St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 22ND FEBRUARY 2023
BOARD ROOM, 5TH FLOOR, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
9.30	1.	Employee of the Month Film - February 2023		Verbal	Assurance	Chair
9.45	2.	Apologies for Absence		Verbal	Assurance	Chair
9.50	3.	Declaration of Interests		Verbal		
9.55	4.	Minutes of the Board Meeting held on 25th January 2023		Attached		
		4.1	Correct Record and Matters Arising	Verbal		
		4.2	Action log			
Performance Reports						
10.00	5.	Integrated Performance Report		NHST (23) 11	Assurance	Anne-Marie Stretch
		5.1	Quality Indicators			Sue Redfern
		5.2	Operational Indicators			Peter Williams
		5.3	Financial Indicators			Nicola Bunce
		5.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
10.20	6.	Committee Report – Executive		NHST (23) 12	Assurance	Ann Marr
10.30	7.	Committee Report – Audit		NHST (23) 13	Assurance	Ian Clayton
10.40	8.	Committee Report – Finance & Performance		NHST (23) 14	Assurance	Jeff Kozer
10.50	9.	Committee Report – Quality		NHST (23) 15	Assurance	Rani Thind
11.00	10.	Committee Report – Charitable Funds		NHST (23) 16	Assurance	Paul Growney

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.10	11.	Freedom to Speak Up – Board Self-Assessment	NHST (23) 17	Approval	Anne-Marie Stretch
11.20	12.	Aggregated Complaints, Claims and Incidents Report Q3	NHST (24) 019	Assurance	Sue Redfern
Closing Business					
11.30	13.	Effectiveness of Meeting	Verbal	Assurance	Chair
	14.	Any Other Business		Information	
	15.	Date of Next Meeting – 29th March 2023		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

MINUTES OF THE TRUST BOARD PUBLIC MEETING
HELD ON WEDNESDAY 25TH JANUARY 2023
Boardroom, 5th Floor, Whiston Hospital

BOARD MEMBERS	
Richard Fraser (RF)	Chairman (Chair)
Ann Marr (AM)	Chief Executive
Jeff Kozer (JK)	Non-Executive Director
Lisa Knight (LK)	Non-Executive Director (via MS Teams)
Gill Brown (GB)	Non-Executive Director (via MS Teams)
Rani Thind (RT)	Associate Non-Executive Director
Anne-Marie Stretch (AMS)	Deputy Chief Executive & Director of Human Resources
Nicola Bunce (NB)	Director of Corporate Services
Christine Walters (CW)	Director of Informatics
Peter Williams (PW)	Medical Director
Gareth Lawrence (GL)	Director of Finance & Information
Geoffrey Appleton (GA)	Non-Executive Director
IN ATTENDANCE	
Denise Baker (DB)	Executive Assistant (Minutes)
Alan Lowe (AL)	Halton Borough Council (Stakeholder Representative)
Yvonne Mahambrey	Quality Matron (Patient Story)
Chris Girvan	Chaplain (Patient Story)
Sue Orchard	Head of Midwifery (Item 15)
Debby Gould	Liverpool Maternity Neonatal System (LMNS) (Observer – Item 15)
Lorna Squires	NHSE (Observer)
Donna Winter	NHSE (Observer)
Deborah Turner	NHSE (Observer)
Dawn Hardie	STHK (Observer)
APOLOGIES	
Ian Clayton (IC)	Non-Executive Director

1.	**Employee of the Month Film** **December 2022** 1.1. The employee of the month for December 2022 was Marilou Vitug, Staff Nurse, Ward 1E. 1.2. The Board watched the film of RC presenting the award. **January 2023** 1.3. The employee of the month for January 2023 was Claire Fagan, Medical Secretary/Team Leader, Newton Hospital. 1.4. The Board watched the film of GL presenting the award. 1.5. RF congratulated the recipients and noted that both in different ways were demonstrating the care and compassion needed to deliver five star patient care.	**RF**
2.	**Patient Story** 2.1 SR introduced Yvonne Mahambrey (YM) and Chris Girvan (CG) who presented the patient story. 2.2 The patient story illustrated the different functions of the Trusts spiritual care team and how comfort could be provided to patients at the end of life. The story also illustrated how improvements had	**SR**

	been made to the process for recording entries to the book of remembrance following feedback from a relative. 2.3 PG commented on the importance of the spiritual support provided for patients alongside their medical care and thanked the team for the contribution to the overall patient experience.LK echoed PG's comments and noted that the patient story is another example of the care and compassionate culture at STHK. 2.4 RF thanked YM and CG for attending and their work in giving spiritual support and comfort to all our patients and their loved ones, irrespective of their religious beliefs.	
3.	**Apologies for Absence** 3.1. Apologies for absence were as noted above. 3.2. The Board sent their best wishes to IC who was unwell.	**RF**
4.	**Declarations of Interest** 4.1. There were no new declarations of interest.	**RF**
5.	**Minutes of the Board Meeting held on Wednesday 30th November 2022** **Minutes of the Previous Meeting** 5.1. The minutes of the Board Meeting held on Wednesday 30th November 2022 were reviewed. 5.1.1. CW requested some minor amendment to the wording of section 18 to provide some additional context as follows: 18.3) Delays were noted in the voice recognition system. 18.4) CW thanked the Board for the investment that had been given to improve the IT infrastructure. 18.5) CW advised that the focus over the next 12 months will include roll out of Workspace for all clinical users from April 2023, continued roll out of CareFlow white boards, and optimising clinical discharge summaries. 18.6) Work continues on the development of a business case for the Southport & Ormskirk replacement EPR. 18.7) IC agreed that the Board are very supportive of the Strategy and he was pleased to note the high standards of performance; that had also been reported at the recent MMDA Board meeting. 18.8) GB queried whether aligning with Southport & Ormskirk would require additional work. CW confirmed that the strategy at STHK could be extended to the larger trust post transaction. 18.9) GB commended the move away from paper records. 18.10) AM noted the amount of admin time that was removed for nurses with the roll out of CareFlow white boards which should allow more quality patient contact time and queried when this would start to be seen in the quality metrics. SR advised that from a risk assessment perspective, the white boards made these were more accessible to the nursing team. CW agreed that most staff would not want to revert back to paper records and noted the increase in the use of mobile electronic devices across the Trust for accessing patient information. 18.11) Task Orchestration will be introduced next year and will prompt staff to complete tasks such as reviewing falls risk assessments.	**GA** CW

	5.2. PW noted that the correct job title for Ascanio Tridente is Clinical Director of Research and Development (item 14.2). **Action Log** 5.3. Action 52 – End to end complaints review of timescales – SR provided a verbal update. During the Covid-19 pandemic a 6 month response target was applied to all complaints. Response targets are currently 100 days however there is a proposal to return to pre-pandemic targets of 30-60 days (complex cases will remain at 6 months). The timescale for acknowledgement of a complaint and recording on Datix is 3 working days for which the Trust is 100% compliant. The review highlighted the long length of time taken for investigations to be completed and additional training had been provided for r Ward Managers and Directorate Managers to improve complaint investigations/responses. Response times are being monitored on a weekly basis and have shown a 4% improvement to 84% which is projected to be 90% by the end of March. Going forward SR will approve any extensions to the normal timescales for responding to complaints. RF thanked SR for the comprehensive response and asked that the improvements against this trajectory be monitored at the Quality Committee. **Action closed.** 5.4. Action 53 – My Name Is .. badges – AMS advised that the trust is re-introducing this initiative and plans for operationalised are being developed, including working with Matrons and Ward Managers to ensure staff always introducing themselves by name to patients; and this will be audited to monitor compliance and the impact on future patient feedback. **Action closed.** 5.5. Action 54 – Recruitment of Ukranian Healthcare professionals – SR reported that STHK had expressed interest in the scheme as part of a joint Merseyside collaborative. Initially 7 nurses were identified, however, 3 had not passed the OSCE exams. One nurse had passed the OSCE exams but had decided to relocate elsewhere in the UK, and the Trust was still working with the collaborative to move forward with the recruitment and induction of the remaining 3 nurses. **Action closed.** 5.6. Action 55 – Weekend therapy provision – SR has discussed the potential impact of additional weekend therapy provision on discharges with the Head of Therapy Services. Therapy staff are part of the daily board rounds and already flex their provision to meet patient needs. Currently new issues identified at the weekend are addressed on a Monday, however the team are currently preparing a business case to formalise and resource a 7 day service. **Action closed.**	
Performance Reports		
6.	**Integrated Performance Report – NHST (23)002** GL introduced the report advising that the proposed new IPR format report is included for information, the reports will dual run to allow members to become accustomed to the new format, and GL asked for any feedback on the new format to be fed back to the Business Information team. 6.1. <u>Quality Indicators</u> 6.1.1. SR presented the report. 6.1.2. SR detailed the Never Event which occurred in December	**GL**

	2022. Investigation had shown that a retained insertion line had been obscured by an electrical lead. Immediate actions following this included amendment to the WHO checklist and equipment count procedures. There was no harm to the patient; a fully apology was given, and Duty of Candour completed. The investigation was on going. 6.1.3. There had been 2 reported cases of C.Diff in December, one hospital acquired and 1 community onset, with 39 cases YTD. 6.1.4. There had been no cases of MRSA reported in December 6.1.5. The registered nurse/midwife fill rate in November was 93.7% 6.1.6. In November there were two falls resulting in severe harm 6.1.7. There had been no grade 3 pressure ulcers reported in November 6.1.8. HSMR April – August was 90.5 6.2. <u>Operational Indicators</u> 6.2.1. RC presented the report. 6.2.2. All cancer indicators had showed improvement in November 2022. 6.2.3. 62 day cancer standard was slightly below target at 83.3%, however, this is significantly higher than regional (68.8%) and national (61%) performance 6.2.4. 2WW was now 85.2% against the target of 93%, reflecting a 30% increase in referrals compared to the 2019/20 baseline. 6.2.5. The 31 day access target was achieved with 97.8% of patient seen. 6.2.6. Bed occupancy in December 2022 was 111% which is reflected in the congestion in ED and the delayed ambulance turnaround times. The ED access performance was 62.8% of patients seen within four hours. 6.2.7. St Helens UTC treated 94% of patients within the 4 hour target. 6.2.8. Analysis of acuity has identified delays in presentation have led to later stage diagnoses; Flu and seasonal variations have also resulted in increased acuity and length of stay. 6.2.9. JK advised that, at a recent Ward Round, concern had been expressed by staff that delayed discharge could result in patients deconditioning and also led to an increased risk of falls. RC agreed that hospital was not the best place for patients who were medically optimised. 6.2.10. AMS queried how the £200m additional funding recently announced to alleviate winter pressures would be used. RC explained that the ICB were reviewing the proposals from each Place and that he had written to the Place directors in St Helens, Knowsley and Halton asking to be involved in the planning for this additional capacity to ensure it would have the greatest impact in releasing hospital capacity, as intended. 6.2.11. AL asked if there was information about the super stranded patients for each Local Authority as he would raise this with Halton Council. RC confirmed that this information was sent to the Directors of Social Services in each borough. 6.2.12. PG commented that there would continue to be problems for hospitals until the recruitment issues in social care were resolved, because this was severely limiting capacity.	

6.2.13. GA commented on the recent discussions at the Place Board and the importance of promoting the whole benefits package to prospective new recruits to the health service.
6.2.14. The referral to treatment target was not achieved with 66.1% compliance and 2,411 patients waiting longer than 52 weeks.
6.2.15. The 6 week diagnostic target was not achieved at 75.6%

6.3. Financial Indicators

6.3.1. GL presented the report.
6.3.2. Month 9 position is £1.2m ahead of plan, which would result in a year end deficit of £3.7m., but it was hoped that the position would continue to improve during Q4
6.3.3. AM asked if the increases in interest receivable had been factored into the ICB planning assumptions for 2023/24 and GL confirmed that this was the case
6.3.4. CIP is in a positive position with £19.7m of schemes delivered recurrently and £28.1 m of schemes identified in total.
6.3.5. Cash balance is currently reduced, however should be in a more positive position in month 10, due to a delayed Health Education England payment but this had subsequently been resolved.
6.3.6. The capital plan was progressing to plan

6.4. Workforce Indicators

6.4.1. AMS presented the report.
6.4.2. In December the absence rate had increased to 7.1% reflecting the higher levels of COVID, flu and other respiratory viruses circulating in the population. This was slightly above the C&M average absence rate of 6.9%.
6.4.3. Mandatory training compliance was 80.4% and targeted action was being taken in relation to Medical and Dental staff who had the lowest levels of compliance.
6.4.4. Appraisal compliance in December achieved the target at 85.1%
6.4.5. GA asked about the percentage of staff that have been taken up the offer of the COVID and Flu vaccinations. AMS responded that the take up of the winter vaccination programmes had been less than last year across the whole NHS.
6.4.6. PW advised that there has been an increase inpatient numbers with non-Covid respiratory symptoms and the surge in admissions predominantly relates to flu, particularly amongst younger people. AMS suggested some targeted publicity to younger members of staff to improve vaccination uptake, however it was noted that the programme was ending in mid-February.
6.4.7. PG queried how stress and anxiety related sickness compares to previous years and whether this had been highlighted as a reason for staff leaving the Trust. AMS advised there is 'soft' intelligence as this was not recorded as a reason for leaving. However, it had also been noted that the causes of stress and anxiety for non-work related reasons had also increased which were linked to the cost of living increases.

