou@sthk.nhs.uk	
Haematology		Dr K Moss	Kat.Moss@sthk.nhs.uk	
Histopathology		Dr Hasan	Noori.Hasan@sthk.nhs.uk	
Histopathology		Dr C Ross	Carol.Ross@sthk.nhs.uk	
General Medicine		Dr M Nasher	Magda.Nasher2@sthk.nhs.uk	
Microbiology		Dr M Vardhan	Madhur.Vardhan@sthk.nhs.uk	
Musculoskeletal		Dr M Mahindrakar	Madhu.Mahindrakar2@sthk.nhs.uk	
Musculoskeletal		Dr J Dawson	Julie.Dawson@sthk.nhs.uk	
Musculoskeletal		Mrs Y Hough	Yvonne.Hough@sthk.nhs.uk	
Nephrology and Acute Medicine		Dr M Khandaker	Mustakim.Khandaker3@sthk.nhs.uk	
Opthalmology		Miss F Shams	Fatemeh.Shams@sthk.nhs.uk	
Orthopaedics		Mr Ballester	Jordi.Ballester@sthk.nhs.uk	0151 290 4234
Orthopaedics		Ms Wharton	Danielle.Wharton@sthk.nhs.uk	
Orthopaedics		Mr Lipscombe	Stephen.Lipscombe@sthk.nhs.uk	
Orthopaedics & Trauma		Mr N Howard	Nicholas.Howard2@sthk.nhs.uk	
Orthopaedics		Mr Cartwright Terry	Matt.CartwrightTerry@sthk.nhs.uk	
Palliative Care		Dr A Thompson	Anthony.Thompson2@sthk.nhs.uk	0151 290 4266
Pathology (cellular)		Charlotte Cox	Charlotte.Cox@sthk.nhs.uk	
Paediatrics		Dr R Garr	Rosaline.Garr@sthk.nhs.uk	
Paediatrics		Dr M Aziz	maysara.aziz@sthk.nhs.uk	
Paediatrics		Dr L Chilukuri	lakshmi.chilukuri@sthk.nhs.uk	
Paediatrics		Dr H Bentur	Hemalata.Bentur@sthk.nhs.uk	
Paediatrics		Dr Basavaraju	Jasavanth.Basavaraju@sthk.nhs.uk	
Paediatrics		Dr Ijaz Ahmad	ijaz.ahmad@sthk.nhs.uk	0151 430 1636
Parkinson's		Dr R Mason	Ryan.Mason2@sthk.nhs.uk	
Parkinson's		Dr S Williams	Sarah.Williams2@sthk.nhs.uk	
Pharmacy		Mr Greg Barton	greg.barton@sthk.nhs.u	
Psychiatry (old age)		Dr Nash	Jayne.Nash@shknhs.mail.onmicrosoft.com	
Psychiatry		Dr C Findlay	Christopher.Findlay@shknhs.mail.onmicrosoft.com	
Psychiatry		Dr N Mercadillo	Nieves.Mercadillo@shknhs.mail.onmicrosoft.com	
Psychotherapy (child and adolescent)		Dr J Boardman	Julie.Boardman@SHKNHS.onmicrosoft.com	
Radiology		Dr V Rachapalli	Vamsidhar.Rachapalli@sthk.nhs.uk	
Radiology		Dr N Ellerby	Nicolas.Ellerby@sthk.nhs.uk	
Radiology		Dr Abhyankar	Meenal.Abhyankar@sthk.nhs.uk	
Reproductive and Child Health		Mrs Sandhya Rao	Sandhya Rao@sthk.nhs.uk	0151 430 2289
Reproductive and Child Health		Miss Vicky Cording	vicky.cording@sthk.nhs.uk	0151 430 1495
Reproductive and Child Health		Mrs Tabassum Safdar	tabassum.safdar@sthk.nhs.uk	
Reproductive and Child Health		Mrs Nidhi Srivastava	nidhi.srivastava@sthk.nhs.uk	
Reproductive and Child Health		Mr T Idama	Tennyson.Idama@sthk.nhs.uk	
Reproductive and Child Health		Miss Zoe Boyes	Zoe.Boyes@sthk.nhs.uk	
Reproductive and Child Health		Ms Saru Palaniappan	Saru.Palaniappan@sthk.nhs.uk	
Reproductive and Child Health		Ms Dcosta	Dimple.DCosta2@sthk.nhs.uk	
Reproductive and Child Health		Ms A Roberts	Anne.Roberts3@sthk.nhs.uk	
Reproductive and Child Health		Ms C Stewart	Claire.Stewart2@sthk.nhs.uk	
Reproductive and Child Health		Ms R Agass	Ria.Agass2@sthk.nhs.uk	
Respiratory		Dr J Heaton	Joanne.Heaton@sthk.nhs.uk	
Sexual Health		Dr E Acha	Estibaliz.Acha@sthk.nhs.uk	
Sexual Health		Dr Rebecca Thompson Glover	Rebecca.ThomsonGlover@sthk.nhs.uk	
Stroke		Dr H Cooper	Helen.Cooper@sthk.nhs.uk	
Stroke		Dr Ganjam	Subba.Ganjam2@sthk.nhs.uk	
Stroke		Dr F Elnagi	Fathalla.Elnagi@sthk.nhs.uk	
Stroke		Dr Lalitha Ranga	Lalitha.ranga@sthk.nhs.uk	0151 430 2441
Stroke		Dr S Mavinamane	sunandra.mavinamane@sthk.nhs.uk	0151 430 1224
Stroke		Dr A Hill	andrew.hill@sthk.nhs.uk	
Stroke		Dr A L Kalathil	Latheef.Kalathil@sthk.nhs.uk	
Stroke		Dr Azmil Abdul-Rahim	Azmil.AbdulRahim@sthk.nhs.uk	

Surgery		Mr Chadwick	Michael.Chadwick@sthk.nhs.uk	
Surgery		Mr Appleton	Nathan.Appleton@sthk.nhs.uk	
Surgery		Mr Bagade	Neeraj.Bagade@sthk.nhs.uk	
Surgery		Ms R Kalaiselvan	Ramya.Kalaiselvan@sthk.nhs.uk	
Surgery		Mr A Samad	Ajai.Samad@sthk.nhs.uk	
Surgery		Mr R Rajaganeshan	raj.rajaganwshan@sthk.nhs.uk	
Surgery		Mr S Kanwar	Sunjay.Kanwar@sthk.nhs.uk	
Surgery		Mr Rapasinghe `	Sukitha.Rupasinghe@sthk.nhs.uk	
Surgery (colorecetal)		Mr Kalaiselvan	Ramya.Kalaiselvan@sthk.nhs.uk	
Urology		Mr J McCabe	john.mccabe@sthk.nhs.uk	
Urology		Mr Samsudin	Azi.Samsudin@sthk.nhs.uk	
Urology		Mr Omar	Ahmad.Omar@sthk.nhs.uk	

Information on local / national specialty group membership within the organisation which has been shared with the CLRN.

Specialty group membership (local and national)					
National / local	Specialty group	Specialty area (if only specific areas within group)	Contact name	Contact email	Contact number
Clinical Research Network, North West Coast	RDI Managers meeting	Research and Development	*Jeanette Anders*	jeanette.anders@sthk.nhs.uk	*0151 478 7850*

Organisation RDI planning and investments

Planned investment			
Area of investment (e.g. Facilities, training, recruitment, equipment etc.)	Description of planned investment	Value of investment	Indicative dates
Commercial Research Income	The RDI Department will reinvest study income to build sustainable research and innovation capacity. This will be achieved by increasing the number of Research Nurses to increase capacity and investing in current RDI staff development. Any study funds not spent/utilised within 12 months of the study closure or without a set plan for expenditure will be allocated to the RDI Department and reinvested in research.	TBC	TBC
Research Delivery infrastructure (e.g. research nurses, health care assistants, administrators)	Ad hoc requests submitted by RDI Manager to the Clinical Research Network, North West Coast for resources to enable delivery of NIHR portfolio studies.	Ad hoc	
Release of clinician time (to prepare NIHR grant applications or to act as Principal Investitgaors)	Ad hoc requests submitted by researchers for resources to enable delivery of both Commercial and Non-Commercial research.	Ad hoc	

Organisation RDI standard operating procedures register

Standard operating procedures				
A suite of SOPs are available upon request.				

Information on the processes used for managing research passports.

Indicate what processes are used for managing research passports
Research Passports are accepted at STHK and letters of access are issued via the RDI Department.

Information on the agreed escalation process to be used when RDI governance issues cannot be resolved through normal processes.

Escalation process
In accordance with RDI management structure: The Research Practitioner Group reports to the Research Development and Innovation Group who reports to the Clinical Effectiveness Council who report to the Quality Committee then to the Trust Board.

Planned and actual studies register

The organisation should maintain or have access to a current list of planned and actual studies which its staff lead or in which they are involved.

Comments

STHK records every research project on the local ReDA database and the NIHR CRN NWC Edge system. These systems are used to register and manage all research projects.

Other information

For example, where information can be found about the publications and other outcomes of research which key staff have led or have otherwise contributed.

