St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26TH APRIL 2023
BOARD ROOM, 5TH FLOOR, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
09.30	1.	Employee of the Month Film - April 2023		Verbal	Assurance	Chair
09.45	2.	Apologies for Absence		Verbal	Assurance	Chair
09.50	3.	Declaration of Interests		Verbal		
10.00	4.	Minutes of the Board Meeting held on 30th March 2023		Attached		
		4.1	Correct Record and Matters Arising	Verbal		
		4.2	Action log			
Performance Reports						
10.10	5.	Integrated Performance Report		NHST (23) 31	Assurance	Gareth Lawrence
		5.1	Quality Indicators			Sue Redfern
		5.2	Operational Indicators			Rob Cooper
		5.3	Financial Indicators			Gareth Lawrence
		5.4	Workforce Indicators			Nicola Bunce
Committee Assurance Reports						
10.30	6.	Committee Report – Executive		NHST (23) 32	Assurance	Ann Marr
10.40	7.	Committee Report – Audit		NHST (23) 33	Assurance	Ian Clayton
10.50	8.	Committee Report – Finance & Performance		NHST (23) 34	Assurance	Jeff Kozer
11.00	9.	Committee Report – Quality		NHST (23) 35	Assurance	Rani Thind

11.10	10.	Strategic People Committee	NHST (23) 36	Assurance	Lisa Knight

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.20	12.	Corporate Risk Register	NHST (23) 37	Assurance	Nicola Bunce
11.30	13.	Board Assurance Framework	NHST (23) 38	Approval	Nicola Bunce
11.40	14.	Trust Objectives 2023-24	NHST (23) 39	Approval	Ann Marr
Closing Business					
11.50	15.	Effectiveness of Meeting	Verbal	Assurance	Chair
	16.	Any Other Business		Information	
	17.	Date of Next Meeting – 31st May 2023		Information	

MINUTES OF THE TRUST BOARD PUBLIC MEETING
HELD ON WEDNESDAY 29TH MARCH 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
Gill Brown (GB)	Non-Executive Director
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
Geoffrey Appleton (GA)	Non-Executive Director (Deputy Chair)
Ian Clayton (IC)	Non-Executive Director (via MS Teams)
Gareth Lawrence (GL)	Director of Finance & Information
Rob Cooper (RC)	Managing Director
Sue Redfern (SR)	Director of Nursing, Midwifery & Quality
Paul Growney (PG)	Non-Executive Director
IN ATTENDANCE	
Denise Baker (DB)	Executive Assistant (Minutes)
Alan Lowe (AL)	Halton Borough Council (Stakeholder Representative)
Emma Graham (EG)	Quality Matron (via MS Teams)
APOLOGIES	
None received	

1.	**Employee of the Month Film** 1.1. The employee of the month for March 2023 was Elaine Carr, Discharge Coordinator, Surgical Care Group. 1.2. The Board watched the film of RC presenting the award to Elaine and shared their congratulations.	**RF**
2.	**Patient Story** 2.1. EG joined the meeting via MS Teams and presented the patient story. 2.2. The patient had suffered a stroke and was admitted to Whiston Hospital prior to being transferred to the Walton Centre NHSFT. Once well enough, Jim was transferred to Seddon Suite at St Helens Hospital to begin his neurological rehabilitation. 2.3. The patient was a relatively young gentleman and had been willing to share his story and experiences with Seddon ward to	**RF**

	help them improve care for other patients. One of his suggestions had been to review the scheduling of rehabilitation sessions and this had been implemented by the ward. The patient had also participated in the recent Quality Ward Round, which had been a powerful way of showcasing the work of the Neuro Rehabilitation team. 2.4. RF congratulated the Seddon Suite team and thanked the patient for sharing their story. 2.5. AM noted the patient's age and discussed the criteria for patient admission to Seddon Suite. The Board agreed that ideally this level of rehabilitation support should be available to all patients following a stroke to optimise recovery. Early stroke discharge services and the community support for stroke patients, made the STHK stroke service the best in Merseyside. 2.6. RT and GA had recently attended the Stroke Unit at Southport Hospital where staff had spoken to them about delays in being able to arrange rehabilitation appointments following discharge. GA felt this illustrated the differences in service provision that were available but that following good acute care, it is essential to also have good community services. PW reported that he had recently attended a meeting to discuss the development of national standards for integrated stroke services, and that there was agreement on the need for community support for patients following their acute episode and intense rehabilitation in the acute sector. One of the issues highlighted had been the variance in services in each Place. It was agreed that PW and GA should discuss this with the St Helens Place lead.	
3.	**Apologies for Absence** 3.1. There were no apologies for absence noted.	**RF**
4.	**Declarations of Interest** 4.1. There were no new declarations of interest.	**RF**
5.	**Minutes of the Board Meeting held on Wednesday 22nd February 2023** **Minutes of the Previous Meeting** 5.1. The minutes of the Board Meeting held on Wednesday 22nd February 2023 were reviewed and approved as an accurate record. **Action Log**	**GA**

	5.2. There were no outstanding actions to be reviewed.	
	Performance Reports	
6.	**Integrated Performance Report – NHST (23)020**	**GL**

GL introduced the report. The board papers included the IPR in the old and new formats as the period of dual running continued, to ensure all Board members were comfortable with the new format. As previously, GL asked that any comments or queries be fed back to his team so the IPR can continue to evolve to meet the neds of the Board. GL also confirmed that colleagues at S&O have been working to the same framework in readiness for post transaction reporting.

6.1. Quality Indicators

6.1.1. SR presented the report.

6.1.2. There had been no Never Events in February, YTD=2,

6.1.3. No MRSA cases reported in January, YTD=1.

6.1.4. There were 6 new C.Diff positive cases reported in February, YTD=51. This compares to 54 cases for the same period last year. Of the 51 cases, 38 have had RCA panel review which identified that 22 cases as unavoidable with no lapses in care and 2 cases had previously been C.Diff positive. The annual tolerance for C.Diff is 56 for 2022/23. SR observed that the trust would have a new target post transaction for the combined organisation.

6.1.5. The Nurse staffing fill rate for January 2023 was 97.5%, this is a 4% increase on the previous month and was thought to reflect the impact of introducing 12 hour shifts, although this would be formally evaluated, when the new work patterns had been embedded for a substantial period

6.1.6. There were 4 severe harm falls reported in January 2023, YTD=26.

6.1.7. There were no grade 3 hospital acquired pressure ulcers reported in January 2023, YTD=1.

6.1.8. There were 91 Community incidents reported in January 2023 compared to 76 the previous year. 77 were no harm pressure skin damage incidents, detected during community nursing team home visits.

6.1.9. HSMR for 2022/23 April to November was 93.7.

6.2. Operational Indicators

6.2.1. RC presented the report.

6.2.2. The 62 day cancer standard was not achieved at 79% for January 2023 against a target of 85%, YTD=81.3%. Although this is below target, STHK was the top performing Trust in C&M, including specialist trusts.

6.2.3. The 2 week wait target was not achieved in January 2023 at 88.6%, YTD=77%, against a target of 93%. Capacity challenges remained because of the significant increase in referrals.

	6.2.4. Emergency Department (ED) type 1 performance for February 2023 was 45.9%, YTD=46.6%. The all type mapped performance for February 2023 is 69.8%, YTD= 70.6%. 6.2.5. Average daily ED attendances were 313 compared to 287 in January. Total attendances for February were 8,771. 6.2.6. Average ambulance turnaround time was not achieved with an average of 43 minutes; there were 1,846 ambulance conveyances in February. This compares to 1,996 in January. 6.2.7. St Helens UTC had 4,087 attendances in January, 97% of which were seen within 4 hours. 6.2.8. There were 129 super stranded patients in February compared with 140 in January, work continues with system partners to improve the situation. 6.2.9. The 18 week RTT target was not achieved in January with 61.7% compliance, YTD= 61.7% against a target of 92%. 6.2.10. There remained 2,648 52+ week waiters. 6.2.11. The 6 week diagnostic target was not achieved in February with a compliance of 72.6% but this was an improved position compared to 63.2% in January. 6.2.12. There has been a slight increase in the number of referrals to District Nurses, however, these are still within the normal expected range (515 in January 2023 and 486 in December 2022). 6.2.13. All patients continued to be clinically triaged to ensure urgent and cancer patients were prioritised for treatment. 6.2.14. JK commented that during his recent visits to the A&E Department and St Helens UTC as part of a Quality Ward Round he had seen how recent initiatives were benefiting patients, despite the continued pressures. 6.2.15. The increase in ambulance assessment and ambulatory care capacity has made a difference to how patients can be cared for and the MDT Hub was receiving calls directly from GPs allowing patients to be correctly sign posted to alternative services to prevent admissions. 6.2.16. IC sought clarification regarding bed occupancy as the report indicates 97% which puts the Trust in the lowest 10% of the country. RC clarified that this figure included paediatric beds which have a high turnover as paediatric patients are recorded as being admitted even if they are simply awaiting test results. 6.2.17. AM commented that the Trust continues to have a high number of patients who do not meet the criteria to reside and it has now been recognised that the trust needs more medical beds. There are continued discussions with system partners to increase substantive bed capacity in the coming year. 6.3. <u>Financial Indicators</u>	

	6.3.1. GL presented the report. 6.3.2. At month 11, the Trust has overachieved against the plan of a £4.9m deficit by £8.4m YTD, delivering a surplus of £2.2m. 6.3.3. CIP targets for 2022/23 had been achieved. 6.3.4. Cash balance is £63.8m 6.3.5. The capital programme remained on course to deliver by the end of the financial year. 6.4. <u>Workforce Indicators</u> 6.4.1. AMS presented the report. 6.4.2. Month 11 saw a decrease in staff absence at 5.7% compared to 6.5% in Month 10. 6.4.3. There was a significant drop in absence among Nurses/Midwives from 8% (Month 10) to 6.3% (Month 11); this compares with 7.04% for the same period last year. Sickness absence appears to be returning to pre-pandemic levels. 6.4.4. Reasons for sickness absence continued to reflect the national data with stress & anxiety listed as the main cause for staff absence followed by coughs & colds. 6.4.5. All long term absence cases relating to stress & anxiety are investigated to ensure staff receive optimal support. 6.4.6. Appraisals compliance has increased since January and the 85% target is being achieved. 6.4.7. There has been a slight increase in mandatory training compliance (February 80.8% vs January 80.4%). 6.5. The Board members provided some comments on the new IPR format and agreed to adopt this for 2023/24 reporting. 6.6. **The IPR Report was noted.**	
Committee Assurance Reports		
7.	**Committee Report – Executive NHST (23)021** 7.1. AM presented the Executive Committee Chair's Report and highlighted the following items. 7.2. Fixed term Investments for transaction/integration planning had been approved for IT and the TUPE process; this funding provision was modelled as part of the transaction business case. 7.3. Nursing establishment increases for the Lilac Centre were approved, reflecting the increased activity at the unit. 7.4. Harm reviews had been completed for all patients where letters had been delayed. The Medical Director provided an interim report advising that the issues had been resolved and could not reoccur, and following the harm reviews there were no moderate of severe harms detected but for 4 patients there had been a slight delay in treatment but this had not resulted in any detriment, and 9 patients were being recalled to clinic for	**AM**

	review. The final report will be presented once these reviews are completed. 7.5. New Hospitals had commissioned an end of defects liability report which had raised some issues, however, discussions with Vinci have provided assurance that appropriate operational solutions are in place, so this was not a patient safety concern for the Trust. 7.6. **The report was noted.**	
8.	**Committee Report – Finance & Performance NHST (23)022** 8.1. JK presented the report and noted that the committee had commended the team on the improved financial performance against plan. 8.2. The committee had reviewed the operational performance metrics in the IPR in detail, but they key points had already been discussed under agenda item 6. 8.3. **The Report was noted.**	**JK**
9.	**Committee Report – Quality NHST (23)023** 9.1. RT presented the report and highlighted the following items. 9.2. A Project Steering group had now been established for the Operation Shakespeare Project with theatres which would oversee the two 2 strands of the project: patient safety and staff wellbeing. This group will provide assurance to the Clinical Effectiveness Council. 9.3. 80% of CIP schemes to date had completed the Quality Impact Assessment process and all were scheduled to be completed by the end of the financial year; this provided assurance that patient safety had not been compromised. 9.4. The committee had received an update on the Ockendon maternity report and had noted that there were 4 essential actions still to be completed. One related to a Conflict of Clinical Opinion Policy to support staff in being able to escalate their clinical concerns in case of disagreement between healthcare professionals, which had been drafted. The remaining 3 actions are progressing. 9.5. The committee had noted that a new Maternity Voices Partnership (MVP) Chair had not yet been appointed, and this continued to be discussed with the Place leads. 9.6. All maternity units across the country were being inspected by the CQC following the Ockenden report and these inspections were all expected to take place before the end of June 2023. 9.7. The Clinical Effectiveness Council report had escalated the increase in Plastic surgery activity in particular the increase in demand for ortho-plastics as a result of capacity issues in Manchester. 9.8. The committee had also noted the continued challenges with obtaining appropriate placements for children with mental health and behavioural problems who were not medically unwell.	**RT**