	6.5. RF thanked the members for a useful discussion and commented that he had found the new IPR format easy to use and understand and particularly liked the increased use of benchmarking. 6.6. **The IPR Report was noted.**	
	Committee Assurance Reports	
7.	**Committee Report – Executive NHST (23)003** 7.1. AM presented the Executive Committee Chair's Report and highlighted the following items. 7.2. The committee had approved a proposal to augment the current Freedom to Speak up (FTSU) Guardian capacity, including developing a network of FTSU champions. RF felt that this was an important development to refine and evolve the trusts approach to FTSU and encourage staff to raise an concerns. 7.3. The inpatient survey results had been a significant improvement and it had been particularly pleasing to see the positive patient feedback in relation to the provision of information, which had been identified as an area for improvement in previous years. 7.4. The Executive Committee had received a number of reports during November and December in response to the identification of problems with being able to produce timely clinic letters. The issue had been investigated and two separate problems had been identified. The first related to the number of licenses for the clinical dictation system which was effectively limiting capacity. Several operational solutions had been put in place and this situation was now much improved. The second issue was the transfer of actions from letters in to the EPR, which was not consistently happening. The faulty process had been identified and corrected and all cases where actions had not been transferred had been reviewed and remedial actions taken. The Medical Director was completing harm reviews for any cases where this had led to a delay in referral or the start of treatment, and the board would be kept informed of the outcome. 7.5. **The report was noted.**	**AM**
	Committee Assurance Reports	
8.	**Committee Report – Quality – NHST (23)004** 8.1. RT presented the report, and it was noted that because the Trust had been at Opel 4 and preparing for industrial action the committee had been streamlined to free up operational capacity. 8.2. The committee had received updates on; the plans to re-start Project Shakespeare to strengthen the safety culture in theatres; increase in temporary placement for CAMH placements working with Knowsley Council and progress in reviewing the acute abdominal pathway. 8.3. The committee had received formal reports on plans to resolve staffing gaps in histopathology, and scheduled quarterly reports for safeguarding, Incidents and Never Events, complaints, claims and Friends and Family test and Infection prevention and control. 8.4. The committee had been assured by the plans address staffing gaps in histopathology, and by the plans to increase community beds to aid safe discharge of medically optimised patients. The recent	**RT**

	positive audit results of NEWs in ED and VTE risk assessments had also been noted. 8.5. The committee has sought further assurance of the impact of transitioning to 12 hours shifts on sickness absence rates and also of the actions being taken to improve the response rates for the Friends and Family test in Maternity which had reduced. 8.6. and any impact on sickness The Theatres project (Project 8.7. **The Report was noted.**	
9.	**Committee Report – Finance & Performance – Meeting stood down, therefore no report** 9.1. JK gave a verbal update on Finance & Performance and reported that due to operational pressures the committee had not met, but all papers had been circulated and the Non-Executive Directors had held a met informally with GL. 9.2. JK reported that he remained confident that the 2022/23 financial plan would be delivered. 9.3. Planning guidance had been received for 2023/24 and the committee would review the draft plan at the February meeting. 9.4. **The Report was noted.**	**JK**
10.	**Committee Report – Strategic People – NHST (23)005** 10.1. LK presented the report. 10.2. The Committee received an update on progress in delivering the Equality, Diversity and Inclusion (ED&I) operational plan. 10.3. The committee had noted the increase in the number of staff identifying themselves as having a disability on ESR, following the introduction of the Reasonable Adjustments Policy and awareness raising. 10.4. An increase in uptake of apprenticeships was noted. 10.5. The People Plan metrics were reported for Q3. 10.6. The frequency of meetings is to be reviewed, particularly in light of proposed transaction and its implications for staff. 10.7. **The report was noted.**	**LK**

	Other Board Reports	
11.	**Corporate Risk Register Quarterly Report – NHST (23)006** 11.1. NB presented the report which detailed the position at the end of December 11.2. There are currently 861 risks on the Risk Register and 30 had been escalated to the Corporate Risk Register (CRR). The report compared these risks with the previous quarter and the same period in 2021/22. 11.3. RF commented that it was a very clear report and provided significant assurance that the executive was effectively identifying and managing risks. 11.4. **The report was noted.**	**NB**
12.	**Board Assurance Framework (BAF) – January 2023 – NHST (23)007** 12.1. NB presented the quarterly review of the Board Assurance Framework, noting the updates and proposed changes since the last review in October.	**NB**

	12.2. There were no proposed changes to the overall risk scores this quarter. 12.3. GB asked for an update in relation to the Widnes UTC and whether the contract would transfer. AM responded that although there was an acknowledgement of the success of the St Helens model where ED attenders could be deflected to the Millennium UTC there did not appear to be a way to enforce the contract award. It was agreed that the BAF should be changed to reflect the need to work with Place leads and Primary Care to optimise the access to alternatives to ED. 12.4. FR commented that there were no surprises in the BAF, because all the issues were regularly discussed at Board 12.5. **The changes to the BAF were approved.**	
13.	**Learning from Deaths Quarterly Report – NHST (23)008** 13.1. PW presented the report. 13.2. Due to operational pressures not all the Q2 and 3 reviews had been completed at the time the report was finalised, but PW provided assurance that there was a plan in place to complete these ahead of the next scheduled report. 13.3. There had been one case rated as red which had subsequently been reviewed at the mortality surveillance group. This concluded that the care provided was appropriate. 13.4. The new structured judgement review (SJR) process was working well and had been rolled out to all reviewers following the initial trail. 13.5. RT asked if all post operative deaths were subject to SJRs and PW confirmed this was the case. 13.6. RT queried if there were sufficient reviewers to complete the SJRs in a timely manner. PW confirmed there were enough reviewers, but more would always be useful, and he was promoting this as part of clinician's personal development. It was noted that all clinical staff could become reviewers and it was not restricted to Consultants 13.7. **The report was noted.**	**PW**
14.	**Workforce Strategy and HR Indicators Report – NHST (23)009** 14.1. AMS presented the report which covers the period July – December 2022 and highlighted the following: 14.2. The Health Work and Wellbeing teams have focussed on supporting staff with cost of living support and a winter wellbeing event. GA complimented HWWB team on the wellbeing event that he and several of the Non-Executive Directors had attended. 14.3. The Trust was awarded Rainbow Badge bronze status in September 2022 for LGBT inclusiveness. 14.4. Staff networks are continuing the go from strength to strength supporting more than 400 staff. 14.5. In December 2022 the Trust launched the Wagestream app to support staff in accessing discretionary earnings; this is currently being accessed by 160 staff. 14.6. The STHK Health Care Academy had been very successful in supporting recruits who were new to healthcare, as a result HCAs are better prepared when they commence work, and the Trust has seen a marked decrease in staff turnover. 14.7. Sickness absence remains an area of concern and training for line managers continues.	**AMS**

	14.8. The flu vaccination programme uptake is above the national average but below the CQUIN target of 70% for patient facing staff. The Trust remains committed to meeting this target. SR clarified that circa 80% of all staff have been vaccinated but only patient facing staff count for the CQUIN target. The reluctance of some staff to accept the vaccine offer was thought to be linked to rumours and anecdotal reports of unpleasant side effects and the communications team were trying to counter this perception. 14.9. HWWB have recorded an increase in DNAs for appointments (>5.2%). This has been attributed to work pressures preventing staff from being released to attend. 14.10. RT shared the example of the Histopathology Department in relation to Pillar 3 who were upskilling staff. RT asked if there was a register of all the new ways of working that were being developed. AMS advised that some areas of the Trust require bespoke ways of working, such as Histopathology; and all information is shared at the People Strategy Meeting. 14.11. GB queried the use of bank and agency staff rather than offering additional shifts to existing staff. AMS explained that substantive staff cannot undertake shifts for an agency in their own trust, and they therefore do agency work elsewhere for higher pay. AM advised that rates of pay have been discussed at CMAST to try and align pay on a provider collaborative basis. 14.12. CW asked if we knew what impact working from home/hybrid working was having on retention or staff leaving and commented that this did not necessarily suit some people. AMS agreed that more work needed to be undertaken on exit interviews and understanding reasons for leaving and would review these findings. 14.13. PG reported on speaking to staff at recent Team Talks and Ward Rounds where it was apparent that some staff continued to be deeply affected by their experiences during COVID and asked if support was still available for these staff. RC confirmed that there is a range of support available through HWWB, including very specialised targeted support. For the individuals who needed it. 14.14. RF thanked AMS for a very comprehensive report and congratulated the HWWB team on the recent Well Being event. 14.15. **The report was noted.**	
15.	**Clinical Negligence Schemes for Trust (CNST) – NHST (23)010** 15.1. SR introduced the report and Sue Orchard (SO) joined the meeting via MS Teams. SR explained that the LMNS were observing the governance in relation to the approval of the CNST safety actions on behalf of the ICB who now had a role in assuring that the compliance statements were accurate. 15.2. SO presented the evidence of compliance against each of the 10 CNST safety actions. 15.3. The Trust has been fully compliant against the CNST safety actions for the past 3 years. 15.4. GB confirmed that the progress in achieving the safety actions was regularly reviewed by the Quality Committee, including assurance from RT as the maternity champion. 15.5. CW commented that the procurement of the new maternity information system was being undertaken with two other local trusts. 15.6. **The CNST Board declaration was approved.**	**SR** SR

Closing Business		
16.	**Effectiveness of Meeting** 16.1. No comments received.	**ALL**
17.	**Any Other Business** 17.1. RF thanked Dawn Hardie for the work she has done over the years and wished her well in her new role	**ALL**
Date of Next Meeting: Wednesday 22nd February 2023		

TRUST PUBLIC BOARD ACTION LOG – 22ND FEBRUARY 2023

No	Date of Meeting (Minute)	Action	Lead	Date Due
56	25.01.23	CNST Update	SR	26.04.23

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(23)11
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 January 2023. (YTD = 2).

There were no MRSA cases in January 2023. (YTD = 1).

There were 6 C. Difficile (CDI) positive cases reported in January 2023 (5 hospital onset and 1 community onset). (YTD = 45). Of the 45 cases, 38 have been reviewed at RCA panel, 22 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 December 2022 was 91.9%. 2022-23 YTD rate is 93.3%.

During the month of December 2022 there were 3 falls resulting in severe harm or death category . (YTD severe harm or above category falls = 22).

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

Community incident reporting levels have decreased to 81 in the month of December 2022. This compares to 72 incidents recorded in December 2021. 66 incidents were related to pressure skin damage, all being no harm.

YTD HSMR (April - August) for 2022-23 is 90.5

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: 22nd February 2023

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (December 2022) at 76.9%. YTD 81.6%. The 31 day target was achieved in December 2022 with 97.2% performance in month against a target of 96%, YTD 97.5%. The 2 week rule target was not achieved in December 2022 with 83.3% in month and 75.7% 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 January 2023 was 52.0% and YTD 46.7%. The all type mapped STHK Trust footprint performance for January 2023 was 73.8% and YTD 70.7%**.** The Trust saw average daily attendances of 287, which is down compared to December, at 333. Total attendances for January 2023 was 8,912.

Total ambulance turnaround time was not achieved in January 2023 with 58 mins on average. There were 1,996 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 1,970 in December 2022.

The UTC had 4,989 attendances in the month of December, compared to 5,004 in month of November. Overall, 80% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in January 2023 was 140 compared with 119 in December. 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 December 2022 with 62.8% compliance and YTD 62.8% (Target 92%). Performance in November 2022 was 66.1%. There were (2,515) 52+ week waiters. The 6 week diagnostic target was not achieved in December 22 with 67.5% compliance. (Target 99%). Performance in November 2022 was 75.6%.

There was a slight decrease in referrals received within the District Nursing Service in December however, the levels are still within average range (486 in December compared to 530 in November). The overall caseload size has slightly decreased from previous months (1,255 in December compared to 1,305 in November). Community matron caseloads saw a significant increase of from 118 to 132 this month, with a total of 27 new for referrals received compared to 16 in November. 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%), of which £6m was a stretch target asked to be delivered non recurrently by the ICS. As at Month 10 (January), the Trust has overachieved against plan by £4.5m YTD, delivering a YTD deficit of £0.4m.

Surplus/Deficit - At the end of Month 10, the Trust is reporting a deficit position of £0.4m, with £451.4m income and £451.8m expenditure year to date. This represents an improvement of £4.5m against the planned YTD deficit of £5.0m. 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. This non recurrent benefit equates to £8.5m YTD.

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 10, these targets have been achieved and focus is now on development of 23/24 CIP schemes as part of the 23/24 financial planning process.

Cash - At the end of M10, the cash balance was £32.2m.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £7.9m. Internally generated depreciation exceeds the 2022/23 capex plan. The plan has been agreed at ICS/ICB level, and the forecast now includes PDC funding (£15.9) which is not drawn down from DHSC.

Human Resources

In January there was a decrease in the absence rate (6.5%) from December 2022 (7.1%). The rate for all Nursing and Midwifery staff group is 8.0% which is a decrease from 9.4% in December 2022.

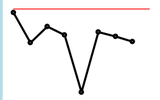
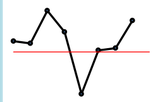
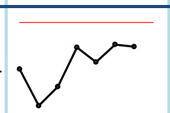
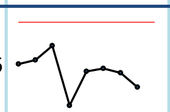
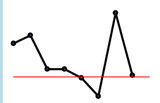
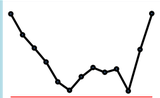
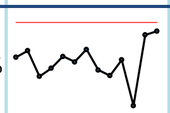
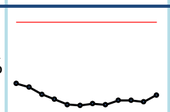
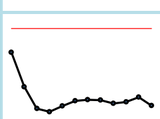
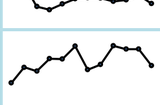
Appraisal compliance in January is 85.6% which is a slight increase on December and remains on target. Mandatory training compliance remains at 80.4% unchanged from December.