Other information (relevant to the capability of the organisation)

STHK aim to increase the number of commercially sponsored studies as these are valuable source of support for NHS trusts. This income can be used to encourage key stakeholders to develop capacity for new research within the Trust and increase the volume, and, therefore, future income generation.
Information about publications and other outcomes of research can be found in the Research Development and Innovation Annual Report or via the research office at research@sthk.nhs.uk.

TRUST BOARD

Paper No: NHST (22)096
Title of paper: Research & Development Operational Capability Statement (RDOCS)
Purpose: The RDOCS is a tool to improve effectiveness and collaborations in research activities.
Summary: The statement provides researchers with an operational overview of resources available to support Research & Development in the organisation and an overview of research collaborations and partnerships with other organisations, including areas of special interest.
Corporate objectives met or risks addressed: Yes • We will maintain a positive organisational culture that supports the achievement of the Trust's objectives • We will meet and sustain national and local research performance standards • We will offer alternative ways of working to the benefit of patient care, safety and efficiency of services
Financial implications: None, however, the RDOCS is viewed by commercial companies who are looking to invest in research and will use the RDOCS to seek out potential sites.
Stakeholders: • Stakeholders: St Helens & Knowsley Teaching Hospital's NHS Trust • North West Coast Clinical Research Network (NWC CRN) • Commercial Partners **External Partners**
Recommendation(s): The RDOCS is for information and will be available on STHK website and a copy in the RDI Office
Presenting officer: Dr Peter Williams
Date of meeting:

Trust Board

Paper No: NHST (22) 097
Title of paper: Compliance with the NHS Constitution
Purpose: To provide assurance to the Board on the Trust's compliance with the patient, public and staff rights contained within the NHS Constitution
Summary: The NHS Constitution establishes a number of rights for patients and staff, with pledges that the NHS is committed to achieving and outlines the responsibilities of staff and patients to make the NHS work more effectively. The Trust is legally required to take account of the NHS Constitution in performing its NHS functions, in both the decisions made and actions taken. The Constitution is updated every 10 years and was last updated in 2021. The Constitution contains seven areas relating to patients, which are: 1. Access to health services 2. Quality of care and environment 3. Nationally approved treatments, drugs and programmes 4. Respect, consent and confidentiality 5. Informed choice 6. Involvement in your healthcare and the NHS 7. Complaint and redress It contains seven rights relating to staff, to ensure they: 1. Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives 2. Have a fair pay and contract framework 3. Can be involved and represented in the workplace 4. Have healthy and safe working conditions and an environment free from harassment, bullying or violence 5. Are treated fairly, equally and free from discrimination 6. Can in certain circumstances take a complaint about their employer to an employment tribunal 7. Can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest. It is good governance for Boards to gain assurance that the Trust meets, and can continue to meet, the requirements. This paper provides a summary of the Trust's position to provide the Board with assurance of compliance. The last review was undertaken and reported to the Board in 2019.

Appendix 1 provides the position statement of the Trust's compliance with the rights of patients and the public and Appendix 2 outlines compliance with rights of staff.
Corporate objectives met or risks addressed: We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families.
Financial implications: There are no direct financial implications arising out of this assurance report.
Stakeholders: Patients, public, staff, commissioners and regulators.
Recommendation(s): Members are asked to consider the assurances provided in the report and approve the actions proposed to strengthen assurance.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 30th November 2022

Appendix 1: NHS Constitution – Patients and public rights

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
1.	Access to health services				
1.1.	You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	The Trust provides NHS services free of charge, other than the exceptions sanctioned by Parliament (e.g. overseas visitors)	Director of Operations and Performanc		Private Patient / Overseas Visitors Policy

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
1.2.	You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Patients can access emergency and urgent care through the Emergency Department or via their GP for access to specific assessment units. Elective care is accessed via a patient's GP. Where necessary, referral criteria are agreed with commissioners to ensure that the most appropriate care is delivered to those who need it. The Trust has a Patient Access Policy in place to ensure that patients receive treatment in accordance with national objectives and targets and the Trust follows all the national guidance and criteria for patient selection. The Policy is currently being updated. The Trust complies with the Equality Act 2010, ensuring that patients are not refused treatment on unreasonable grounds. It uses the Equality Delivery System for the NHS (EDS2) as the mechanism for reviewing compliance and this is monitored through the Trust's Equality and Diversity Steering Group, which includes representatives from the local community. Improved patient access and experience was rated as achieved for the 2021 submission of EDS2. The Trust has an Equality and Human Rights Policy which aims to: • Ensure that the Trust meets its statutory requirements as defined by the Equality Act 2010 • Support the Human Rights of patients, visitors and employees in the Trust as defined by the Human Rights Act 2008 • Ensure that the Trust anticipates the consequences of its actions on our local communities and ensure that, as far as possible, negative consequences are eliminated and opportunities for promoting equality are maximised wherever possible. Patients who have paid privately for some elements of the care are still able to access free NHS services at the Trust. Non-EEA residents are able to access free NHS care in certain circumstances including emergency care in line with national guidance. This will be reviewed following Brexit. An equality analysis is conducted on proposed service changes, including cost improvement plans to ensure that any disadvantages are identified and eliminated wherever possible.	Director of Operations and Performance & Director of Nursing, Midwifery and Governance		Patient Access Policy, Equality and Human Rights Policy and Standard Operating Procedure for carrying out an Equality Analysis are in date and available on intranet. Equality and Diversity Steering Group reports to People Council. Annual update on delivery of equality and diversity is included in the Quality Account.

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
1.3.	You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Assessment of patients' individualised needs and plans of care are documented within clinical records, including a number of risk assessments. These are regularly audited for completeness. A system of electronic alerts is in place to identify those who require reasonable adjustments to be made to their journey and adjusted pathways have been developed in a number of areas to provide bespoke processes for those with additional needs/protected characteristics, including accessible information. Suitably qualified staff are in place to support this right, with all staff required to complete robust recruitment checks, induction, mandatory training and annual appraisals.	Director of Operations and Performance & Director of Nursing, Midwifery and		Trust wide record keeping audit programme reported to the Clinical Effectiveness Council (CEC) Patient surveys, complaint reports and nursing care indicator audits reviewed by the PEC
1.4.	Not Applicable – Commissioning responsibility to commission and put in place services to meet community needs.				
1.5.	Not Applicable – Commissioning responsibility in certain circumstances, to go to other countries for treatment				
1.6.	Not Applicable – Commissioning responsibility in certain circumstances, to go to other countries for treatment if covered by Withdrawal Agreement				
1.7.	You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of sex, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	See 1.2 above	Director of Nursing, Midwifery and Governance		See 1.2 above

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
1.8.	You have the right to access certain services commissioned by NHS bodies within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution and relate to 2 week cancer target and 18 week target.	The Trust has historically met the majority of national referral to treatment times, which are monitored by the Board monthly with action plans in place to meet any areas of underperformance. The pandemic impacted negatively on the Trust's ability to consistently meet all of the referral times, however, the Trust's performance compares favourably with other trusts and staff continue to implement the recovery plans to regain a compliant position.	Director of Operations and Performance		Integrated Performance Report (IPR)
2.	Quality of care & environment				
2.1.	You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	The Trust is registered with the CQC without conditions and was rated as outstanding in March 2019. Clinical and Quality Strategy in place. All staff are subject to the full recruitment checks prior to commencing in post and are required to complete induction/mandatory training and annual appraisals. Safer staffing reports are reviewed by the Quality Committee. Medical and nursing staff are required to complete revalidation. Patient Safety Council maintains overview of the safety of services, including incident reporting and follow-up of actions arising from root cause analysis investigations into serious incidents. Lessons learned are shared via bimonthly safety briefing issued with Team Brief and via Care Group bulletins, as well as team meetings at ward level to ensure safety culture across the Trust. Medical Care Group has a lessons learned forum in place. System in place for cascading and acting on patient safety alerts via the Central Alerting System (CAS).	Director of Nursing, Midwifery and Governance		Clinical and Quality Strategy progress report IPR including training figures & CQC registration. Annual medical Revalidation Report. Patient Safety Council reports to the Quality Committee (QC) CAS report to Patient Safety Council. Safer staffing reports to the QC and the Board Latest review by MIAA provided substantial assurance on lessons learned (2021)

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
2.2.	You have the right to be cared for in a clean, safe, secure and suitable environment.	Services are provided from two relatively new hospitals that are well-maintained through the PFI contract and a community hospital with effective contract monitoring in place. The Trust was ranked first in the latest patient-led assessment of the care environment (PLACE) and scored top marks for standards of cleanliness. Regular infection prevention and control audits are completed and actions developed to improve standards. The Trust is currently below the annual threshold for C-Difficile, although a stretching level has been set for 2022-23. The Trust is compliant with Health and Safety legislation. The Trust has a local security management specialist in place to actively promote a safe and secure environment, including awareness raising via e-bulletin. The Trust introduced an on-line hate crime reporting mechanism to support staff, patients, visitors and members of the local community who are victims of hate crime.	Director of Estates and Facilities		PLACE inspection reports IPR Health and Safety reports to the People Council (PC) Friends and Family Test (FFT) results and Patient Surveys reported to the PEC Complaints and PALS reports to the QC and Board
2.3.	You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Nutrition and hydration for patients is monitored via the monthly audits of nursing care indicators, which are reported to the Nutritional Steering Group and Patient Experience Council. Patients are risk assessed using the National Institute for Health and Care Excellence (NICE) recommended Malnutrition Universal Screening Tool (MUST) to ensure appropriate nutrition is provided to the patients as per the documented plan of care. A number of wards throughout the hospital have protected mealtimes, which is assessed via the Quality Care Assessment Tool (QCAT). Significant improvements have been noted with the recording of MUST assessments since the introduction of e-risk assessments. A training booklet has been produced for nursing staff which has been rolled out across the Trust.	Director of Nursing, Midwifery and Governance		Healthwatch, patient survey and Nursing Care Indicator reports to Patient Experience Council. QCAT peer assessments.