	9.9. **The Report was noted.**	
10.	**Committee Report – Strategic People NHST (23)024** 10.1. LK presented the report. 10.2. The Committee were advised that the transaction TUPE consultation process for S&O staff had now ended, but engagement meetings continued. 10.3. The committee had received a report on the work of the HWWB service and the range of support available to staff which had been reflected in the recent staff survey results. 10.4. CW passed on thanks to the HWWB team and commended them for the support provided to her team following the death of a colleague. 10.5. The committee had reviewed the detailed HR KPI dashboard 10.6. **The report was noted.**	**LK**

	Other Board Reports	
11.	**Operational Plan – Budget, Activity & Workforce Plan NHST (23)025** 11.1. GL presented the final plan proposal for STHK for Board approval which had been updated following the most recent discussions with the ICB. The deadline for submission of final plans was 30th March 11.2. The plan assumes £0.1m surplus for the year with a CIP target of 4.9% (£28.6m). 11.3. There were still issues being discussed with the ICB, such as the virtual ward funding allocations, which might improve the position 11.4. The Trust has been allocated additional capacity funding estimated at £5m. 11.5. Cash balance is expected to remain strong. 11.6. The following risks were highlighted: 11.6.1. Elective activity will be PBR, as a result there is a system risk that month 1 activity will not be delivered due to the junior doctors' industrial action. 11.6.2. Negotiations with ICB continue in relation to the bariatric surgery contract. 11.6.3. The plan includes the community diagnostic capacity but the funding has yet to be allocated. 11.6.4. CQUIN contract negotiations have yet to conclude, however, the proposed CQUINs are considered deliverable. 11.7. There is potential for excess inflation funding to be distributed which could provide a £5.5m opportunity for STHK. 11.8. It was noted that the STHK and S&O plans had been developed collaboratively and would come together post transaction. 11.9. **The Board approved the 2023/24 opening budget and operational plan.**	**GL**

12.	**CQC Compliance and Registration NHST (23)026** 12.1. SR presented the report, which provided assurance that the Trust continues to meet the CQC fundamental standards for registration. 12.2. The trust maintains regular contact with the CQC via the relationship manager and there are no issues of concern that have been raised or enforcement actions were taken during 2022/23. 12.3. SR advised that the Trust had completed the process of registering the Southport and Formby District General Hospital and Ormskirk District General Hospital sites, which will take effect when the transaction is completed. 12.4. SR noted that the CQC fees for 2023/24 had not yet been confirmed 12.5. **The report was noted.**	**SR**
13.	**Mixed Sex Annual Declaration NHST (23)027** 13.1. SR presented the report. 13.2. The report provided assurance to the Board that the Trust is compliant with national guidance to eliminate mixed sex accommodation. 13.3. It was noted that the changes made during COVID to add cubicles to ICU meant there were no longer concerns in relation to staff stepping down from an ICU admission. 13.4. There were no complaints and no breaches declared in 2022/23. 13.5. RF commented that this was an excellent position. 13.6. **The Board approved the declaration.**	**SR**
14.	**2022 Staff Survey Report and Action Plan NHST (23)028**	**AMS**
	14.1. AMS presented the report. 14.2. The NHS staff survey was undertaken in October/November 2022 with the results published on 9th March; Bank staff were included in this survey for the first time. 14.3. 228 NHS organisations in England took part in the survey, 124 of which are in the STHK benchmarking group. 14.4. All staff were invited to take part in the survey and the response rate was 40.4% (2,691 completed questionnaires), the majority of respondents are aged over 50 and female; 90% of responders are white. 14.5. The results had improved or stayed the same across all 9 themes. The lowest scoring theme related to flexible working, but this had improved compared to the 2021 results. 14.6. The trust performed above the benchmarking group average in 8 themes and at the average level for the 9th. In three themes the trust scored the highest score 14.7. Each theme is determined by the combined responses to a number of questions and the survey report also provides performance at individual question level. There are 5 individual questions where STHK scored significantly worse than the	

	national average and these would be examined in detail.; AMS noted that there remained a disparity between the number of staff who had declared a disability on ESR compared to those who considered themselves to have a disability in the survey results. 14.8. All Managers have been given access to the data via the interactive dashboard and reviewed the results for their area in order to develop local action plans. The drill down facility enabled analysis of all questions with more than 11 responses (so that individuals could not be identified) 14.9. The Executive will monitor delivery of the action plans and assurance will be provided via the Strategic People Committee. 14.10. Board members discussed the reported discrimination staff receive from patients and whether there was more that could be done to support staff but also recognise the sensitivities for example where patients have dementia. There is a national working group which STHK has applied to join which is developing a national approach to tackle this issue. 14.11. AM advised that the current policy regarding abuse from patients/families is under review following learning from a recent incident. 14.12. PG asked if the respondent demographics were reflective of the Trust workforce; AMS confirmed this to be the case. 14.13. RF felt this was a very positive set of results, given the national trends and challenges the trust has faced, and it was particularly gratifying to see that improvements had occurred in those areas of focus, from the previous year's action plan, such as appraisals. 14.14. AMS noted that it is was important to use the staff survey results and triangulate these results with other data /surveys to ensure that actions are targeting the correct issues of concern for staff. 14.15. **The report was noted.**	
15.	**Nurse Staffing Establishment Review NHST (23)029**	**SR**
	15.1. SR presented the report which provides findings of the 6 monthly Nurse Staffing Establishment review undertaken between January – March 2023. 15.2. The review is undertaken using national guidance for adult inpatient wards and provides assurance that the nurse establishments align to e-Roster, ESR and the financial ledger. 15.3. 28 of the 33 inpatient wards were found to have the correct staffing. Four wards were staff above the agreed establishment and additional HCA capacity had been identified for the remainder, for which a business case was being prepared for consideration by the Executive Committee. 15.4. GB suggested sickness rates for Midwives be reported separately from Registered Nurses as sickness amongst midwives has been reported as notably higher in other reports and it may be helpful to have this recorded in future reviews as	

	a comparison. SR agreed to take this into account and confirmed that the other tools were used or being developed to review the staffing levels in other areas, such as maternity, Paediatric ICU, theatres, and community nursing 15.5. **The report was noted.**	
16.	**Gender Pay Gap Annual Declaration NHST (23)030**	**AMS**
	16.1. AMS presented the report. 16.2. The report covers the Trust workforce and the Lead Employer Doctors in Training. In accordance with the Equality Act 2010 the trust must publish its Gender Pay Gap information 16.3. Factors that affect the gender pay gap include length of service and Local Clinical Excellence (LCEA) Awards for Doctors. GA noted that the LCEA is only paid to Doctors; Nurses receive no bonuses and as the majority of nurses are females this will directly impact the gender pay gap. 16.4. RF noted that females are also historically more likely to be affected by career breaks/working part time due to family commitments and queried whether the Trust offers childcare services. AMS confirmed that the Trust does not provide childcare services, but does run a childcare vouchers scheme as part of the salary sacrifice facilities, which reduces the cost of childcare 16.5. AMS detailed the actions proposed to better understand and reduce the gender pay gap. 16.6. **The report was noted**.	
	Closing Business	
17.	**Effectiveness of Meeting**	**ALL**
	17.1. RF commended the quality of the papers and noted the range of issues discussed.	
18.	**Any Other Business**	**ALL**
	18.1. The Trust Board congratulated staff for pulling together and supporting one another to ensure patient safety and service delivery were maintained during recent industrial action.	

Date of Next Meeting: Wednesday 26th April 2023

TRUST PUBLIC BOARD ACTION LOG – 26th April 2023

No	Date of Meeting (Minute)	Action	Lead	Date Due
57	22.02.23 (11.5)	FTSU – Comparison between S&O/STHK working models and evaluation of results	AMS	31.05.23
58	22.02.23 (12.15)	Review of complaints process	SR	31.05.23

Paper No: NHST(23)31
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 March 2023. (YTD = 2).

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

There were 6 C. Difficile (CDI) positive cases reported in March 2023 (4 hospital onset and 2 community onset). (YTD = 57). Of the 57 cases, 48 have been reviewed at RCA panel, 29 cases were deemed unavoidable as no lapses in care were identified. 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 February 2023 was 97.5%. 2022-23 YTD rate is 93.8%.

During the month of February 2023 there was 1 fall resulting in severe harm or death category. (YTD severe harm or above category falls = 27).

There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in February 2023. (YTD = 1).

Community Incident reporting levels have increased to 81 in the month of February 2023 compared to 78 in the previous year. 69 incidents were reported to be due to pressure skin damage, 68 were classified as no harm and 1 classified as low harm.

YTD HSMR (April - December) for 2022-23 is 94.0

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 22/23 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: G Lawrence
Date of Meeting: 26th April 2023

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (February 2023) at 77.8%. YTD 81.0%. The 31 day target was achieved in February 2023 with 97.7% performance in month against a target of 96%, YTD 97.4%. The 2 week rule target was not achieved in February 2023 with 89.3% in month and 78.1% 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 March 2023 was 48.4% and YTD 46.8%. The all type mapped STHK Trust footprint performance for March 2023 was 72.2% and YTD 70.7%**.** The Trust saw average daily attendances of 324, which is up compared to February, at 313. Total attendances for March 2023 was 10,038.

Total ambulance turnaround time was not achieved in March 2023 with 60 mins on average. There were 2,182 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 1,846 in February 2023.

The UTC had 3,716 attendances in the month of February, compared to 4,087 in month of January. Overall, 96% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in March 2023 was 127 compared with 129 in February. 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 February 2023 with 62.1% compliance and YTD 62.1% (Target 92%). Performance in January 2023 was 61.7%. There were (2,360) 52+ week waiters. The 6 week diagnostic target was not achieved in February 2023 with 72.6% compliance. (Target 99%). Performance in January 2023 was 63.2%.

There was a slight decrease in referrals received within the District Nursing Service in February however, the levels are still within average range (470 in February compared to 515 in January 2023). The overall caseload size has seen a slight increase to 1,291. February saw a community matron caseload of 132, compared to 131 in the month of January. 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 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. The draft position for 22/23 as at Month 12 is a £7.1m surplus, which would represent an overachievement against plan of £12.0m. 22/23 reporting is yet to be finalised and therefore this position may change prior to final M12 reporting.

Surplus/Deficit - At the end of Month 12, draft reporting gives a surplus position of £7.1m. This represents an improvement of £12.0m against the planned 22/23 deficit of £4.9m. 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 £10.2m.

CIP - The Trust's final CIP target was £28.1m for financial year 2022/23, of which £22.1m was to be delivered recurrently and £6m non-recurrently, as agreed with C&M ICS. As at Month 12, these targets have been achieved and focus is now on progressing 23/24 CIP schemes.

Cash - At the end of M12, the cash balance was £25.6m.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £26.0m. This includes £18.0m of PDC funding provided by Department of Health & Social Care.

Human Resources

There was an increase in the rate of absence from 5.7% in February to 6.1% in March. However, this figure remains lower than January's rate of 6.5%. The rate for all Nursing and Midwifery staff group increase from 6.3% in February to 7.9% in March 2023. N.B This includes normal sickness and COVID19 sickness reasons.

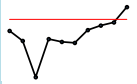
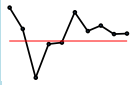
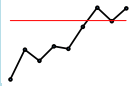
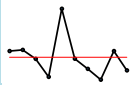
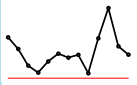
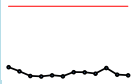
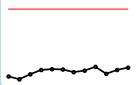
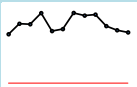
Appraisal compliance remains unchanged from February at 86.8% and is above target. Mandatory training compliance continues to improve at 81.5% in March compared to 80.8% in February.