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

Jan-23

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

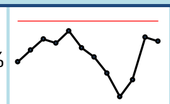
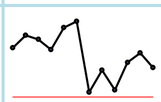
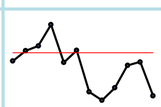
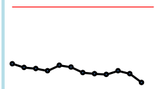
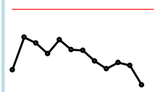
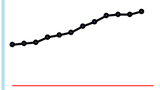
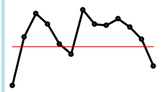
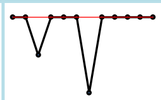
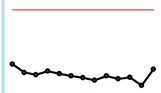
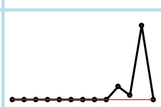
	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jan-23	2.9%	2.5%	No Target	2.6%		HSMR under expected values in all domains	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits. We continue to independently benchmark performance using CRAB data. Specific conditions which have shown higher than expected mortality are reviewed via the LFD Group	PW
Mortality: SHMI (Information Centre)	Q	▲	Sep-22	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Aug-22	92.1	90.5	100.0	96.9					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Aug-22	112.5	100.5	100.0	105.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jul-22	96.1	95.4	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	Aug-22	77.6	80.0	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	Aug-22	100.5	103.3	100.0	103.9					
% Medical Outliers	F&P	T	Jan-23	3.5%	1.9%	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	Jan-23	48.3%	33.3%	52.5%	46.8%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Dec-22	65.0%	62.7%	90.0%	74.3%		IP discharge summaries - remain challenging and detailed work has gone on to identify key areas of challenge. The IT team has been involved to find a sustainable solution particularly in A&E. 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. Urgent letters are prioritised and typed within 24h of dictation.		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 - Issues identified within admin and IT capacity with work ongoing with IT and Admin teams to resolve.	PW
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Dec-22	27.2%	29.7%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Dec-22	97.6%	97.9%	95.0%	97.2%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q3	86.9%	87.3%	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	▲ £	Jan-23	0	2	0	1		1 never event reported from interventional cardiology services	Quality and patient safety	Improvement actions in place based upon immediate review findings.	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	Jan-23	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 onset and community onset MRSA	Q F&P	▲ £	Jan-23	0	1	0	2		There were no MRSA cases in January 2023. (YTD = 1). There were 6 C. Difficile (CDI) positive cases reported in January 2023 (5 hospital onset and 1 community onset). (YTD = 45). Of the 45 cases, 38 have been reviewed at RCA panel, 22 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	▲ £	Jan-23	6	45	56	32					
Number of hospital onset and community onset Methicillin Sensitive Staphylococcus Aureus (MSSA)	Q F&P		Jan-23	2	36	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Dec-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	▲	Dec-22	3	22	No Contract target	22		3 falls resulting in severe harm category in December 2022 (Ward 1B, 2A and Other area).	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	Dec-21			No Target	26			Quality and patient safety	We continue to emphasise the importance of thrombosis prevention. All cases of HAT reviewed. Appropriate prescribing and care identified. eVTE assessment tool paused following withdrawal of electronic medical proforma in ED. Work ongoing with ED and AMU teams to ensure correct completion of paper proforma.	PW
To achieve and maintain CQC registration	Q		Jan-23	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	Dec-22	91.9%	93.3%	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	Dec-22	2	15	No Target	30					

Jan-23

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	▲ £	Dec-22	83.3%	75.7%	93.0%	84.6%		2WW referrals remain high. This has been accepted as the new norm. Capacity remains a challenge due to increased demand, staff sickness and vacancies and increasing patient cancellations.	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.Cancer surgical Hub at St Helens 5. ESCH plans reignited 6. FDP Programme progressing; plan to resubmit revenue bid to CDC 7. Cancer Specific PTL supporting to expedite delays prior to patient breaches 8. Work with PLACE to utilise A&G as first line to prevent referrals into organisation on incorrect pathways	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Dec-22	97.2%	97.5%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Dec-22	76.9%	81.6%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Dec-22	62.8%	62.8%	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, but staff sickness, vacancies and increasing demand are impacting on ability to deliver.	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. Urgent, cancers and long waiters remain the priority patients for surgery at Whiston with application of P-codes effectively implemented.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Dec-22	67.5%	77.9%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Dec-22	2,515	2,515	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jan-23	0.6%	0.9%	0.8%	0.82%		Underperformance in cancelled ops has been due to staff sickness/absence and medical NEL pressures. The team is confident that this will recover going forward, although performance remains at risk.	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Dec-22	100.0%	99.5%	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	▲	Jan-23	52.0%	46.7%	95.0%	55.8%		Accident and Emergency Type 1 performance for January 2023 was 52.0% and YTD 46.7%. The all type mapped STHK Trust footprint performance for January 2023 was 73.8% and YTD 70.7%. The Trust saw average daily attendances of 287, which is down compared to December, at 333. Total attendances for January 2023 was 8,912. Total ambulance turnaround time was not achieved in January 2023 with 58 mins on average. There were 1,996 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 1,970 in December 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. <u>Flow through the Hospital</u> COVID action plan to enhance discharges commenced in April 20 with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity. The continued absence of face to face assessments from social workers is causing some delays.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Jan-23	73.8%	70.7%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Jan-23	0	21	0	0					

Jan-23

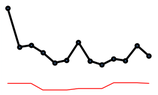
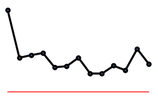
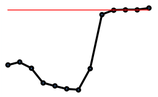
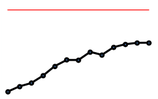
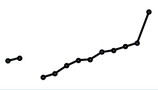
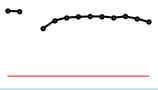
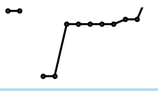
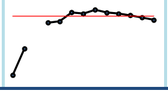
St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jan-23	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Jan-23	14	169	No Target	254		Decrease in the number of new complaints received in January and % new (Stage 1) complaints resolved within agreed timescales remains challenging, however there was an improvement in month compared to the previous month.	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 further to 30 and 60 day response times that were in place pre-pandemic. Additional temporary resources remain in place to increase response rates within the Medical Care Group .	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jan-23	14	177	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jan-23	92.9%	76.8%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to January 23 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	Jan-23	375	359		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Jan-23	140	134		108					
Friends and Family Test: % recommended - A&E	Q	▲	Dec-22	75.3%	78.8%	90.0%	79.0%		Recommendation rates remain above target for inpatients and postnatal areas, but below target for the remaining. 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	▲	Dec-22	97.0%	95.2%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Dec-22	100.0%	95.0%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-22	83.3%	92.5%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Dec-22	100.0%	95.9%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Dec-22	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-22	94.6%	93.9%	95.0%	93.8%					

Jan-23

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	▲	Jan-23	6.5%	6.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In January there was a decrease in the absence rate (6.5%) from December 2022 (7.1%) The rate for all Nursing and Midwifery staff group is 8.0% which is a decrease from 9.4% in December 2022. 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.	We recognise the impact of cost of living and industrial action on staff absences. Therefore, additional support is being provided to staff and managers including monthly financial wellbeing sessions and mental wellbeing support through Rugby League Cares. 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	Jan-23	8.0%	8.0%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Jan-23	85.6%	85.6%	85.0%	65.9%		Appraisal compliance in January is 85.6% which is a slight increase on compliance for December (85.1%) and remains on target. Mandatory training compliance is 80.4% which unchanged from December.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Appraisal compliance has remained steady in month and remains on target. Mandatory training remains unchanged just below the 85% target. Recovery actions continue to be delivered and monitored through People Council with particular focus on the Medical and Dental workforce.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jan-23	80.4%	80.4%	85.0%	74.7%					
NHS National Quarterly Pulse Survey : % recommended Care	Q	▲	Q2 2022-23	66.8%					The Q3 NQPS is superseded by the annual National Staff Survey that takes place in Q3. The figures for this have not yet been released other than under embargo and cannot yet be reported in IPR. The Q2 figures remain the latest NQPS results.	Staff engagement, recruitment and retention.	The Q3 survey (Annual Staff Survey) closed on 25th November and results have been released. This was a full census survey with the Trust reporting 40% response rate with 2,961 respondents. The response rate is up by 3% on 2021. Data is currently under analysis but remains under embargo until national publication in March.	AMS
NHS National Quarterly Pulse Survey : % recommended Work	Q	▲	Q2 2022-23	50.6%								
Staffing: Turnover rate	Q F&P UOR	T	Jan-23	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	Jan-23	Discontinued	Discontinued	N/A			The Trust financial position contains non-recurrent savings of £5.7m which are supporting delivery of the plan. The non recurrent savings are offsetting the non delivery of National ERF and increased inflation pressures (excluding energy and PFI) above funded levels. The capital plan includes external funding that has still not yet been received by the Trust.	Non-recurrent benefits will impact the underlying position of the Trust going into next financial year. Delays in the capital being received could impact the delivery of the capital programme.	The Trust will continue to liaise with the ICS so that they are fully aware of the non recurrent support within the Trust. The Trust is liaising with National supply chain who are working on plans to minimise inflation impacts. The Trust continues to do all preparatory work to ensure there will be no slippage in the capital programme.	GL
Progress on delivery of CIP savings (000's)	F&P	T	Jan-23	28,100	28,100	28,100						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Jan-23	(424)	(424)	(4,949)						
Cash balances - Number of days to cover operating expenses	F&P	T	Jan-23	27	27	10						
Capital spend £ YTD (000's)	F&P	T	Jan-23	7,900	7,900	26,100						
Financial forecast outturn & performance against plan	F&P	T	Jan-23	7,051	7,051	(4,949)						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jan-23	93.9%	93.9%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-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	▲ £	95.0%	89.5%	100.0%	100.0%	93.1%	83.3%	100.0%	100.0%	100.0%	88.0%	81.8%	100.0%	100.0%	93.6%	85.0%		96.0%		
	Total > 62 days		1.0	1.0	0.0	0.0	1.0	2.0	0.0	0.0	0.0	1.5	2.0	0.0	0.0	6.5			6.0		
	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	0.0	0.0	0.0			0.5		
Lower GI	% Within 62 days	▲ £	76.0%	81.0%	80.0%	86.7%	90.5%	76.5%	79.3%	65.2%	83.3%	42.9%	66.7%	66.7%	57.1%	71.4%	85.0%		79.7%		
	Total > 62 days		3.0	2.0	1.0	1.0	1.0	2.0	3.0	4.0	2.0	4.0	1.0	1.0	6.0	24.0			24.5		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	5.0			4.0		
Upper GI	% Within 62 days	▲ £	77.8%	100.0%	100.0%	36.4%	90.0%	84.6%	100.0%	85.7%	70.0%	75.0%	80.0%	93.8%	71.4%	82.8%	85.0%		83.2%		
	Total > 62 days		1.0	0.0	0.0	3.5	0.5	1.0	0.0	1.0	1.5	1.0	1.0	0.5	2.0	8.5			9.5		
	Total > 104 days		0.0	0.0	0.0	1.0	0.5	0.0	0.0	0.0	0.5	1.0	0.0	0.5	1.0	3.5			3.0		
Urological	% Within 62 days	▲ £	96.0%	65.3%	88.0%	93.9%	90.0%	81.0%	79.2%	78.1%	85.0%	73.1%	83.3%	78.2%	87.9%	80.1%	85.0%		80.5%		
	Total > 62 days		0.5	8.5	1.5	1.0	1.5	4.0	2.5	3.5	1.5	3.5	2.5	6.0	2.0	27.0			32.5		
	Total > 104 days		0.5	0.0	0.5	0.0	0.0	0.0	0.5	1.5	0.5	1.5	1.0	0.0	0.0	5.0			4.0		
Head & Neck	% Within 62 days	▲ £	0.0%	100.0%	0.0%	50.0%	16.7%	0.0%	44.4%	0.0%	25.0%	0.0%	0.0%	0.0%	66.7%	15.7%	85.0%		24.4%		
	Total > 62 days		2.0	0.0	1.0	1.0	2.5	3.5	2.5	1.5	1.5	1.5	4.5	3.5	0.5	21.5			15.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	2.0	0.5	0.0	0.5	1.0	2.0	1.5	0.5	8.0			2.0		
Sarcoma	% Within 62 days	▲ £					100.0%							100.0%	0.0%	66.7%	85.0%		100.0%		
	Total > 62 days						0.0							0.0	1.0	1.0			0.0		
	Total > 104 days						0.0							0.0	0.0	0.0			0.0		
Gynaecological	% Within 62 days	▲ £	50.0%	100.0%	37.5%	60.0%	75.0%	66.7%	100.0%	45.5%	25.0%	50.0%	75.0%	80.0%	0.0%	56.3%	85.0%		67.3%		
	Total > 62 days		3.0	0.0	5.0	2.0	1.0	2.0	0.0	3.0	4.5	1.0	1.0	0.5	1.0	14.0			17.0		
	Total > 104 days		0.0	0.0	1.5	1.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	3.5			2.5		
Lung	% Within 62 days	▲ £	88.9%	64.3%	76.9%	55.6%	50.0%	92.3%	69.6%	30.8%	64.7%	66.7%	85.7%	70.6%	36.4%	66.2%	85.0%		77.2%		RC
	Total > 62 days		1.0	2.5	1.5	2.0	1.5	0.5	3.5	4.5	3.0	1.5	1.5	2.5	3.5	22.0			18.0		
	Total > 104 days		0.0	0.5	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.5	0.0	0.0	1.5	3.0			1.5		
Haematological	% Within 62 days	▲ £	50.0%	100.0%	100.0%	0.0%	100.0%	100.0%	75.0%	75.0%	69.2%	0.0%	80.0%	75.0%	60.0%	71.2%	85.0%		60.5%		
	Total > 62 days		1.0	0.0	0.0	2.0	0.0	0.0	1.0	2.0	2.0	1.0	0.5	1.0	2.0	9.5			17.0		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	2.0			5.0		
Skin	% Within 62 days	▲ £	91.4%	92.9%	93.4%	100.0%	97.7%	93.4%	95.5%	86.9%	79.7%	92.8%	90.3%	92.3%	86.7%	90.6%	85.0%		93.3%		
	Total > 62 days		3.0	3.0	2.0	0.0	1.0	2.5	1.5	5.5	7.5	2.5	5.5	3.0	5.0	34.0			29.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.0	1.0	2.0	0.0	0.0	0.5	1.0	1.5	7.0			1.5		
Unknown	% Within 62 days	▲ £		100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	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			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		
All Tumour Sites	% Within 62 days	▲ £	85.0%	83.4%	85.4%	86.3%	90.3%	83.2%	85.4%	77.6%	76.0%	78.4%	82.6%	83.3%	76.9%	81.6%	85.0%		85.2%		
	Total > 62 days		15.5	17.0	12.0	12.5	10.0	17.5	14.0	25.0	23.5	17.5	19.5	18.0	23.0	168.0			170.5		
	Total > 104 days		1.5	0.5	2.0	3.0	1.5	3.0	3.0	7.5	2.5	6.0	3.5	3.5	6.5	37.0			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%	66.7%	100.0%	100.0%			0.0%		100.0%	100.0%	80.0%	85.0%		100.0%		
	Total > 31 days		0.0			0.0	1.0	0.0	0.0			1.0		0.0	0.0	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	▲ £								100.0%					100.0%	100.0%	85.0%				
	Total > 31 days									0.0					0.0	0.0					
	Total > 104 days									0.0					0.0	0.0					
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)012
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 January 2023. There were three Executive Committee meetings held during this period as the NHSE Transaction Assessment visit took place on 19th January. No new investment decisions were made during this period. At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration and preparation for the proposed transaction.
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: 22nd February 2023

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were three Executive Committee meetings held during January 2023. There was no meeting on 19th January because this coincided with the NHSE Transformation Team transaction assessment visit.