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
2.4.	You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	The Clinical and Quality Strategy has a number of key performance indicators to help monitor the delivery of the Strategy. The Trust has a comprehensive Clinical Audit programme in place, which includes action plans to address any areas identified for improvement as part of the audit process. There is a QCAT accreditation scheme in place, which has been revised in 2022 in line with the CQC domains. Patient feedback is used to drive continuous improvement, through the 5-a-day, FFT, Healthwatch reports and patient surveys. Wards display their FFT results and the actions being taken to address issues, via You said We did poster. The Trust sets annual objectives, which include quality targets. The published Annual Quality Account provides a succinct summary of the quality of care provided by the Trust. Commissioners hold the Trust to account to deliver CQuIN and other quality targets. The Trust continues to implement its policy for learning from deaths, 'Mortality Review – Responding to and Learning from the Death of Patients under the Management and Care of the Trust'	Medical Director/ Director of Nursing, Midwifery and Governance		Clinical and Quality Strategy IPR Clinical Audit Programme reports to the CEC FFT report to PEC Annual Quality Account Trust's annual objectives Reports to Clinical Quality and Safety Group (CQPG)
3.	Nationally approved treatments, drugs & programmes				
3.1.	You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.	The Trust has a Medicines Management Policy and a Medicines Optimisation Strategy and Implementation Plan in place to ensure that patients receive appropriate drugs. All NICE guidance is reviewed to ensure it is relevant and compliance is monitored when guidance does apply, in line with the Policy for the Implementation of NICE Guidelines. Please note that a key part of this right relates to the funding of drugs and treatments, which is a commissioning responsibility.	Medical Director		NICE and medicines management reports to the CEC
3.2.	Not applicable – Commissioner responsibility regarding drug funding				
3.3.	Not applicable – Relates to national immunisation programme				

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
4.	Respect, consent & confidentiality				
4.1.	You have the right to be treated with dignity and respect, in accordance with your human rights.	The Trust's values include kind and compassionate, respectful and considerate and the Trust has ACE behavioural standards in place that focus on ensuring patient's have a positive experience. There are procedures in place for managing any instances where these standards are not maintained. Staff are actively encouraged to challenge poor behaviour and compliance with this is assessed during local quality reviews. Code of Confidentiality applicable to all staff, Chaperone Policy and Provision of Same-Sex Accommodation Policy. Professional standards and codes of conduct in operation for a number of clinical staff, including medical and nursing staff, through their regulatory bodies. The Trust received positive scores (7.3/10 and 9.6/10) for ensuring privacy for discussing conditions and for patients being treated in the latest in-patient survey (2021) with privacy for discussing conditions better than the national average.	Director of Nursing, Midwifery and Governance		Trust vision, values and behavioural standards Policies available on intranet 2021 In-patient Survey reported to the PEC
4.2.	You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Safeguarding Policy and Procedures in place. Safeguarding Steering Group for adults and children meets regularly to review the effectiveness of the policy and the Trust's arrangements for protecting patients from abuse. Safeguarding training is part of the mandatory training requirement for staff, with compliance monitored by the Steering Groups. Staff aware of the need to report any abuse and to take action to prevent further abuse. Any allegations of abuse raised by patients/carers are thoroughly investigated and actions taken.			Safeguarding Policy Safeguarding Steering Group reports to PSC IPR Incident Reporting and Management Policy

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
4.3.	You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests	Consent Policy in place and being implemented. Consent audits undertaken as part of the Trust's Clinical Audit Programme. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy supported by checklist to aid communication. MCA/DoLS training is mandatory for all staff. Learning Disability passports in use in the Trust and learning disability training is now mandatory for clinical staff.	Medical Director		Clinical Audit Programme reports to the CEC All policies are available on the intranet Mandatory training figures reported in IPR
4.4.	You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Consent Policy has been updated to reflect the Montgomery ruling and the need to ensure greater level of detail is provided when gaining consent. Where possible consent is obtained during pre-operative appointment to allow maximum time for information to be provided to patients and considered by them. Detailed information relating to changes in case law circulated to key staff, following training session to raise awareness. Consent audits undertaken as part of the Trust's Clinical Audit Programme. Regular consent training available. Number of information leaflets in place for patients to support decision-making	Medical Director		Consent Policy Information leaflets Consent audit
4.5.	You have the right of access to your own health records and to have any factual inaccuracies corrected.	Access to Health Records Policy available on the Trust's website for patients/public. The policy includes flowchart of the process to obtaining health records and how to have amendments to inaccurate entries recorded.	Director of Nursing, Midwifery and		Access to Health Records Policy

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
4.6.	You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.	Code of Confidentiality applicable to all staff which gives staff clear guidance on how to keep information and secure. Information Governance training is mandatory for all staff and we have a proactive Information Governance Team who issue regular updates to all staff groups on the importance of information security. The Trust is compliant with the Data Security and Protection Toolkit and received substantial assurance from MIAA for the latest self-assessment completed in June. The Trust has a robust Information Governance Structure and has a Caldicott Guardian and Senior Information Risk Owner (SIRO) in place.	Director of Informatics		Data Security and Protection Toolkit monitoring via Information Governance (IG) Steering Group IG report to the Board IG Steering Group Minutes
4.7.	You have the right to be informed about how your information is used.	In line with its obligations under the Data Protection Act the Trust displays its “fair processing notice” on the Trust website which informs service users how we use their information. This information is also displayed in all wards and other public facing locations in the form of leaflets entitled, “The NHS & Your Information” and “How We Use and Protect Your Personal Information” these leaflets clarify how service user information is used, stored, shared and kept secure.	Director of Informatics		Patient leaflets available on the Trust website
4.8.	You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.	See 4.7 above	Director of Informatics		See 4.7 above
5.	Informed choice				

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
5.1.	You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	Marshalls Cross Medical Centre do not refuse patients and, in addition, are contracted to deliver the Special Allocation Scheme (SAS), wherein they register patients who have been removed from other practice patient lists so they can continue to access healthcare services. These patients are required to attend the practice as home visits are not provided and the patients sign a disclaimer to confirm they understand that staff cannot do a home visit if this is required.	Director of Operations and Performance		Provision of SAS
5.2.	You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.	The practice tries to meet requests to see a specific doctor, working with patients to ensure a suitable appointment is secured. The practice is currently reviewing the number of appointments available to ensure capacity is aligned to demand.	Director of Operations and Performance		Patient Survey action plan
5.3.	You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally	The Trust publishes its Quality Account on an annual basis, complying with the information requirements established by the Department of Health and provides performance information as part of the public Board papers on-line. In addition, information is provided centrally and used by regulators to monitor the Trust's performance, including regularity of inspection by CQC who publish their ratings on the website. The Trust publicises its CQC rating in line with the legal requirement	Director of Operations and Performance		NHS website
5.4.	You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution	The Trust provides information about its services through the website and via GPs. Patients are able to select their provider of choice for services accessed through the NHS e-referral service (choose and book). Please note partial responsibility for upholding this right rests with commissioners – please refer to the NHS Constitution Handbook for further details.	Director of HR		Patient & Visitor and GP sections of Trust's website.

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
6.	Involvement in your healthcare & in the NHS				
6.1.	You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.	A key part of the care planning process and patient documentation includes involvement of patients/carers, including identifying what matters to them. Individual Care and Communication Record for patients at the end of their life includes sections for communication and patient/carer preferences. Results from the latest in-patient survey show a score of 7.4/10 for patients feeling they were as involved as much as they wanted to be in decisions about care and treatment, which is in line with the national average. Please note an element of upholding this right rests with commissioners, including the options for personal health budgets.	Medical Director/ Director of Nursing, Midwifery and Governance		Clinical and nursing documentation Individual Care and communication record
6.2.	You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	The Trust has being open and honest as one of its five values. There are systems and processes in place to support staff and to ensure compliance with the duty of candour, including a Being Open Policy and mandatory fields when reporting moderate and severe harm incidents on Datix. Being open and the duty of candour are covered in the incident reporting section of mandatory training. In addition, the Trust has a policy for learning from deaths.	Director of Nursing, Midwifery and Governance		Being Open Policy Duty of Candour fields on Datix Letters submitted to patients/carers following investigations. Mortality Review – Responding to and Learning from the Death of Patients under the Management and Care of the Trust Policy

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
6.3.	You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	Improvements to services are made as a result of feedback from patients through the friends and family test, patient surveys and through the complaints system. The Trust has a Patient Participation Group who provide their views on a range of issues, including the Trust's website and Patient Experience and Inclusion Strategy. Patients/patient representatives are involved in discussions about building modifications and provide input into making them fit for purpose. Full public consultations are undertaken as required. Please note an element of upholding this right rests with commissioners when planning which services to commission.	Director of HR		Quality Account includes information on changes made as a result of patient input.