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

Mar-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	Mar-23	2.7%	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	▲	Oct-22	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Dec-22	104.6	94.0	100.0	96.9					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Dec-22	103.7	102.0	100.0	105.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Nov-22	102.2	97.7	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	Dec-22	80.1	81.6	100.0	88.6		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. Increased discharges in recent months with improved integrations with system partners,	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Dec-22	94.6	99.7	100.0	103.9					
% Medical Outliers	F&P	T	Mar-23	1.8%	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	Mar-23	51.2%	35.9%	52.5%	46.8%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Feb-23	62.0%	62.6%	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	▲	Feb-23	34.0%	30.4%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Feb-23	97.4%	97.9%	95.0%	97.2%					

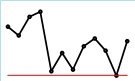
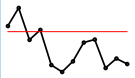
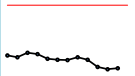
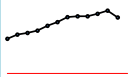
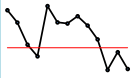
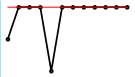
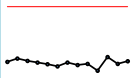
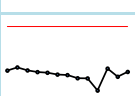
Mar-23

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

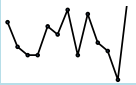
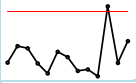
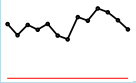
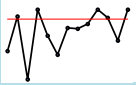
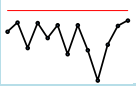
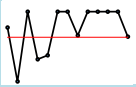
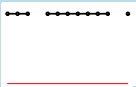
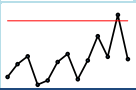
	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q3	86.9%	87.3%	83.0%	84.8%		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	▲£	Mar-23	0	2	0	1		RCA in progress	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	Mar-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	▲£	Mar-23	0	1	0	2		There were no MRSA cases in March 2023. (YTD = 1). There were 6 C. Difficile (CDI) positive cases reported in March 2023 (4 hospital onset and 2 community onset). (YTD = 57). Of the 57 cases, 48 have been reviewed at RCA panel, 29 cases were deemed unavoidable as no lapses in care were identified. 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	▲£	Mar-23	6	57	56	32					SR
Number of hospital onset and community onset Methicillin Sensitive Staphylococcus Aureus (MSSA)	Q F&P		Mar-23	4	44	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Feb-23	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	▲	Feb-23	1	27	No Contract target	22		1 fall resulting in severe harm category in February 2023	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	Apr-22	0	0	No Target	31			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		Mar-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	Feb-23	97.5%	93.8%	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	Feb-23	1	17	No Target	30					

Mar-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	▲ £	Feb-23	89.3%	78.1%	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	▲ £	Feb-23	97.7%	97.4%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Feb-23	77.8%	81.0%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-23	62.1%	62.1%	92.0%	68.2%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. Recovery plans are in place, 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	▲	Feb-23	72.6%	76.0%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-23	2,360	2,360	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Mar-23	0.6%	0.9%	0.8%	0.82%		Achievement of targets in February and March. Underperformance YTD 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	▲ £	Feb-23	100.0%	99.6%	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	▲	Mar-23	48.4%	46.8%	95.0%	55.8%		Accident and Emergency Type 1 performance for March 2023 was 48.4% and YTD 46.8%. The all type mapped STHK Trust footprint performance for March 2023 was 72.2% and YTD 70.7%. The Trust saw average daily attendances of 324, which is up compared to February, at 313. Total attendances for March 2023 was 10,038. Total ambulance turnaround time was not achieved in March 2023 with 60 mins on average. There were 2,182 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 1,846 in February 2023.	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	▲	Mar-23	72.2%	70.7%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Mar-23	0	24	0	0					

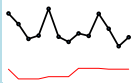
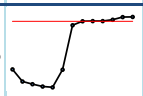
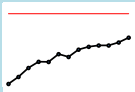
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Mar-23	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Mar-23	27	203	No Target	254		Increase in the number of new complaints received in the latest month and % new (Stage 1) complaints resolved within agreed timescales remains challenging.	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 60 day response times. 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	Mar-23	21	222	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Mar-23	85.7%	77.5%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to March 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	Mar-23	351	358		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Mar-23	127	133		108					
Friends and Family Test: % recommended - A&E	Q	▲	Mar-23	83.3%	79.4%	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	▲	Mar-23	94.9%	95.3%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Mar-23	100.0%	95.8%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-23	96.0%	92.9%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Mar-23	95.2%	96.6%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Mar-23	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-23	94.1%	94.1%	95.0%	93.8%					

Mar-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
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Mar-23	6.1%	6.3%	Q1 - 4.25%, Q2 - 4.35%, Q3 - 4.72%, Q4 - 4.68%	7.0%		There was an increase in the rate of absence from 5.7% in February to 6.1% in March. The rate for all Nursing and Midwifery staff group increase from 6.3% in February to 7.9% in March 2023. This includes normal sickness and COVID19 sickness reasons.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The recent MIAA audit resulted in an outcome of Substantial Assurance in relation to sickness absence management. There's sustained effort in relation to good absence management practices. Employees who are absent from work due to sickness are contacted regularly to provide them with appropriate support and advice. 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. Where applicable, referral to occupational health is undertaken and reasonable adjustments implemented. Training is offered to new & existing managers as required. The training schedule for the new financial year is being planned. 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.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Mar-23	7.9%	7.9%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Mar-23	86.8%	86.8%	85.0%	65.9%		Appraisal compliance in March remains unchanged from February at 86.8% and remains above target. Mandatory training compliance has increased to 81.5% in March (80.8% in February).	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Appraisal compliance remains above target. Mandatory training has improved slightly but remains just below the 85% target. Recovery actions continue to focus on the Medical and Dental workforce and subject of clinical fire safety Plans to be delivered and monitored through People Council and Executive Committee .	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Mar-23	81.5%	81.5%	85.0%	74.7%					
NHS National Quarterly Pulse Survey : % recommended Care	Q	▲	Q3 2022-23	77.8%					The Q3 NQPS is superseded by the annual National Staff Survey that takes place in Q3.	Staff engagement, recruitment and retention.	Following publication of the Q3 survey (Annual Staff Survey) data on 9th March, papers will be presented to the Trust Board and Strategic People Committees on findings and resultant actions.	AMS
NHS National Quarterly Pulse Survey : % recommended Work	Q	▲	Q3 2022-23	70.0%								
Staffing: Turnover rate	Q F&P UOR	T	Mar-23	0.9%	12.0%	No Target	14.0%		Staff turnover remains stable and below the national average of 14%.			AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T										GL
Progress on delivery of CIP savings (000's)	F&P	T										
Reported surplus/(deficit) to plan (000's)	F&P UOR	T										
Cash balances - Number of days to cover operating expenses	F&P	T										
Capital spend £ YTD (000's)	F&P	T										
Financial forecast outturn & performance against plan	F&P	T										
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T										

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	2022-23 YTD	2022-23 Target	FOT	2021-22	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	100.0%	100.0%	93.1%	83.3%	100.0%	100.0%	100.0%	88.0%	81.8%	100.0%	100.0%	100.0%	95.7%	94.4%	85.0%		96.0%		
	Total > 62 days		0.0	0.0	1.0	2.0	0.0	0.0	0.0	1.5	2.0	0.0	0.0	0.0	0.5	7.0			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	▲£	80.0%	86.7%	90.5%	76.5%	79.3%	65.2%	83.3%	42.9%	66.7%	66.7%	57.1%	44.4%	62.5%	68.3%	85.0%		79.7%		
	Total > 62 days		1.0	1.0	1.0	2.0	3.0	4.0	2.0	4.0	1.0	1.0	6.0	5.0	3.0	32.0			24.5		
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	2.0	0.0	7.0			4.0		
Upper GI	% Within 62 days	▲£	100.0%	36.4%	90.0%	84.6%	100.0%	85.7%	70.0%	75.0%	80.0%	93.8%	71.4%	83.3%	100.0%	84.4%	85.0%		83.2%		
	Total > 62 days		0.0	3.5	0.5	1.0	0.0	1.0	1.5	1.0	1.0	0.5	2.0	1.0	0.0	9.5			9.5		
	Total > 104 days		0.0	1.0	0.5	0.0	0.0	0.0	0.5	1.0	0.0	0.5	1.0	1.0	0.0	4.5			3.0		
Urological	% Within 62 days	▲£	88.0%	93.9%	90.0%	81.0%	79.2%	78.1%	85.0%	73.1%	83.3%	78.2%	87.9%	75.6%	68.4%	78.3%	85.0%		80.5%		
	Total > 62 days		1.5	1.0	1.5	4.0	2.5	3.5	1.5	3.5	2.5	6.0	2.0	5.5	6.0	38.5			32.5		
	Total > 104 days		0.5	0.0	0.0	0.0	0.5	1.5	0.5	1.5	1.0	0.0	0.0	0.5	1.5	7.0			4.0		
Head & Neck	% Within 62 days	▲£	0.0%	50.0%	16.7%	0.0%	44.4%	0.0%	25.0%	0.0%	0.0%	0.0%	66.7%	42.9%	16.7%	18.8%	85.0%		24.4%		
	Total > 62 days		1.0	1.0	2.5	3.5	2.5	1.5	1.5	1.5	4.5	3.5	0.5	2.0	2.5	26.0			15.5		
	Total > 104 days		0.0	0.0	0.0	2.0	0.5	0.0	0.5	1.0	2.0	1.5	0.5	1.0	1.5	10.5			2.0		
Sarcoma	% Within 62 days	▲£			100.0%							100.0%	0.0%	100.0%	0.0%	62.5%	85.0%		100.0%		
	Total > 62 days				0.0							0.0	1.0	0.0	0.5	1.5			0.0		
	Total > 104 days				0.0							0.0	0.0	0.0	0.0	0.0			0.0		
Gynaecological	% Within 62 days	▲£	37.5%	60.0%	75.0%	66.7%	100.0%	45.5%	25.0%	50.0%	75.0%	80.0%	0.0%	0.0%	50.0%	54.3%	85.0%		67.3%		
	Total > 62 days		5.0	2.0	1.0	2.0	0.0	3.0	4.5	1.0	1.0	0.5	1.0	1.0	1.0	16.0			17.0		
	Total > 104 days		1.5	1.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	0.0	0.5	4.0			2.5		
Lung	% Within 62 days	▲£	76.9%	55.6%	50.0%	92.3%	69.6%	30.8%	64.7%	66.7%	85.7%	70.6%	36.4%	77.8%	46.2%	65.1%	85.0%		77.2%		
	Total > 62 days		1.5	2.0	1.5	0.5	3.5	4.5	3.0	1.5	1.5	2.5	3.5	1.0	3.5	26.5			18.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.5	0.0	0.0	1.5	1.0	1.5	5.5			1.5		
Haematological	% Within 62 days	▲£	100.0%	0.0%	100.0%	100.0%	75.0%	75.0%	69.2%	0.0%	80.0%	75.0%	60.0%	60.0%	71.4%	69.5%	85.0%		60.5%		
	Total > 62 days		0.0	2.0	0.0	0.0	1.0	2.0	2.0	1.0	0.5	1.0	2.0	2.0	1.0	12.5			17.0		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0			5.0		
Skin	% Within 62 days	▲£	93.4%	100.0%	97.7%	93.4%	95.5%	86.9%	79.7%	92.8%	90.3%	92.3%	86.7%	90.5%	94.1%	90.9%	85.0%		93.3%		
	Total > 62 days		2.0	0.0	1.0	2.5	1.5	5.5	7.5	2.5	5.5	3.0	5.0	3.5	2.0	39.5			29.5		
	Total > 104 days		0.0	0.0	0.0	1.0	1.0	2.0	0.0	0.0	0.5	1.0	1.5	2.0	0.0	9.0			1.5		
Unknown	% Within 62 days	▲£	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%			100.0%		0.0%	89.5%	85.0%		88.2%		
	Total > 62 days		0.0		0.0		0.0	0.0	0.0	0.0			0.0		1.0	1.0			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	▲£	85.4%	86.3%	90.3%	83.2%	85.4%	77.6%	76.0%	78.4%	82.6%	83.3%	76.9%	79.0%	77.8%	81.0%	85.0%		85.2%		
	Total > 62 days		12.0	12.5	10.0	17.5	14.0	25.0	23.5	17.5	19.5	18.0	23.0	21.0	21.0	210.0			170.5		
	Total > 104 days		2.0	3.0	1.5	3.0	3.0	7.5	2.5	6.0	3.5	3.5	6.5	7.5	5.0	49.5			24.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£		100.0%	66.7%	100.0%	100.0%			0.0%		100.0%	100.0%			80.0%	85.0%		100.0%		
	Total > 31 days			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		
Acute Leukaemia	% Within 31 days	▲£						100.0%					100.0%		0.0%	80.0%	85.0%				
	Total > 31 days							0.0					0.0		0.5	0.5					
	Total > 104 days							0.0					0.0		0.0	0.0					
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				

RC

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)032
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 March 2023. There were five Executive Committee meetings held during this period. New investment decisions were made during this period were: • Tissue Viability Nurse Specialist Business Case 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, this included allocation of temporary transitional funds to delivery the post transaction integration priorities.
Trust objectives met or risks addressed: All Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 26th April 2023

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were five Executive Committee meetings held during March 2023.