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. 5th January 2023

2.1 Trust Board Agenda - January

The Director of Corporate Services presented the draft Trust Board agenda based on the agreed workplan for review and approval. Committee also discussed the employee of the month nominations for December and January.

2.2 Staff Bank Pay Rates

The Deputy CEO/Director of HR presented an alternative incentive scheme following the limited impact of the 2021/22 winter scheme. It was agreed to continue working with CMAST to agree a coordinated approach for all the acute and specialist trusts in Cheshire and Merseyside.

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

The Deputy CEO/Director of HR reported that S&O were experiencing the same operational pressures as STHK and other trusts across the country.

The temporary transfer of some orthopaedic surgery to Ormskirk Hospital was due to start on 9th January for a period of 6 weeks to enable a programme of planned repairs to the theatres at Whiston and St Helens Hospitals.

2.4 Trust External Auditor

The Director of Finance and Information reported that the current contract for external audit was coming to an end and a new auditor would need to be appointed. A paper was being prepared for the February Audit Committee meeting.

3. 12th January 2023

3.1 Industrial Action

The Director of Nursing, Midwifery and Governance provided an update on the preparations for the RCN strikes planned for 18th and 19th January. The Trust was working closely with the strike committee to agree derogations and ensure that safe services were maintained for inpatient and emergency services. Non urgent elective and outpatient activity had been cancelled. The brief also included the arrangements for a strike incident room to respond to the situation on the days of the strike. There would be official picket lines outside both Whiston and St Helens Hospitals. It was agreed that where possible non urgent meetings

should be stood down on these two days to free clinical and operational capacity to respond to the strike and maintain safe levels of service.

3.2 Anchor Institution and Prevention Pledge Action Plan

The Director of Integration presented an update on the development of the Trust as an anchor institution. The Trust had received the Social Value Award in summer 2022 and the next phase was to sign up to the ICB prevention pledge. There were 14 different commitments within the pledge, two of which are universal and then each organisation can select 6 of the remaining 12 to focus on during 2023/24. Committee reviewed the proposed commitments and agreed the selection. An action plan would be developed to demonstrate how the Trust will deliver or improve the delivery of these commitments which would then be submitted to the ICB Health and Equalities Group by March 2023, with regular progress reports to the Executive Committee.

3.3 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for December 2022. The improved cancer access target performance was noted. There had been 1 never event reported in December, as a result of a retained guidewire and the Director of Nursing, Midwifery and Governance reported on the investigation and action plan. The committee reviewed and amended the commentary for the IPR cover sheet.

3.4 Risk Management Council – Chairs Assurance Report

The Director of Corporate Services presented the report and noted that due to operational pressures the Risk Management Council had not met but the Care Group and service reports had been prepared and circulated. 30 risks were escalated to the corporate risk register, but no new high risks had been added during December. A chair's assurance report was received from the Claims Governance Group.

3.5 Procedural Document Development Policy

The Director of Nursing, Midwifery and Governance introduced the policy which had been reviewed as part of the preparation for integrating policies ahead of the proposed transaction with Southport and Ormskirk Hospital NHS Trust. This is an overarching policy to provide guidance on the corporate standard for policies and the process for review and approval. The policy was approved.

3.6 Southport and Ormskirk Hospital NHST (S&O)

The Director of Corporate Services presented the schedule of meetings that had been requested by NHSE as part of the transaction assessment process and the arrangements for the site visits at Whiston and Southport Hospitals.

4. 26th January 2023

4.1 Safer Staffing Report – December 2022

The Director of Nursing, Midwifery and Governance introduced the report which confirmed the overall registered nurse/registered midwife fill rate in December (month 9) had been 91.86% and the overall HCA fill rate 111.85%. The paper also included the triangulation

review of the staffing levels in month 8, including incidents on any wards where the staffing levels had been below establishment at the time. There had been no maternity diverts in November.

The report also included the regular update on Nurse/HCA recruitment and staff turnover. It was noted that the starter and leaver numbers were in balance, but the overall number of band 5 vacancies was not reducing as quickly as expected. The retention team were now conducting telephone interviews with all leavers to improve the quality of the exit interview information.

4.2 Waiting list modelling of P2/P3 patients

The Managing Director/ Director of Operations presented the report which demonstrated the impact on the total waiting list of prioritising P2 long waiters. The analysis showed that the P2 waiting list had remained stable (the numbers removed were replaced with an equal number of new additions) but to sustain this position there was an impact on the P3 and P4 (less clinically urgent) waiting lists, particularly in orthopaedics and plastic surgery. Additional capacity was therefore needed to reduce the overall waiting list and several options were being explored to achieve this in the short term, including Sunday operating sessions. The two new theatres at Whiston Hospital would provide additional capacity in the medium term, when these were completed in 2024/25.

4.3 Patient Letters – Harm reviews

The Medical Director presented an update on the harm reviews undertaken for patients where actions from dictated letters had not been transferred to EDMS. 2,636 letters had been identified as not following the correct process and these had all been reviewed to identify if any actions had not been picked up by other failsafe mechanisms. 108 letters remained following this review and all these records where being reviewed by a clinical harm review group and reported as incidents. 47 harm reviews had been completed, with 31 confirmed as no harm, 4 as low harm, and 12 requiring more information to reach a conclusion and all these patients were being recalled. The remaining 61 reviews were scheduled to be completed by 9th February and a further report would then be presented to the Executive Committee.

4.4 Mandatory Training and Appraisal Compliance Performance

The Deputy CEO/Director of HR presented the report for December 2022. Appraisal performance had improved and the target of 85% achieved. Mandatory training performance had improved a small amount but there was still marked variation between staff groups with medical and Dental staff continuing to have the lowest compliance levels. The Medical Director had reported the figures at the Clinical Directors forum and was developing a targeted action plan to improve compliance. The Director of Corporate Services confirmed that face to face fire safety training for patient facing staff was mandated and only the fire safety awareness training could be delivered by e-learning.

4.5 Southport and Ormskirk Hospital (S&O)

The Director of Corporate Services presented the highlight report from the Transaction Programme board which provided an update on all the workstreams.

It was confirmed that the NHSE transaction challenge meeting has now been arranged for 2nd March 2023.

Committee approved temporary resources to support the HR and Communications and Engagement workstreams and discussed proposals for the single domain name for the new Trust.

Committee also discussed feedback from the recent ICB meeting where the transaction had been discussed.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)013
Title of paper: Committee Report – Audit
Purpose: To report to the Trust Board on the Audit Committee, 8th February 2023

Summary

Meeting attended by:

I Clayton – NED & Chair
J Kozer – NED
G Brown – NED
G Lawrence – Director of Finance & Information
N Bunce – Director of Corporate Services
S Redfern – Director of Nursing
C Oakley – Deputy Director of Finance & Information
K Jenkinson – Assistant Director of Finance
C McNamara – Assistant Director of Procurement
M Derrick – Audit Manager, Grant Thornton UK LLP
G Baines – Assurance Director, MIAA
A Poll - Senior Audit Manager, MIAA
R Barker - MIAA Anti-Fraud Specialist
C Hewson – Minuting Secretary

Agenda Items

For Assurance

A) External Audit

- Grant Thornton provided a verbal summary and highlighted areas within the Audit Progress and Sector Update report.
- The plan is for Grant Thornton to deliver the financial audit in line with the 30th June 2023 statutory deadline.
- The audit plan will be presented at the Audit Committee Meeting in April 2023.
- The auditors annual report will be presented in July 2023 following the auditor's opinion.

B) Internal Audit

- MIAA discussed the internal audit report progress covering the annual review on payroll and transactional process. Since the last Audit Committee Meeting, focus has been on the annual review of payroll and transactions with the overall conclusion of high assurance.
- MIAA discussed the summary of HFMA Financial Controls checklist. The detailed mandated report includes 72 lines of enquiry, of which 12 lines required a deep dive. MIAA confirmed that there was evidence to support the self-assessment score.

C) MIAA Anti-Fraud Services

- Received three queries in the period, one has opened into an investigation on the case management system.

- A proactive detection exercise has begun for the 2022/23 national fraud initiative exercise.

D) Audit log
- The committee noted progress against actions from previous audits including three finalised reports, three reports waiting for MIAA sign off and seventeen reports containing recommendations not yet implemented.

E) Losses and Special Payments
- £161k losses and special payments registered for the 2022/23 year to date, which is 56% of the full year total for 2021/22 full year total of £289k.

F) Aged Debt
- Total NHS invoiced debt: £34.3m of which £20.4m has been due for more than 30 days.
- NHS debt predominantly relates to "Hosted Services" such as MMDA and Lead Emplyer.
- Total Non NHS invoiced debt: £5.6m of which £4.3m has been due for more than 30 days.

G) Tender and Quotation Waivers
- The committee noted that 11 waivers have been registered for the period November 2022 to January 2023.

H) Year end items
- An update was provided on progress to date of year end items, such as preparations for stocktakes, review of timetables. Draft accounts are due for submission on 27th April 2023 and final accounts on 30th June 2023.
- A Risk enquiry checklist was provided by Grant Thornton as part of their requests for information from management. The Trust has produced responses that Audit Committee verified were a true reflection and authorised the responses to be submitted.

I) New NHS Provider Code of Governance
- The Committee was briefed on three new Corporate Governance documents which were published by NHS England in the autumn of 2022. These documents were:
  • Code of Governance for NHS Provider Trusts
  • Guidance on Good Governance and Collaboration
  • System Working and Collaboration: Role of Foundation Trust Councils of Governors – not relevant for this Trust

J) Procurement response to PO/Non PO review
- NHS Counter Fraud Agency undertook a PO/Non PO expenditure review as part 3 of a national proactive exercise around potential vulnerabilities to fraud. The NPE measured three procurement fraud risk areas (disaggregate spend, contract management, and purchase order (PO) vs non-PO spend). The report favoured higher PO coverage as an indicator of greater grip and control and reduced vulnerability to fraud.

K) Auditor Procurement
- The Committee was briefed on the process for the procurement of external audit services which will be required by March 2024, of the key issues in the audit market that may

impact on the procurement process, and the steps that will be needed over the coming year for the procurement of external audit services.

- It was agreed that the contract for external audit services with Grant Thornton, which is due to expire in 2023/24 would be extended for a further twelve months.

Risks noted/items to be raised at Board – None noted

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: 8th February 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)014
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 16th Feb 2023

Summary

Meeting attended by:

J Kozer – NED & Chair
P Growney – NED
I Clayton – NED
R Cooper – Managing Director STHK
G Lawrence – Director of Finance & Information
S Redfern – Director of Nursing & Midwifery
D Stafford – Assistant Director of Operations - Medical Care
C Dawn – Assistant Director of Operations - CSS
S Pitt – Finance Business Partner – CSS/Community

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was below the 85% target in December, at 76.9%.
- Target 31 day performance was met in December, at 97.2% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in December, at 83.3% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 52.0% in January and 46.7% year to date. All type mapped STHK Trust footprint performance was 73.8% in January and is 70.7% year to date. The Trust saw average daily attendances of 287, which is a decease compared to December at 333. Total attendances for January were 8,912.
- The ambulance turnaround time target was not achieved in January, at 58 minutes on average. The Trust was the second busiest in C&M and fourth busiest across the North West.
- In January, overall sickness had decreased to 6.5%, from 7.1% in December.

B) Finance Report Month 10

- At Month 10, the Trust is reporting a year to date deficit of £0.4m and forecast outturn surplus of £7.1m, an improvement of £12.0m against plan.
- Included within the financial position are non-recurrent benefits of approximately £8.5m YTD 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 have been included in the 23/24 financial planning process.
- Capital expenditure for the year to date (excluding PFI lifecycle maintenance) totals £7.9m.

- At the end of Month 10, the Trust has a cash balance of £32.2m. The reduction in the cash balance compared to previous months relates to the non-recurrent elements of the position, PFI payments and expected working capital movements.
- Agency expenditure of £9.9m is included in the year to date position, in line with expenditure at Month 10 of 21/22. Premium Payment Scrutiny Council meetings have been reintroduced.
- The Better Payment Practice Code (BPPC) requirement has been achieved for non-NHS invoices by value at 97.1% against a target of 95%.