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
7.	Complaint and redress				
7.1.	You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated	The Managing Concerns and Complaints Policy includes requirement to acknowledge complaints within 3 working days, which is reported to the Quality Committee. 100% of complaints have been acknowledged within this timeframe for each year for the last three years. There is a formal process in place for ensuring that all complaints are managed appropriately, including a full investigation and providing feedback to complainants.	Director of Nursing, Midwifery and Governance	Green	Managing Concerns and Complaints Policy Complaint report to QC Complaints section in Quality Account
7.2.	You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent	Managing Concerns and Complaints Policy includes a section on discussing the handling of the complaint with the complainant. The Complaints Team ensure that patients are fully involved in the process as required. Each acknowledgement letter provides information on the timescales for providing the response.	Director of Nursing, Midwifery and Governance	Green	Managing Concerns and Complaints Policy
7.3.	You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken	The Complaints Team liaise with the complainant to ensure they are aware of any delays. Each complaint has a written response, which informs the complainant of the outcome of the investigation and what actions are to be taken to resolve any issues identified. Where required, face-to-face meetings are held between complainants and members of the Trust to ensure that the complainant is satisfied with the Trust's response. Complaint surveys are undertaken to ascertain if patients are happy with the process and the results are presented to the Quality Committee quarterly. Complaint responses are signed off by the Chief Executive, the Director of Nursing, Midwifery and Governance or the Deputy Chief Executive/Director of HR.	Director of Nursing, Midwifery and Governance	Green	Managing Concerns and Complaints Policy

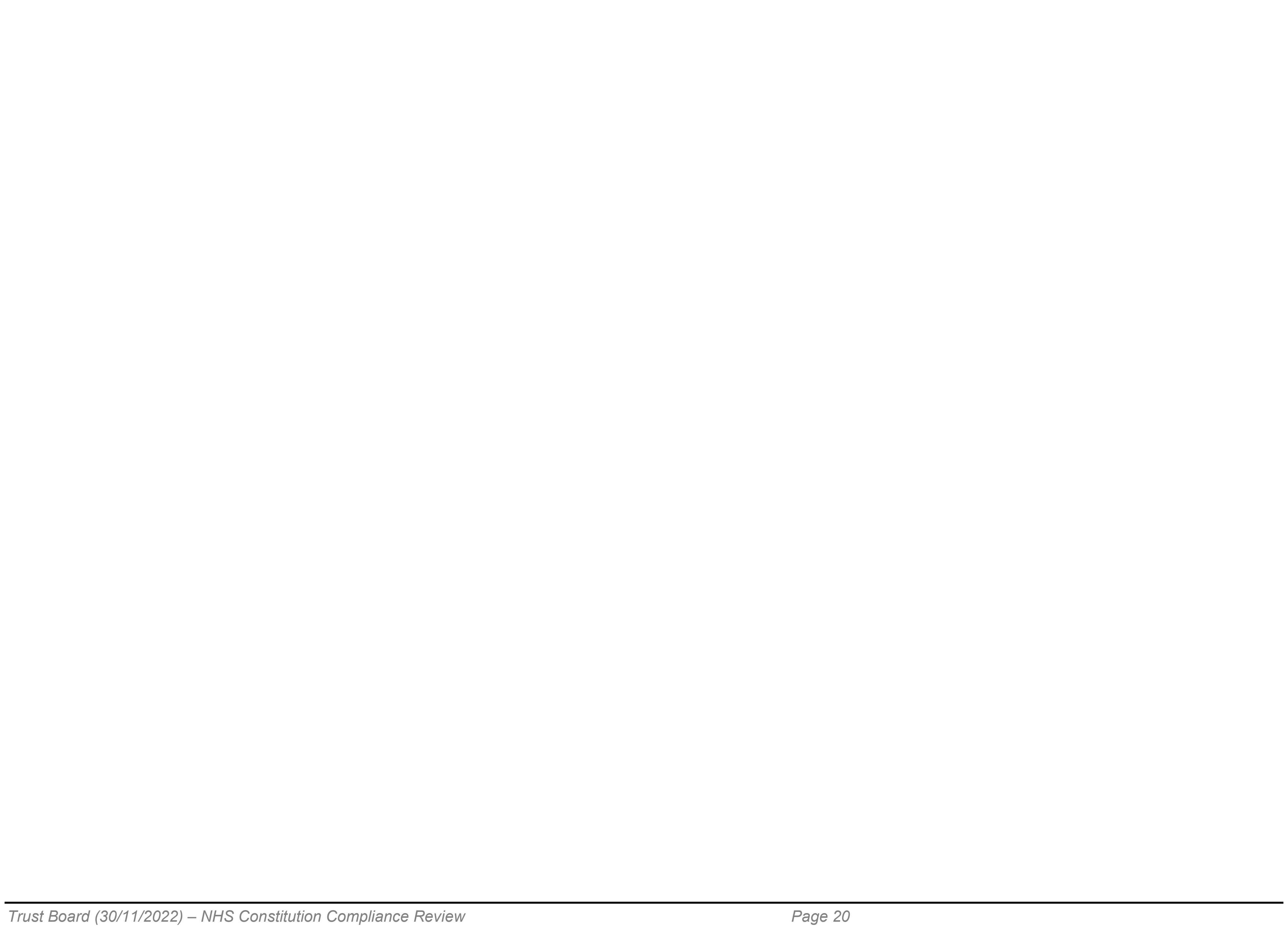
No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
7.4.	You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS	Managing Concerns and Complaints Policy includes a section on Parliamentary and Health Service Ombudsman The quarterly Complaints Report to the Quality Committee provides an update on the number of complaints that have been reviewed by the Ombudsman.			Managing Concerns and Complaints Policy Complaint report to QC
7.5.	Not applicable – Relates to the right to seek judicial review, but any person with a direct/personal interest in a decision made or action taken by the Trust would seek independent legal advice				
7.6.	You have the right to compensation where you have been harmed by negligent treatment	Claims Handling Policy in operation and overseen by the Legal Department. Trust is covered by NHS Resolution and works closely with them on responding to any claims that are received.	Director of Nursing, Midwifery and Governance		Summary of claims included in Aggregated Data Report

Appendix 2: NHS Constitution – Staff rights

No.	Right	Position statement	Exec Lead		Comment/ Evidence
1.	Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives				
1.1.	Right to fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults with whom you live.	There are a number of workforce policies in place to ensure fair treatment including those for Special Leave, Reasonable Adjustments, Annual Leave, Flexible Working and other associated Equality Diversity & Inclusion policies. The Trust has positive staff survey results and was in the top 20% of trusts where the staff would recommend the organisation as a place to work in the last survey.	Director of HR		2021 Staff survey results Policies available on the intranet
1.2.	Right to request other 'reasonable' time off for emergencies (paid and unpaid) and other statutory leave (subject to exceptions).	Special Leave Policy in place, allowing for staff to take time off for emergencies and to undertake work in public positions, for example as a school governor or justice of the peace. There is also the Reasonable Adjustment Policy which includes disability leave allowance.			Policies available on the intranet Staff survey results
1.3.	Right to expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying or harassment)	Range of policies in place to protect staff, including, Respect and Dignity at Work, Resolution & Grievance, Transgender Staff Support Policy and other associated ED&I policies. Staff satisfaction is measured through the NQPS and the national staff survey, which reported a better than average score for staff experiencing bullying or harassment.			Policies available on the intranet Staff survey results National Quarterly Pulse Survey (NQPS)
2.	Have a fair pay and contract framework				
2.1.	Right to pay; consistent with the National Minimum Wage or alternative contractual agreement and right to fair treatment regarding pay.	All non-medical roles below very senior manager level are covered by Agenda for Change (A4C) – all these posts are reviewed against the job evaluation handbook. Medical and dental staff pay scales are compliant with appropriate Terms and Conditions. VSM posts are job evaluated as per the role and pay scales set accordingly – these are published in the Remuneration Report in the Trust's Annual Report Local negotiating committees meet to agree workforce policy.	Director of HR		A4C T&C and job evaluation handbook Trust Annual Report NHS England Guidance on pay for very senior managers in NHS trusts and foundation trusts JNCC & TJLNC minutes

3.	Be involved and represented in the workplace				
3.1.	Right to be accompanied by either a Trade Union official or a work colleague at disciplinary or grievance hearings in line with legislation, your employer's policies or your contractual rights	This statutory right is covered in the relevant policies, including Disciplinary Policy and Resolution & Grievance Policy	Director of HR		Policies available on the intranet in line with ACAS guidance and best practice
3.2.	Right to consultation and representation either through a Trade Union or other staff representatives (for example where there is no Trade Union in place) in line with legislation and any collective agreements that may be in force	Please see 3.1 Range of trade union representation throughout the Trust.			Policies available on the intranet Partnership Agreement signed by all trade unions representing a range of staff groups and professional bodies
4.	Have healthy and safe working conditions and an environment free from harassment, bullying or violence				
4.1.	Right to work within a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work	Number of workforce policies in place, e.g. The Respect and Dignity at Work Policy, ACE Behavioural Standards, Violence & Aggression Against Staff Policy. In addition, there are a number of other relevant policies in place, including Incident Reporting and Management, Health and Safety and Security Management. Local Security Management Specialist in place in the Trust to provide expert advice and guidance. All frontline staff are required to undergo conflict resolution training every three years. Strategic Safety & Security Management Group meets and reports to People Council. Action plan in place to address any issues highlighted in staff survey, which is monitored by the People Council. Health Work and Wellbeing Service in place which offers a wide range of support for staff.	Director of HR		Strategic Safety & Security Management Group reports to People Council Staff Survey results and action plan report to Workforce Council Analysis of incidents against staff at Valuing our people Steering Group with assurance on remedial action to Workforce Council.

