St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 31ST MAY 2023
BOARD ROOM, 5TH FLOOR, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
10.00	1.	Employee of the Month Film - May 2023		Verbal	Assurance	Chair
10.15	2.	Patient Story		Verbal	Assurance	Chair
10.30	3.	Apologies for Absence		Verbal		
10.35	4.	Declaration of Interests		Verbal		
10.40	5.	Minutes of the Board Meeting held on 26th April 2023		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.50	6.	Integrated Performance Report		NHST (23)040	Assurance	Gareth Lawrence
		6.1	Quality Indicators			Sue Redfern
		6.2	Operational Indicators			Peter Williams
		6.3	Financial Indicators			Gareth Lawrence
		6.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
11.15	7.	Committee Report – Executive		NHST (23)041	Assurance	Ann Marr
11.25	8.	Committee Report – Finance & Performance		NHST (23)042	Assurance	Jeff Kozer
11.35	9.	Committee Report – Quality		NHST (23)043	Assurance	Rani Thind

11.45	10.	Committee Report – Strategic People	NHST (23)044	Assurance	Lisa Knight

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.55	11.	Aggregated Incidents, Complaints and Claims Report	NHST (23)045	Assurance	Sue Redfern
12.05	12.	Approval of Quality Account	NHST (23)046	Approval	Sue Redfern
12.15	13.	2022-23 Trust Objectives Review	NHST (23)047	Assurance	Ann Mar
12.25	14.	Learning from Deaths Quarter 4	NHST (23)048	Assurance	Peter Williams
12.35	15.	Review of Complaints Process	NHST (23)049	Approval	Sue Redfern
Closing Business					
12.45	16.	Effectiveness of Meeting	Verbal	Assurance	Chair
	17.	Any Other Business		Information	
	18.	Date of Next Meeting – 28th June 2023		Information	

Title of paper: Supporting the best start for women and babies through the support of the Infant Feeding team.

Date of meeting: 31/05/2023

Background.

The Infant Feeding Team was established in 2008 to increase the breastfeeding initiation rates and lead on the implementation of the UNICEF Baby Friendly Initiative care standards in maternity. The team support patients with their feeding choices through antenatal education and provides advice and support before and after birth. The team support in-patients in the maternity and neonatal unit, paediatric wards and throughout the wider Trust. The team also support outpatients through telephone and face to face contact.

For women and their families, being a new parent is an exciting but often confusing experience. To help new parents, the team provide a weekly drop-in clinic which is extremely well attended where they receive advice and support irrespective of their feeding choices. This support is invaluable for improving health outcomes and addressing health inequalities for women and babies. The infant feeding team have developed effective multi-disciplinary team working to ensure women and their babies are provided with the correct support and advice, with the aim to reduce unnecessary re admissions to hospital.

The team also provide training and support for all maternity and neonatal unit staff, including doctors. The team also complete clinical audits for the UNICEF Baby friendly programme, which is a national requirement for maternity services.

The infant feeding team drop-in clinic is supported by the Trust volunteer service, who is an invaluable part of the team and fulfils an essential role our busy drop-in clinic, welcoming and booking in families and providing reassurance. A second volunteer has now been allocated.

The team recently achieved our highest ever breastfeeding initiation rate within the Trust (65.7% of births that occurred in March 2023) which is more than a 100% increase in initiation rates from when the team was first established, and the team are committed in their efforts to continue this trend.

The patient/family experience.

Lizzie accessed support from the Infant feeding team and will be providing an account of her experience to Trust Board.

This account will reflect Lizzie's second experience of the infant feeding team, and specifically the drop-in clinic. Lizzie firstly engaged with the infant feeding team with her son Reggie who was born 4 and a half years ago and currently with daughter Sophie who was born on 20th March 2023. Lizzie has had infant feeding support for very different issues with both babies. Lizzie experienced gestational diabetes in her pregnancy and Sophie was born prematurely at 36+6 weeks gestation and had complications that required enhanced care due to jaundice and weight loss. Thankfully all of those issues have now resolved, and Sophie is thriving.

Lizzie is a local GP and has informed us that the infant feeding team treated her like any other mother and not like a GP "that should be in the know already". Unfortunately, Lizzie had felt that there was a lack of support for her to continue breast-feeding from other healthcare professionals outside of the maternity service, but that the infant feeding team provided her with

the confidence, advice, information, and support to continue.

In her role as a GP, Lizzie has also been able to advertise the infant feeding team with other GP colleagues and patients.

The service improvements that Lizzie suggested would be beneficial are:

Provision of tea and coffee

Pre covid, tea and coffee and other light refreshments were provided at the infant feeding team drop-in clinic whereas now only light refreshments are provided. This helped to make the clinic more informal and encouraged parents to stay and form relationships with each other once they have received specific support from the team. This had been invaluable in the past with son Reggie, as Lizzie did not have a local support network, and this provided her the opportunity to meet likeminded people and create close friendships. This is something that Lizzie would be keen to see return to the drop-in clinic.

Mother and baby parking

Currently this is not provided, and it makes attending hospital with a small infant in a car seat or a pram difficult to navigate.

Lessons learned.

There is a requirement to increase knowledge and skills in relation to infant feeding for neonatal/ paediatric staff including medical staff to ensure women are provided with consistent, evidence-based information, advice, and support to enable the maintenance of breast feeding.

Next steps.

Parental education -The team are keen to develop a Padlet (easy and intuitive customisable interface/platform accessed via a user password) which can keep families informed as to what support is available and includes links to our videos and leaflets. This will be accessible at any time.

Staff education – The team are committed to provide evidence-based practice education to all relevant staff who are required to provide infant feeding support.

Improving attendance at antenatal workshops-
- Explore the feasibility to send invitation texts to patients.
- Review the ability to share presentations, videos and links to the Trust website (and Padlet) for patients to review at home. This would support the service to fulfil our communication pledges within the Trust Maternity Strategy and the IT vision of providing a completely digitised experience.

Service expansion- Review of the provision of the infant feeding team to support and maintain the increase in breastfeeding initiation and continuation rates and provide enhance feeding support. as the team currently provides a Monday to Friday 9-5 service.

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Lizzie's story.

Supporting the best start for women and babies through the support of the infant feeding team.

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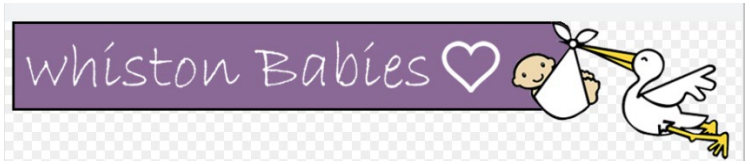
The infant feeding team

- Established in 2008
- 2.4wte (1.4 Midwives/1.0 support) Mon-Fri 9-5
- Parent and Staff education
- Direct patient care
- Telephone support
- Readmissions to maternity and paediatrics
- Implementing UNICEF Baby Friendly Initiative
- Increasing breastfeeding initiation and continuation rates
- Drop in clinic



St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Reggie and little sister Sophie

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

The Infant Feeding Drop In Clinic

- 10 am - 12 noon every Friday (except bank holidays) Parentcraft Room 2nd floor Whiston
- It is extremely well attended by families living within St Helens, Knowsley, Halton and beyond we expect between 10-20 families per week.
- Families receive advice and support irrespective of their feeding choices.
- This support is invaluable for improving health outcomes, addressing health inequality as well as providing a point of contact in the team for evidence-based information sharing.
- The clinic is supported by the Trust volunteer service, our volunteers are an invaluable part of the team and fulfilling an essential role our busy drop-in clinic, welcoming and booking in families and providing reassurance.

The service improvements that Lizzie suggested would be beneficial are

Mother and baby parking provision

Provision of tea and coffee.

Next steps……

- ***Parental education -*** The team are keen to develop a Padlet (easy and intuitive customisable interface/platform accessed via a user password) which can keep families informed as to what support is available and includes links to our videos and leaflets. This will be accessible at any time.
- ***Staff education -*** The team are committed to provide evidence-based practice education to all relevant staff who are required to provide infant feeding support. The team are highly motivated to continue the development of close working relationships with our colleagues across the Trust who may encounter women and babies who need infant feeding support.
- ***Improving attendance at antenatal workshops -*** Explore the feasibility to send invitation texts to families and review the ability to share presentations, videos and links to the Trust website (and Padlet) for them to review at home. This would support the service to fulfil our communication pledges within the Trust Maternity Strategy and the IT vision of providing a completely digitised experience.
- ***Service expansion -*** Review of the provision of the infant feeding team to support and maintain the increase in breastfeeding initiation and continuation rates and provide enhanced feeding support, as the team currently provides a Monday to Friday 9-5 service. We aspire to extend the service to enhance the focus on direct patient care in the future.

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 - Verbal
58	22.02.23 (12.15)	Review of complaints process	SR	31.05.23 – Agenda

Integrated Performance Report

Integrated Intelligence & Improvement Service

St Helens and Knowsley Teaching Hospitals NHS Trust

Board Summary

Overview

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.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jan-23	86.9	100		Top 30%
Friends and Family Test: % Recommended	Apr-23	95.0%	90.0%	95.0%	Top 50%
Nurse Fill Rates	Mar-23	98.4%			
C.difficile	Apr-23	5		5	Bottom 40%
E.coli	Apr-23	9		9	Top 30%
Pressure Ulcers (Avoidable level 2+)	Mar-23	12		36	
Falls With Harm	Mar-23	5		55	
Stillbirths	Apr-23	0	0	0	
Never Events	Apr-23	0	0	0	
Complaints Responded In Agreed Timescale %	Mar-23	85.7%			

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-23	70.7%	75.0%		Bottom 50%
Cancer 62 Days	Mar-23	79.2%	85.0%		Top 10%
30 Minute Ambulance Breaches	Apr-23	374	0	374	
A&E Standard	Apr-23	73.7%	95.0%	73.7%	Bottom 30%
Average NEL LoS (excl Well Babies)	Apr-23	3.4		3.4	Top 20%
Average Number of Super Stranded Patients	Apr-23	127		127	
Discharges Before Noon	Apr-23	16.9%	33.0%	16.9%	
G&A Bed Occupancy	Mar-23	97.3%			Bottom 10%
Patients Whose Operation Was Cancelled	Apr-23	1.0%	0.8%	1.0%	
RTT 18+	Apr-23	18,131	0	18,131	Top 50%
RTT 52+	Apr-23	1,775	0	1,775	Bottom 30%
% of E-discharge Summaries Sent Within 24 Hours	Apr-23	60.5%	90.0%	60.5%	
OP Letters to GP Within 7 Days	Mar-23	19.7%			