For Approval

C) 2023/24 Draft Financial Plan

- The committee received an update on the 2023/24 draft financial plan.
- The draft plan gives a deficit of £59.8m, assuming expenditure of £563.4m and income of £503.6m.
- The committee reviewed the planning assumptions:
    - CIP at 3.7% (£21.6m)
    - Removal of non-recurrent system and ERF funding available in 2022/23
    - Excludes CDC costs
- The 22/23 CIP target of 3.7% (£21.6m) consists of:
    - National CIP 1.1%
    - Covid 1.6%
    - Convergence 0.7%
    - Other 0.3%
    - **Total 3.7%**
- Potential 22/23 CIP schemes of c.£20m have been identified to date.
- Initial capital allocation of £11.1m (£4.5m capital budget and £6.6m PFI lifecycle maintenance funded from PFI unitary payment).
- Risks associated with the draft plan include:
    - PbR payment basis for elective work resulting in loss of income if activity not delivered
    - Risks to activity as result of Covid rates, industrial action and delayed discharges affecting bed capacity
    - CQUIN schemes and targets not fully worked up
    - S&O transaction
    - Cash balances will be utilsied in year resulting in loan requirement
    - PFI inflation significantly higher than funded
    - Income rebasing/reallocation exercise ongoing with C&M ICS
- The committee noted that discussions regarding final 2023/24 income allocations are ongoing with C&M ICS and therefore the income plan is likely to change prior to submission of the final plan on 30th March.
- The committee noted the 2023/24 draft financial plan and recommended Board approval of the 2023/24 draft expenditure budget, noting the potential changes to income allocations prior to the final draft plan submission that could improve the position.

For Information • **CIP Council Update** – Update noted by the committee • **Capital Council Update** – Update noted by the committee • **Procurement Steering Council Update** – Update noted by the committee **Risks noted/items to be raised at Board** N/A
Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: J Kozer, Non-Executive Director
Date of meeting: 22nd February 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)015
Reporting from: Quality Committee
Date of Committee Meeting: 14th February 2023
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Geoffrey Appleton, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery and Governance Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance **In attendance:** Rajesh Karimbath, Assistant Director of Patient Safety Anne Rosbotham-Williams, Deputy Director of Governance Julie Tunney, Deputy Director of Quality Stephen Beckett, Head of Quality, Clinical Support Services Care Group Debbie Stanway, Head of Nursing and Quality, Medical Care Group Lynn Evans, Head of Nursing and Quality, Urgent and Emergency Care Group Tracy Greenwood, Head of Nursing and Quality, Community and Primary Care Services Care Group Lynn Ashurst, Associate Head of Nursing and Quality Sue Orchard, Head of Midwifery Sarah Howard, Maternity Quality and Safety Matron **In attendance to present specific reports or feedback:** Adam Rudduck, Assistant Director of Organisational Development Elspeth Worthington, Assistant Medical Director
Matters Discussed The action log was discussed with updates provided in relation to on-going safety culture improvement work in theatres, CQC engagement meeting relating to the transaction with Southport and Ormskirk Hospital NHS Trust and work to improve Friends and Family Test response rates and the overall experience of women within Maternity Services. The absence of a Maternity Voices Partnership (MVP) chair was noted as a risk, with discussions ongoing with ICB to resolve. **Integrated Performance Report** (IPR) The IPR was discussed by the Committee and the following points were highlighted: • Performance against the 62 day cancer standard was 76.9% (below target of 85%) in December 2022, however this was above the national average of 66% and StHK was the best performing Trust in Cheshire and Merseyside

- Workforce challenges in endoscopy were negatively impacting on achievement of the cancer targets, which is being addressed by active recruitment and the development of extended roles for staff
- Work is underway to enhance transitional care to reduce the number of new-born babies requiring admission to the neonatal unit, enabling them to remain with their mothers

Trust Objectives Aligned to the Quality Committee

An update was provided on the seven objectives that sit within the remit of the Quality Committee, noting that:

- Four were on track, relating to reduction in avoidable harm due to falls, implementing the Ockenden recommendations within Maternity Services, reducing the number of incidents regarding lost property and decreasing the number of concerns raised by carers attempting to contact the wards
- Two were partially achieved, with mitigating actions being taken to improve the effectiveness of discharge processes and to ensure patients remain hydrated, including completion of fluid balance charts
- There remain significant challenges in achieving the measures to ensure the timely assessment and care of patients in the Emergency Department, leading to some delays in triaging patients within 15 minutes of arrival, with actions in place to mitigate this

Mersey Internal Audit Agency Spot Check – update on action plan

An update on the delivery of the actions required following the MIAA quality spot check on two ward areas was provided, noting in particular the key themes of leadership, triangulation of data and provision of assurance going forward. A number of new measures have been put in place to support both new and existing ward managers and in areas where key performance indicators have declined, including audit results. The audit results will also feed into the work programme for the senior nursing team weekly quality engagement events across the organisation, including focus on fluid balance chart completion. Also noted that the CQC Assurance Group has now been set up. Confirmation was provided that the actions for the two ward areas have been delivered and improvements were noted in a number of subsequent audit results, providing assurance that changes were embedded.

Patient Safety Council report

A number of papers were received, including:

- Infection prevention report December 2022 providing assurance of measures in place following outbreaks of COVID and influenza. Trust training compliance has improved from previous month with Level 1 above target and Level 2 improving, with options discussed regarding provision of training in clinical areas
- VTE compliance report noted actions required to increase compliance with eVTE completion and the new NICE guidance
- Patient falls report Q3 noted a 14.09% improvement in the total falls per 1000 bed days, compared to 2021-22. In addition, the electronic white boards being implemented in wards should see an increase in the rate of falls risk assessments completed within 6 hours of admission
- Patient safety report noted 17 new incidents were reported to StEIS in November and December
- Safeguarding activity report quarter 3 noted that activity remains significant and that training compliance had improved
- 1 new CAS alert received with mitigating actions in place to maintain safety
- Learning from claims and inquests report noted 47 claims received in Q3

- Medical Care Group Safety Q3 report highlighted an increase in the number of reports of patients with delays in handover from ambulances to ED
- Clinical Support Services Q3 report highlighted an increase in incident reporting, with the main themes remaining consistent with previous period and noted that the learning is shared with relevant teams
- Q3 Nursing Care Indicators/Tendable Audits noted challenging areas and the progressive plans to conduct peer audit and ensure the completion of action plans
- Deep dive into diabetes related incidents noted the measures and improvement actions in place particularly in ED supported by the diabetes team. Diabetes related incidents in Q3 (2) has reduced significantly compared with Q1 (13).
- Controlled drugs (CD) management update provided assurance that the overall numbers and severity of CD incidents have returned to pre-pandemic levels. All reported incidents were either no harm or low harm, with no concerns raised
- Maternity service report Q1 and Q2 highlighted lessons learned and the improvements to practice being made and noted an increase in antenatal and new born screening incidents, for which the Council requested further information and assurance of actions. The Committee did note the work being taken by maternity services in relation to this increase
- A number of policies and procedures were approved

Patient Experience Council report

The Council received a number of reports, including

- Complaints and PALS, noting response times for first stage complaints remain below the target of 90% responded to within the agreed timescale. PALS have achieved a less than 5% conversion rate of concerns to formal complaints
- Comprehensive patient experience report was provided by the Patient Experience and Inclusion Team, highlighting a number of actions taken following feedback from the wide range of mechanisms in place to capture both negative and positive comments
- Healthwatch Halton noted that work is needed to improve information flows for patients discharged to care homes, following their outreach visits
- Detailed Estates and Facilities report which including an update on ongoing works to upgrade the paediatric emergency department and installation of a virtual view on 2A to improve the experience of patients in one of the side rooms
- The Learning Disability Autism Spectrum Disorder and Mental Health report noted the increase in activity, including sustained increase in Deprivation of Liberty Safeguards
- Primary and Community Care and Clinical Support Services reports highlighted the actions taken to respond to both positive and negative feedback, including complaints, with assurance provided regarding the low levels of complaints in both Care Groups
- The Council noted the required actions to improve both fluid balance recording and reassessment of malnutrition universal screening tool (MUST)
- The increased use of interpreters was noted and the actions taken to increase levels of deaf awareness and the need for British Sign Language interpreters
- The Council were pleased to note the increase in dementia training compliance and the involvement of a person with learning disabilities in the recruitment of the new Learning Disability Specialist Practitioner
- Quality Committee Assurance Report January 2023 was noted

Inpatient Survey Report

The Committee received a report outlining the latest inpatient survey results, noting that the Trust was ranked 1st for explanations provide to patients following their operations or procedures and was rated in the top 10 for 14 questions compared to similar trusts. The Trust was better or somewhat better than most of all trusts for 10 questions and about the same for 36 questions. The Trust was somewhat worse than other trusts for one question which related to patients waiting for a bed. A detailed action plan is in place to further improve.

Clinical Effectiveness Council report

The report noted the following:

- Presentation received from Resuscitation Services, highlighting service developments including planned advanced life-saving courses and the deteriorating patient pilot focus groups formed to identify needs/training gaps. It was noted that the Resuscitation Team will continue to focus on areas with the lowest training rates to improve compliance. The current rate of in-hospital cardiac arrests is 0.42 per 1000 hospital admissions which benchmarks very favourably against other Trusts and the survival to discharge rate is 18.5% which is above the national average
- The Council approved a number of policies and procedures, including AKI Policy, noting there was a plan in place to review all overdue policies within the Council's remit
- The Council discussed the frequency of patients being coded as "Senility and other organic mental disorders" after death, which has consistently alerted on SMR but reviews by learning from deaths group have not demonstrated any avoidable deaths
- The Intensive Care National Audit and Research Centre (ICNARC) Q1 & Q2 report noted that all domains were green (no concern) for the first time
- NICE Q1 & Q2 report noted high compliance in Q1 with only small number of guidelines requiring review with any outstanding guidelines escalated to clinical teams. Q2 has lower compliance as teams are still responding to requests
- Challenges noted within the Pharmacy Aseptic Unit due to recruitment issues alongside increased workload, with ongoing meetings with finance team to develop proposals for additional Pharmacists to be recruited
- Learning from Deaths report and Quality Committee Assurance Report January 2023 was noted

Mandatory Training Compliance Report

The Committee noted compliance with core mandatory training, which covers the 10 areas in the core skills framework used by all NHS organisations. Target compliance is set at 85% other than information governance which is set nationally at 90%. The Committee noted the steady increase in overall compliance and the requirement to continue to improve, particularly for medical and dental staff group and annual face to face fire safety training, which is mandated nationally. The expansion of e-learning opportunities has contributed to the improved compliance.

Assurance provided:

- Continued reduction in overall falls rate
- Improvement in training compliance in safeguarding across all areas of training
- Improvements in ED care in relation to diabetes
- Improvements in national inpatient survey
- Low rate of in-hospital cardiac rates compared to national figure
- Standard Mortality Ratio (SMR) alerts due to Senility and other Organic Mental Disorders have been reviewed with no issues raised

• High levels of compliance with NICE guidance reviews
Decisions taken: • No formal approvals required
Risks identified and action taken: • Ongoing work with ICB to ensure recruitment of MVP chair • Clinical Directors and Clinical Lead for VTE developing improvement actions to improve compliance with VTE risk assessment in accordance with the new NICE guidance • Pharmacy Team are developing proposals to increase staffing levels within the Pharmacy Aseptic Unit to meet increased demand • Development of enhanced roles and proactive recruitment in place to increase endoscopy capacity
Recommendation(s): That the Board note the report, the assurances provided and the actions being taken to address areas of concern.
Committee Chair: Rani Thind, Non-Executive Director
Date of meeting: 22nd February 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)016

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 15th February 2023

Summary:

Meeting attended by:

P Growney – NED & Chair
G Lawrence – Director of Finance
K Hughes – Assistant Director of Communications
D Littler – Charity Fundraiser
D Pye – Financial Accountant

Apologies Received from L Knight

Agenda Items:

1) Action log update – The committee reviewed the actions and updates were supplied.
2) A discussion took place on the implications of the transfer of Southport and Ormskirk Hospitals Charity on 1st April.
3) Investment Portfolio – The committee reviewed the portfolio and noted the contents of the report.
4) Income & Expenditure Position – The committee reviewed the reported noting the levels of income and expenditure this year.
5) Fundraising Update – The committee were informed of various events taking place and the implications of the S&O charity transfer were mentioned.
6) Any other business - A presentation of proposed expenditure for the Lilac Centre was positively received. Issues around fundraising are to be followed up.

There were no issues to escalate to the Board.

Corporate objective met or risk addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board is asked to note the contents of the report.