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. 2nd March 2023

The main part of the meeting on 2nd March was used as preparation for the NHSE Transaction challenge meeting that took place on 3rd March.

2.1 CQUIN 2023/24

The four mandatory CQUIN targets plus the other selected CQUIN – identification and response to frailty in Emergency Departments, were approved.

2.2 Transaction Business Case – Microsoft Licences

The Director of Informatics presented a mini business case for transitional funding to support the integration of services/systems post transaction. The business case was approved.

2.3 Transaction – approach to service integration and service transformation

The Managing Director presented a paper outlining the planned approach to service integration, post transaction. This detailed the prioritisation criteria, the proposed timetable and the plans for monitoring and benefits tracking. The approach was supported.

2.4 Transaction – Organisational Development and Cultural Engagement Plan

The Deputy CEO/Director of HR introduced a paper setting out the detailed proposals for managing organisational change, supporting integration, and developing a single culture for the new organisation, post transaction. The plan was approved.

3. 9th March 2023

3.1 End of liability defects survey

The Director of Corporate Services provided an update on the New Hospitals end of construction liability period defects surveys. This was primarily a commercial issue between New Hospitals and Vinci Construction, but the Trust had sought assurance in relation to issues of patient and staff safety. The Trust fire officer has undertaken a risk assessment of the intumescent paste around the fire doors which was found to have gaps in some cases. The risk was assessed as low because of the building fire compartmentalisation. A programme to replace the fire doors was underway in any event and as part of this the sealant behind the architrave would be replaced.

New Hospitals has commissioned an independent survey to provide additional assurance on the integrity of the fire compartmentalisation.

Independent expert and commissioning records had been reviewed to provide assurance in relation to the issues identified with electrical substation compartmentation and electrical safety, and whilst final reports had not yet been received, there was assurance that these issues were being mitigated as part of the Vinci FM building management systems.

3.2 Trust Board Agenda - March

The Director of Corporate Services presented the draft Trust Board agendas for the March meetings. It was agreed to postpone the approval of trust objectives for 2023/24 to allow the development of objectives for the new organisation to be developed for approval in April.

3.3 Southport and Ormskirk Hospital NHS Trust – Transaction

The Director of Corporate Services reported that the supplementary assurance information requested by the NHSE Provider Transformation team had been submitted.

The statutory consultation reports in respect of Healthwatch and the TUPE process were drafted and submitted to NHSE for inclusion in the information pack for ministers.

Work continued to finalise the draft transaction agreement with NHSE and the two ICBs.

Extraordinary Board meetings had been arranged for 16th March to approve the S&O dissolution request (by S&O Board) and approve the draft transaction agreement.

3.4 Industrial Action

The Medical Director briefed the committee on the contingency planning for the junior doctors planned industrial action the following week. The plans in place would provide sufficient cover to continue with urgent elective activity, but there would be some impact on activity to eliminate 78+ week waiters, although it was hoped this would be minimal.

3.5 CMAST Feedback

The Chief Executive provided feedback from recent meetings in relation to the Liverpool Clinical Services Review, the role of networks in the ICB and plans to review the Cheshire and Merseyside gynaecological cancer pathway.

4. 16th March 2023

4.1 Risk Management Council Chair's Assurance Report

The Director of Corporate Services presented the chair's assurance report. It was noted that the meeting had been stood down as part of the business continuity plans during the junior doctors' industrial action, but all papers had been prepared and circulated.

The risk register held a total of 852 risks in February of which 29 had been escalated to the Corporate Risk Register (CRR). During the month 5 high/extreme risks had been closed or de-escalated from the CRR and two new risks had been added. Both new risks related to the annual prioritisation process for medical equipment replacement.

The RMC papers had also included reports from the Claims Governance Group, the CIP Quality Impact Assessment process and on the FOI improvement plan.

4.2 Mandatory Training and Appraisal Compliance

The Deputy CEO/Director of HR presented the compliance figures for February 2023. Appraisal compliance had now increased to 87% but Mandatory training compliance remained at 80%. There had been a further small improvement in compliance for Medical and Dental staff.

4.3 Endoscopy Regional Hub – Capital Bid

The Managing Director explained that the national endoscopy team were seeking prospective bids to create endoscopy regional hubs. St Helens Hospital site could potentially accommodate a hub and would be collocated with the Community Diagnostic Centre. The proposals had been developed into a bid for consideration by the national team should capital be allocated for this purpose in 2023/24. The Executive Committee supported the submission of the bid.

4.4 Integrated Performance Report (IPR)

The Director of Finance and Information presented the February IPR for review. Discharge summary performance was discussed, and it was noted that actions had been put in place to increase capacity which should quickly start to improve performance.

4.5 Southport and Ormskirk Hospitals NHS Trust - Transaction

Transaction business cases for a one off cost to support cultural integration and a fixed term resource to support the EPR procurement and integration were approved.

5. 23rd March 2023

5.1 Nurse Establishment Review

The Director of Nursing, Midwifery and Governance introduced the paper which set out the results of the nursing establishment review. The paper provided assurance that the budgeted establishment was sufficient to provide safe care. The paper was due to be presented to the Trust Board at the March meeting.

Committee asked for further assurance in relation to recruitment plans and staff turnover.

5.2 Tissue Viability Nursing Specialist Business Case

The Director of Nursing, Midwifery and Governance introduced the business case to increase the substantive establishment of the Tissue Viability team by 1 FTE in response to increased demand, and recent success in reducing the incidence of pressure ulcers. The business case was approved.

5.3 Gender Pay Gap Report

The Deputy CEO/Director of HR introduced the Gender Pay Gap Report for 2022. The Gender Pay Gap information would be published by the statutory deadline of 31st March 2023, following presentation to the Trust Board.

5.4 Payroll Tender Opportunities

The Deputy CEO/Director of HR briefed the committee on an opportunity to expand the payroll service into another part of the country. The committee approved the proposals to pursue this opportunity if the commercial terms were sufficient to cover the trust's costs/risks.

5.5 Internal Audit Plan 2023-24

The Director of Finance and Information presented the proposed internal audit plan for 2023/24 for the post transaction organisation. The plan reflected the BAF, due diligence and integration risks. The draft plan would be presented to both Trust audit committees for approval.

5.6 Wagestream for Lead Employer Doctors

The Deputy CEO/Director of HR introduced a proposal to extend the Wagestream salary draw-down facilities to junior doctors in the North West who were part of the collaborative bank. This followed successful implementation at the Trust, giving staff the facility to draw down payments for additional hours, which was attractive to staff who worked additional bank shifts. There were no costs to the Trust and the proposal was approved.

5.7 Southport and Ormskirk Hospitals NHS Trust - Transaction

Committee discussed the implications of the SPI committee decision being delayed and how momentum with transaction preparations could be maintained during this period.

5.8 Frontline Digital Maturity Funding

The Director of Informatics presented an update on the joint EPR procurement with S&O and Warrington and Halton Hospitals NHSFT (WHH), which was complicated because the current EPR contract at WHH was due to expire in 12 months.

6. 30th March 2023

6.1 Nurse Safe Staffing Reports – Month 10 and 11

The Director of Nursing, Midwifery and Governance introduced the reports. In January 2023 the overall registered nurse fill rate had been 93.87% and in February the overall registered nurse fill rate was 97.53%.

The impact of the RNC industrial action in January was noted.

The reports also included an update on recruitment, and it was reported that the first 12 international nurses for 2023/24 had been recruited and would joint the Trust in May to start their OSCE training.

6.2 Cheshire and Merseyside Collaborative Staff Bank

The Deputy CEO/Director of HR confirmed that the COVID-19 vaccination programme had now officially ended but the circa 400 vaccinators that had been recruited were being retained on a "reservist bank" in case they were needed again in the future.

Work on establishing an endoscopy collaborative bank had commenced in February and was due to go live in May, to support the Community Diagnostic Centres. To date there had been 73 expressions of interest in joining the bank to provide staff to 8 trusts.

6.3 Southport and Ormskirk Hospital NHS Trust – Transaction

The Deputy CEO/Director of HR presented proposals on the HR activities that could be progressed ahead of the transaction once the ratings decision was known.

The Director of Finance reporting on discussions with both Trust's auditors in relation to part year accounts, now the transaction could not be completed for 1st April.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)33
Title of paper: Committee Report – Audit
Purpose: To report to the Trust Board on the Audit Committee, 12th April 2023

Summary

Meeting attended by:

I Clayton – NED & Chair
J Kozer – NED
G Brown – NED
G Lawrence – Director of Finance & Information
S Redfern – Director of Nursing
C Oakley – Deputy Director of Finance & Information
K Jenkinson – Assistant Director of Finance
C McNamara – Assistant Director of Procurement
J Farrar – Audit Partner, Grant Thornton UK LLP
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
V Martin - MIAA Anti-Fraud Specialist
A Lawrinson – Minuting Secretary

Agenda Items

For Assurance

A) External Audit

- Grant Thornton provided a verbal summary and highlighted areas within the audit plan for 2022/23. The full plan is set out within the Audit Committee papers.
- The audit plan sets out the key matters for the audit and the basis of the work programme.
- An update of IFRS 16 and changes within auditing standards was noted.
- Audit materiality was confirmed as being £7.5m for the 2022/23 audit. Issues above £300k will be reported to the Audit Committee.

B) Internal Audit

- MIAA presented the annual head of internal audit opinion for 2022/23. The overall assurance level provided is “substantial” assurance.
- MIAA provided an update on the progress to date of internal audit reports.
- MIAA presented the plan for internal audit work for 2023/24, which was initially prepared on the basis that the transaction with Southport & Ormskirk would have occurred on 1st April 2023, and so may need some changes until the transaction date is confirmed.

C) MIAA Anti-Fraud Services

- The 2022/23 anti fraud annual report was presented. There have been 12 referrals in the 2022/23 year, 3 investigations are ongoing, 2 remain open and 7 have been

closed without meeting the threshold of fraud investigations. There were 6 referrals brought forward from the prior year, 3 of these have been closed, 2 are with the CPS awaiting confirmation that they have been accepted and 1 is ongoing.
- Work is ongoing on the reporting of conflicts of interests.
- The 2023/24 anti fraud plan was presented.

D) Audit log
- 8 reports have been signed off by MIAA since the last Audit Committee, with a further 3 being completed by the Trust and waiting on MIAA sign off.
- This leaves 11 in progress reports, of which 2 have final work due to be completed in the next month, 5 are external audit recommendations, 1 is new this month, leaving 3 reports with further work to be completed.

E) Losses and Special Payments
- £222k losses and special payments registered for the 2022/23 year compared to £289k for 2021/22.

F) Aged Debt
- Total NHS invoiced debt: £7.7m overdue of which £4.8m has been due for more than 90 days.
- NHS debt predominantly relates to “Hosted Services” such as MMDA and Lead Employer.
- Total Non NHS invoiced debt: £6.2m overdue of which £3.7m has been due for more than 90 days.

G) Tender and Quotation Waivers
- The committee noted that 24 waivers have been signed off for the period January 2023 to March 2023

H) Accounting policies
- The accounting policies for the year to March 2023 were reviewed. These were based on standard NHSE disclosure and prior year accounts.