5.	Be treated fairly, equally and free from discrimination				
5.1.	Right to a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status	Equality and Human Rights Policies are in place, supported by a number of other policies, including Recruitment and Selection, to reduce risk of discrimination. The Trust monitors compliance with the Equality Act through the Equality Delivery System which is overseen by local Healthwatch. 2022 is a transition year for EDS as the framework is being updated in preparation for EDS2022. This includes key elements relating to staff and working practices within the Trust. The Trust also monitors workforce compliance with the EA through WRES, WDES, GPG & PSED reporting. In 2022 the Trust was also gained a bronze award in the Rainbow accreditation.	Director of HR		Policies available on the intranet Equality Delivery System (EDS2022) WRES & WDES PSED Rainbow Accreditation 2021 Annual Staff Survey HR case tracker
6.	Can in certain circumstances take a complaint about their employer to an Employment Tribunal				
6.1.	Right to appeal against wrongful dismissal	This is covered in the Disciplinary Policy, which states that staff have the right of appeal for all the stages of the disciplinary procedure. There is a clear appeal process. It is also covered in the Capability Policy.	Director of HR		Policies available on the intranet
6.2.	If internal processes fail to overturn a dismissal, you have the right to pursue a claim in the employment tribunal, if you meet required criteria	The Trust Disciplinary Policy is in line with ACAS guidance and employment law. Staff have the right to an appeal against their dismissal. The Trust works with ACAS conciliation service try to mitigate cases being pursued at Employment Tribunal			Policies available on the intranet
7.	Can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest				
7.1.	Right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	The Raising Concerns & Speaking out Safely Policy provides protection for staff who report wrongdoing. The Trust has signed up to the "Speaking our Safely" campaign and has 4 nominated Freedom to speak our Guardians, as well as a confidential telephone line and the anonymous Speak in Confidence email option for staff to raise concerns.	Director of HR		Policies available on the intranet
7.2.	Right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	The Raising Concerns & Speaking Out Safely Policy provides protection for staff who report wrongdoing. The trust has signed up to the "Speaking our Safely" campaign, has 4 nominated Freedom to Speak Up Guardians and has the anonymous email route, Speak in Confidence in place.			Policies available on the intranet
8.	Have employment protection (NHS employees only).				
8.1.	Right to employment protection in terms of continuity of service for redundancy purposes if moving between NHS employers	There are a number of contractual obligations and Trust Policies in place for staff that are legally compliant, including Pay Protection and Managing Organisational Change.	Director of HR		Policies available on the intranet Agenda for Change Terms and Conditions Handbook
9.	Can join the NHS Pension Scheme				
9.1.	Right to join the NHS Pension Scheme	All new starters who are eligible to join the NHS Pension Scheme are automatically registered.	Director of HR		Included with new starter information when staff join the Trust



TRUST BOARD

Paper No: NHST(22) 098
Title of paper: Arrangements for 2023/24 Trust Board Meetings.
Purpose: To advise Board members of the proposed dates for Trust Board meetings throughout the next Financial Year; the supporting timetable, and agreed work plan.
Summary: 1. Board meetings have been held on the last Wednesday of each month and it is proposed that this arrangement will continue during 2023/24. 2. The paper confirms the dates for agenda setting, collation and distribution of papers and of actual meetings. 3. The Board also maintains a work plan to schedule agenda items throughout each year to ensure that it meets all statutory requirements and delivers the duties and responsibilities in the Trust's standing orders. 4. This schedule, once approved, is used to inform the work plans of the Board committees 5. The work plan may be amended as a result of the annual board effectiveness review that is conducted between January and April each year, or in light of any new statutory or regulatory requirements.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements which ultimately support the Trust in achieving its Annual Objectives.
Financial implications: None directly from this report.
Stakeholders: Directors, ICB, Regulators and other stakeholders and partners.
Recommendation(s): The Trust Board are asked to: 1. Approve the proposed dates and associated administrative timetable for Trust Board meetings. 2. Approve the proposed schedule of planned agenda items for Trust Board meetings.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 30th November 2022.

SCHEDULE OF TRUST BOARD MEETING DATES (2023/24)

1. Meeting Schedule

1.1. Board meetings are held on the last Wednesday of each month with the exception of August and December.

1.2. The Trust believes in being open and transparent and members of the public are able to attend the public section of each Board meetings. Public Trust Board Meetings commence at 09.30 or 10.00a.m.and are scheduled to run for 2 - 3 hours. Depending on the on-going situation with the incidence of COVID-19 members of the public will be offered the opportunity to observe the Board meeting remotely via video link.

1.3. There is a change in start times from previous years to enable the Chief Executive to attend the Regional Leadership Team meetings in her role as Lead for the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST)

1.4. Four meetings a year (April, June, October, and February) include discrete sessions for discussion on strategy, which are held in private following public Trust Board meetings.

1.5. In addition, where necessary, meetings include discrete closed sessions for discussion on items of a sensitive or confidential nature, which are held in private following public Trust Board meetings.

2. Administrative Arrangements

2.1. Board agendas are developed by the Executive Committee on behalf of the Chairman at least ten days in advance of meetings.

2.2. Both hard copies and electronic versions of the Board papers are distributed to members on the Friday preceding each Board meeting.

2.3. Papers for Public Board Meetings are uploaded onto the Trust internet site on the Tuesday before each meeting.

2.4. The following table captures the schedule for the 2022/23 Financial Year. Meetings that include a strategy session are shaded grey.

Financial Year 2023/24	Agenda set	Board papers to be received	Electronic & hard copies circulated	Electronic copies on internet	Board date
April	Thurs 06 Apr	Tue 18 Apr	Fri 21 Apr	Tue 25 Apr	Wed 26 Apr
May	Thurs 04 May	Tue 23 May	Fri 26 May	Tue 30 May	Wed 31 May
June	Thurs 08 Jun	Tue 20 Jun	Fri 23 Jun	Tue 27 Jun	Wed 28 Jun
July	Thurs 06 Jul	Tue 18 Jul	Fri 21 Jul	Tue 25 Jul	Wed 26 Jul
August					
September	Thurs 07 Sep	Tue 19 Sep	Fri 22 Sep	Tue 26 Sep	Wed 27 Sep
October	Thurs 05 Oct	Tue 17 Oct	Fri 20 Oct	Tue 24 Oct	Wed 25 Oct
November	Thurs 02 Nov	Tue 21 Nov	Fri 24 Nov	Tue 28 Nov	Wed 29 Nov
December					

January	Thurs 11 Jan	Tue 23 Jan	Fri 26 Jan	Tue 30 Jan	Wed 31 Jan
February	Thurs 08 Feb	Tue 20 Feb	Fri 23 Feb	Tue 27 Feb	Wed 28 Feb
March	Thurs 07 Mar	Tue 19 Mar	Fri 22 Mar	Tue 26 Mar	Wed 27 Mar

3. Proposed Trust Board Work Plan (2023/24)

The work plan is provisional pending the annual Board and Committee effectiveness review which reports in May.