Presenting officer: Paul Growney, Chair, Charitable Funds Committee

Date of meeting: 22nd February 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)017
Title of paper: Freedom to Speak Up Annual Self-Assessment 2023
Purpose: Board members are asked to review and approve the annual Freedom to Speak Up Self- Assessment for 2023
Summary: The Trust's 'Freedom to Speak Up' and 'Raise a Concern' vision is to promote an open and transparent culture across the organisation to ensure that all members of staff feel safe, supported, and confident to speak out and is to the Trust's objective of delivering 5 Star patient care. Trust Boards are required to have an oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive self-assessment. conducted at least every 2 years. The Trust Board undertook Self-Assessment 2022 as part of its assurance process. The Trust consistently has scored high on the NHS staff survey, on ability of staff members to raise concerns, with the latest published in 2022. Trust has scored higher aggregated score than national average for all domains, in particular on domains of Morale, Staff engagement and We have a voice that counts and questions in staff survey relating to raising concerns Q 17 a- & b and Q 21 e &f. The Trust scored highest in the northwest region in 2021 report with 74.9% positive score on staff perception of feeling safe to speak up about anything that concerns them in the organisation, and higher than national mean positive scores of 65.6%. Trust recorded a mean Freedom to Speak up Index score of 82.3% for 2020-21, an increase from 81.9% for 2019, and 81% in 2018. The Trust score is significantly higher than the national mean score for all acute Trust of 79%. This provides assurance of Trust commitment to creating an open and honest culture.
Corporate objectives met or risks addressed: Care, safety, pathways, communication, system
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff, regulators and commissioners
Recommendation(s): That the Board review and approve the self-assessment
Presenting officer: Anne-Marie Stretch, Deputy CEO, Director of Human Resources and Executive Lead to Freedom to Speak up
Date of meeting: 22 February 2023

Freedom to Speak Up review tool for NHS trusts and foundation trusts

2023

NHS England and NHS Improvement

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Fully	• Chairman - Non-executive and Chief Executive - Executive are nominated FTSU Guardians • Trust value 2022-23, emphasises the commitment to attract and develop, caring, highly skilled staff. • Trust Objective 2022-23: 'developing organisational culture and supporting workforce', encourages staff to speak up • Engagement events in place to encourage staff to showcase achievements and offers opportunities for staff to raise concerns to senior leaders directly. • High visibility of Board members through Trust Brief Live, Quality Ward Rounds, service visits and communication channels with Executive and Non-Executive team members. • Formal and informal discussions with all staff groups and receive feedback. • Regular communication to appreciate work of staff members – Thank you Thursday emails, Chief Executive Communications, Team Brief and Board meeting reports highlighting appreciation. • Positive staff survey results published in 2022. Changes made to improve areas based on feedback from survey. • CQC inspection published 2019 - Outstanding rating • Improvement in Speak up index for 2020 compared with 2018 and 2019 (published 2021) • Lead by example with ACE behavioural standards.	
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment, and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative, and engaging communication strategy to tell positive stories about speaking up.	Fully	• Chairman and Chief Executive are nominated FTSU Guardians. • Chief Executive (FTSU) and Deputy Chief Executive (Executive lead for FTSU) review of FTSU concerns and actions • Strong culture and promoting openness and honesty at Board sessions. • FTSU report presented to Quality Committee every 6 months. • Continuous evaluation of FTSU model and raising concerns options. • Continued communication with staff members of methods for 'Raising Concerns' though Team Brief, engagement events and induction process. • Development of Staff App with FTSU/ Raising concerns information • Development programme for various staff groups in place. • FTSU and HR collaboration in reviewing any cases with detriment / bullying allegations. • Communication to support changes made because of speaking up. • Examples of positive changes shared widely through 'You said we did' in Teambrief.	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	**Fully**	• Clear and consistent Trust vision, encompassing speaking up and embedded throughout the Trust. • Speaking up integrated into Trust values and objectives, supported in delivery by the nominated executive lead. • Clinical and Quality Strategy links speaking up and being open process in ensuing patient and staff safety. • Board members updated with progress made regarding FTSU through scheduled regular reports. • Provision of several channels for staff to raise concerns including internal and external routes, this includes Guardians, speak in confidence system, Ask Ann system and Raising Concerns Hotline. • Consistent higher than national score in NHS Staff Survey for Freedom to Speak up Index related questions (published in 2022). • ACE behavioural standards existent and well-advertised. • Freedom to speak up report received by Quality Committee, content in accordance with recent NGO guidance published on FTSU reports.	
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events	**Fully**	• The Guardians are supported by the Executive Lead for FTSU to complete any necessary training required for the role. • The Guardians are supported with time for FTSU activities, in negotiation with line managers. . • Regular meetings and updates between Guardians and key executives and non-executive lead. • The Guardians are active participants of the North West FTSU Group and the National FTSU Group. • Guardians have developed external relationships with local networks. • Internal collaboration with HR, Patient Safety Teams and Guardian for Safe Working.	
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years	**Fully**	• Raising Concerns & Speaking Out Safely – Policy and Procedure in place. Plan in place to integrate and adopt national template in 2023 • Quarterly update on speaking up/ speak in confidence usage provided to Trust workforce Council.	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
• reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.		• Trust achieved high assurance on MIAA audit conducted in 2020 reviewing the raising concerns process and actions taken in addressing issues/ sharing lessons learnt.	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	**Fully**	• Assurance of consistent reporting of concerns using various methods • Contact with individuals, teams, HR and relevant to ensure that changes made has a positive impact. • Risks identified are reported to risk register appropriately. • Feedback from individuals on their experience and support from FTSU/ Raising concerns procedures. • Feedback from FTSU events and training on the processes used by the Trust.	
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	**Partial**	• The Guardian presents paper to the Quality Committee every 6 months, with Executive and Non-Executive members represented. The Trust Board receives assurance from Quality Committee.	• The FTSU report is presented to Quality Committee - a sub-committee of the board, with Executive and Non-Executive members represented. Effectiveness to be reviewed annually.
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	**Partial**	• Current Guardians appointed with Freedom to speak up role integrated to existing substantive clinical/ non-clinical role. • Functional role and responsibilities matched against national job description and guidance. • Additional Freedom to speak up role to be advertised shortly which will comply with this standard.	• Use of NGO advised recruitment process for any future FTSU champion or guardian role recruitment
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	**Fully**	• Case review findings discussed at the guardians meeting and Executive lead meetings • NGO prescribed reflection tool to be completed in 2023, reviewing speak up process as integrated organisation.	
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website	**Fully**	• Freedom to speak up and Raising Concerns reports shared with Trust Quality committee and Workforce Council. • Trust achieved high assurance on MIAA audit conducted in 2020 reviewing the raising concerns process. • Consistent high scores of NHS Staff surveys on ability to raise concerns.	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
• discussion at the public board • welcoming engagement with the National Guardian and her staff		• Information and contact details of Guardians on the Trust intranet and Staff App • Active membership and participation in the North West FTSU network. • Freedom to speak up information as content in annual quality accounts	
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	**Fully**	• As members of a unitary board, the Executive and Non-Executive members are committed to the Trust values and objectives, supporting speak up • Appraisals to include how the Executive and Non-Executive members have supported speaking up. • NGO prescribed reflection tool to be completed in 2023, reviewing speak up process as integrated organisation.	

END

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23) 019

Title of paper: Incidents, Complaints, Concerns & Claims – Quarter 3 2022-23

Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 3 2022-23

Summary

Incidents

- 5333 incidents reported in Q3, which is a 12.25% increase on Q2 2022-23 (4751)
- 4390 patient incidents in Q3, a 15.28% increase on Q2 2022-23 (3808)
- 40l patient incidents graded as moderate or above in Q3, a 42.86% increase on Q2 2022-23 (28), with 40 incidents reported in same period Q3 2021-22
- The highest number of incidents reported relate to:
    - Pressure ulcers = 741 (which include pressure ulcers acquired prior to admission to Trust services)
    - Patient slips, trips or falls = 541

Complaints

- 53 first stage complaints were received in Q3, a 15% decrease (9) from Q2
- Clinical treatment was the main reason for complaints, in line with previous quarters
- ED continues to receive the most complaints
- The Trust commenced working to a response time of 100 working days from 1 August 2022, with the first of these falling due at the end of December 2022

Claims

- There were 47 claims in Q3, the same number as Q2 2022-23
- Pre-action claims (requests for records from solicitors) account for 29 of these, with 18 NHS Resolution (NHSR) instructed claims
- 11 pre-action claims converted to NHSR instructed claims in Q3
- 22 inquests were notified by the Coroner in Q3 compared to 16 in Q2, with 14 inquest files closed during that period

PALS

- 1202 contacts were received in Q3, which is a 7% increase from Q2 2022-23
- 95.59% of PALS enquiries were resolved, with 35 PALS enquiries converted to formal complaints, a 4.41% conversion rate

• There was a slight change to the top themes in Q3 compared to Q2 as; patient care/nursing care did not feature in the top 5 subjects being replaced by admissions and discharges with 7.65% of contacts
Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 22nd February 2023

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarter 3 2022-23, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

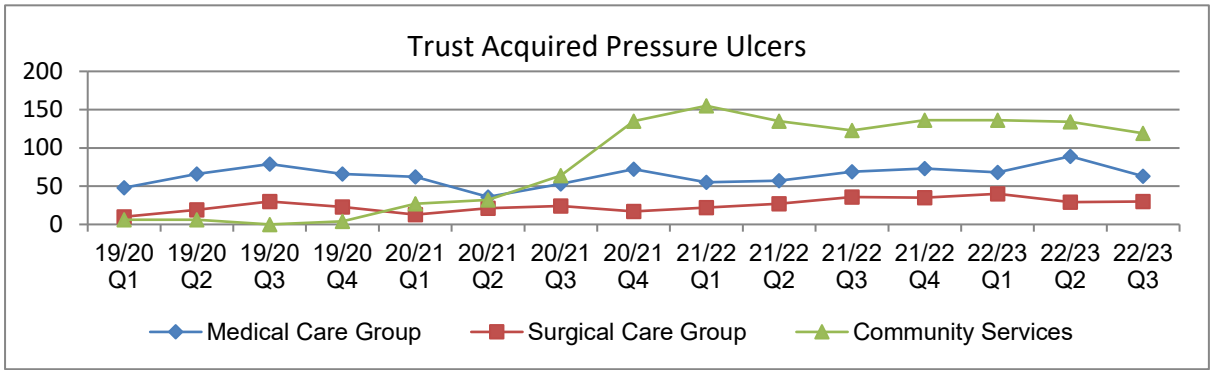
During Q3, 5333 incidents were reported, of which 82.32% (4390) were patient safety incidents. This is a 12.25% increase from Q2 2022-23 in all incidents and 15.28% increase in patient incidents.

	22/23 Q3
Incidents affecting patients	4390
Incidents affecting staff	411
Incidents affecting the Trust or other organisation	511
Incidents affecting visitors, contractors or members of the public	21
Total	5333

Q3 had 23 incidents reported to StEIS, the same number as Q2 2022-23. During Q3 2022-23, there were 40 patient safety incidents categorised as moderate harm, severe harm or death. In comparison, during Q2 2022-23 there were 28 incidents reported moderate or above, while in the same period last year (Q3 2021-22) there were 40 incidents graded moderate or above.

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3
Moderate	23	30	27	26	21	15	22
Severe	7	6	9	14	9	10	13
Death	3	2	4	2	2	3	5

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories during Q3 were pressure ulcers (741) and falls (541). Pressure ulcer figures include all patients who are admitted with pre-existing pressure ulcers, Trust acquired pressure ulcers are detailed below. These incident types are consistently the highest reported incidents in previous quarters.

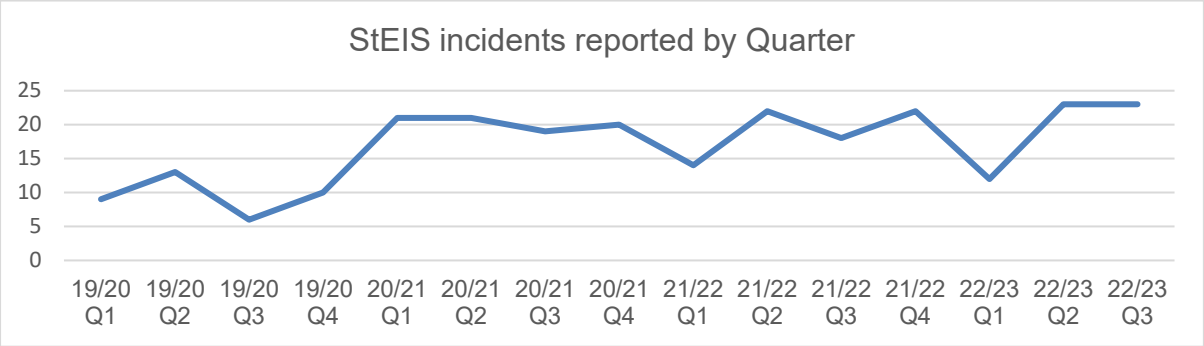


No severe harm Trust acquired pressure ulcers, with lapses in care were identified in Q3 2022-23.

STHK Acquired PU	2019-20				2020-21				2021-22				2022-23		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
None	6	7	6	1	7	8	15	69	87	78	98	124	144	149	135
Low	55	83	103	92	94	81	126	152	144	135	120	112	96	96	65
Moderate	3	0	0	0	1	0	0	1	0	0	0	0	0	1	1
Severe	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
Ungraded to date	0	1	0	0	0	0	0	2	0	6	9	8	4	6	11
Total	64	91	109	93	102	89	141	224	232	219	228	244	244	252	212

2.1. Review of incidents reported to StEIS in Q3 2022-23

During Quarter 3 2022-23 the Trust had 23 incidents which were reported to StEIS, which met the serious incident reporting criteria.



During Q3 there were 17 StEIS reports submitted to the CCG. All reports were shared within the agreed timeframe. Actions taken and lessons learned are shared both internally and with the CCG.

2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q3. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm incidents and Level 1 incidents are monitored within the Care Groups.

2.3. Benchmarking

The table below shows the most recent data (published September 2022) provided by NHS England comparing patient safety incidents reported to the NRLS by the Trust to the national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe harm or death vary due to the relatively small numbers. National figures are published every September.