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: 21st June 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)034
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 20th Apr

Summary

Meeting attended by:

J Kozer – NED & Chair
G Appleton – NED
P Growney – NED
R Cooper – Managing Director STHK
G Lawrence – Director of Finance & Information
P Williams – Medical Director
C Oakley – Deputy Director of Finance & Information
N Bunce – Director of Corporate Services

Apologies received from:

AM Stretch – Deputy Chief Executive/Director of HR
I Clayton – NED

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was below the 85% target in February, at 78%.
- Target 31 day performance was achieved in February, at 97.7% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in February, at 89.3% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 48.4% in March and 46.8% year to date. All type mapped STHK Trust footprint performance was 72.2% in March and is 70.7% year to date. The Trust saw average daily attendances of 324, which is an increase compared to February at 313. Total attendances for March were 10,038.
- The ambulance turnaround time target was not achieved in March, at 60 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- Nationally led discharge summit coming up to develop C&M improvement plan.
- In MArch, overall sickness had increased to 6.1%, from 5.7% in February.

B) Finance Report Month 12

- Trust is currently compiling the annual accounts and is reporting a draft year to date surplus of £7.1m, an improvement of £12.0m against plan in line with forecast.
- Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £26m in line with forecast.
- At the end of Month 12, the Trust has a cash balance of £25.6m in line with forecast.

- Agency expenditure of £12.5m is included in the year to date position which is an increase on the equivalent position in 21/22. Premium Payment Scrutiny Council meetings have been reintroduced.
- Financial planning for 2023/24 continues, ICS plans rejected nationally. Further adjustments to STHK plan to be brought to future committees.
- Committee discussed potential impact on Trust should an ICS deficit to trigger national protocol including measures around investment approval.

C) Cost Improvement Programme update
- 2022/23 CIP programme target made up of £22.1m recurrent and £6m non recurrent met.
- Care groups and CIP Council now focussed on delivery of 23/24 CIP requirement.
- Identification of schemes a rolling programme with £29.9m of the 2023/24 schemes fully worked up.

D) 21/22 National Cost Collection index publication
- Publication of 20/21 and 21/22 index delayed due to pandemic.
- STHK index for 21/22 is 88, which indicates that the Trust is providing care below the national average.

For Approval

E) 2023/24 Finance & Performance Committee Workplan
- The committee received a draft workplan for pre transaction.
- Further workplan to be shared in line for post transaction

For Information

- **CIP Council Update** – Update noted by the committee

Risks noted/items to be raised at Board
N/A

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

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)035
Reporting from: Quality Committee
Date of Committee Meeting: 18th April 2023
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery and Governance Peter Williams, Medical Director Rob Cooper, Managing Director Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance **In attendance:** Anne Monteith, Assistant Director of Safeguarding Anne Rosbotham-Williams, Deputy Director of Governance Debbie Stanway, Head of Nursing and Quality, Medical Care Group Julie Tunney, Deputy Director of Quality Karen Barker, Associate Head of Nursing and Quality Lynn Evans, Head of Nursing and Quality, Urgent and Emergency Care Group Rajesh Karimbath, Assistant Director of Patient Safety Stephen Beckett, Head of Quality, Clinical Support Services Care Group Sue Orchard, Head of Midwifery Tracy Greenwood, Head of Nursing and Quality, Community and Primary Care Services Care Group **In attendance to present specific reports or feedback:** Emma Graham, Corporate Matron
Matters Discussed The action log was discussed, with an update given regarding an audit of patient readmission rates following fractured neck of femur surgery, where the Trust was previously highlighted as an outlier. The audit from April – December 2022 highlighted that the majority of patients were readmitted with other conditions with only 13.1% due to orthopaedic causes. This was lower than the national average of similar cases and a reduction on the previous year, demonstrating improving performance. Further work is being undertaken to review the whole pathway, orthogeriatric cover and to reduce the time from presentation to surgery. This will be reported to the Clinical Effectiveness Council going forward. **Integrated Performance Report** (IPR) The IPR was discussed by the Committee and the following points were highlighted:

- Clostridium difficile slightly over the threshold of 56 at 57 at year end, however 29 of the 48 cases reviewed were unavoidable
- Performance against the 62 day cancer standard was 81% (below target of 85%) year to date, however this was above the national average and performance for 31 day target was met year to date
- Work continues system-wide to reduce bed occupancy and the number of super-stranded patients, noting a discharge summit with national leaders is to be held later this month for Cheshire and Merseyside
- Plans are in place to reduce the number of patients waiting over 65 weeks
- Financial position was shared with the Committee noting the delivery of full capital programme, delivery of cost improvement plans supported by quality impact assessments and delivery of surplus
- Confirmation was provided that there were no identified themes in the complaints received by maternity services, which had increased in March, noting that actions are being taken where warranted
- Assurance was provided that maternity is not an outlier in relation to 3rd and 4th degree perineal tears
- Noted that patients can access required treatment and care through appropriate speciality clinics following funding ceasing for the COVID clinic

Patient Safety Council report

A number of papers were received, including:

- Infection prevention report providing assurance that reportable infections other than Klebsiella bacteraemia were below threshold and that training compliance was continuing to increase
- Pressure ulcer rates remain low with incidents relating to lapses in care at 0.09 per 1000 bed days
- StEIS report, with the Committee receiving additional details of the two reported infection incidents, noting that these had been reported once the full investigation and findings had been presented to panel
- Clinical Support Services Care Group quarterly update, highlighting the work to reduce the top incident themes
- A detailed report was provided by Paediatrics on incidents relating to self-harm and absconding, which highlighted the challenges in caring for this cohort of patients; the Council noted the support in place for the directorate to manage the situation and the ongoing actions to provide the safest possible care, supported by Safeguarding Team, Legal Services Department and Mersey Care
- Controlled drugs (CD) management update provided assurance regarding safe storage and management of CDs

Infection Control Report Quarter 4

The report noted the increase in respiratory viruses and nosocomial infections during the winter period, the changes to COVID testing and thresholds for healthcare associated infections. Lessons learned from the one MRSA bacteraemia in 2022-23 were shared, noting the ongoing proactive monitoring for all infections, including outbreak areas and implementation of preventative actions. The Committee noted the trial of electronic recording for visual infusion phlebitis (VIP) scores. The Committee was provided with assurance that relevant actions are taken if any areas are identified as requiring support in meeting the water safety requirements, which will be provided in future reports.

It was noted that additional sessions have been put in place to increase compliance with training which is below target for level 2, although above target for level 1.

Nurse Staffing Establishment Review
The report provided details of the latest review of inpatient ward nursing establishments, noting the report had previously been presented to Board. The Committee noted that a new tool for ED is being piloted which was used to inform this report. The review found that 28/33 areas had the right establishment and skill mix for patient acuity, with further analysis and business cases being developed to align the other areas. Monitoring of the impact of the 12 hour shifts is ongoing, noting this has contributed to a higher fill rate in some areas. The Committee commended the increase in recruitment and retention of health care assistants, the work to maintain patient safety and the work to review staffing levels in community services, paediatrics and ED.

Quality Ward Round (QWR) Report
A detailed report was presented outlining the 2022-23 QWR programme, noting that 34 of the planned 37 were completed, despite operational pressures throughout the year. The paper provided a breakdown of the key themes identified from the actions noted at the events, in particular workforce and safety. Positive feedback was provided by clinical teams and those participating in the QWRs, noting that staff welcomed the opportunity to engage with members of the Board and Executive Team face to face and share their achievements and challenges. An update on actions identified in 2022-23 will be included in each QWR in 2023-23 to provide assurance they have been delivered.

The Quality Bus was launched on Monday 17th April, with staff reminded of the Trust's values and behavioural standards, with staff from a wide range of areas providing comments on how they achieve these in their daily practice.

Safeguarding Activity Report Quarter 4
The report noted the ongoing work to achieve green assurance rating from ICB on the two outstanding areas of training and health assessments for looked after children. There were steady improvements in all areas of training other than Mental Capacity Act training that dipped slightly in Q4. The Committee noted the increasing levels of activity across the team and the successful recruitment of additional staff to meet this. The suspension of plans to implement liberty protection safeguards to replace deprivation of liberty safeguards was noted. Assurance was provided regarding the processes for ensuring that appropriate identification and follow up for children attending the ED with non-accidental injuries is in place.

Patient Experience Council report
The Council received a number of reports, with the following highlighted to the Committee:

- Policies within the remit of the Council are all in date other than the Complaints Policy that requires small amendments and will be re-presented to May's meeting
- Patient story featured the positive work of the paediatric respiratory team who provided intensive care to enable a premature baby to be cared for at home
- Ongoing work with Healthwatch to resolve any concerns and share positive feedback with teams
- Low rate of conversion of PALS concerns to formal complaints
- Awareness raising of proactive learning from complaints and concerns to allay fears that highlighting issues may have a negative impact on care

Complaints, Claims, Concerns and Friends and Family Test Quarter 4 report
The Committee received details of the latest quarter's activity, with lessons learned and actions taken as a result. The following key points were noted:

- Higher number of first stage complaints closed (61) than received (53) in Q4
- ED continues to receive the highest number of complaints, although reducing
- 6 new NHS Resolution instructed claims received
- Slight increase in the number of inquests, with ongoing assurance that the Trust is able to provide comprehensive statements and lessons learned reports, reducing the need for clinicians to attend in person
- Slight decrease in PALS activity, with themes remaining consistent
- FFT recommendation rates above target for inpatients, antenatal/postnatal and community maternity services

Clinical Effectiveness Council report
Verbal update noted the following:

- Comprehensive report from the Resuscitation Team noting the ongoing work to strengthen emergency cover at St Helens Hospital, implementation of a DNACPR Steering Group and development of training video/podcasts to support staff. Positive results from both the national cardiac arrest audit and the deteriorating patient pilot, including improved NEWS2 compliance. Key areas with lower compliance with basic life support and immediate life support are being targeted to improve
- Approval of two new standard operating procedures, SOP for acute oncology same day emergency care (SDEC)/ambulatory care at St Helens and SOP for UK Oncology Nursing Society (UKONS) 24 hour telephone triage
- Discussion of the maternity key performance indicators

Assurance provided:

- Continued reduction in pressure ulcer and falls rates per 1000 bed days
- MRSA screening is 99.3% compliant
- Positive feedback provided on the QWR programme
- Improvement in training compliance in safeguarding across majority of areas
- Low rate of in-hospital cardiac arrest rates and higher survival rates for patients who have had cardiac arrest to discharge compared to national figure

Decisions taken:

- Terms of reference for Patient Experience Council approved

Risks identified and action taken:

- Ongoing work to improve mandatory training

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

Committee Chair: Rani Thind, Non-Executive Director

Date of meeting: 26th April 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: EC(23)036

Reporting from: Strategic People Committee

Date of Committee Meeting: Monday 17th April 2023

Reporting to: Trust Board

Attendance:

Lisa Knight	Non-Executive Director (Chair)
Gill Brown	Non-Executive Director
Ian Clayton	Non-Executive Director
Rob Cooper	Managing Director
Nicola Bunce	Director of Corporate Services
Malise Szpakowska	Deputy Director of HR
Christine Oakley	Deputy Director of Finance & Information

In attendance:

Hayley McCann	Minutes
Konstantinos Chalkidis	Minutes

Apologies:

Anne-Marie Stretch	Deputy CEO/Director of HR
Claire Scrafton	Deputy Director of HR & Governance
Gareth Lawrence	Director of Finance
Sue Redfern	Director of Nursing

Agenda Items:

- S&O TUPE Update
- Workforce Dashboard
- AHP Turnover Deep Dive
- 2022/23 Staff Survey Results

Assurance Provided:

S&O TUPE Update

- The committee noted that the final measures were sent to Southport and Ormskirk in March, and some further clarifications questions have been received from some regional staff side colleagues, which were being responded to.
- The final measures document had been circulated to Southport and Ormskirk staff on Thursday 13th April.

Workforce Dashboard

The item detailed the following key metrics:

- Absence

There has been a slight increase in respiratory illnesses related absence

- Appraisals and Mandatory Training

Appraisal rates are remaining static and Mandatory Training is still challenged for medical colleagues, but there had been an improvement in compliance.

- Turnover rates

Turnover in month was below target. AHP turnover is above target at 16.35%. Time to hire

This has increased to 76.7 days which could be improved if vacancies were advertised as soon as the vacancy is approved. Time to hire for medics has increased to 142 days, which is skewed because of the junior doctor recruitment process.

Committee requested that additional wellbeing metric be added to the workforce dashboard.

AHP Deep Dive

- Analysis demonstrated that AHPs have spikes of leaving the Trust after 2 years and 5 years in post, so seek career progression. Therefore, the main focus of actions is to develop career development pathways and opportunities within the Trust.
- A AHP Workforce Development Lead position has been created to lead an 18 month improvement programme which will include the development of a preceptorship programme for AHP staff.