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-23	83.9%	85.0%	83.9%	
Mandatory Training	Apr-23	82.2%	85.0%	82.2%	
Sickness: All Staff Sickness Rate	Apr-23	5.8%	4.3%	5.8%	Top 10%
Staffing: Turnover rate	Apr-23	0.9%		0.9%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Apr-23	600	12,200	600	
Cash Balances - Days to Cover Operating Expenses	Apr-23	19	10	19	
Reported Surplus/Deficit (000's)	Apr-23	427	5,588	427	

Board Summary - Quality

Quality

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 April 2023. (YTD = 0).
There were no MRSA cases in April 2023. (YTD = 0).
There were 5 C. Difficile (CDI) positive cases reported in April 2023 (4 hospital onset and 1 community onset). (YTD = 5). The annual tolerance for CDI for 2023-24 has not yet been published (the 2022-23 limit is being used in the absence of publication of the 2023-24 objectives).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for April 2023 was 99.5%. YTD rate is 99.5%.
During the month of March 2023 there were 2 falls resulting in severe harm or death category. (2022-23 YTD severe harm or above category falls = 29).
There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in March 2023. (2022-23 YTD = 1).
Community incident reporting levels decreased to 67 in the month of March 2023 compared to 118 in the previous year of 2022. 54 incidents were reported to be due to pressure skin damage, all recorded as no harm.
YTD HSMR (April - January) for 2022-23 is 92.9

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Jan-23	86.9	100		Top 30%	
Friends and Family Test: % Recommended	Apr-23	95.0%	90.0%	95.0%	Top 50%	
Nurse Fill Rates	Mar-23	98.4%				
C.difficile	Apr-23	5		5	Bottom 40%	
E.coli	Apr-23	9		9	Top 30%	
Pressure Ulcers (Avoidable level 2+)	Mar-23	12		31		
Falls With Harm	Mar-23	5		52		
Stillbirths	Apr-23	0	0	0		
Never Events	Apr-23	0	0	0		
Complaints Responded In Agreed Timescale %	Mar-23	85.7%				

Board Summary - Operations

Operations

Performance against the 62 day cancer standard was below the target of 85.0% in month (March 2023) at 79.2%. YTD 80.9%. The 31 day target was achieved in March 2023 with 98.5% performance in month against a target of 96%, YTD 97.5%. The 2 week rule target was not achieved in March 2023 with 87.9% in month and 78.9% YTD against a target of 93%. The deterioration in performance for 2 week rule, is related to the significant increase in referrals, compared to the same period in 2019, resulting in capacity challenges.

Accident and Emergency Type 1 performance for April 2023 was 51.3% and YTD 51.3%. The all type mapped STHK Trust footprint performance for April 2023 was 73.7% and YTD 73.7%. The Trust saw average daily attendances of 311, which is down compared to March, at 324. Total attendances for April 2023 was 9,330.

Total ambulance turnaround time was not achieved in April 2023 with 53 mins on average. There were 2,291 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,182 in March 2023.

The UTC had 4,890 attendances in the month of March, compared to 3,716 in the month of February. Overall, 97% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in April 2023 was 127 compared with 127 in March. 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 April 2023 with 62.4% compliance and YTD 62.4% (Target 92%). Performance in March 2023 was 62.3%. There were (1,775) 52+ week waiters. The 6 week diagnostic target was not achieved in April 2023 with 65.0% compliance. (Target 99%). Performance in March 2023 was 68.8%.

There was a slight increase in referrals received within the District Nursing Service in March however, the levels are still within average range (495 in March compared to 470 in February). The overall caseload size has seen a slight decrease to 1,084 in March compared to 1,291 in February. March saw a Community matron caseload of 148, compared to 132 in the month of February. 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. In addition, both nursing and medical trainee industrial action has resulted in cancellation of elective activity, particularly in medical specialties. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Integrated Performance Report

Integrated Intelligence & Improvement Service

St Helens and Knowsley Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Mar-23	70.7%	75.0%		Bottom 50%	
Cancer 62 Days	Mar-23	79.2%	85.0%		Top 10%	
30 Minute Ambulance Breaches	Apr-23	374	0	374		
A&E Standard	Apr-23	73.7%	95.0%	73.7%	Bottom 30%	
Average NEL LoS (excl Well Babies)	Apr-23	3.4		3.4	Top 20%	
Average Number of Super Stranded Patients	Apr-23	127		127		
Discharges Before Noon	Apr-23	16.9%	33.0%	16.9%		
G&A Bed Occupancy	Mar-23	97.3%			Bottom 10%	
Patients Whose Operation Was Cancelled	Apr-23	1.0%	0.8%	1.0%		
RTT 18+	Apr-23	18,131	0	18,131	Top 50%	
RTT 52+	Apr-23	1,775	0	1,775	Bottom 30%	
% of E-discharge Summaries Sent Within 24 Hours	Apr-23	60.5%	90.0%	60.5%		
OP Letters to GP Within 7 Days	Mar-23	19.7%				

Board Summary - Workforce

Workforce

There was a decrease in the rate of absence from 6.1% in March to 5.8%. The rate for all Nursing and Midwifery staff group decreased from 7.9% in March 2023 to 7.5%.
N.B This includes normal sickness and COVID19 sickness reasons.
Appraisal compliance has dipped from March to 83.9% ,just below target. Mandatory training compliance continues to improve at 82.2% in April compared to 81.5% in March .

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Apr-23	83.9%	85.0%	83.9%		
Mandatory Training	Apr-23	82.2%	85.0%	82.2%		
Sickness: All Staff Sickness Rate	Apr-23	5.8%	4.3%	5.8%	Top 10%	
Staffing: Turnover rate	Apr-23	0.9%		0.9%		

Board Summary - Finance

Finance

The Trust's Board approved 2023/24 financial plan was submitted to NHSE on 4th May, at a surplus of £5.6m. In order for the Trust to deliver this plan, it will need to achieve the elective recovery active target of 107%, Trust CQUIN target and a CIP target of £28.4m (c.5%), of which £7.0m (c.1%) is to be delivered non-recurrently.
At Month 1, the Trust is reporting a surplus of £0.4m, in line with plan. This however assumes that there will be no reduction for underperfromance of elective recovery during April.

Surplus/Deficit - At Month 1, the Trust is reporting a YTD surplus of £0.4m, in line with plan.
CIP - The Trust's 2023/24 CIP target is £28.4m, of which £21.4m is to be delivered recurrently and £7.0m non-recurrently. As at Month 1, schemes delivered or at finalisation stage totalled £12.4m in year and £3.6m recurrently. Work will continiue in order to increase the level of recurrent CIP during the first quarter.
Cash - At the end of M1, the cash balance was £40.8m which is broadly in line with plan.
Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £0.6m. No PDC funding (provided by Department of Health & Social Care) has been used.

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Apr-23	600	12,200	600		
Cash Balances - Days to Cover Operating Expenses	Apr-23	19	10	19		
Reported Surplus/Deficit (000's)	Apr-23	427	5,588	427		

How to Interpret - Summary Table

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-22	81.6	100	88.2	Top 20%
Friends and Family Test: % Recommended	Sep-22	93.9%	90.0%	94.8%	Bottom 50%
Nurse Fill Rates	Sep-22	93.7%		93.7%	
C.difficile	Sep-22	2	6	33	Bottom 50%
E.coli	Sep-22	10		38	Top 40%
Pressure Ulcers (Avoidable level 2+)	Aug-22	6		21	
Falls With Harm	Aug-22	4		23	
Stillbirths	Sep-22	0	0	0	
Hospital Associated Thrombosis (HAT)					
Complaints Responded In Agreed Timescale %	Sep-22	66.7%		71.6%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-22	70.4%	75.0%	73.7%	Top 50%
Cancer 62 Days	Aug-22	76.0%	85.0%	82.4%	Top 10%
30 Minute Ambulance Breaches	Sep-22	418	0	2,200	
A&E Standard	Sep-22	47.3%	95.0%	47.3%	Top 30%
Average NEL LoS (excl Well Babies)	Sep-22	3.6		3.6	Top 20%
Average Number of Super Stranded Patients	Sep-22	155		135	
Discharges Before Noon	Sep-22	22.9%	33.0%	21.9%	
G&A Bed Occupancy	Sep-22	97.3%		97.3%	Bottom 10%
Patients Whose Operation Was Cancelled	Sep-22	1.1%	0.8%	1.0%	
RTT 18+	Sep-22	14,455	0	14,455	Top 50%
RTT 52+	Sep-22	2,424	0	2,424	Bottom 40%
% of E-discharge Summaries Sent Within 24 Hours	Sep-22	63.4%	90.0%	62.4%	
OP Letters to GP Within 7 Days	Sep-22	19.7%		19.6%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-22	83.5%	85.0%	64.7%	
Mandatory Training	Sep-22	78.7%	85.0%	77.8%	
Sickness: All Staff Sickness Rate	Sep-22	5.9%	4.3%	6.4%	Top 10%
Staffing: Turnover rate	Sep-22	0.8%		1.1%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ m YTD	Sep-22	500	26,100	4,300	
Cash Balances - Days to Cover Operating Expenses	Sep-22	28	10	28	
Reported Surplus/Deficit (000's)	Sep-22	-2,188	-4,949	-2,188	

The IPR is broken into four sections: **Quality**, **Operations**, **Workforce** and **Finance**.

Each section has a number of metrics underpinning it. In addition to the metric name, the summary table has the following columns:

- **Period** – this is the latest complete months data available for that metric
- **Score** – this is the performance for the month as defined by the 'Period'
- **Target** – this is the target, where applicable
- **YTD** – this is the performance for the Financial Year to Date (Apr to latest month as defined by the 'Period')
- **Benchmark** – where available this makes use of national YTD data to benchmark against other Trusts. For some metrics a low value is good (eg C.Difficile) and for others a high value is good (e.g. 62 day cancer %). Regardless of whether a low metric value is good or bad, the Top 10% represents where STHK are in the top 10% best performing Trusts for a given metric. The bottom 10% represents where STHK are in the 10% worst performing Trusts.

Metric Category Description - Quality

Quality Metrics

Mortality – HSMR (low score is good)
Hospital Standardised Mortality Ratio (HSMR) is a ratio of observed deaths to expected deaths. HSMR uses a basket of 56 diagnosis groups that nationally account for circa 80% of in-hospital deaths. A score of 100 means that the Trust has the same number of deaths as expected. A score of less than 100 means the Trust has less deaths than expected and a score of greater than 100 means STHK had more deaths than expected. Where the HSMR is greater than 100 but RAG rated amber – this means that although there were more deaths than expected it is not statistically. If HSMR is RAG rated red, this means that there is a statically significant higher number of deaths compared to expected levels.