% of all reported incidents	April 20 to March 21		April 21 to March 22	
	National %	Trust %	National %	Trust %
No harm	72.7%	82.4%	70.6%	79.0%
Low	24.6%	17.0%	26.0%	20.2%

Moderate	2.2%	0.4%	2.9%	0.5%
Severe	0.3%	0.1%	0.3%	0.3%
Death	0.2%	0.02%	0.2%	0.1%

2.4. Dissemination of learning

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

3. Complaints

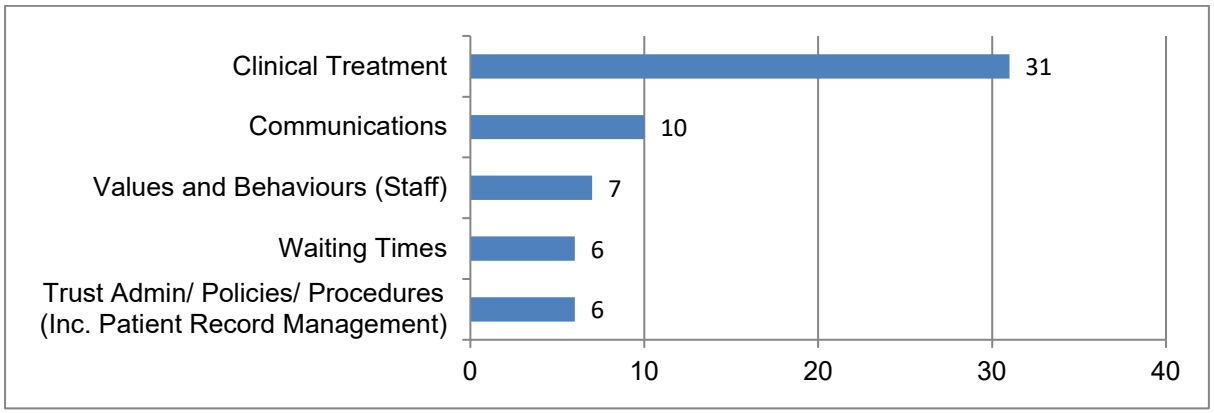
The table below shows the number of received and opened first stage complaints by quarter. The Trust experienced a decrease in complaints in the first three quarters of 2022-23, compared to 2021-22; if this trend continues then the Trust will have less complaints than any of the previous 4 years. There have been 28 2nd stage complaints so far this year, which is an increase on the previous 4 years. The main reasons for complainants submitting a second stage complaint are for further information or if they do not agree with the findings.

The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved in 2019-20, 2020-21 and 2021-22. The Trust's response time to first stage complaints as agreed with the complainant has improved from the figures in Q1 and Q2, and is closer to the figures for 2021-22. The Trust resolved 61 1st stage complaints in Quarter 3 of 2022-23, of which 50 were in time and 11 were out of time.

*data correct as a 10 January 2023. There may be some subsequent changes if complaints are discontinued or reclassified.

Indicator	2018 -19	2019 -20	2020 -21	2021 -22	2022-23 Q1	2022-23 Q2	2022-23 Q3
Total number of new complaints including community services	273	325	251	266	45	62	53
Total number of new complaints received (excluding community services)	267	320	242	254	43	61	52
Acknowledged within 3 days – target 100%	99.3%	100%	100%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	92%	93%	94%	79%	72%	71%	82%
Number of overdue complaints	1	1	4	7	6	6	3
Second stage complaints	36	36	23	32	7	13	8

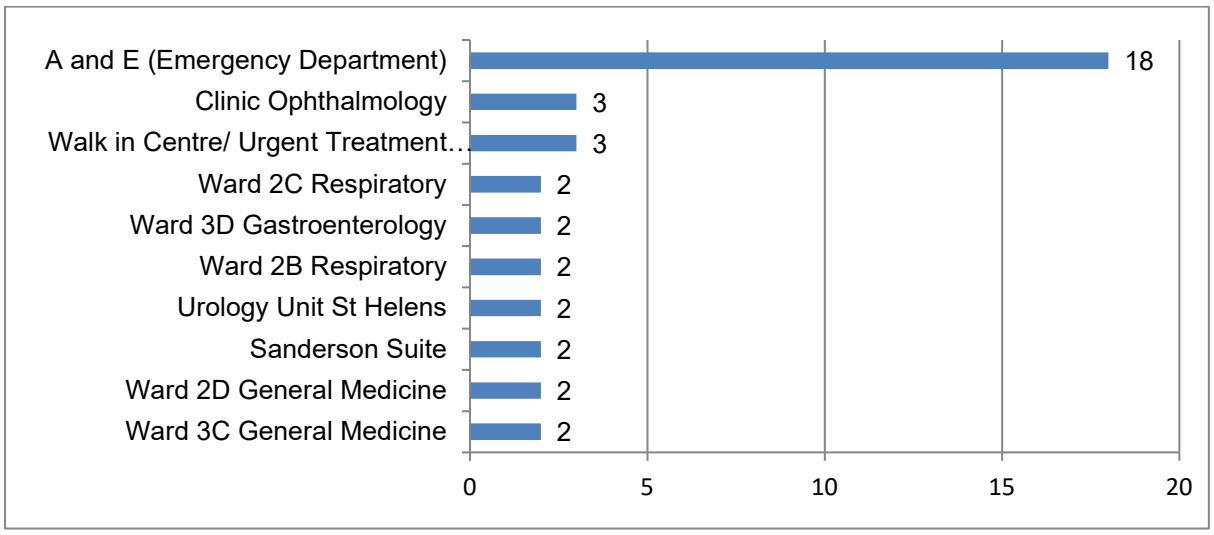
3.1. Top five reasons for complaints Q3 2022-23



Clinical treatment remained the main reason for complaints (which is consistent with Q1 and Q2). Complaints about communications increased after only receiving 3 in Q2. Values and Behaviour (Staff), which did not feature in the top five in Q1 or Q2, received 7 complaints this quarter. This will be monitored in the final quarter of the year to see if the pattern continues.

3.2. Complaints by top location

The Emergency Department received the highest number of complaints in Q3 with 18, which is 7 more than Q2. However this should be considered in the context of the extreme pressure and high levels of activity within ED currently. 3 complaints were received for the ophthalmology clinic (2 related to delays in treatment and 1 to staff attitude, although there was no identified trend in relation to the concerns raised) and 3 for the urgent treatment centre (all 3 involved delay in diagnosis/treatment and issues with communication). It is of note that 22 departments/services received a single complaint in Q3 2022-23.



3.3. Comparison of written complaints received with neighbouring trusts

Complaints data is now collected and published on an annual basis. The last data was published on 24 November 2022 for the 2021-22 period. It is of note that locally, STHK was one of only 4 Trusts (1 of 2 acute trusts) that resolved more complaints than it received during that period.

Organisation name	Total New Complaints	Total Resolved	Number Upheld	Number Partially Upheld	Number Not Upheld	*% Upheld*	*% Partially Upheld*	*% Not Upheld*
Alder Hey Children's NHS Foundation Trust	167	152	67	52	33	*44.1*	*34.2*	*21.7*
Bridgewater Community Healthcare NHS Foundation Trust	43	43	19	10	14	*44.2*	*23.3*	*32.6*
Cheshire and Wirral Partnership NHS Foundation Trust	223	207	40	109	58	*19.3*	*52.7*	*28.0*
Clatterbridge Cancer Centre NHS Foundation Trust	44	33	15	11	7	*45.5*	*33.3*	*21.2*
Countess of Chester Hospital NHS Foundation Trust	222	165	59	48	58	*35.8*	*29.1*	*35.2*
East Cheshire NHS Trust	113	105	15	53	37	*14.3*	*50.5*	*35.2*
Liverpool Heart and Chest Hospital NHS Foundation Trust	38	32	1	10	21	*3.1*	*31.3*	*65.6*
Liverpool University Hospitals NHS Foundation Trust	475	364	88	156	120	*24.2*	*42.9*	*33.0*
Liverpool Women's NHS Foundation Trust	54	58	8	39	11	*13.8*	*67.2*	*19.0*
Mid Cheshire Hospitals NHS Foundation Trust	269	209	27	112	70	*12.9*	*53.6*	*33.5*
Southport and Ormskirk Hospital NHS Trust	273	267	57	143	67	*21.3*	*53.6*	*25.1*
St Helens and Knowsley Teaching Hospitals NHS Trust	264	278	39	100	139	*14.0*	*36.0*	*50.0*
Walton Centre NHS Foundation Trust	81	84	11	22	51	*13.1*	*26.2*	*60.7*
Warrington and Halton Teaching Hospitals NHS Foundation Trust	296	326	86	156	84	*26.4*	*47.9*	*25.8*
Wirral Community Health and Care NHS Foundation Trust	32	34	16	9	9	*47.1*	*26.5*	*26.5*
Wirral University Teaching Hospital NHS Foundation Trust	220	183	26	97	60	*14.2*	*53.0*	*32.8*

3.4. Closed complaints

During Q3 61 first stage complaints were closed, of which 50 were completed within the agreed timescales. It should be noted that the majority of the complaints are not upheld. Additional information on complaints is contained in Appendix 1.

3.5. Dissemination of learning

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

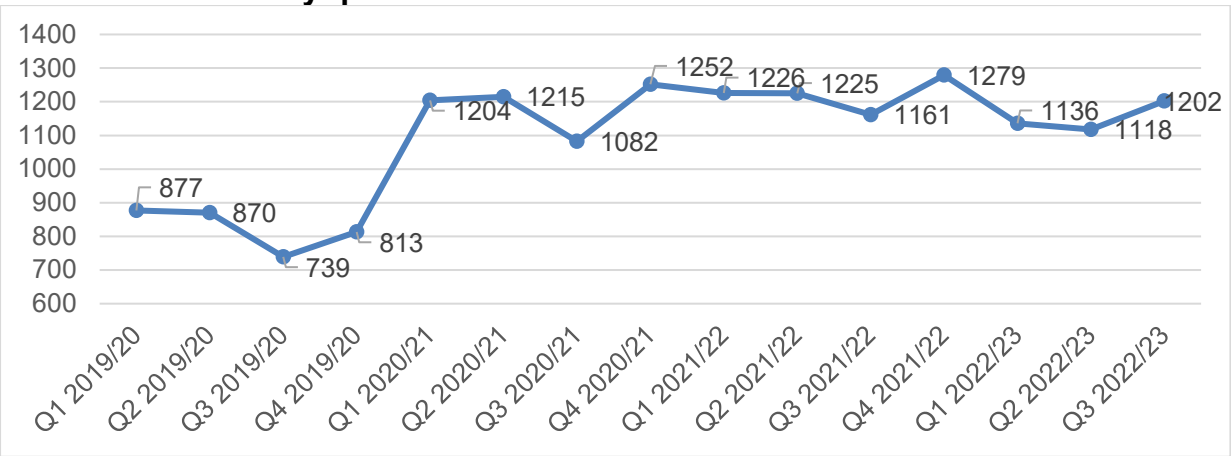
3.6. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

In Q3 the Trust did not receive any new PHSO matters and none were closed. There is a significant backlog of complaints within the PHSO currently.

4. PALS

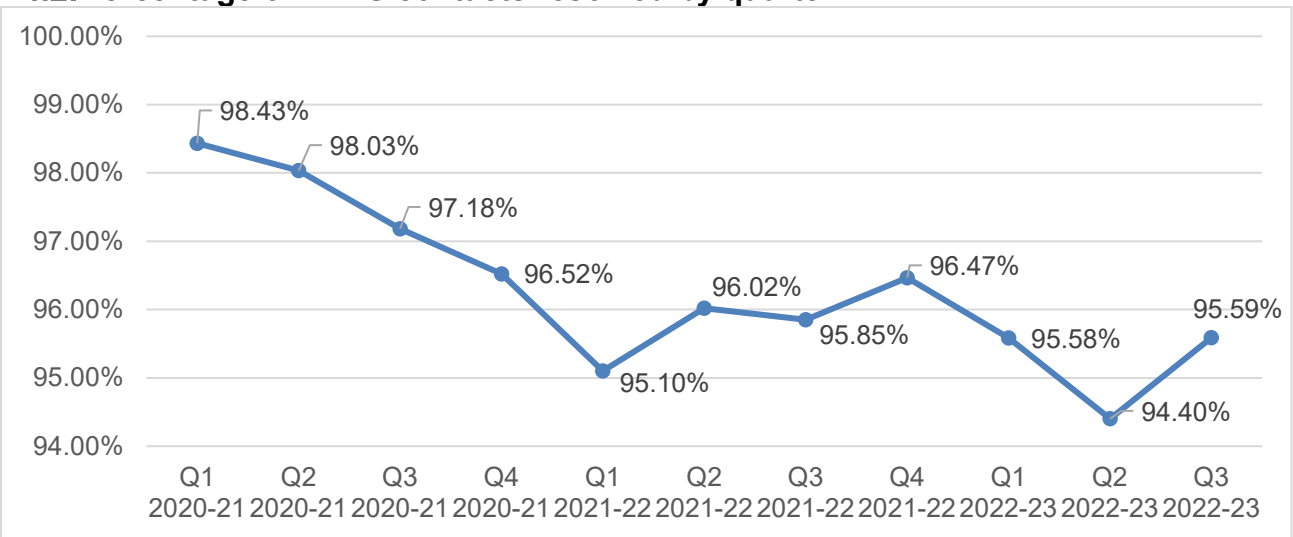
1202 contacts were received in Q3 2022-23, which showed a 7% increase from Q2. During Q1-Q3 2022-23 there have been total of 3456 contacts which is a 4.51% decrease from Q1-Q3 2021-22.