ANNUAL TRUST BOARD CALENDAR 2023/24

Month			ToR	A	M	J	J	A	S	O	N	D	J	F	M	Report	Presenter
Scheduled agenda items	General	Employee of the month		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Anne-Marie	Richard
		Patient story			✔		✔		✔		✔		✔		✔	Sue	Various
		Apologies		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Declaration of interests	8	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Minutes of the previous meeting		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Action list / matters arising		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Meeting Effectiveness Review		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Any other business		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
	Committee Reports	Audit (inc approval of Corp Governance Manual and Standing Financial Instructions)	2,6,7,10,11,14,15,32,33,34	✔	✔				✔	✔				✔		Gareth	Ian
		Executive	3,11,16,18	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nicola	Ann
		Finance and Performance	11	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Gareth	Jeff
		Quality (inc Safer Staffing, Maternity and Infection Control)	11, 25	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Sue	Rani
		Strategic People Committee	11	✔			✔			✔			✔			Anne-Marie	Lisa
		Charitable Funds	11			✔				✔				✔		Gareth	Paul
	Operational performance reports	Integrated performance report	3,4	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Gareth	
		Corporate Risk Register	3	✔			✔			✔			✔			Nicola	
		Board Assurance Framework	3	✔			✔			✔			✔			Nicola	
		Aggregated Incidents, Complaints and Claims report	3,9		✔					✔			✔			Sue	
		Informatics Report and Strategy update	3								✔					Christine	
		Learning from Deaths Quarterly Report	3	✔			✔			✔			✔			Peter	
		Workforce Strategy and HR indicators report	3				✔						✔			Anne-Marie	
	Annual reports	Adoption of Annual Accounts	1		✔											Gareth	
		Approval of Quality Account	25		✔											Sue	
		NHS Licence Conditions Board declarations	1			✔										Nicola	
		Audit Plan approval	33		✔											Gareth	
		Board and Committee Effectiveness Review	5,12,13		✔											Nicola	
		Information Governance Annual Report	1,3				✔									Christine	
		Trust objectives approval & mid year review	3,24,31		✔						✔				✔	Nicola	Ann
		Medical revalidation annual declaration	20						✔							Jacqui Bussin	
		Audit Letter sign-off	1,33						✔							Gareth	
		Charitable Funds Accounts & Annual Report	1							✔						Gareth	
		Research & Development Annual Report	4								✔					Peter	
		Research & Development Annual Capability Statement	4								✔					Peter	
		Biennial Review of NHS Constitution	1								✔					Nicola	
		Trust Board meeting arrangements	1								✔					Nicola	
		EPRR Compliance statement	1						✔							Sue	
		WRES & WDES Reports and Action Plans	1,3				✔									Anne-Marie	
		Clinical and quality strategy update	24,25										✔			Peter	
		Safeguarding Annual Report (Adult & Children)	1							✔						Sue	
		Operational Plan - Budget and activity approval	1,2,7,29,30										✔		✔	Gareth	
		National Quality Board - annual workforce plan approval and 6 month staffing review/Workforce Safeguards Report	1, 3						✔					✔		Sue	Anne-Marie
		Infection Control Annual Report	3						✔							Sue	
		CQC registration	1,25												✔	Sue	
		Mixed sex annual declaration	1												✔	Sue	
		Fit and Proper Persons Chair's Report	8			✔										Nicola	Richard
		Freedom to speak up - Board Self Assessment	20											✔		Anne-Marie	
		CNST Self Declaration & Approval					✔									Sue	
		Gender Pay Gap Annual Declaration	20			✔										Anne-Marie	
		DSPT Results and Action Plan					✔									Christine	
		Staff survey report and action plan	20												✔	Anne-Marie	
		Total scheduled items		17	18	17	21	0	17	21	19	0	19	16	18		
Closed Session	Chair and NED meeting (or as required)			✔		✔				✔				✔		Richard	
	Chief Executives report				✔		✔		✔		✔		✔		✔	Ann	
	Southport and Ormskirk ALTC/Transaction Update			✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Ann	
	Serious untoward incidents		1		✔		✔		✔		✔		✔		✔	Sue	
	Suspensions		17		✔		✔		✔		✔		✔		✔	Anne-Marie	
	Feedback from external meetings and events				✔		✔		✔		✔		✔		✔	All	
	Review of meeting effectivness				✔		✔		✔		✔		✔		✔	Richard	
	Director mandatory training / Corporate Law update		20							✔						External facilitators	

TRUST BOARD

Paper No: NHST (22) 099
Title of paper: Charitable Funds Approval 2021/22
Purpose: To Approve the Whiston and St Helens Charity Accounts
Summary: The following paper demonstrates the charitable funds accounts for 2021/22. During the year the charity has secured an additional £163k of income and invested £127k on charitable activities throughout the Trust.
Corporate objectives met or risks addressed: Financial Governance
Financial implications: N/A
Stakeholders: Trust Board
Recommendation(s): **To Approve the Accounts for submission**
Presenting officer: G Lawrence – Director of Finance & Information
Date of meeting:

Whiston and St Helens Hospitals' Charity

(Registered Number 1053125)

Annual Accounts 2021/2022

ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

FUNDS HELD ON TRUST
ANNUAL ACCOUNTS 2021-22

The accounts of the funds held on trust by the Trust

FOREWORD

The Trustee has been appointed under S11 of the NHS and Community Care Act 1990.

The Whiston and St Helens Hospitals' Charity is registered with the Charity Commission and includes funds in respect of St Helens and Knowsley Teaching Hospitals NHS Trust.

MAIN PURPOSE OF THE FUNDS HELD ON TRUST

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the St Helens & Knowsley Teaching Hospitals NHS Trust.

Statement of Trustee responsibilities

In its capacity as Trustee of the Charitable Funds the St Helens and Knowsley Teaching Hospitals Trust Board is responsible for:-

- keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable them to ensure that the accounts comply with requirements in the Charities Act 2011, the FRS102 SORP and applicable Accounting Standards.
- establishing and monitoring a system of internal control; and
- preparing financial statements on a going concern basis.
- maintaining proper accounting records, safeguarding assets and taking reasonable steps for the prevention and detection of fraud or other irregularities.

The Trustee is required under the Charities Act 2011 to prepare accounts for each financial year. These accounts should give a true and fair view of the financial position of the funds held on trust. In preparing the accounts, the Trustee is required to:

- apply on a consistent basis relevant accounting policies;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.
- ensure there is no relevant information of which the Charity's independent examiners are unaware.

The Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 3 to 11 attached have been compiled from and are in accordance with the financial records maintained by the Trustee.

By Order of the Trustee
Signed:

Chairman P.Growney Date 19.10.22

Trustee G.Lawrence Date 19.10.22

Independent Examiner's Report to the Trustees of Whiston and St Helens Hospitals' Charity.

I report to the charity trustees on may examination of the accounts of the charity for the year ended 31 March 2022 which are set out on pages 3 to 11.

Responsibilities and basis of the report

As the charity's trustees you are responsible for the preparation of the accounts in accordance with the Charities Act 2011 ("the Act").

I report in respect of my examination of the charity's accounts carried out under section 145 of the Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me case to believe that in any material respect:

1. acounting records were not kept in respect of the charity as required by section 130 of the Act, or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Nicola Mason FCA
MHA Moore and Smalley
Richard House
9 Winckley Square
Preston
PR1 3HP

Statement of Financial Activities for the year ended 31 March 2022
(Includes the Income and Expenditure Account)

	Note	Unrestricted Funds £	Restricted Funds £	**2021-22 Total Funds £**	2020-21 Total Funds £
Income and Endowments from					
Donations and legacies	**2**	34,436	113,580	**148,017**	287,197
Other trading activities	**3**	0	402	**402**	1,266
Income from Investments	**4**	2,997	11,958	**14,955**	14,995
Total Income and Endowments		**37,433**	**125,940**	**163,373**	303,458
Expenditure on					
Raising funds	**5**	115	2,094	**2,209**	469
Charitable Activities	**6**	39,444	88,392	**127,836**	244,462
Total Expenditure		**39,559**	**90,486**	**130,045**	244,931
Net Gains/(losses) on investments		4,182	16,690	**20,872**	72,540
Net income/(expenditure)		**(2,126)**	**35,454**	**33,328**	58,528
Transfer between Funds		0	0	**0**	0
Net movement in funds		**2,056**	**52,144**	**54,200**	131,067
Reconciliation of Funds					
Fund balances brought forward at 31 March 2021		125,982	546,787	**672,769**	541,702
Fund balances carried forward at 31 March 2022		**128,038**	**598,930**	**726,968**	672,769

The notes at pages 6 to 11 form part of this account.

Balance Sheet as at 31 March 2022

	Note	Unrestricted Funds £	Restricted Funds £	**Total at 31 March 2022 £**	Total at 31 March 2021 £
Fixed Assets					
Investments	**11**	128,038	364,110	**492,149**	471,277
Total Fixed Assets		128,038	364,110	**492,149**	471,277
Current Assets					
Debtors	**7**	0	4,792	**4,792**	11,131
Cash at bank and in hand	**10**	0	379,255	**379,255**	377,273
Total Current Assets		0	384,047	**384,047**	388,404
Creditors: Amounts falling due within one year	**8**	0	149,227	**149,227**	186,912
Net Current Assets/(Liabilities)		0	234,820	**234,820**	201,492
Total Net Assets		**128,038**	**598,930**	**726,968**	672,769
Funds of the Charity					
Income Funds:					
Restricted	**12.1**	0	598,930	**598,930**	546,787
Unrestricted	**12.2**	128,038	0	**128,038**	125,982
Total Funds		**128,038**	**598,930**	**726,968**	672,769

The notes at pages 6 to 11 form part of this account.

Signed: G.Lawrence

Date: 19.10.22

Statement of cash flows as at 31 March 2022

	Note	**Total at 31 March 2022 £**	Total at 31 March 2021 £
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	**9**	**(12,973)**	187,413
Cash flows from investing activities:			
Dividends, interest and rents from investments	**9**	**14,955**	14,995
Net cash provided by (used in) investing activities		**14,955**	14,995
Cash flows from financing activities:			
Net cash provided by (used in) financing activities		**0**	0
Change in cash and cash equivalents in the reporting period		**1,982**	202,408
Cash and cash equivalents at the beginning of the reporting period		**377,274**	174,866
Cash and cash equivalents at the end of the reporting period	**10**	**379,255**	377,274

Notes to the Accounts

1. Accounting Policies

The financial statements have been prepared in accordance with the Accounting and Reporting by Charities - Statement of Recommended Practice (FRS 102) and with the Charities Act.

The Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason the accounts have been prepared on a going concern basis.

1.1 Accounting Convention

The financial statements have been prepared on the basis of historic cost (except that investments are shown at market value).

1.2 Income and Endowments

a) All income and endowments are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;

ii) certainty - when there is reasonable certainty that the incoming resource will be received:

iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

b) Donations and legacies

Donations and legacies include all income received by the charity that is, in substance, a gift made to it on a voluntary basis. A donation or legacy may be for any purpose a gift made to it on a voluntary basis. A donation or legacy may be for any purpose of the charity (unrestricted funds) or for a particular purpose of the charity (restricted income funds or endowment funds).

c) Other trading activities

Income from other trading activities includes income earned from both trading activities to raise funds for the charity and income from fundraising events. To fall within this analysis heading, the income must be received in exchange for supplying goods and services in order to raise funds for the charity. While selling donated goods is legally considered to be the realisation of a donation in kind, in economic terms it is similar to a trading activity and is therefore included in this analysis heading.

d) Investments

Investment income is earned from holding assets for investment purposes and includes dividends, interest, and rents from investment property.

1.3 Expenditure

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

a) Raising funds

Expenditure on raising funds includes all expenditure incurred to raise funds for charitable purposes. It includes the costs of all fundraising activities, events, non-charitable trading activities, and the sale of donated goods.

b) Charitable Activities

Charitable Activities are the payments, made to third parties (including NHS bodies) in the furtherance of the funds held on trust's charitable objectives to relieve those who are sick. They are accounted for on an accruals basis. They include support costs and costs relating to the governance of the charity.

1.4 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.5 Structure of Funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are designated funds. The major funds held within these categories are disclosed in note 12. Transfers between funds only occur as a result of funds being amalgamated for administration purposes or as a result of endowment funds becoming realisable.

1.6 Investment Fixed Assets

Investment fixed assets (quoted stocks and shares) are shown at market value, ex dividend, and are included in the balance sheet at the end of the accounting period (disclosed in note 11)

1.7 Change in the Basis of Accounting

There has been no change in the basis of accounting during the year.

1.8 Transfer between Funds

There has been no change to the accounts of prior years.

1.9 Financial Instruments

i) Debtors - Debtors are amounts owed to the charity and are measured on the basis of their recoverable amount.

ii) Cash at bank and in hand- held to meet the day to day running costs of the charity as they fall due.

iii) Creditors - Creditors are amounts owed by the charity and are measured at the amount that the charity expects to have to pay to settle the debt. Amounts which are owed in more than a year are shown as long term creditors.

2. Donations and legacies

		Unrestricted Funds	Restricted Funds	**Total 2021/22 Amount received in aggregate**	Total 2020/21 Amount received in aggregate
		£	£	**£**	£
Donations		26,936	112,580	**139,517**	118,267
Legacies		5,000		**5,000**	9,322
Grants receivable	NHS Charities Together			**0**	129,600
	Grant to purchase Paxman Scalp Coolers			**0**	28,508
	TOTY Award Grant			**0**	1,500
	Dans Fund for Burns			**0**	0
	NHS Charities/Amazon Giving Christmas Grant	2,500		**2,500**	0
	Sickkids Sensory SP Grant to Paediatrics A&E		1,000	**1,000**	0
		34,436	113,580	**148,017**	287,197

3. Other trading activities

	Unrestricted Funds	Restricted Funds	**2021/22 Total**	2020/21 Total
			£	£
Bingo			**0**	535
Christmas Jumper event			**0**	16
Easter Raffle/Tombola			**0**	27
Forget Me Not Event (Cancelled)			**0**	-1,260
Pink Events			**0**	1,190
Raffles/Tombolas		402	**402**	164
Valentine Bingo			**0**	595
	0	402	**402**	1,266

4. Income from Investments

	Held in UK	**2021/22 Total**	2020/21 Total
	£	**£**	£
*Investments in a Common Deposit Fund or Common Investment Fund	14,790	**14,790**	14,932
Bank Account Interest	165	**165**	63
	14,955	**14,955**	14,995

** Net of management costs*

5. Expenditure on Raising funds

	Unrestricted Funds	Restricted Funds	**Total 2021/22 Amount expended in aggregate**	Total 2020/21 Amount expended in aggregate
			£	£
Hope Bag Collection Envelopes		325	**325**	0
HSJ Event			**0**	35
Percy Pig Collection Tubs		1,769	**1,769**	0
Pink Events			**0**	395
Raffles/Tombolas			**0**	39
Thank you cards	115		**115**	0
	115	2,094	**2,209**	469

6. Expenditure on Charitable activities

	Unrestricted Funds	Restricted Funds	**Total 2021/22 Amount expended in aggregate**	Total 2020/21 Amount expended in aggregate
	£	£	**£**	£
Patients welfare and amenities	5,930	39,326	**45,256**	34,957
Staff welfare and amenities	19,939	279	**20,218**	1,795
Education and Training	3,000	13,398	**16,398**	15,247
Grants made to St Helens & Knowsley Hosp.			**0**	52,003
Other Expenditure	3,106	2,285	**5,392**	100,900
Independent examiners fees	241	959	**1,200**	1,080
Salaries *	6,321	28,525	**34,846**	33,984
Software support/Bank/Stationery	907	3,619	**4,526**	4,495
	39,444	88,392	**127,836**	244,462

** The charity does not directly employ staff, they are recharged from the Trust. The recharge is based on 1 full-time and 2 part-time members of staff.*

7. Analysis of Debtors

	31 March 2022	31 March 2021
Amounts falling due within one year:	**£**	£
Prepayments	**1,074**	6,350
Accrued income	**3,717**	4,781
Total debtors falling due within one year	**4,792**	11,131
Total debtors	**4,792**	11,131

8. Analysis of Creditors

	31 March 2022	31 March 2021
Amounts falling due within one year:	**£**	£
Other creditors	**144,477**	181,142
Accruals	**4,749**	5,771
Total creditors falling due within one year	**149,227**	186,912
Total creditors	**149,227**	186,912

9. Reconciliation of net movement in funds to net cash flows from operating activities

	Total at 31 March 2022	Total at 31 March 2021
	£	£
Net movement in funds for the reporting period (as per the SOFA)	**54,200**	131,067
Adjustments for:		
Dividends, interest and rents from investments	**(14,955)**	(14,995)
Net (Gains)/losses on investments	**(20,872)**	(72,539)
(Increase)/decrease in debtors	**6,340**	(3,730)
Increase/(decrease) in creditors	**(37,686)**	147,610
Net cash provided by (used in) operating activities	**(12,973)**	187,413

10. Analysis of cash and cash equivalents

	Total at 31 March 2022	Total at 31 March 2021
	£	£
Cash at bank and in hand	**379,255**	377,273
Total cash and cash equivalents	**379,255**	377,273

11. Analysis of Fixed Asset Investments

	2021/22	2020/21
	£	£
Market value at 31 March 2021	**471,277**	398,737
Less: Disposals at carrying value	**0**	0
Add: Acquisitions at cost	**0**	0
Net gain/(loss) on revaluation	**20,872**	72,540
Market value at 31 March 2022	**492,149**	471,277

Market value at 31 March 2022	Held in UK	Held outside UK	**2021/22 Total**	2020/21 Total
	£	£	**£**	£
Investments in a Common Deposit Fund or Common Investment Fund	492,149	0	**492,149**	471,277
	492,149	0	**492,149**	471,277

12. Analysis of Funds

12.1 Restricted Funds

	Balance 31 March 2021	Incoming Resources	Resources Expended	Transfers	Gains and Losses	**Balance 31 March 2022**
	£	£	£	£	£	**£**
Burns & Plastics	47,233	5,275	(13,675)		1,307	**40,140**
Cancer/Leukaemia	41,912	2,918	(2,704)		1,337	**43,463**
Cardio Respiratory	12,447	5,294	(3,077)		467	**15,131**
Care of the Elderly	6,924	5,693	(863)		286	**12,040**
Childrens Fund	3,604	1,297	(1,125)		123	**3,899**
General Medicine	2,078	471	(1,342)		71	**1,278**
General Surgery	1,077	2,212	(291)		81	**3,079**
Intensive Care Unit	25,528	10,070	(3,368)		998	**33,228**
Obs & Gynae	15,219	4,820	(7,867)		437	**12,608**
Ophthalmology	31,027	2,529	(1,882)		990	**32,664**
Rheumatology	10,991	397	(3,093)		327	**8,622**
SCBU	10,722	4,459	(3,136)		361	**12,406**
St Helens Hospital	25,292	666	(1,533)		790	**25,216**
Whiston Hospital	15,429	344	(990)		480	**15,263**
A&E	9,417	2,460	(673)		299	**11,502**
Breast Care	73,775	7,066	(12,427)		792	**69,207**
Chaplaincy	357	158	(170)		12	**357**
Dermatology	9,606	214	(673)		299	**9,446**
Diabetes	3,466	153	(840)		109	**2,888**
Gastrology	4,890	656	(831)		147	**4,861**
Haematology/Microbiology	10,012	223	(695)		312	**9,852**
Lilac Centre	143,156	67,564	(26,114)		5,337	**189,943**
Medical Education	20,840	465	(1,285)		649	**20,668**
Radiography	4,609	99	(583)		138	**4,262**
Theatres/Anaes	8,557	246	(629)		274	**8,448**
Urology	8,617	192	(619)		268	**8,458**
Total	546,787	125,940	(90,486)	0	16,690	**598,930**

Details of restricted funds

Name of fund	**Description of the nature and purpose of each fund**
SCBU	Benefit of the services provided by the Special Care Baby Unit

All Restricted Funds are for the benefit of the services provided by the department named in the fund as the example above.