Friends & Family Test: % Recommended (high score is good)
The inpatient Friends and Family test

Nurse Fill Rates (high score is good)
The Registered Nurse/Midwife Overall (combined day and night) Fill Rate

C.Difficile (low is good)
The number of hospital onset and community onset Clostridium Difficile cases.

E.Coli (low is good)
The number of Escherichia coli cases.

Pressure Ulcers (Avoidable level 2+) (low is good)
The number of avoidable hospital acquire pressure ulcers of grade 2 or higher

Falls with harm (low is good)
Number of falls in hospital resulting in either moderate harm, severe harm or death

Stillbirths (low is good)
Number of Stillbirths (death occurring during labour - intrapartum)

Never Events (low is good)
The number of never events

Complaints Responded in Agreed Timescales (high is good)
The percentage of new (Stage 1) complaints resolved in month within the agreed timescales

Metric Category Description - Operations

Operational Metrics

Cancer Faster Diagnosis Standard (high is good)
Percentage of patients having either cancer ruled out or diagnosis informed within 28 days of being referred urgently by their GP for suspected cancer.

Cancer 62 days (high is good)
Percentage of patients that have first treatment within 62 days of being referred urgently by their GP for suspected cancer.

30 Minute Ambulance Breaches (low is good)
Number of ambulance patients waiting over 30 minutes from arrival to handover

A&E Standard (high is good)
Mapped Footprint A&E attendances: The percentage of attendances whose total time in ED was under 4 hours.

Average NEL LOS (excluding well babies) (low is good)
Average Non-Elective length of stay (excluding well babies)

Average Number of Super Stranded Patients (low is good)
The average number of patients in hospital whose length of stay is 21 days or more.

Discharges Before Noon (high is good)
The percentage of patients either discharged from the ward or transferred to the discharge lounge between 7am and noon. Please note this is only for patients with a length of stay of 1 day or more

G&A Bed Occupancy (low is good)
The percentage of General and Acute beds occupied

Patients Whose Operation Was Cancelled (low is good)
Percentage of operations cancelled at the last minute for non-clinical reasons. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery

RTT 18+ (low is good)
The number of patients waiting 18 weeks or more for treatment to commence from referral.

RTT 52+ (low is good)
The number of patients waiting 52 weeks or more for treatment to commence from referral.

% E Discharge Summaries Sent Within 24 Hours (high is good)
Percentage of inpatient E-Discharge summaries sent within 24 hours

OP Letters to GP Within 7 Days (high is good)
Percentage of outpatient E-attendance letters sent within 14 days

Metric Category Description - Workforce

Workforce Metrics

Appraisals (high is good)
Percentage of staff that have a valid appraisal

Mandatory Training (high is good)
Percentage of staff that are compliant with mandatory training

Sickness: All Staff Sickness Rate (low is good)
Percentage of WTE calendar days lost due to sickness

Staffing: Turnover Rate (low is good)
The in-month staff turnover rate

Metric Category Description - Finance

Finance Metrics

Capital Spend £M
Capital Spend £M

Cash Balances – Days to Cover Operating Expenses
Cash Balances – Days to Cover Operating Expenses

Reported Surplus/Deficit (000's)
Reported Surplus/Deficit (000's)

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-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%	93.1%	83.3%	100.0%	100.0%	100.0%	88.0%	81.8%	100.0%	100.0%	100.0%	95.7%	93.1%	94.2%	85.0%		96.0%		
	Total > 62 days		0.0	1.0	2.0	0.0	0.0	0.0	1.5	2.0	0.0	0.0	0.0	0.5	1.0	8.0			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	▲£	86.7%	90.5%	76.5%	79.3%	65.2%	83.3%	42.9%	66.7%	66.7%	57.1%	44.4%	62.5%	78.9%	69.2%	85.0%		79.7%		
	Total > 62 days		1.0	1.0	2.0	3.0	4.0	2.0	4.0	1.0	1.0	6.0	5.0	3.0	2.0	34.0			24.5		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	2.0	0.0	1.0	8.0			4.0		
Upper GI	% Within 62 days	▲£	36.4%	90.0%	84.6%	100.0%	85.7%	70.0%	75.0%	80.0%	93.8%	71.4%	83.3%	100.0%	72.7%	83.5%	85.0%		83.2%		
	Total > 62 days		3.5	0.5	1.0	0.0	1.0	1.5	1.0	1.0	0.5	2.0	1.0	0.0	1.5	11.0			9.5		
	Total > 104 days		1.0	0.5	0.0	0.0	0.0	0.5	1.0	0.0	0.5	1.0	1.0	0.0	1.0	5.5			3.0		
Urological	% Within 62 days	▲£	93.9%	90.0%	81.0%	79.2%	78.1%	85.0%	73.1%	83.3%	78.2%	87.9%	75.6%	68.4%	78.0%	78.2%	85.0%		80.5%		
	Total > 62 days		1.0	1.5	4.0	2.5	3.5	1.5	3.5	2.5	6.0	2.0	5.5	6.0	4.5	43.0			32.5		
	Total > 104 days		0.0	0.0	0.0	0.5	1.5	0.5	1.5	1.0	0.0	0.0	0.5	1.5	1.0	8.0			4.0		
Head & Neck	% Within 62 days	▲£	50.0%	16.7%	0.0%	44.4%	0.0%	25.0%	0.0%	0.0%	0.0%	66.7%	42.9%	16.7%	100.0%	20.0%	85.0%		24.4%		
	Total > 62 days		1.0	2.5	3.5	2.5	1.5	1.5	1.5	4.5	3.5	0.5	2.0	2.5	0.0	26.0			15.5		
	Total > 104 days		0.0	0.0	2.0	0.5	0.0	0.5	1.0	2.0	1.5	0.5	1.0	1.5	0.0	10.5			2.0		
Sarcoma	% Within 62 days	▲£		100.0%							100.0%	0.0%	100.0%	0.0%	100.0%	66.7%	85.0%		100.0%		
	Total > 62 days			0.0							0.0	1.0	0.0	0.5	0.0	1.5			0.0		
	Total > 104 days			0.0							0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Gynaecological	% Within 62 days	▲£	60.0%	75.0%	66.7%	100.0%	45.5%	25.0%	50.0%	75.0%	80.0%	0.0%	0.0%	50.0%	44.4%	53.2%	85.0%		67.3%		
	Total > 62 days		2.0	1.0	2.0	0.0	3.0	4.5	1.0	1.0	0.5	1.0	1.0	1.0	2.5	18.5			17.0		
	Total > 104 days		1.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	0.0	0.5	0.5	4.5			2.5		
Lung	% Within 62 days	▲£	55.6%	50.0%	92.3%	69.6%	30.8%	64.7%	66.7%	85.7%	70.6%	36.4%	77.8%	46.2%	50.0%	63.7%	85.0%		77.2%		
	Total > 62 days		2.0	1.5	0.5	3.5	4.5	3.0	1.5	1.5	2.5	3.5	1.0	3.5	4.0	30.5			18.0		
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.5	0.0	0.0	1.5	1.0	1.5	0.0	5.5			1.5		
Haematological	% Within 62 days	▲£	0.0%	100.0%	100.0%	75.0%	75.0%	69.2%	0.0%	80.0%	75.0%	60.0%	60.0%	71.4%	25.0%	65.6%	85.0%		60.5%		
	Total > 62 days		2.0	0.0	0.0	1.0	2.0	2.0	1.0	0.5	1.0	2.0	2.0	1.0	3.0	15.5			17.0		
	Total > 104 days		1.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0			5.0		
Skin	% Within 62 days	▲£	100.0%	97.7%	93.4%	95.5%	86.9%	79.7%	92.8%	90.3%	92.3%	86.7%	90.5%	94.1%	90.8%	90.9%	85.0%		93.3%		
	Total > 62 days		0.0	1.0	2.5	1.5	5.5	7.5	2.5	5.5	3.0	5.0	3.5	2.0	4.0	43.5			29.5		
	Total > 104 days		0.0	0.0	1.0	1.0	2.0	0.0	0.0	0.5	1.0	1.5	2.0	0.0	2.0	11.0			1.5		
Unknown	% Within 62 days	▲£		100.0%		100.0%	100.0%	100.0%	100.0%			100.0%		0.0%	50.0%	82.6%	85.0%		88.2%		
	Total > 62 days			0.0		0.0	0.0	0.0	0.0			0.0		1.0	1.0	2.0			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	▲£	86.3%	90.3%	83.2%	85.4%	77.6%	76.0%	78.4%	82.6%	83.3%	76.9%	79.0%	77.8%	79.2%	80.9%	85.0%		85.2%		
	Total > 62 days		12.5	10.0	17.5	14.0	25.0	23.5	17.5	19.5	18.0	23.0	21.0	21.0	23.5	233.5			170.5		
	Total > 104 days		3.0	1.5	3.0	3.0	7.5	2.5	6.0	3.5	3.5	6.5	7.5	5.0	5.5	55.0			24.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£	100.0%	66.7%	100.0%	100.0%			0.0%		100.0%	100.0%			100.0%	81.8%	85.0%		100.0%		
	Total > 31 days		0.0	1.0	0.0	0.0			1.0		0.0	0.0			0.0	2.0			0.0		
	Total > 104 days		0.0	0.0	0.0	0.0			0.0		0.0	0.0			0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲£					100.0%					100.0%		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)041
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 April 2023. There were three Executive Committee meetings held during this period because of the Easter bank holiday and the need to prepare for the Junior Doctors industrial action. There were no new investment decisions were made during this period. At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration and preparation for the proposed transaction.
Trust objectives met or risks addressed: All Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 31st May 2023

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were three Executive Committee meetings held during April 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. 13th April 2023

2.1 Industrial Action

The Managing Director reported on the impact of the junior doctors' industrial action over the Easter bank holiday weekend. Although there had been fewer staff than usual in some areas, safe levels of care had been maintained for patients throughout. The support of consultant and other medical staff who had stepped in to maintain safety and care for the patients was recognised and the committee expressed its thanks. The main impact had been on elective patients and the waiting list backlog because planned activity was cancelled to free capacity to staff the unplanned and emergency areas.

It was noted that the Royal College of Nursing was planning a further period of industrial action over the May bank holiday weekend, and planning had commenced to manage the hospital services during this period.

2.2 Integrated Performance Report (IPR)

The Director of Finance and Information presented the draft IPR for March and the committee reviewed the KPI performance and any areas where further commentary was required.

2.3 Risk Management Council Chairs Assurance Report

The Risk Management Council (RMC) had not taken place because business continuity arrangements had been initiated in preparation for the junior doctors' industrial action, but the papers had been prepared and circulated.

The Managing Director presented the report and noted that the total number of risks recorded at the end of March was 820, of which 811 had been graded and 30 of these had been escalated to the Corporate Risk Register (CRR). No new high/extreme risks had been added to the CRR in March.