4.1. Total contacts by quarter



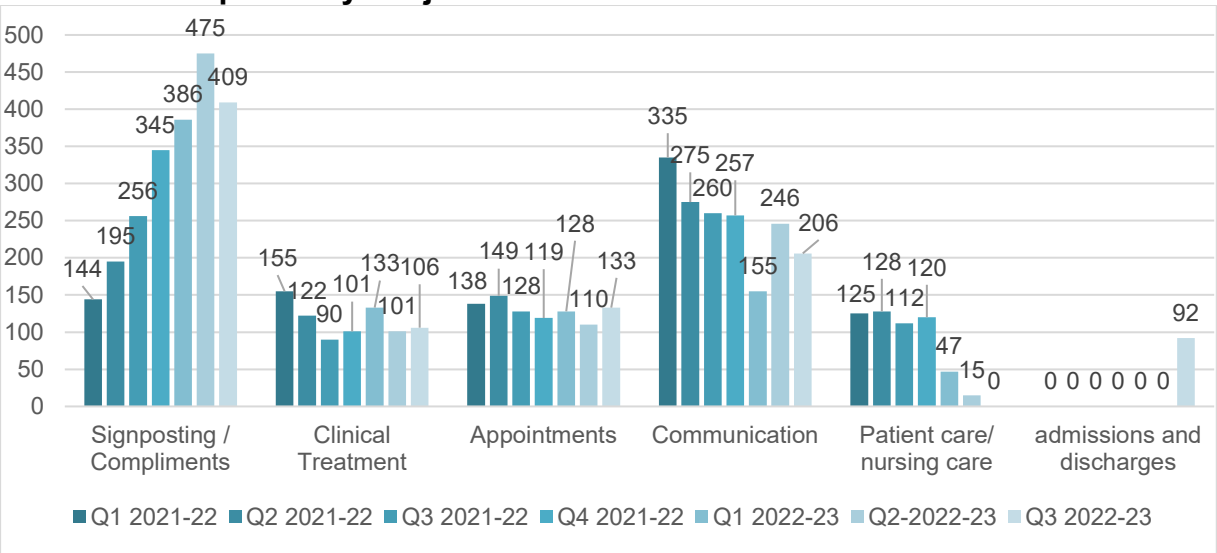
In Q3 2022-23, 95.59% of PALS enquiries were resolved, with 35 PALS enquiries converted to formal complaints, a 4.41% conversion rate, which is a slight decrease from 5.60% in Q2 2022-23. So far during 2022-23, 95.58% of PALS enquiries were resolved, which is a conversation rate of 4.42% (97) to formal complaints.

4.2. Percentage of PALS contacts resolved by quarter



The top 4 subjects have remained the same since Q1 2022-23, however, during Q3 there was a slight change as patient care/nursing care was replaced by admissions and discharges in the top 5 subjects, with 7.65% of contacts relating to this subject in Q3.

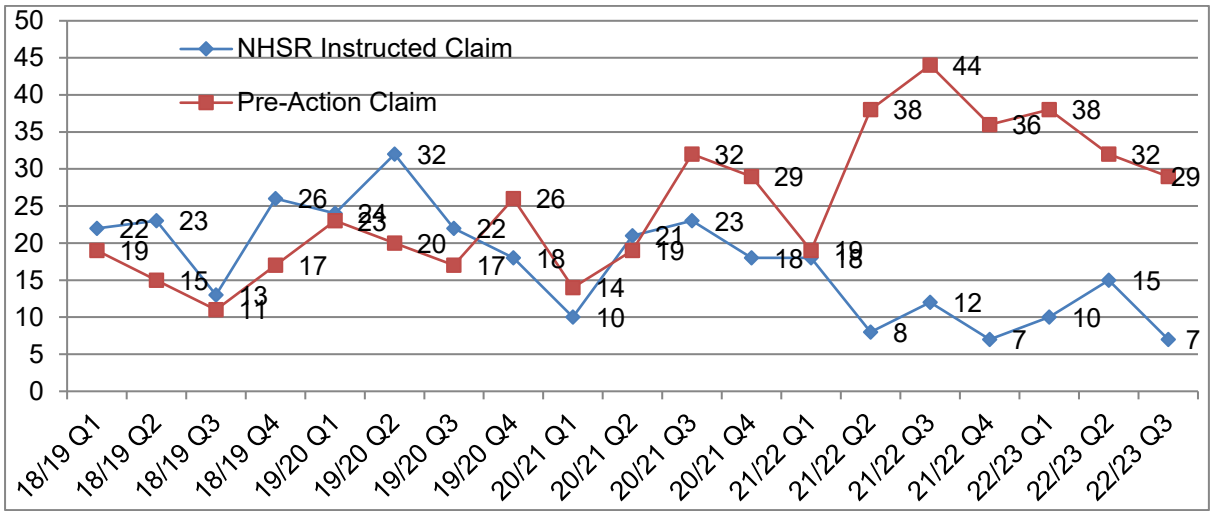
4.3. PALS enquiries by subject



5. Clinical Negligence Claims

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

Pre-action and NHSR instructed claims received by quarter

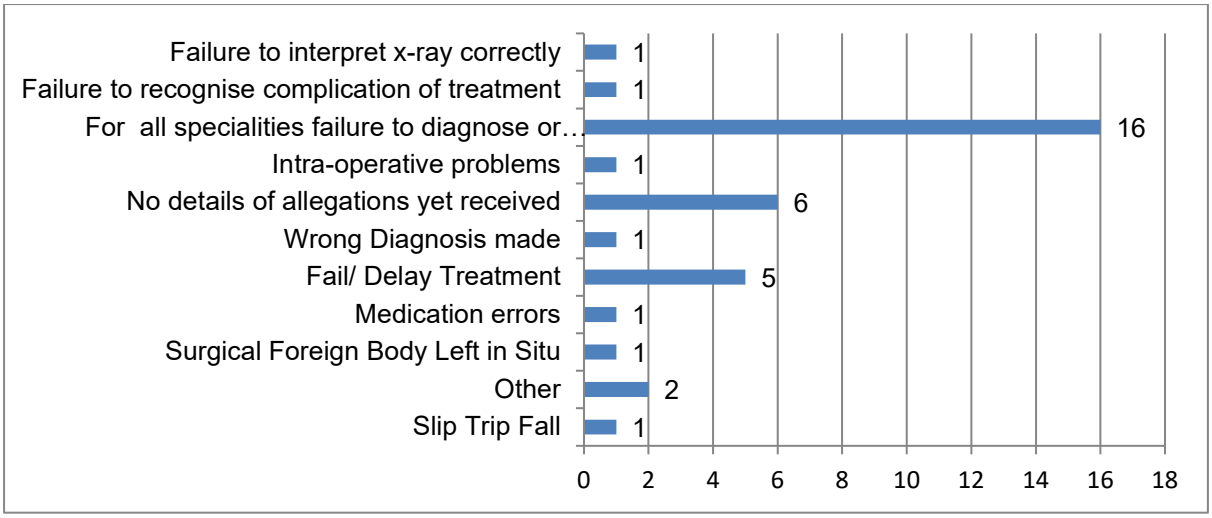


The Trust received 7 new NHSR instructed claims. In addition, 11 more pre-action claims became NHSR instructed claims. This is likely to reflect the fact that claimants' solicitors are requesting less extensions of limitation and starting to proceed with some potential claims that were put on standstill in the most restrictive stages of the pandemic.

Failure/delay in diagnosis was the main reason for claims. This is consistent with previous quarters, other than Q2 2021-22 when failure/delay in treatment was the largest cause of claims.

The Trust has received a number of COVID related claims which are being defended.

Main reasons for new claims Q3 2022-23



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

6. Inquests

22 inquest notifications were received in Q3, an increase of 6 from Q2 and the highest quarter since the 34 received in Q2 2021-22. Across the last 4 quarters the Trust has received an average of 20 inquests per quarter.

The recent trend for the coroner to not require attendance in person from the Trust established in the first quarter of 2022-23 has continued. This is where the coroner decides that all of the Trust's witness statements can be read under Rule 23 and, therefore, staff do not need to attend to give evidence. This may be reflective of the quality of written evidence and reassurance that the Coroner has regarding the Trust's processes.

14 inquests were closed in Q3. There were no Prevention of Future Deaths (PFD) Orders this quarter and the Trust was not asked to provide any further evidence by the Coroner on any matter. It is of note that the Trust has not received a PFD for over 18 months.

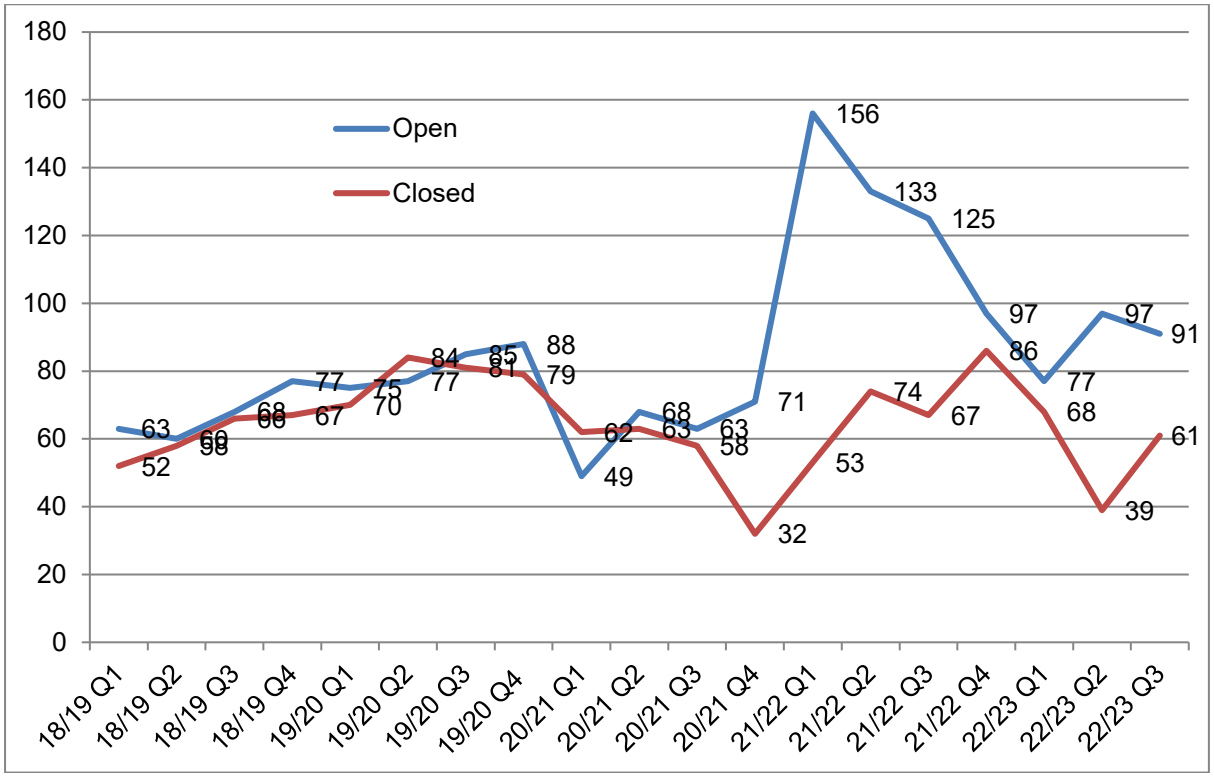
7. Recommendations

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

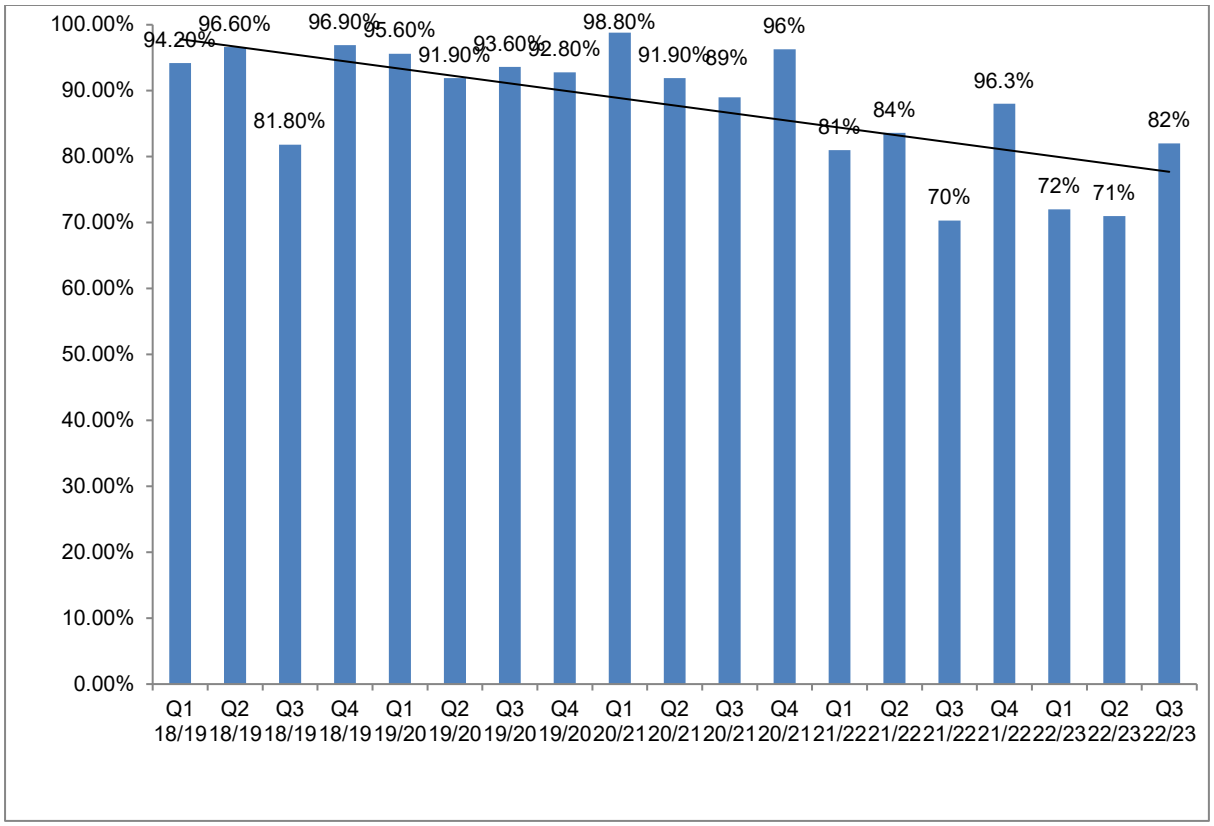
ENDS

Appendix 1 – summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in last 4 quarters

	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	Total
Not upheld locally	36	21	16	17	90
Partially upheld locally	32	35	18	29	114
Upheld locally	17	12	5	15	49
Total	85	68	39	61	253