12.2 Unrestricted Funds

	Balance 31 March 2021	Incoming Resources	Resources Expended	Transfers	Gains and Losses	**Balance 31 March 2022**
	£	£	£	£	£	**£000**
Unrestricted	125,982	37,433	(39,559)		4,182	**128,038**
Total	125,982	37,433	(39,559)	0	4,182	**128,038**

Trustee and connected persons transactions

	2021/22	2020/21
Total number of trustees	**12**	12

Trustee expenses reimbursed

Not applicable

Trustee remuneration

Not applicable

Details of transactions with trustees or connected persons

Not applicable

Trustee Indemnity Insurance

Not applicable

Related party transactions

During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Whiston and St Helens Hospitals' Charity.

The charitable fund has made revenue and capital payments to the St Helens & Knowsley Teaching Hospitals NHS Trust where the Trustees (whose names are listed below) are also members of the Trust Board.

List of Trustees as at 31st March 2022:

Ms A M Marr
Mrs A M Stretch
Mr N Khashu
Mr R Pritchard-Jones
Ms S Redfern
Mr R Fraser
Ms V Davies
Mr J Kozer
Mr P Growney (Chairperson of Charitable Funds Sub-committee)
Ms L Knight (Assiciate Non-Executive Director and attends Charitable Funds Sub-Committee)
Mr I Clayton
Ms G Brown

Details of all charitable fund account related party transactions with St Helens and Knowsley Teaching Hospitals NHS Trust:

Note 6: Grants to St Helens & Knowsley Teaching Hospitals NHS Trust - £0
Note 8: Creditors falling due within one year - £149,227

Post Balance Sheet Events

A commitment of £41k, for the Rainbow Garden, was noted in the minutes. This was funded via a grant from NHS Charities Together and will be recognised as expenditure in 2022/23.

TRUST BOARD

Paper No: NHST (22) 100

Title of paper: IT Strategy Annual Progress Report **-** Digital Excellence at the Heart of 5 Star Patient Care

Purpose: This paper provides an update on progress made on the Digital Strategy since the last board update in November 2021.

Summary:

This update is accompanied by :
- A short presentation by the Director of Informatics.
- A short video showing the differences for Clinician and Patients that have been achieved in the second year of the current strategy and the resultant appetite for further transformation.
- An Infographic explaining what the strategy means to patients, clinicians, the Trust and the wider Accountable Care System in Cheshire and Merseyside.

In summary, considerable progress has been made on the roadmap in the Informatics Strategy for completion over the last 12 months. Some deliverables have been delayed, due to a variety of factors, but mitigation plans are in place to ensure these deliverables are put back on track and delivered before the end of the current strategy.

A revised EMRAM assessment standard, HIMSS 2022, has been published this year which is considerably more rigorous than the 2018 standard. The Trust will now be required to be assessed against the revised standard to measure its digital maturity improvements. In addition, the Centre has set out a Minimum Digital Foundation (MDF) standard that Trusts are expected to achieve by March 2025 by identifying 8 pillars of digital enablement that are needed. MDF will enable the Trust to achieve at least HIMSS 2022 Level 5 and meet the What Good Looks Like (WGLL) standard. The Trust is expected to receive financial support from national funding of £2.658m over the next 3 financial years to support it in achieving the MDF standard. With this investment from the centre, the EPR programme will be extended to enable the Trust to adopt some of the MDF extended functionality provided by System C under a CCN to the existing contract. Unfortunately, the funding awarded to the Trust does not cover all the functionality required to meet the MDF standard, such as Closed Loop Medications, Milk, Blood Products and Specimen Collection and full Clinical Business Intelligence.

Highlight achievements over the last 12 months include:
- Connect has been further rolled out, extensively, including specialist referrals, tasks and the use of images.
- Significant progress has been made in the digitisation of admission documentation. This has saved members of the Multi-Disciplinary Team considerable time as digital information is now entered just once in the admission pathway and then available online for all those who need to review it. Feedback from staff has been positive as shown in the video.
- Digitisation of a number of forms into one Social History and Activities of Daily Living (SHADL), form. This is used by anyone who cares for a patient during their stay and is involved in their discharge planning, saving time as all the information, which historically would have been kept on different forms in different locations, is now contained on this digital form.

- Mobile Orders and Results has streamlined the clinicians access to orders and results from any location within the Trust, including the launch of the digitised Histology Catalogue Almost 90% of orders across the Trust are now placed electronically.
- Workspace has been deployed to enable Clinicians to access the full patient clinical information in multiple systems through a single login, with a tailored easy to use view. Feedback again is positive, as clinicians do not have to search for information in multiple locations and systems.
- The infrastructure that Careflow ~~and all other applications~~ reside on has been completely replaced, resulting in much improved performance and better user experience for our staff including faster logon times.
- New booking system for Phlebotomy clinics introduced.
- Microsoft Office 365 rolled out across the Trust.
- Windows 10 operating system rolled out to all devices.
- In Careflow Vitals - Digital versions of the Adult Bed Rails Risk Assessment and Vision Test within the CareFlow Vitals system available on mobile devices and desktop PCs.
- In Clinical Noting digitised Discharge Planning Checklist and Food/Fluid Chart within the clinical notes section of CareFlow EPR and Workspace.
- Systems upgraded including Careflow software upgrades, EPMA Upgrade and EDMS upgrade.
- Digital Intrapartum Notes on Careflow Maternity launched.
- Informatics achieved 4-star rating from the Service Desk Institute – up from the 3-star rating of the previous year, demonstrating we are a business led support function.
- Analytical software installed on all PCs, laptops and mobile devices which allows the identification of under perfoming devices and resolve any issues before they impact the user and their ability to do their job.

Progress has not been made as planned in the following:

- The Trust was hoping to have adopted Clinical Narrative to enable a functionally richer, streamlined data capture at the point of care. This has been paused due to delivery dependencies but will restart in March 2023 as a collaborative project with SOHT, following an expedited Clinical Transformation process, where the Trust can adopt template pathways and content from System C's Content Factory, with minimal configuration, so the digitisation of paper can be optimised and deployed at pace.
- Patient Flow will be optimised to address some of the Trust operational concerns about the functionality of the solution in partnership with System C, and in collaboration with SOHT.
- The eMIS Community System is now live in a small number of services and will be rolled out at pace across the majority of services by the end of March 2023.

The roadmap for the next 12 months has been reprioritised to deliver a number of key projects and deliverables pending the restart of the Clinical Narrative project. Highlights include:

- Workspace to be fully embedded across all clinical users through clinical engagement and tailored training and support at the point of care.
- The paperless order comms project to be relaunched to further improve Clinician's access to salient results and to digitise those areas that are still placing orders on paper.
- Resource has been assigned to optimise the clinic structures and introduce a new appointment letter solution, and digital outcoming in outpatients.
- Discharge Summaries will be automated to take advantage of the improved integrated TTO functionality enabled by the recent ePMA upgrade removing the reliance on ICE.
- ePMA will be fully rolled out into the few areas which still prescribe on paper.
- The Trust will pilot a Patient Portal.

- A voice recognition pilot will be undertaken to understand the benefits and feasibility that voice activated care can bring to clinicians and patients.
- The Trust's existing digital dictation solution used by clinicals to dictate clinic letters will be replace with a modern solution.
- The Trust will contract (subject to central funding) a package of optimisation and extended digital capabilities with central funding to enable it to meet a number of the MDF requirements.
- A replacement Maternity system will be procured in collaboration with SOHT and other trusts in C&M.
- The Trust will continue to extend its involvement in digital Place-based care across its footprint.
- A new digital strategy, in collaboration with SOHT, will be developed to focus on clinical, operational and corporate services, in support of the collaboration and convergence of both organisations.

Corporate objectives met or risks addressed: This update is aligned to the Trust's Strategic objectives

Financial implications: Additional investment is expected from the NHS England to assist the Trust in achieving many of the MDF requirements that Trusts are expected to achieve by March 2025.

Stakeholders: Trust Board, staff, patients, Places , ICS and NHSe.

Recommendation(s): The Trust Board to note the update to the Informatics Strategy

Presenting officer: Christine Walters, Director of Informatics

Date of meeting: 30th November 2022