2.4 Emergency Department Patient Harm Review

The Director of Nursing, Midwifery and Governance introduced the paper which explored the impact of the operational pressures experienced in quarter 3 and January and February data from 2022/23, and specifically how long waits and corridor use had affected patients.

The report covered falls, complaints and incidents and reported how processes and policies in the department had been adapted to respond to the challenges of corridor care and longer waiting times. This included adding oxygen condensers that could be used on the corridors

for patients requiring low levels of oxygen, and a policy of moving patients with higher oxygen needs into a cubicle. Low rise trolleys had been purchased to reduce the risk of falls. The hard work of the teams to make these challenging circumstances as safe as possible was noted. The number of incidents reported correlated with the period of highest operational pressures and greatest demand (December 2022). The number of complaints received had actually reduced during this period.

2.5 Southport and Ormskirk Hospital NHST

The NHSE Provider Transformation team had confirmed that although the Strategy, Performance and Investment Committee had not gone ahead on 4th April the transaction risk rating recommendation had been circulated to members for a decision to be made by correspondence. This decision was expected by 17th April and assuming the rating was green or amber the next stage would be ministerial approval.

The Director of Finance and Information briefed the committee on the challenges of securing auditors to undertake part year audits following the transaction delay.

The Deputy CEO/Director of HR reported that the CQC were conducting a system review of social care in Sefton, and S&O would be a participant.

3. 20th April 2023

3.1 Trust objectives 2023/24

The Director of Corporate Services presented the draft objectives for 2023/24 proposed by each Director. It was noted that these had been drafted as combined objectives for the post transaction organisation. With a small number of amendments, the objectives were agreed to be recommended to the Trust Board for approval.

3.2 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly review of the BAF and the committee agreed a number of changes that would be recommended to the Trust Board.

3.3 Appraisal and Mandatory Training Compliance

Appraisal compliance was stable at 87% in March and mandatory training compliance had increase slightly to 81%. Committee discussed the actions that had been taken to improve compliance levels for medical and dental staff and with the mandatory face to face fire safety training module for clinical staff.

3.4 Testing of IT systems

The Director of Informatics presented a paper setting out the lessons learnt and proposed changes to the pre implementation testing process for any IT system upgrades, with the objective to avoid unforeseen consequences. The new process involved greater levels of user involvement and sign off. However, it was highlighted that old legacy systems that had been adapted locally and were unsupported by the supplier would always be more vulnerable. To mitigate this, additional audits would take place to understand how these systems were used operationally before upgrades were planned.

3.5 Southport and Ormskirk Hospital NHST

A historic never event dating from 2015 had been detected and reported.

The new electronic prescribing system had been successfully piloted in the Spinal Injuries Unit.

The Director of Corporate Services reported that the NHSE Transaction rating decision had been delayed, but it was reported there were no queries or concerns for the Trust to answer. The NHSE Regional Director (North West) and Director of Provider Development were scheduled to meet with ministers and Department of Health officials to discuss the issues raised by the Southport MP in relation to the future strategic service reconfiguration.

Key pre day one actions for the transaction continued to be progressed as far as possible via the weekly transaction programme board. This board had escalated the need for subject matter experts to be identified at both trusts and supported to work together to progress the core clinical safety policies that needed to be harmonised as soon as the organisations came together. All directors agreed to support this work.

4. 27th April 2023

4.1 Safer Staffing Report - March

The report included the headline staffing fill rates for March and a deep dive into the impact of staffing in February 2023. The overall RN/RM full rate was over 98% and the HCA fill rate was 122% in March. This continued the improving trend since January. Committee reflected on the impact of the introduction of 12 hour shifts, which had been requested by staff. A formal evaluation of the 12 hour shifts would be undertaken later in the year, when they had been operational on all wards for 6 months. This would include an assessment of the impact on bank and agency spend. Additional work was being undertaken to improve the process for requesting and recording supplementary care shifts and linking these to individual patients.

The report also provided an update on recruitment and retention rates for nurses. The improvements in time to hire for registered nurses was noted. The committee requested that actions be expedited to reduce this period. There were currently 37 offers made and 11 international nurses due to join the Trust in May.

4.2 2022/23 Quality Account

The draft quality account was considered by the committee and progress against the 2022/23 quality priorities reviewed. Following final updates, the draft would be circulated to stakeholders for comment and then was due to be approved at the Trust board in May.

4.3 Harm Reviews – Electronic Document Management System (EDMS) Upgrade

The Medical Director presented the final report following completion of the harm reviews, where some actions had not been followed up, after the EDMS system upgrade. 2636 patient

letters were originally identified as being impacted by the system change, which were all triaged. Of these 108 were identified as needing a full harm review. These reviews found that for 104 patients there had been no harm but for 4 there had been a slight delay in treatment (which had caused no physical detriment).

The Director of Informatics reminded the committee that the issue with EDMS had been rectified so no further patients would be impacted.

4.4 Partnership Update

The Director of Integration briefed the committee on the development of the ICB five year strategy and Joint Forward Plan with each of the place based partnerships.

The paper also included a briefing on the actions that had been agreed following the recent discharge summit.

St Helens place had recently published an annual report detailing progress in 2022/23 and setting out its ambitions for 2023/24.

The Mid-Mersey Boroughs Collaborative had also recently met and were focusing on joint working opportunities in relation to admissions avoidance, neuro diversity pathways and establishing a workforce skills academy.

4.5 Southport and Ormskirk Hospital NHS Trust

The Director of Transformation is leaving S&O for a secondment to CMAST, and a handover had taken place. This will enable momentum to be maintained in relation to supporting the fragile services and the strategic service reconfiguration programme.

There was no transaction update, because the position had been discussed in depth at the Board meeting the previous day.

4.6 RCN Industrial Action

Committee discussed the plans for the scheduled industrial action and the outcome of the high court decision about the end of the RCN mandate.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)042
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 25th May 2023

Summary

Meeting attended by:

J Kozer – NED & Chair
P Growney – NED
I Clayton – NED
G Appleton - NED
R Cooper – Managing Director STHK
G Lawrence – Director of Finance & Information
P Williams – Medical Director
J McCabe – Divsional Medical Director - Surgery
J Foo – Assistant Director of Operations - Medical Care
B Woodall – Assistant Director of Operations - CSS
T Truong – Finance Business Partner – CSS/Community

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was below the 85% target in March, at 79.2%.
- Target 31 day performance was met in March, at 98.5% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in March, at 87.9% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 51.3% in April. All type mapped STHK Trust footprint performance was 73.7% in April.
- The ambulance turnaround time target was not achieved in April, at 53 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- In April, overall sickness had decreased to 5.8% from 6.1% in March.

B) Finance Report Month 1

- At Month 1, the Trust is reporting a year to date surplus of £0.4m which was in line with plan.
- Included within the financial position are non-recurrent benefits of approximately £8.5m YTD which are offsetting pressures in relation to underachievement of national Elective Recovery Fund (ERF) income, non-pay inflation and the 22/23 pay award impact above funded levels. These underlying pressures have been included in the 23/24 financial planning process.
- Capital expenditure for April (excluding PFI lifecycle maintenance) totals £0.6m.
- At the end of Month 11, the Trust has a cash balance of £40.8m.
- Agency expenditure of £1.3m is included in the position. This exceeds the 3.7% target that has been set nationally. Work is ongoing within Care groups on reducing the agency bill.
- The financial position does not include any impact for PbR changes. The Trust awaits central guidance on how activity will be dealt with as a result of the impact industrial action.
- The financial position does not include the expenditure impact of the industrial action.
- The Trust continues to see high levels of inflation on products which are currently being non recurrently mititgated

C) CIP Programme Update/Medical Care Update

- The Trust continues to work towards the CIP target of £28.4m of which £21.4m to be delivered recurrently and £7m to be delivered non recurrently.
- Over £31m of ideas have been currently generated throughout the Trust
- The Trust has delivered/finalised £15.8m of schemes.
- Medical Care continue to have high level of engagement throughout the caregroup focussing on
    - Maximising productivity
    - 95% challenge through all specialities
    - Budget holder cost controls

D) Elective Recovery

- Progress continues to be made in achieving elective recovery targets
- 65+ week patients continue reduce and are montired on a weekly basis
- Continued focus on
    - Diagnistic waits
    - 62 day cancer
    - Validation
- April activity was affected by industrial actions but continues to be strong in comparison to 19/20 activity.

For Information

- **Capital Council Update** – Update noted by the committee
- **Procurement Steering Council Update** – Update noted by the committee

Risks noted/items to be raised at Board

N/A

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: J Kozer, Non-Executive Director
Date of meeting: 31st May 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)043
Reporting from: Quality Committee
Date of Committee Meeting: 23rd May 2023
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Geoffrey Appleton, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery and Governance Peter Williams, Medical Director Rob Cooper, Managing Director Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance **In attendance:** Anne Rosbotham-Williams, Deputy Director of Governance Debbie Stanway, Head of Nursing and Quality, Medical Care Group 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 Teresa Keyes, Deputy Director of Nursing and Quality 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 Hayley Proudlove, Head of Strategic Resourcing Louise Ford, Corporate Matron Sean Brady, Senior Pharmacy Technician Quality & Safety
Matters Discussed The action log was discussed with one action due in July and two actions outstanding. **Quality Account 2022-23** The draft annual Quality Account was presented, noting that it had been shared with stakeholders last week, with positive comments noting that the Trust remains outstanding. The work to ensure patients in the Emergency Department are managed safely was also commended, as well as the positive patient and staff survey results and the achievement of the best national results for the Patient-led Assessment of the Care Environment (PLACE). The Committee noted that there is no longer a requirement to have the account independently audited, but requested

that this is undertaken next year following the transaction with Southport and Ormskirk Hospital NHS Trust. The Committee approved the draft account for submission to May's Board meeting for final approval.