Staff Survey

- The committee reviewed the detailed staff survey results for the 2022 survey, following the presentation at the March Trust Board.
- The actions from the survey will be managed by a staff survey operational group and managers will help develop the bespoke action plans for their services. Committee noted the departments/specialities where focused work was required because the responses were below the trust average.
- Committee also discussed how the Trusts offers of flexibility could be branded and promoted to staff, so there was greater awareness of the options already available.

Decisions Taken: There were no decisions taken.

Risks identified and action taken: There were no new risks identified.

Matters for escalation: None

Recommendation(s): The Trust Board note the report.

Committee Chair: Lisa Knight, Non-Executive Director

Date of Meeting: 26th April 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(23)037

Title of paper: Corporate Risk Register Report – April

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

Summary:

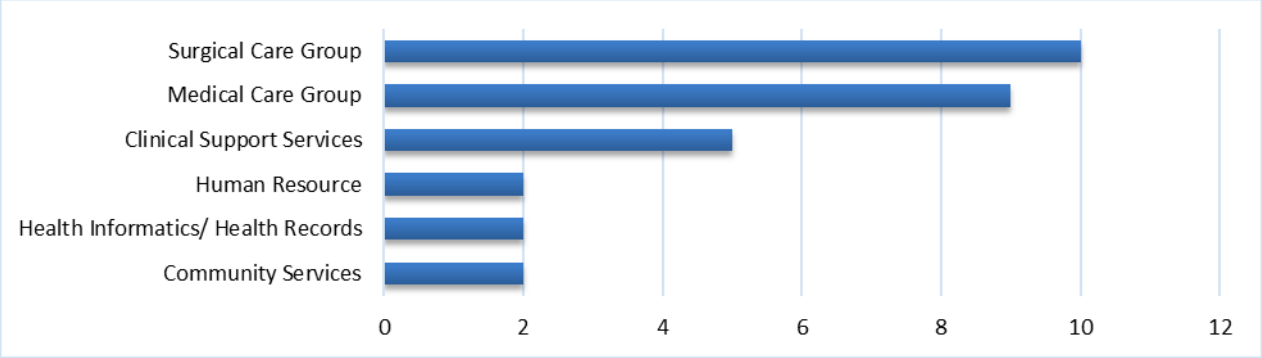
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

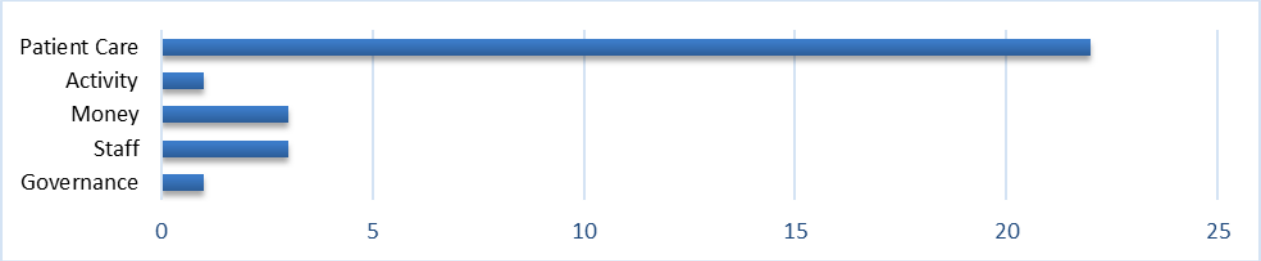
This report (appendix 1) is based on Datix information and covers the risks reported and reviewed during March 2023. The report shows,

- The total number of risks on the risk register was 820 compared to 861 in January
- 55.12% (452) of the Trust's reviewed risks are rated as Moderate or High, compared to 56.6% (480) in January.
- There are 30 high/extreme risks that have been escalated to the CRR (appendix 2) compared to 30 in January.

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



The risk categories of the CRR risks are -



The report also includes comparisons of the Trust risk profile with the previous quarterly report (January 2023) and against the same period last year – April 2022 (Appendix 3).

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

Financial implications: None directly from this report.

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

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 26th April 2023

Appendix 1

CORPORATE RISK REGISTER REPORT – APRIL 2023

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/04/2023	Previous Reporting Period 01/03/2023	Previous Reporting Period 01/02/2023
Number of new risks reported	44	19	22
Number of risks closed or removed	59	30	24
Number of increased risk scores	1	6	4
Number of decreased risk scores	15	20	24
Number of risks overdue for review	72	87	85
Total Number of Datix risks	**820***	**835**	**857**

** Includes 9 risks that have been reported but not yet scored or approved in DATIX as it is a live system, remainder of the report is based on the 811 scored risks.*

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

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
33	**32**	**17**	**88**	**9**	**180**	**70**	**157**	**29**	**158**	**18**	**9**	**11**	**0**
82 = 10.11%			**277 = 34.16%**			**414 – 51.05%**				**38 = 4.69%**			

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

2.1 Surgical Care Group – 202 risks reported 24.91% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**6**	**3**	**14**	**3**	**39**	**25**	**42**	**11**	**41**	**9**	**1**	**3**	**0**
14 = 6.93%			**56 = 27.72%**			**119 = 58.91%**				**13 = 6.44%**			

2.2 Medical Care Group – 131 risks reported 16.15% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**5**	**2**	**11**	**2**	**23**	**7**	**18**	**10**	**32**	**4**	**3**	**5**	**0**
16 = 12.21%			**36 = 27.48%**			**67 = 51.15%**				**9 = 9.16%**			

2.3 Clinical Support Care Group – 126 risks reported 15.54% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**3**	**0**	**16**	**0**	**25**	**9**	**26**	**6**	**30**	**3**	**1**	**1**	**0**
9 = 7.14%			**41 = 32.54%**			**71 = 56.35%**				**5 = 3.97%**			

2.4 Primary Care and Community Services Care Group – 49 risks reported 6.04% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
3	**1**	**0**	**6**	**0**	**15**	**1**	**9**	**1**	**11**	**2**	**0**	**0**	**0**
4 = 8.16%			**21 = 42.86%**			**22 = 44.90%**				**2 = 4.08%**			

2.5 Corporate – 303 risks reported 37.36% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**17**	**12**	**41**	**4**	**78**	**28**	**62**	**1**	**44**	**0**	**4**	**2**	**0**
39 = 12.87%			**123 = 40.59%**			**135 = 44.55%**				**6 = 1.98%**			

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

	High	Moderate	Low	Very low	**Total**
Facilities (Medirest/TWFM)	0	13	13	6	**32**
Nursing, Governance, Quality & Risk	1	15	16	4	**36**
Health Informatics/ Health Records	2	18	13	5	**38**
Finance	1	10	24	8	**43**
Medicines Management	0	24	28	4	**56**
Human Resource	2	55	29	12	**98**
Total	**6**	**135**	**123**	**39**	**303**

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

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

Appendix 2 - Summary of the Corporate Risk Register – April 2023

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies, **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	31/03/2023	4 x 2 = 8	✓	Strategic People Committee
2	Money	1152	**If** there is an increase in bank and agency, **then** there is a risk to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	31/03/2023	4 x 3 = 8	✓	Finance & Performance Committee
3	Patient Care	1263	**If** the Trust cannot achieve the required numbers of patient discharges and transfers, **then** there is a risk to operational performance	3 x 3 = 9	3 x 5 = 15	18/07/2022 Rob Cooper	30/03/2023	3 x 2 = 6	✓	Executive Committee
4	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	08/02/2023	4 x 3 = 12	✓	Executive Committee
5	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance, **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	18/01/2023	4 x 2 = 8	✓	Finance & Performance Committee
6	Patient Care	2082	**If** there is no robust established daily process for review of all medical patients who remain in the ED/EAU due to the lack of an available bed on the ward, **then** this can result in patient safety and experience issues	4 x = 12	3 x 5 =15	27/05/2022 Peter Williams	08/01/2023	3 x 2 = 6	✓	Quality Committee
7	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	06/03/2023	2 x 2 = 4	✓	Quality Committee
8	Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels, **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 3 = 12	4 x 5 = 20	09/12/2021 Rob Cooper	30/03/2023	2 x 4 = 8	✓	Executive Committee
9	Patient Care	2545	**If** the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, **then** there is a risk that compliance with this standard may not be maintained	4 x 4 = 16	4 x 4 = 16	21/07/2021 Sue Redfern	28/03/2023	4 x 2 = 8	✓	Quality Committee
10	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient for diagnostic imaging results	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	03/02/2023	5 x 2 = 10	✓	Quality Committee
11	Patient Care	2767	**If** inpatient maternity staffing shortfalls persist **then** there could be a negative impact on patient safety. It will also have an impact on patient experience. Inpatient maternity staffing shortfall	3 x 3 = 9	3 x 5 = 15	23/03/2022 Sue Redfern	30/03/2023	2 x 3 = 6	✓	Quality Committee
12	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to	5 x 4 = 20	5 x 4 = 20	21/10/2020	20/03/2023	5 x1= 5	✓	Quality Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
			delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.			Rob Cooper				
13	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	31/03/2023	3 x 2 = 6	✓	Executive Committee
14	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas, **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	27/10/2020 Sue Redfern	13/02/2023	3 x 2 = 6	✓	Executive Committee
15	Staff	3178	**If** there are not sufficient staff in post in blood sciences, **then** there is a risk to service delivery	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	15/03/2023	4 x 2 = 8	✓	Strategic People Committee
16	Patient Care	3199	**If** medical patients are to 'forward wait' on a medical ward **then** there is a risk to patient safety, dignity, and experience	4 x 4 = 16	4 x 4 = 16	02/11/2021 Sue Redfern	08/03/2023	4 x 1 = 4	✓	Executive Committee
17	Patient Care	3251	**If** the current end of life solution for outpatient letter printing fails before a replacement system is implemented, **then** there is a risk that letters will be delayed or could impact other EPR functionality	4 X 5 = 20	4 X 5 = 20	21/10/2021 Christine Walters	21/03/2023	1 x 1 = 2	✓	Executive Committee
18	Patient Care	3349	**If** the stock of Olympus scopes is not maintained, **then** there is a risk to business continuity for the endoscopy service	4 x 5 = 20	4 x 5 = 20	29/04/2022 Rob Cooper	03/02/2023	4 x 2 = 8	✓	Executive Committee
19	Patient Care	3371	**If** medical wards are to accommodate an additional patient due to insufficient medical beds, **then** there is a risk to patient safety, dignity and patient experience.	4 x 4 =16	4 x 4= 16	29/04/2022 Sue Redfern	08/03/2023	2 x 2 = 4	✓	Executive Committee
20	Money	3392	If capital funding is not approved to purchase specialist replacement endoscope equipment, then Patients may need to undergo 2 separate procedures	3 x 3 = 9	3 x 5 = 15	03/02/2023 Rob Cooper	03/02/2023	3 x 2 = 6	✓	Executive Committee
21	Patient Care	3475	**If** there is a delay in NWAS transferring patients who have had a stroke for neuro radiology intervention(thrombectomy), **then** this can make a significant difference to patient outcomes.	4 x 5 = 20	4 x 4 = 16	09/08/2022 Rob Cooper	10/02/2023	4 x 1 = 4	✓	Executive Committee
22	Patient Care	3496	**If** there are insufficient staff to provide effective Operational Site Management overnight, **then** there could be an impact on patient safety	3 x 3 = 9	3 x 5 = 15	27/10/2022 Sue Redfern	15/02/2023	3 x 1 = 3	✓	Executive Committee
23	Patient Care	3527	**If** there is not sufficient plastic surgery capacity commissioned **then** non urgent patients in North Wales may face extended waits to be seen, and there will be a reduction in follow up appointments for cancer patients	4 x 5 = 20	4 x 5 = 20	21/09/2022 Rob Cooper	22/03/2023	4 x 1 = 4	✓	Executive Committee
24	Patient Care	3532	**If** the ENT service does not have the appropriate equipment, **then** it will not be compliant with BAHNO recommendations for nasoendoscopy	3 x 5 = 15	3 x 5 = 15	30/11/2022 Rob Cooper	15/03/2023	3 x 2 = 6	✓	Executive Committee
25	Patient Care	3535	**If** operational pressures mean that a 5th surgical patient needs to be accommodated in the bays on surgical wards, **then** there is a requirement for additional staffing to provide the required level of care	5 x 4 = 20	5 x 4 = 20	15/11/2022 Sue Redfern	17/03/2023	5 x 2 = 10	✓	Executive Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
26	Patient Care	3574	**If** Careflow does not allocate patients correctly **then** there is a risk that outpatient appointments will not be scheduled	3 x 5 = 15	3 x 5 = 15	09/11/2022 Rob Cooper	03/02/2023	3 x 3 = 9	✓	Executive Committee
27	Money	3598	**If specialist orthopaedic drills are not replaced before the current equipment becomes obsolete, then theatre productivity will decrease**	3 x 5 = 15	3 x 5 = 15	23/02/2023 Rob Cooper	23/02/2023	3 x 2 = 6	✓	Executive Committee
28	Patient Care	3600	**If there are not the required number of surgical diathermy machines, then patient procedures could be cancelled**	3 x 5 = 15	3 x 5 = 15	09/02/2023 Rob Cooper	09/02/2023	3 x 1 = 3	✓	Executive Committee
29	Staff	3624	**If there are not suitable trained staff available out of hours to support clinicians, then endoscopy therapeutic interventions could be delayed.**	3 x 5 = 15	3 x 5 = 15	19/01/2023 Sue Redfern	19/01/2023	3 x 1 = 3	✓	Executive Committee
30	Patient Care	3647	**If the design of the endoscopy suite at St Helens is not adapted to meet national guidance for single sex recovery facilities, then there is a risk of not maintaining JAG accreditation.**	3 x 5 = 15	3 x 5 = 15	09/03/2023 Rob Cooper	09/03/2023	3 x 2 = 6	✓	Executive Committee

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

Risks that have been de-escalated from the CRR or closed since January are

Risk Category	Datix Reference	Risk Description
Operational Risk	767	**If** ED are unable to recruit to nursing vacancies and maintain nursing establishment **then** there is a risk to patient safety
Patient Care	2080	**If** the Emergency department is congested with lack of flow, **then** there is an increased likelihood of patients being cared for on the corridors which will affect Patient privacy and dignity, safety, quality of care, Patient experience, Staff morale, and Ambulance Turnaround compliance
Patient Care	3180	**If** the Trust cannot secure sufficient staff to undertake supplementary care for the patients who need it, **then** there is a risk to the quality and safety of care
Governance	3302	**If** the Trust does not centralise the Subject Access Request process and ensure Information Governance is part of this process, **then** there is a risk data breaches will continue to occur, and the Information Commissioner's Office (ICO) will issue further warnings. Centralising the Subject Access Request Process due to ICO Infringement Order
Patient Care	3482	**If** the trust cannot offer attractive posts for junior Drs that meet the deanery requirements**, then** the number of trainees allocated to the Trust could be reduced.

Appendix 3

Trust Risk Profile – January 2023

Comparison of the Trust risk profile in the last Board Report

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
36	**35**	**16**	**87**	**9**	**185**	**72**	**170**	**33**	**175**	**9**	**10**	**11**	**0**
87 = 10.26%			**281 = 33.14%**			**450 = 53.07%**				**30 = 3.54%**			

Trust Risk Profile – April 2022

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

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

ENDS

NHS
St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)038
Title of paper: Review of the Board Assurance Framework (BAF) – April 2023
Purpose: For the Executive Committee to review and agree any proposed changes to the BAF that will be recommended to the Trust Board.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in January 2023. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. Please note, the objectives matrix has not yet been updated for the 2023/24 Trust objectives because they are to be approved at the April Board meeting. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** Risk 2 – proposed to reduce to 8 as 2022/23 financial plan achieved Risk 3 – proposed to reduce to 16 in recognition of new financial year and plans to achieve operational targets for 2023/24 Risk 6 – proposed to reduce to 15 in recognition of safe staffing fill rates/ International nurse recruitment etc.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE, CQC, ICB
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 26th April 2023

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

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

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Original Risk Score	Key Controls	Sources of Assurance	Current Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with ICP/ICB • NHSE/I Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20	Development of a revised Clinical Strategy (Post Transaction Clinical Strategy now being developed)	Routinely achieve 30% of discharges by midday 7 days a week Demonstrate a reduction in similar incidents because of sharing lessons learnt from incidents, never events, claims, inquests, and mortality reviews (review included in Quality Account to be approved in May 2023) ~~Revise the maternity performance dashboard in line with Ockenden recommendations (Included in the shadow IPR which will be implemented in full in April)~~ Alignment of key clinical and quality policies across the new organisation (September 2023)	Deteriorating patient improvement project – Project resources in place for 12 months, with quarterly updates to CEC – final evaluation report March 2024) Birth Rate Plus review of maternity staffing (report not yet finalised – now rescheduled for June 2023) ~~Improve mandatory and core skills training compliance (Revised to March 2023)~~ ~~Delivery of the 2022/23 CNST Maternity Safety Bundle (March 2023)~~ Undertake a deep dive in to falls and the impact of the falls action plan (deferred to May 2023) ~~Review ward quality audit programme and reporting (February 2023)~~	5 x 1 = 5	PW/ SR

Risk 2 – Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSE/I Single Oversight Framework rating • NHSE Protocol Impact; • Unable to deliver viable services • Loss of market share • External intervention • Investment decisions double lock process	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSE annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/Sos • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports (Inc. GIRFT) • Annual audit programme • CQUIN monitoring Other; • NHSE & ICB monthly reporting • Contract Monitoring Board • NHSE & ICB Review Meetings • Use of Resources reviews • Contract Review Boards • St Helens Place Based Partnership Board • ICB Reporting & Peer to Peer Reviews • Financial sustainability self-assessment	4 x 3 = ~~12~~ 4 x 2 = 8	Continue collaboration across C&M to deliver transformational CIP contribution ~~2022/23 contracts remain unsigned for the C&M ICB (December 2022)~~	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g., as lead employer to maintain cash balances ~~Reduction in bank and agency spend compared to 2021/22 (March 2023)~~	Seek all possible sources of capital funding including national bids to support capacity planning (Ongoing) ~~Continue to monitor impact of COVID-19 on elective recovery plans and achievement of planned ERF income (March 2023)~~ ~~Delivery of the agreed 2022/23 financial plan (March 2023)~~ Delivery of final agreed 2023/24 financial plan (March 2024)	4 x 2= 8	GL

Risk 3 – Sustained failure to maintain operational performance/deliver contracts	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit reps • ICB CEO Meetings •	~~4 x 5=20~~ 4 x 4 = 16	Implementation of routine capacity and demand modelling	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow COVID-19 and restoration escalation plan to release capacity and trigger mutual aid in place and operational. Assurance that there is sufficient system response to operational pressures and delayed discharges – additional community beds managed by the Trust are operational Phase 2 – Discharge Lounge improvement work to optimise capacity (audit of effectiveness taking place and will be reported to Executive Committee – May 2023)	~~Widnes UTC ICB Review (September 2022)~~ Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) ~~Deliver the 2022/23 waiting list reduction and recovery targets (March 2023)~~ ~~Maintain capability to respond to future waves of COVID and/or flu with minimum disruption to other services (March 2023)~~ Assess the impact on activity of the opening of the new Royal Liverpool Hospital (formal evaluation planned after 6 months – Analysis to be completed May 2023)	4 x 3 = 12	RC

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

Risk 5 – Failure to work effectively with stakeholders	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSE/I Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M ICB leadership and programme boards • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley Place Directors to develop plans for PBPs in these Boroughs • Annual staff engagement events programme • ED&I Steering Group • Member of CMAST Provider Collaborative	4 x 3 = 12	Effective working with the Shaping Care Together programme in Southport and Formby and West Lancashire	C&M Integrated Care System performance and accountability framework ratings and reports Development of good working relationships with the ~~new~~ Primary Care Networks New NHS Operating framework in place ~~with Hewitt review on going~~	~~Continued engagement with C&M ICB and CMAST as part of the system response to COVID-19 and restoration and recovery.~~ Continue as a full partner of St Helens Place Based Partnership, contributing to the delivery of the improvement objectives Work with NHSE and other Providers to provide management support for S&O fragile services (ALTC extended as Transaction date delayed) Work with NHSE/ICB and national colleagues to progress the formal transaction with S&O (May 2023) ~~Work with Place system partners to coordinate responses to UEC pressures and maintain patient flow (March 2023)~~ Deliver 92% bed occupancy target for each PBP (March 2024)	4 x 2 = 8	AMS/RC

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management Strategy	To Board; • Strategic People Committee • People Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce operational plans • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • National Quarterly Pulse Surveys • WRES, WDES, EDS3 pilot and Gender Pay Gap, reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Group Other • HR benchmarking • Nurse & Midwifery staffing benchmarking	~~5 x 4 = 20~~ 5 x 3 = 15	~~Equality Delivery System 2 – action plan (February 2023)~~ Increase frequency of the Strategic People Committee meetings in 2023/24 Evaluation of the impact of introducing 12 hour long day nursing shifts (October 2023)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with HEE's ~~Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3~~ Capacity to deliver the recovery and restoration plans via the CDC (September 2023) Establish diagnostic collaborative bank (Revised to September 2023) ~~Develop sustainable COVID vaccination programme staffing arrangements, retention, and reservist initiatives for C&M (Revised to March 2023)~~ Achieve 2023/24 targets for international recruitment and Nurse Associate expansion (March 2024)	~~Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going)~~ ~~Restoration of appraisal and mandatory training compliance with the 85% target (March 2023)~~ Delivery of the 2022 staff survey action plan (March 2024) ~~Refreshed People Strategy 2023 – 25 (Revised to February 2023)~~ Completion of the TUPE transfer of S&O staff (consultation completed, transfer will take place on the date of the transaction) Revise reporting (Datix) system to allow more robust recording of incidents relating to ED&I and Staff safety (Datix replacement now scheduled for September 2023) Achieve the Mandatory Training and Appraisal compliance targets of 85% (March 2024)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards ~~and social distancing (COVID-19)~~ • Compliance with NHS Estates HTMs • Green Plan	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns/Data • PLACE Audit Results and benchmarking • Premises Assurance Model benchmarking • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Maintain 10 year strategic estates development plan to support the Trusts service development and integration strategies. Create strategic site development plans for the S&O hospital sites when transaction completed.	Implementation of new National Standards of Cleaning - continued engagement with NHSE and proposals agreed with IPC (May 2023) Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken) ~~Test compliance against HTM/HBN guidance revised because of COVID learning.~~ Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published	3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2023/24) Delivery of the Whiston Additional Theatres Scheme (2023/24) ~~Delivery of the 2022/23 approved capital schemes~~ ~~Delivery of additional CDC and TIF capital schemes (Revised to March 2023)~~	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Original Risk Score	Key Controls	Sources of Assurance	Current Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share contracts	4 x 5= 20	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Careflow/MDF benefits realisation programme monitoring	4 x 4= 16	Annual Corporate Governance Structure review Technical Development	ISO27001 ~~Service Improvement Plans~~ IT Communications Strategy Digital Maturity Assessment	Review benefits of ISO27001 – if not superseded plan for implementation revised to March 2024 Achieve HIMMS Level 5 2018 standards and minimum digital foundation and WGLL standards (March 2025) Migration from end-of-life operating systems to include decommissioning of Microsoft 2012 (October 2023) Delivery of the EPR Digital Maturity Programme (March 2025) Delivery of Community EPR (Completion revised to July 2023) Respond to cyber threat alerts and update systems as required (on going) Test major incident and data recovery plans (June 2023)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)039

Title of paper: Trust Objectives 2023/24

Purpose: To review and agree the draft Trust Objectives for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), in anticipation of the transaction with Southport and Ormskirk Hospital NHS Trust.