Integrated Performance Report (IPR)
The IPR was discussed by the Committee and the following points were highlighted:

- Trust-level bed occupancy remains high at 97.3%, which includes paediatric beds; the rate for general and acute adult beds is higher and above 100% which is impacting on patient flow and congestion in the Emergency Department
- 62 day cancer standard was 79.2% in March, which is below the target of 85%, however the Trust is the best performing trust in Cheshire and Merseyside and continues to deliver the 31 day target
- National shortages of key clinicians, including pathology, are impacting on the achievement of some targets, with plans in place at specialty level to mitigate risks
- The Committee noted that there had not been a decrease in ED attendances during periods of industrial action in April
- Meetings had been held with North West Ambulance Service to work together to improve ambulance handovers and with system leaders to look at standardising processes, building on the work undertaken in St Helens Place
- The threshold for clostridium difficile infections has been set at 46 this year, compared to 56 for 2022-23, noting the 18% reduction will be challenging. An infection prevention summit is planned to look at how this can be achieved

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

- Update on proactive learning identified from new born screening incidents
- Patient safety report highlighting learning from 3 StEIS reported incidents and 15.89% reduction in rate of falls per 1000 bed days
- Safeguarding, highlighting significant activity. It was noted that the assurance amber rating is being removed to leave compliant or non-compliant, with two areas currently not being achieved in relation to training and looked after children health assessments completed within the timescale. The Committee noted the collaboration being undertaken with the local authority to improve health assessment compliance
- Bevan Court 2 falls reduction plan noted the significant improvement in reducing falls following the work with the Falls Team, which included improved risk assessments, care planning and documentation. The Committee noted the work being undertaken to increase the skills of agency staff providing supplementary care
- Nursing care indicators, Medical and Surgical Care Groups safety report, claims and inquests report, Central Alerting System assurance report and manual handling report were also received and discussed at the meeting

Incidents, Serious Incidents Thematic Review and Never Events Quarterly Report

- The report summarised information for quarters 3 and 4, noting one never event and that falls were the highest reported serious incident. The Trust continues to support a good incident reporting culture and has a similar level of severe and above harm incidents compared to national figures

Nurse/Midwife Staffing Quarter Four Report

The Committee received a detailed report showing increased fill rates for both qualified and unqualified staff, with a reduction in the number of agency requests and wards with fill rates below 90% and 85%. It was noted that no reported incidents of staffing shortfalls resulted in patient harm. The Committee noted the work underway to collate accurate figures for supplementary care to obtain a detailed picture of demand and ability to meet this. Future reports will include ED and theatres to ensure full understanding of all areas. The work to increase recruitment and retention was shared noting the significant reduction in staffing gaps and the number of staff currently in the recruitment pipeline. A target of 40 days for recruitment has been agreed, which will contribute to further reduce gaps.

CQuIN Quarter 3 Report

The report noted that of the 13 national indicators in scope, two were not achieved relating to:

- 65% referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones set out in rapid cancer diagnostic and assessment pathways
- Achieving 70% of patients with confirmed Community Acquired Pneumonia to be managed in concordance with British Thoracic Society CAP care bundle as the CURB 65 score is not being consistently recorded, with action being taken to increase the recording of this in ED, AMU and respiratory

It was noted that there were no financial penalties applied for 2022-23 and that discussions are ongoing with commissioners to finalise this year's CQuINs.

Medicines Management Audit Report

The report noted the sustained improvement in medicines management across the Trust, noting, in particular, that a number of areas scored 100% in the latest audits and that ED had shown improved performance.

Quality Care Assessment Tool (QCAT) Presentation

The presentation highlighted that 34 ward areas had completed their self-assessment in August 2022, with 41% having had a peer assessment, which confirmed the overall rating in all but one area. Areas of good practice and for improvement were noted and the need for ongoing commitment from specialist areas and all teams to deliver the 2023-24 programme to ensure all areas have a peer assessment completed.

Patient Experience Council report

The Council received a number of reports, including Equality Delivery System 2 final report, comprehensive patient experience report, Healthwatch Knowsley, estates and facilities, learning disability and autism spectrum, QCAT detailed report, nursing care indicators, dementia and delirium, inpatient survey, Bereavement Group and Surgical Care Group patient experience report.

The following points were highlighted to the Committee:

- Significant increase in activity within the Spiritual Care Team, both for patients and staff compared to previous year
- Slight increase in dementia training levels with active promotion of the training by the team, with increased emphasis on compliance with all mandatory and compulsory training to be undertaken during appraisal
- Ongoing delivery of actions arising from inpatient survey, with updates on the three overdue actions
- Benefits of twice daily discharge huddles to reduce delays

- Work to improve the mortuary viewing facilities following concerns raised by a relative

Clinical Effectiveness Council report

- Detailed presentation provided outlining the work and achievements of the Acute Kidney Injury (AKI) team, including improved mortality data and good compliance with Advancing Quality Alliance (AQuA) programme
- The following were approved:
    - Cancer Virtual Wards Policy, which will enable patients to avoid a hospital admission whilst receiving consultant overview
    - Learning from Inpatient Deaths Policy, noting the addition of a green with positive learning category
    - Mortality Surveillance Group Terms of Reference
    - Framework for Assurance of Pharmacy Aseptic Unit
- Presentation received relating to Medical Emergency Team, with a deep dive requested to review the cause of increase in calls
- Reports were also received relating to laboratory performance, noting in particular the ongoing issues with histopathology medical staffing due to national shortages, with the team proactively working to ensure urgent samples are prioritised

The meeting noted a range of positive practices taking place across a number of areas.

Assurance provided:

- Reduction in rate of falls across the Trust, with significant improvement work undertaken on Bevan Court 2
- 65% reduction in number of healthcare assistants leaving since the establishment of the HCA Academy
- AKI AQuA performance ranked 2nd in North West for care appropriateness and 3rd overall

Decisions taken:

- Quality Account approved for submission to the Board for approval

Risks identified and action taken:

- High rate of bed occupancy, with work ongoing to improve discharge processes in conjunction with system partners
- 18% reduction of clostridium difficile threshold to 46 for 2023-24 with infection prevention summit to be arranged

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: 31st May 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)044

Reporting from: Strategic People Committee

Date of Committee Meeting: Monday:22nd May 2023

Reporting to: Trust Board

Attendance:

Lisa Knight	(LK)	Non-Executive Director (Chair)
Sue Redfern	(SR)	Director of Nursing, Midwifery &Governance
Claire Scrafton	(CS)	Deputy Director of HR & Governance
Malise Szpakowska	(MS)	Deputy Director of HR
Ian Clayton	(IC)	Non-Executive Director
Rob Cooper	(RC)	Managing Director
Catherine Lothian	(CL)	Assistant Director of HR - Lead Employer
Kelly Stephenson	(CL)	Head of HR Governance & Performance

In attendance:
Konstantinos Chalkidis - Minutes

Apologies:

Anne-Marie Stretch	(AM)	Deputy CEO/Director of HR
Gareth Lawrence	(GL)	Director of Finance
Gill Brown	(GB)	Non-Executive Director
Nicola Bunce	(NB)	Director of Corporate Services

Agenda Items:

- S&O TUPE Update
- Workforce Dashboard
- People Strategy/Trust Objectives – end of year update and Q4 action plan 2022/23
- Lead Employer Annual Report

Assurance Provided:

S&O TUPE Update
The committee noted that there are no further updates.

Workforce Dashboard
The item detailed the following key metrics:

Absence

- All Trust Sickness while above target has seen a positive in month reduction 5.82% vs 6.10%. There has been a minor rise in absenteeism due to respiratory diseases, which is already beginning to decrease. Stress/Anxiety/ Depression remain the main reason for sickness absence.

Appraisals and Mandatory Training

- Mandatory training remains challenged (82%) however all staff groups (except for Estates and Facilities) have seen an in-month improvement. Appraisal has dipped below target in month (84%) with Non-Clinical Support being the main contributor to that dip (71% April, 90% March).

Turnover rates

- It was noted that providing ongoing assistance and training to HCAs resulted in a 65% reduction in leavers over a six-month period. It is the most significant increase in the utilisation of the internal transfer system.

Time to hire

- Vacancy rates have slightly increased in month across all staff groups and remain below the national benchmark (7.40%) at 6.82.

It was noted that DNA rates for Occupational Health appointments continue to negatively impact the departments performance. Further work needs to be done to identify if 9% is a realistic DNA target. At the next People Council fully detailed review will be provided about the interventions that are being put in place and the success or not around managing DNA performance within Occupational Health.

People Strategy/Trust Objectives – end of year update and Q4 action plan 2022/23

- Assurance provided to the group that these actions have been fully considered monitored and delivered.
- In terms of updating HR policies, there are policies still outstanding. These are being prioritised for approval as soon as possible. The recent Industrial Action impacted on the ability of policies to be reviewed and approved via staff side organisations. Plans are in place to fast track the remaining policies to be updated.
- It was noted that in regards the use of Framework agency spend, there are currently no set targets from NHSE, seeing downward movement in terms of the agency fill rates.

Lead Employer Annual Report 2022/23

- The committee received assurance that the Lead Employer service was being compliance managing in line with contracts and any risks have been well managed.
- Employee Relations open cases have been reduced by 41%.
- 82% first contact with the new help desk team is being resolved during the first call.
- There has been a compliance increase of 6% for mandatory training within the North West as a result of a target training records project
- Payroll MIAA Audit received significant assurance for the LE payroll service
- Over 19,000 work schedules have been processed.
- There has been a 100% increase of shifts booked through the North West Collaborative Bank and an increase of 3 host organisations joining during 2022/23 ensuring the bank remains the largest of it's kind within England.
- LE have conducted their annual trainee satisfaction survey, which highlighted that trainees are satisfied with their experiences and that they are confident in the information being shared from Lead Employer

The Committee noted that The Lead Employer service continues to be well managed, meet contractual requirements is highly regarded nationally as experts in HR and Employment matters relating for Doctors in Training and that there remain opportunities to continue to grow and shape LE shared service in the future.

The LE report was welcomed by the committee, and it was requested that the report is presented on a quarterly basis in the future.
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 are requested to note the report.
Committee Chair: Lisa Knight, Non-Executive Director
Date of Meeting: 22nd May 2023

Trust Board

Paper No: NHST (23)045

Title of paper: Incidents, Complaints, Concerns & Claims – Quarter 4 2022-23

Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 4 2022-23

Summary

Incidents

- Total incidents reported in Q4 = 4740 (11.34% decrease on Q3 2022-23)
- Total patient incidents in Q4 = 3870 (12.09% decrease on Q3 2022-23)
- Total patient incidents graded as moderate or above in Q4 = 30 (23.08% decrease on Q3 2022-23)
- The highest number of incidents reported relate to:
    - Pressure ulcers = 752 (which include pressure ulcers acquired prior to admission to Trust services)
    - Patient slips, trips or falls = 505

Complaints

- 52 new first stage complaints were received in Q4
- Clinical treatment was the main reason for complaints, in line with previous quarters
- ED remained the main department to receive complaints, although numbers have reduced
- The Trust closed 61 first stage complaints during Q4 with 82% responded to within the timescale agreed

Claims & Inquests

- 43 new claims in Q4 of which 6 were NHS Resolution (NHSR) instructed claims
- In addition, 10 pre-action claims converted to NHSR instructed claims in Q4
- Failure/delay in diagnosis remained the main cause of new claims
- 24 inquests were opened and 24 inquests were closed
- No Prevention of Future Death reports were received

PALS

- 1168 contacts were received in Q4, a 2.8% decrease from Q3 2022-23. Overall, there were 4594 contacts received in 2022-23
- 95.91% of PALS enquiries were resolved, with 34 PALS enquiries converted to formal complaints, a 4.09% conversion rate. During 2022-23, 95.67% of PALS enquiries were resolved, which is a conversation rate of 4.33% (131) to formal complaints
- Majority of the top 5 subjects are the same for Q4 with the exception of waiting time subject moving to the top 5, removing the patient care/nursing care subject
- Communication was the highest subject in Q4 (37.77%)

Corporate objectives met or risks addressed: Care and safety

Financial implications: None as a direct consequence of this paper

Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff

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

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

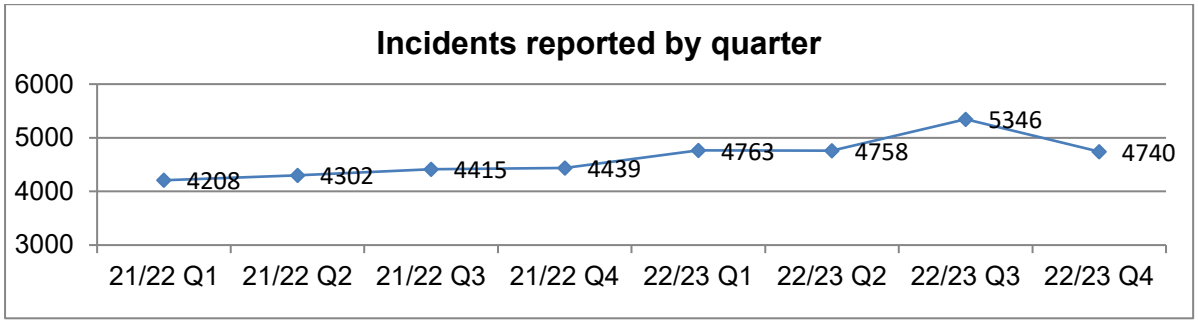
Date of meeting: 31st May 2023

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarter 4 2022-23, highlighting any trends. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

During Q4, 4740 incidents were reported, of which 81.65% (3870) were patient safety incidents. This is an 11.34% decrease from Q3 2022-23 in all incidents and 12.09% decrease in patient incidents. There was a spike in Q3 and Q4 saw a return to more standard level of reporting in the Trust as shown in the chart below.

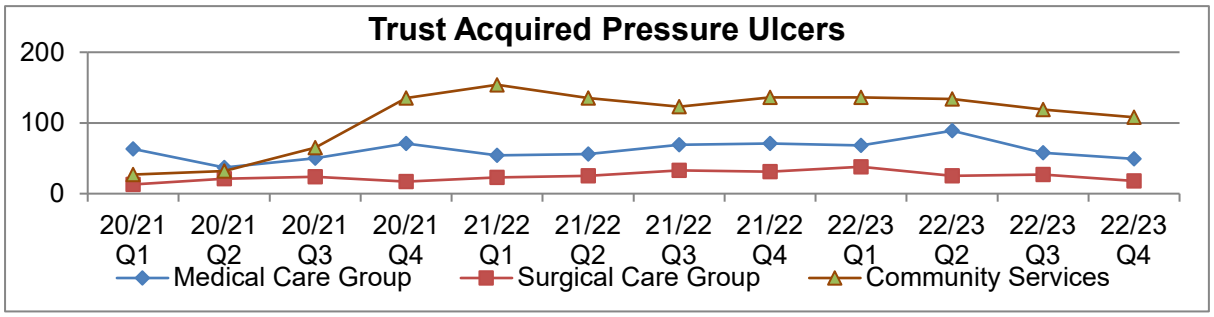


	22-23 Q4
Incidents affecting Patients	3870
Incidents affecting Staff	366
Incidents affecting the Trust or other organisation	484
Incidents affecting Visitors, Contractors or Members of the Public	20
Total	4740

Q4 2022-23, there were 30 patient safety incidents categorised as moderate harm, severe harm or death. In comparison, in Q3 2022-23 there were 39 incidents reported moderate or above, showing a marked decrease.

StEIS reported incidents								
	21-22 Q1	21-22 Q2	21-22 Q3	21-22 Q4	22-23 Q1	22-23 Q2	22-23 Q3	22-23 Q4
Moderate	24	30	27	26	22	18	20	17
Severe	7	6	11	15	8	9	11	8
Death	2	2	4	2	2	1	8	5

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories during Q4 were pressure ulcers (752), which includes all patients who are admitted with pre-existing pressure ulcers. The second highest reported category is slips, trips and falls (505). These are consistently the highest reported incidents in previous quarters.

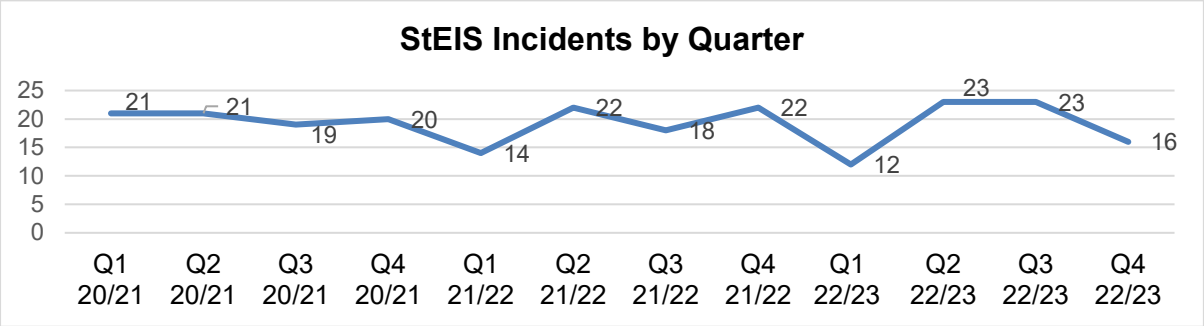


No severe harm Trust acquired pressure ulcers, with lapses in care were identified in Q4 2022-23.

STHK Acquired PU	2020-21				2021-22				2022-23			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
None	8	8	13	69	85	74	97	120	141	146	132	109
Low	94	82	126	153	145	141	126	117	100	99	67	60
Moderate	1	0	0	1	0	0	0	0	0	1	0	0
Severe	0	0	0	0	1	0	1	0	0	0	0	0
Ungraded	0	0	0	2	0	1	1	1	1	2	5	6
Total	103	90	139	223	231	216	225	238	242	248	204	175

2.1. Review of incidents reported to StEIS in Q4 2022-23

During Q4 2022-23 the Trust had 16 incidents which were reported to StEIS. In comparison, the Trust reported 23 incidents during Q3 2022-23. These incidents met the serious incident reporting criteria.



During Q4 there were 25 StEIS reports submitted to commissioners. All reports were submitted within the agreed timeframes. Actions taken and lessons learned are shared both internally and with commissioners.

2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q4. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm and level 1 incidents are monitored within the Care Groups.

2.3. Benchmarking

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

% of all reported incidents	April 2020 to March 2021		April 2021 to March 2022	
	National %	Trust %	National %	Trust %
No harm	72.7%	82.4%	70.6%	79.0%
Low	24.6%	17.0%	26.0%	20.2%
Moderate	2.2%	0.4%	2.9%	0.5%
Severe	0.3%	0.1%	0.3%	0.3%
Death	0.2%	0.02%	0.2%	0.1%

2.4. Dissemination of learning

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

3. Complaints

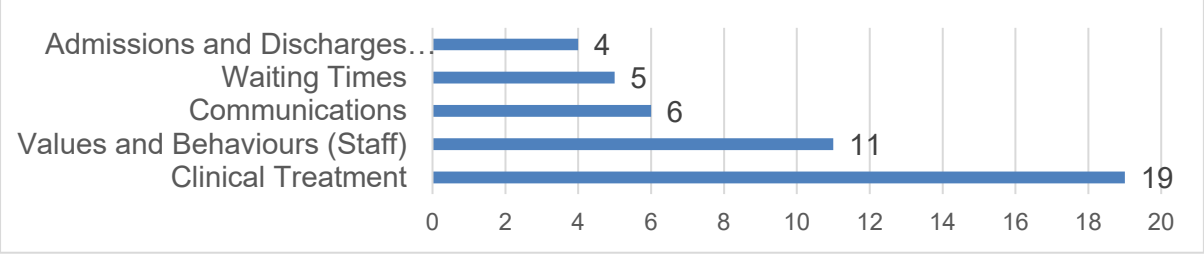
The table below shows the number of received and opened first stage complaints by quarter. The Trust experienced a decrease in complaints in Quarter 4, compared to the previous quarter and a significant drop compared to pre-pandemic numbers, that is a decrease of 39.5% from 86 in quarter 4 2019-20 to 52 this quarter. The Trust has therefore received less complaints than in any of the 3 previous financial years. There have been 38 2nd stage complaints this year, which is an increase on the previous 4 years. The main reasons for complainants submitting a second stage complaint are for further information or if they do not agree with the findings.

The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard for the last four years. The Trust resolved 61 complaints during Quarter 4.

Indicator	2019-20	2020-21	2021-22	2022-23				
				Q1	Q2	Q3	Q4	Total
Total new complaints including community services	325	251	266	44	62	53	52	211
Total new complaints received (excluding community services)	320	242	254	42	62	52	48	204
Acknowledged within 3 days	100%	100%	100%	100%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	93.4 %	94%	80%	70%	71.7%	80%	82%	77%
Number of overdue complaints	1	4	7	6	6	3	10	10
Second stage complaints	36	23	32	7	13	8	10	38

*data correct as a 18th April 2023. There may be some subsequent changes if complaints are discontinued or reclassified.

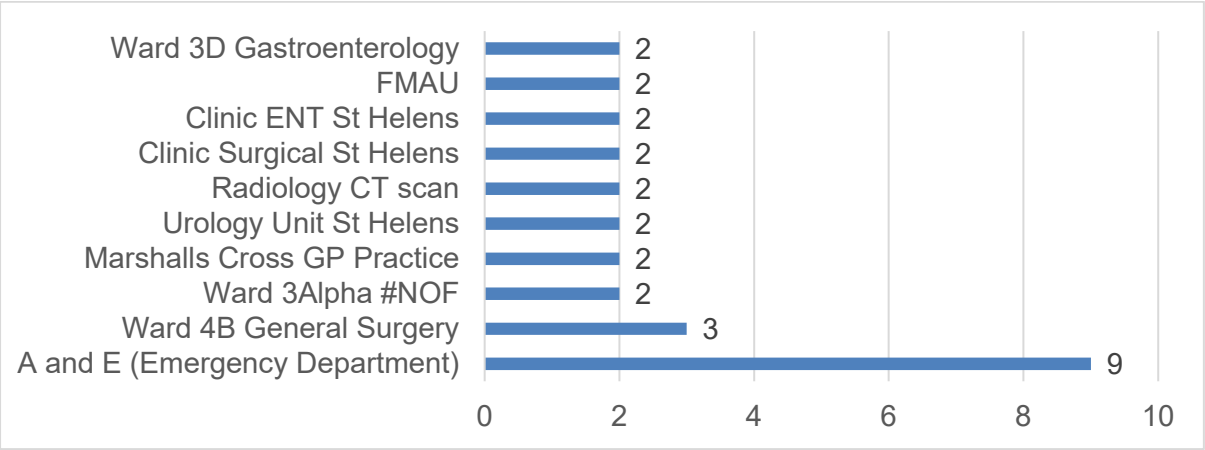
3.1. Top five reasons for complaints Q4 2022-23



Clinical treatment remained the main reason for complaints, with values and behaviours and communications featuring as the next highest which is consistent with previous quarter.