Summary:

1. The STHK Trust Board agreed thirty-one Trust objectives for 2022/23 which incorporated the quality improvement objectives. As part of the Agreement for Long Term Collaboration with Southport and Ormskirk Hospital NHS Trust annual objectives were also set in 2022/23 for that organisation. The final appraisal of whether these objectives have been achieved will be presented in May/June 2023.
2. The Executive Committee has now drafted Trust Objectives for the anticipated new organisation for 2023/24 for approval by the Trust Board, so they can be launched to Trust staff at the Start of the Year Conference which is scheduled for Friday 28th April 2023.
3. The objectives have been drafted on the assumption that the transaction with Southport and Ormskirk Hospital NHS Trust (S&O), to create Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) will proceed.
4. The Trust Board had already agreed that the new Trust will retain the vision of delivering Five Star Patient Care.
5. The draft objectives are therefore split into 9 categories: 5 representing the Trust's Five Star Patient Care criteria of care, safety, pathways, communication, and systems. A further 4 categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency, and productivity; and strategic planning are also included.
6. The same 2023/24 quality improvement objectives have been included in the Quality Accounts of both STHK and S&O and are incorporated into the proposed Trust objectives. These were agreed following a consultation exercise with staff and stakeholders:

    i. Implement and embed the national Patient Safety Incident Response Framework (PSIRF) (Patient safety)
    ii. Continue to ensure the timely and effective assessment and care of patients in the Emergency Department (Patient safety)

iii. Ensure patients in hospital remain hydrated (Clinical effectiveness) iv. Improve the effectiveness of the discharge process for patients and carers (Patient experience) v. Improve the overall experience for women using the Trust's Maternity Services (Patient experience)
Trust objective met or risk addressed: for the Board to set the annual objectives for the new Trust that will advance the vision of delivering Five Star Patient Care.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff, patients, regulators, and all stakeholders.
Recommendation(s): The Board approves the 2023/24 Trust objectives
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 26th April 2023

DRAFT 2023/4 Trust Objectives

Objective	Lead Director	Measurement	Governance Route	Comments
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Quarterly audit of most dehydrated patients to ensure appropriate treatment in place, including IV fluids/fluid balance	Quality Committee	Quality Account improvement objective
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	MD	• % of patients with triage >15 minutes who have observations undertaken prior to triage • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trusts Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring	Quality Committee	Quality Account improvement objective
1.3. Recognise our deteriorating patients, providing individualised patient-centred care to achieve the right outcome for the patient	MedD/DoN	• Provide education and training for staff to understand how to identify and respond to patient deterioration. • Timeliness of NEWS observations • Completion of deteriorating patient proformas for all patients a NEWS of 5 or above.	Quality Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Implement and embed the national Patient Safety Incident Response Framework (PSIRF) (QA)	DoN	• Approval of business case for required staffing to implement and maintain PSIRF • Development of Trust-wide education plan • Launch and implementation of PSIRF in line with national requirements	Executive Committee	Quality Account Improvement objective
2.2 Create a unified safety culture for the new Trust	DoN	• Align the Incident reporting, risk, and incident management, FTSU, safeguarding and IPC frameworks across the new Trust • Provide clear guidance and appropriate training/guidance for staff where the existing reporting systems need to change. • Agree year 1 quality improvement objectives for each service as part of integration planning	Executive Committee	
2.3 Improve the overall experience for women using the Trust's Maternity Services (QA)	DoN	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys of women receiving maternity care; • Increasing involvement of women and their partners in their care • Increased access to medical history of the mother and baby • Increased information about induction and labour • Increased information about physical recovery after birth • Support for infant feeding • Increasing involvement of women and their partners in their care • Timely discharge • Increased access to medical history of the mother and baby Develop an action plan to deliver the National Maternity Strategy (March 2023) recommendations and deliver the year one objectives.	Quality Committee	Quality Account Improvement objective

Objective	Lead Director	Measurement	Governance Route	Comments
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)	MD	• Improved Inpatient Survey satisfaction rates for receiving discharge information • Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 20% target for patients discharged before noon during the week • Baseline audit of sample of delayed discharges to identify if delay in receiving take home medications and other hospital processes were the primary factors in the delay, with target to reduce this in subsequent quarterly audits	Quality Committee	Quality Account improvement objective
3.2 Improve access to the Urgent Community Response Team	MD	• Respond to 70% of calls within 2 hours • Increase the number of local pathways for direct access to services and making these more accessible to patients • Reduce unnecessary GP appointments	Finance and Performance Committee	2023/24 planning guidance
3.3 Cancer – Early Diagnosis Ambition	MD/ MedD	• Increase the % of cancer's diagnosed at stage 1 and 2 in line with the 75% early diagnosis ambition by 2028 • Achieve the NHS Faster Diagnosis Standard (FDS) for Cancer to ensure that 75% of patients referred with a suspicion of cancer have a this diagnosed or ruled out within 21 days of referral. • Ensure that local pathways support the delivery of the FDS through the FDS Prioritisation Group.	Finance and Performance Committee	2023/24 planning guidance

Objective	Lead Director	Measurement	Governance Route	Comments
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Implement a new speech recognition system to improve the turnaround times for clinic letters	DoI/MD/ MedD	• Implement the new system and train staff in its use • Achieve a 48 hour (working week) turnaround target by June 2024	Finance & Performance Committee	
4.2 Improve complaints response times	DoN	• 80% of first stage complaints to have a formal response within 60 working days by Q4 • % of complaints resolved with the first response to increase to 85%	Executive Committee	
4.3 Create new staff communication and engagement processes that reflect the enlarged organisation, are accessible for all staff, irrespective of where they work and promote a single culture and values.	DoHR	• Achieve a higher level of participation in the new trust communications systems e.g., Trust Brief Live • Create a range of communication channels to suit staff in different roles and locations • Create two way communications mechanisms • Evaluate the success/impact of Trust wide communications in the first year of the new Trust	Strategic People Committee	
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Deliver the 2023/24 Frontline Digitisation Programme Milestones	DoI	• Achieve minimal digital foundation standards as part of the “What good looks like” framework • Produce the EPR replacement Outline Business Case and achieve NHSE/Treasury approval. • Secure the 2023/24 element of the technology funds award	Executive Committee	
5.2 Convergence of the digital agenda between the STHK and S&O legacy systems to optimise	DoI	• Create a single digital services team to provide a standardised response across all Trust sites and maintain system access	Executive Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
performance and develop a single IT strategy for the new organisation		• Create a single EPR team to maximise the potential to improve patient care • Improve the reliance and resilience of technology platforms at the Southport and Ormskirk Hospital sites, so that clinicians have access to the systems they need to provide high quality patient care • Develop a new IT performance dashboard to ensure a consistent service is provided across the Trust as quickly as possible		
5.3 Improve access to patient information via the implementation of Narrative Digital Clinical Documentation.	DoI	• Clinicians can access the patient information they need • Patient information entered electronically only has to be entered once.	Executive Committee	
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				
People Plan Pillars – Looking After our People				
6.1 Align HR policies for the new Trust, ensuring that all staff have access to the same levels of support wherever they work	DoHR	• Harmonise HR policies where appropriate, and ensure all HR policies are reviewed and current by Q3 • Provide a consistent range of support services to improve the health, well-being, and resilience of staff • Develop standardised inclusive leadership training and guidance for managers to implement the new Trust policies.	Strategic People Committee	
People Plan Pillars - Belonging to the NHS				
6.2 Support the integration of the two trusts teams into to a single organisational structure	DoHR	• Agree the priority actions from the two trust 2022 staff surveys to improve staff experience and engagement and deliver them in 2023/24 • Provide a wide ranging package of support for services/staff groups that are integrating to deliver the new trust operating model, including HR, OD and wellbeing	Strategic People Committee	

		• Provide bespoke change management support/training aligned to the Organisational Change Policy as the new management and leadership structure is created.		
6.3. Improve mandatory training compliance, so that all staff across the Trust are equipped with the core skills and knowledge they need to perform effectively.	DoHR	• Achieve 85% compliance with mandatory training collectively and for all staff groups • Align the mandatory training requirements and TNAs across the new Trust, so that all staff are clear on what is expected. • Review delivery models for mandatory training with subject matter experts, to ensure this is fit for purpose for the new organisation	Strategic People Committee	
6.4 Embed a standardised approach to annual appraisals for the new Trust to support staff to deliver high quality patient care.	DoHR	• Working with subject matter experts create a single approach to high quality and effective appraisals for all staff, based on good practice and acting on feedback from the two former Trust's Staff Surveys. • Achieve 85% compliance with staff appraisals collectively and across all staff groups	Strategic People Committee	
People Plan Pillar – New Ways of Working				
6.5 Optimise time to care by implementing a single approach to e-rostering, activity manager and e-job planning systems to ensure the optimal deployment of the workforce to achieve the right number and skill mix of staff	DoHR	• Standardise the application of e-rostering and e–job planning across all sites • Monitor and evaluate the efficacy of the e-rostering and e-job planning applications to support workforce deployment requirements to achieve safe patient care and enable flexible working	Executive Committee	
People Plan Pillar – Growing for the Future				
6.6 Make the Trust the best place to work by increasing opportunities for new staff to join the organisation and existing staff to fulfil their ambitions for career development and progression within our organisation.	DoHR	• Recruit additional nurses and medical and dental staff via international recruitment programmes • In partnership with the Medical Director and Director of Nursing, Midwifery & Governance continue to create a strong pipeline of new clinical roles including Trainee Nurse Associates, Advanced Clinical Practitioners and Physician Assistants	Strategic People Committee	

		• Support flexible approaches to working, maximising the new pensions flexibilities and retire and return options • Expand the internal transfer scheme to all areas of the Trust to improve retention rates • Continue to create diverse and innovative offerings to aid recruitment and retention in staff groups with a traditionally high turnover • Maximise the use of the apprenticeship levy to support more staff to undertake further training in Advanced Clinical Practice and Leadership Development		
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Elective Care Recovery	MD	• Eliminate waits of over 65 weeks for elective care by March 2024(except where the patient chooses to wait longer) • Deliver the system specific activity targets assigned to the Trust • Maximise the capacity and efficiency of the Trusts resources to reduce long waiting times. • Provide mutual aid in specific specialities to support the delivery of system recovery targets	Finance and Performance Committee	2023/24 planning guidance
7.2 Urgent and emergency care	MD	• Improve A&E waiting times so that no less than 76% of patient are seen within 4 hours by March 2024 • Achieve year 1 planned progress in achieving the 95% target for diagnostic tests to be completed within 6 weeks by March 2025 • Consistently achieve ambulance handover times of less than 30 minutes • Increase the number of direct access pathways for assessment/speciality review	Finance and Performance Committee	2023/24 planning guidance

7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g GiRFT to ensure that all services meet best practice standards	MD	• Continued participation in national programme of GiRFT and other reviews and delivery of the resulting action plans and use these to inform the new organisations Clinical Strategy • Previous review action plans monitored at committee level to provide assurance that change has resulted in improved metrics • Complete the integration of services across the new Trust and optimise service delivery utilising the available estate and facilities to address the fragile services at Southport and Ormskirk	Finance and Performance Committee	
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Continue working with partner organisations in the Cheshire and Merseyside Integrated Care System to develop and deliver opportunities for collaboration at scale to increase efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration with system partners	Executive Committee	
8.2 Delivery of the agreed 2023/24 Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2023/24 • Delivery of the agreed Cost Improvement Programme and transaction business case benefits • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme, to progress the strategic estates delivery plans	Finance and Performance Committee	
8.3 Deliver the agreed capital schemes	DoCS	• Progress the strategic site development plans, including additional theatre, bed, and diagnostic capacity • Reduce the high risk back log maintenance at the Southport and Ormskirk Hospital sites and improve facilities for patients and staff.	Finance and Performance Committee	

9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements, including post transaction conditions whilst working collaboratively to achieve system success	DoCS	• Meet statutory and regulatory responsibilities/requirements, including for unified reporting for the new Trust both internally and externally • Meet the post transaction integration, performance and delivery plans including the agreed transaction benefits.	Trust Board	
9.2 Work with each of the Place Based Partnerships where the Trust provides services to improve the health of the local population	DoInt/ MD	• Position the Trust as a key partner in each Place Based Partnership • Maximise the potential of the Trust as an anchor institution in our communities to improve health, education, and employment. • Work in partnership to achieve the 92% acute bed occupancy ambition to improve patient flow in hospital and ensure medically optimised patients are discharged at the right time, to an appropriate care setting to meet the patients' individual needs	Trust Board	
9.3 Ensure the Trust continues to influence and fully participate in the Integrated Care System to achieve a clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations • Continue the development of effective Provider Collaboratives that enhance collaboration and integration of services and coordinate delivery of the elective activity targets by maximising system capacity	Trust Board	
9.4 Take forward the Shaping Care Together Programme to identify the options to achieve a safe and sustainable service configuration between Southport and Ormskirk Hospital Sites for agreement with the Cheshire and Merseyside and Lancashire and South Cumbria ICBs, to be put forward for public consultation.	MD/ DoCS	• Continue to develop plans to address the fragile clinical services at the Southport and Ormskirk sites, working with clinicians across the new Trust and other providers as necessary • Develop a plan, with the Shaping Care Together programme that will deliver sustainable clinical services	Trust Board	