3.2. Complaints by top location

The Emergency Department received the highest number of complaints in Q4 with 9, which is a reduction from 18 in Q3; overall numbers of complaints relating to ED are decreasing, despite the significant pressures and long waiting times. Three complaints were received for Ward 4B, Surgical Assessment Unit, which relate to clinical treatment and have not yet been closed. No other area received more than 2 complaints.



3.3. Comparison of written complaints received with neighbouring trusts

NHS Digital have moved back to an annual reporting of KO41a data, which forms the basis of any national comparison. Although the last financial year is complete, the Trust has not yet received a formal request for 2022-23 data, therefore, no recent comparator data is available.

3.4. Closed complaints

During Q4, 61 first stage complaints were closed (83 all stage complaints in total), with 50 (82%) first stage complaints responded to within agreed timescales. 29.5% of complaints were fully upheld as highlighted in the table below.

	Jan 2023	Feb 2023	Mar 2023	Total
Not Upheld Locally	5	12	5	22
Partially Upheld Locally	6	7	8	21
Upheld Locally	3	7	8	18
Total	14	26	21	61

3.5. Dissemination of learning

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

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

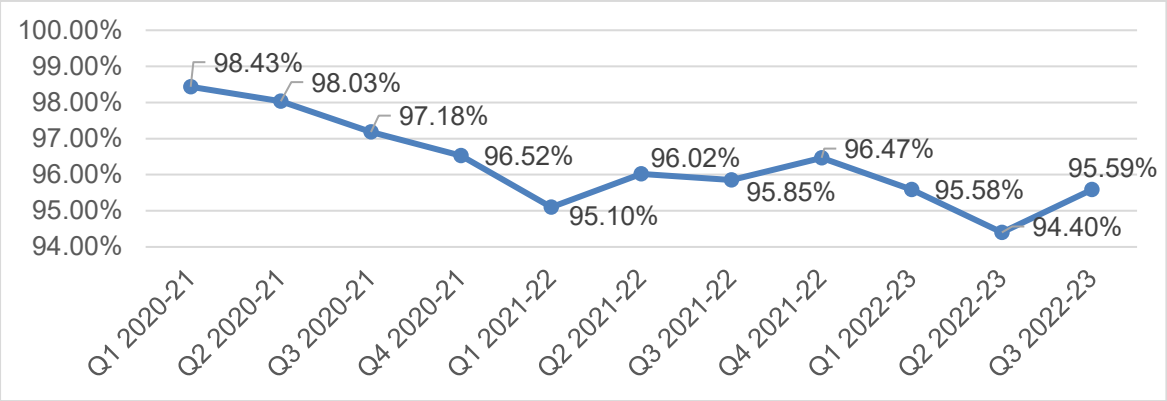
In Q4 the Trust was notified that 3 preliminary investigations were closed with no further action. 1 formal investigation was also closed with no further action required. One request for information was received. The PHSO are currently operating with a significant backlog.

4. PALS

1164 contacts were received in Q4, which is a 2.8% decrease from Q3 2022-23. Overall there were 4594 contacts received in 2022-23 and 8.5% decrease from the same period last year.

In Q4 2022-23, 95.91% of PALS enquiries were resolved, with 34 PALS enquiries converted to formal complaints, a 4.09% conversion rate, which is a slight decrease from 4.41% in Q3 2022-23. During 2022-23, 95.67% of PALS enquiries were resolved, which is a conversation rate of 4.33% (131) to formal complaints.

4.1. Percentage of PALS contacts resolved by quarter



The majority of the top 5 subjects are the same for Q4 with the exception of waiting time which moved into the top 5, removing the patient care/nursing care subject. Communication was the highest subject in Q4 with 37.77% of concerns raised relating to this subject.

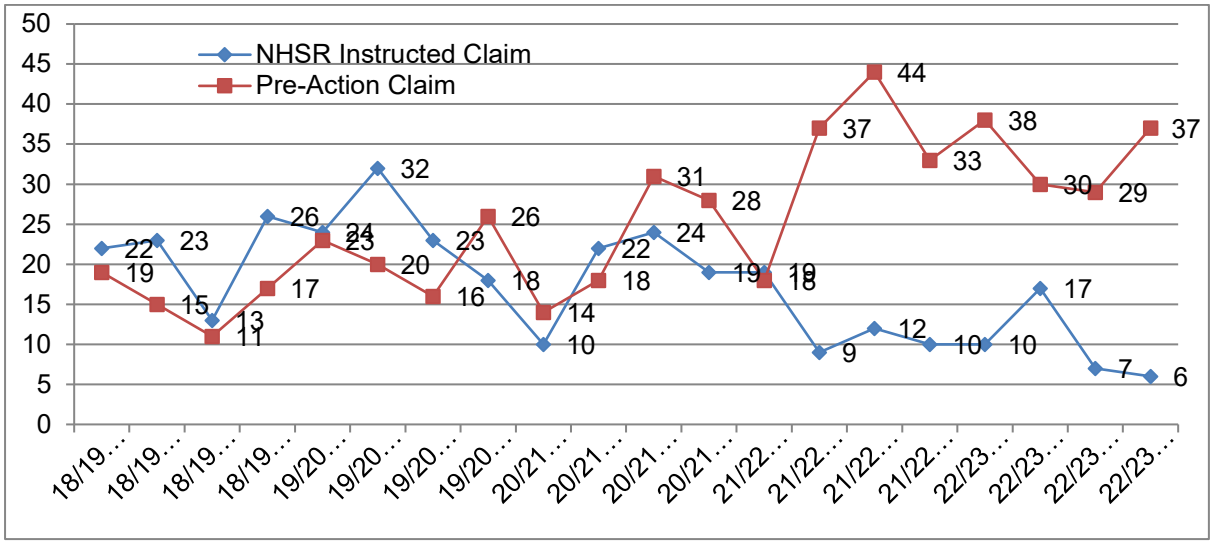
Q4 top 5 subjects (total concerns = 834)			
1	Communications	315	37.77%
2	Appointments	109	13.07%
3	Admissions and Discharges	85	10.19%
4	Clinical Treatment	93	11.15%
5	Waiting Times	44	5.28%

Q3 top 5 subjects (total concerns = 793)			
1	Communications	321	40.48%
2	Appointments	133	16.77%
3	Admissions and Discharges	92	11.60%
4	Clinical Treatment	106	13.37%
5	Patient Care/Nursing Care	22	2.77%

5. Clinical Negligence Claims

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

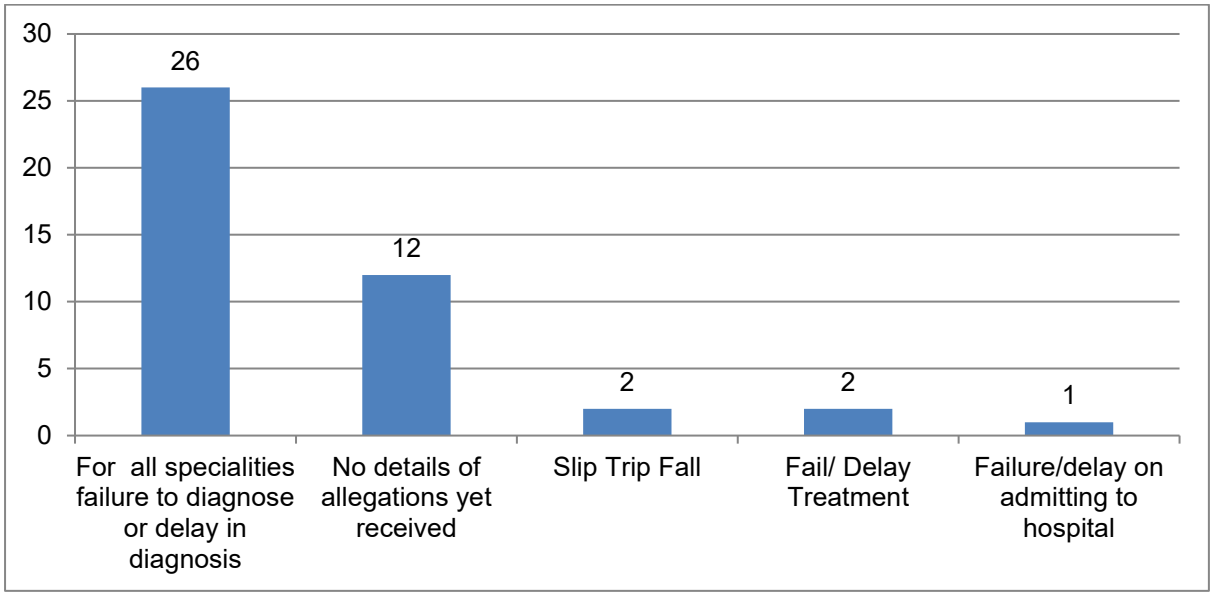
Pre-action and NHSR instructed claims received by quarter



The Trust received 6 new NHSR instructed claims. In addition, 10 more pre-action claims have become NHSR instructed claims. This is likely to reflect the fact that claimants' solicitors are requesting less extensions of limitation and starting to proceed with some of the potential claims that were put on standstill in the most restrictive stages of the pandemic.

Failure/delay in diagnosis was the main reason for claims. This is consistent with previous quarters. Accident and Emergency remained the highest area for new claims. No other area had more than 1 new NHSR instructed claim in Q4.

Main reasons for new claim Q4 2022-23



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

6. Inquests

24 inquest notifications were received in Q4, an increase of 2 from Q3 and the highest quarter since the 34 received in Q2 2021-22. Across 2022-23 the Trust has received an average of 24.3 inquests per quarter.

24 inquests were closed in Q4. There were no Prevention of Future Deaths (PFD) Orders this quarter and the Trust was not asked to provide any further evidence by the Coroner on any matter. It is of note that the Trust has not received a PFD for two years.

7. Recommendations

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

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(23)046
Title of paper: Quality Account 2022-23
Purpose: To submit to the Board the final draft version of the Quality Account for 2022-23 for review and approval.
Summary: The final draft of this year's Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012. The deadline to publish the Account is 30th June. The Quality Committee reviewed and approved the draft at their meeting held on 23rd May. The Director of Nursing, Midwifery and Governance and Deputy Director of Governance presented the draft Account to a number of partners including commissioners and Healthwatch at an event on 18th May and the written feedback from our partners will be included in the final published account when received. However, the verbal feedback on the day was positive and did not request any amendments. There was no requirement for the Account to be reviewed by our External Auditors this year, which is the same as last year. The final draft is attached as Appendix 1.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch
Recommendation(s): Members are asked to review and approve the Quality Account.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 31st May 2023

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Quality Account 2022-23

Our vision is to provide 5 star patient care

Trust's values and ACE behavioural standards

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Our Values and Behaviours

Experiences	I try to make everybody I meet feel special.	I treat everyone the way they want to be treated.	I do my best to stop what I am doing to greet someone and give them my full attention.	I take responsibility for my actions and responses in any situation.	I find all the facts before I make a decision or a comment.
Communication	I will include everybody and make sure nobody is ever left out.	I respectfully listen to what others have to say.	I greet everyone new by saying 'hello' with a smile and tell them my name and job.	I willingly share information and experience and am honest when I don't know an answer.	I will be clear in communication and always check I have been understood.
Attitudes	I try to understand people and do not make judgements.	I am sensitive to others regardless of race, culture, ethnicity, religion, gender, sexual orientation, age or disability.	I am always polite and helpful no matter how I am feeling.	I will do the right thing at all times.	I will look for a solution to a problem.

What our patients said about us in 2022-23

Ultrasound / Gynaecology (St Helens)

Today I visited ultrasound and gynaecology departments. Both were extremely considerate and caring. I was very worried when I arrived but everyone I saw put me at ease. The staff I saw ranged from a student to a clinical lead. All were very professional and a great example for the NHS. Fortunately my results were very positive. Thank you to all involved.

Ward 3A (Surgical Care)

Best hospital experience I've had. All the staff both medical and other have been great. Really can't fault the place.

Burney Breast Unit (St Helens)

My appointment came through very quickly at a terribly worrying time which I was grateful for. All the staff from reception through to medical staff were so friendly and super attentive. I received 5* care and was put at great ease.

Mersey Regional Burn Centre

From admission to the end of my stay on 4D I was treated extremely well. I felt my care was paramount to everyone that helped look after me, I could not have asked for better treatment. Every question I asked was answered. From the bottom of my heart, Thank you!!!

Occupational Therapy

Friendly and welcoming staff (receptionist and physio). Appointment was on time in a clean, tidy environment with adequate privacy. I felt like I had enough time to be assessed and have all my questions and concerns answered. Thank you

Prosthetics Department

My visit to this hospital was a surprise due to my previous experiences at other NHS facilities. From parking the car to leaving one hour later. The staff in the department I visited (prosthetics) where excellent, helpful and friendly. More importantly they were efficient and professional. Having worked in the pharmaceutical industry, I must also comment on the cleanliness of the general hospital. Everywhere in the building appears clean and well maintained. A credit to all the staff.

Sanderson Suite

Yesterday I had an operation at Sanderson Suite/Day Case Unit and the team there did an amazing job. I'm very happy and grateful with the care, service and attention which I received from anyone involved. I couldn't ask for more. Stay positive, keep up the good work and God bless you all!

Emergency Department/Ward 1D

Thank you for the care my dad received on 1D over the last couple of weeks. From admission at A&E to discharge the care was very attentive. The nurses on ward 1D are a credit to the hospital. Thank you so much for going that extra mile.

Emergency Department/Ward 4C

I was admitted via A&E. From the moment they realised how bad my situation was the speed I was dealt with was amazing. I was admitted Tuesday and by Thursday morning I had been operated on and they had saved my life. The treatment and care I received while on ward 4c was truly outstanding and I would like to thank everybody concerned from the bottom of my heart x

Ophthalmology

Excellent experience on the Eye Outpatients Dept. The staff were very friendly and professional. The consultant explained everything in great detail. He arranged further tests on an urgent basis. He then telephoned me at home with the results. I could not have wished for better care. Thanks to a wonderful team

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1. Section 1

1.1. Statement on quality from the Chief Executive of the Trust

We are pleased to present the Trust's 14th annual Quality Account, which demonstrates our commitment to continually reviewing, developing and improving the care and services that we provide.

2022-23 continued to present many challenges for staff with ongoing demands on an already stretched workforce. Staff continue to work incredibly hard to provide the best care and treatment for our patients, maintaining essential services, as well as meeting the needs of patients in a number of different settings.

The Trust has retained its outstanding Care Quality Commission (CQC) rating and has maintained contact with our CQC relationship manager throughout the year. The Trust has continued to monitor key quality indicators via the monthly comprehensive Integrated Performance Report (IPR), which is reviewed by the Board and its Committees.

I was, however, extremely disappointed that during the year there was 1 methicillin-resistant staphylococcus aureus (MRSA) bacteraemia and two never events, relating to wrong site surgery and a retained guide wire. Actions have been taken following these as part of the Trust's commitment to learning from incidents and these are outlined in more detail in section 3.

Our vision to provide 5-star patient care remains the Trust's primary objective so that patients and their carers receive services that are safe, person-centred and responsive, aiming for positive outcomes every time. The mission and vision have remained consistent and embedded in the everyday working practices of staff throughout the Trust, where delivering 5-star patient care is recognised as everyone's responsibility. The vision is underpinned by the Trust's values, five key action areas and the ACE behavioural standards of **A**ttitudes, **C**ommunication and the **E**xperiences we create.

The Trust has delivered a comprehensive programme of quality improvement clinical audits throughout the year, with a number of actions taken as a result of the audit findings (detailed in section 2.4.2). Delivery of the quality improvement and clinical audit programme is reported to the Quality Committee via the Clinical Effectiveness Council.

In addition, the Trust relaunched the quality care accreditation tool (QCAT) programme, with wards completing a self-assessment against all elements of the tool. These are being followed up by peer review audits to validate the findings. The Trust also reinstated the quality ward rounds with members of the Trust Board visiting a number of areas throughout the year to see and hear first hand how staff are striving to provide the best possible care for patients that is safe, effective, caring, responsive and well-led.

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience andthe Patient Safety Councils, both of which report to the Trust Board's Quality Committee, and the Equality and Diversity Steering Group which reports to the Workforce

Council. This ensures effective external representation in the oversight and governance structure of the Trust. Meetings have continued to be held virtually to maximise attendance.

The Trust has a Patient Participation Group, which met quarterly throughout the year and patients have continued to share their experiences of their care via patient stories for the Board and the Patient Experience Council.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the particular challenges faced during the year. It outlines our quality improvement priorities for 2023-24.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2022-23 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and services we have continued to deliver during the ongoing challenges in 2022-23.

I remain extremely proud of all our staff who continue to give the best of themselves to care for the people who need us, as well as supporting each other through these very difficult times. One example of the commitment of our staff is shown by how many long-serving employees we have, who are thanked each year by a celebration of their dedicated service. This year we celebrated the 40 years' service of 9 members of staff and the 25 years' service of 52 staff. I would like to thank these staff and all our staff for everything they continue to deliver during the most challenging times we face.

Ann Marr OBE
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust

1.2. Summary of quality achievements in 2022-23

Quality of services overall
Outstanding rating awarded by the CQC, the best possible rating, in the latest report received in March 2019.

Well-led
- Best NHS Trust in England for the fourth time in the latest national Patient Led Assessments of the Care Environment (PLACE) programme, with 100% for cleanliness and condition of the buildings and ranked the top acute Trust for disabled access and facilities, scoring 99%.
- Disability Confident Scheme, Leader (Level 3)
- Rainbow Badge Accreditation, Bronze (LGBT Foundation, 2022)
- Veterans Aware (Armed Forces, 2021)
- The Information Governance (IG) Team achieved the rating of 'Substantial Assurance for the DSPT (Data Security & Protection Toolkit)
- IT Service Desk increased from 3-star to 4-star rating, following Service Desk Institute (SDI) audit

Staff
- National staff survey
    - Best national score for staff each having a voice that counts
    - Highest score in the region for:
        - Being a compassionate and inclusive employer
        - Positive staff engagement
        - High staff morale
        - Working as a team
        - Providing a safe and healthy environment
        - Giving staff a voice that counts
        - Recognising and rewarding staff
- Awarded the National Preceptorship for Nursing Quality Mark in March 2023, following the introduction of the preceptorship framework in July 2022
- Received the best quality improvement award at the Maternity and Neonatal Safety Improvement Programme Optimisation Celebration event in March 2023 for effective teamwork in keeping babies less than 32 weeks gestation warm, achieving significantly higher results than the national average for two consecutive years
- Hannah Angland, Advanced Nurse Practitioner was awarded the British Empire Medal in the Queen's Birthday Honours
- Julie Tunney, Deputy Director of Quality was presented with the Chief Nursing Officer of England's Gold Award for her outstanding contribution to nursing
- Carys Hammond, Community Midwife Manager was recognised by HRH Princess of Wales for services to the local community
- Sarah Grundy, Ward Manager (Ward 1C) received the Silver Award in the Innovation Ward category at the British Journal of Nursing Awards 2022

Patient Safety
- Ongoing improvements in the safety of care demonstrated by:
    - No prescribing incidents resulting in moderate or severe harm
    - Medication incidents resulting in moderate harm or above remain at 1 incident

reported in 2022-23 and 1 incident in 2021-22
  - Medical device incidents resulting in moderate harm or above were reduced from 2 incidents in 2021-22 to 0 incidents in 2022-23
  - 16% reduction in inpatient falls per 1000 bed days, decreasing from 8.667 falls per 1000 bed days in 2021-22 to 7.290 in 2022-23
  - 20% reduction in inpatient falls of moderate harm or above per 1000 bed days, decreasing from 0.253 falls per 1000 bed days in 2021-22 to 0.202 in 2022-23.
  - 1 category 3 pressure ulcer during 2022-23 down from 2 in 2021-22 with lapses in care identified
- 94.18 % average registered nurse/midwife safer staffing fill rate for the year, above the 90% target

Patient experience

- Scored very well compared to other acute trusts nationally in the latest inpatient survey with the top score for staff explaining how an operation or procedure had gone and in the top ten nationally for 30% of the questions asked
- The Community Frailty Team won the Community Involvement Award at the St Helens Care Recognition Awards
- Our award-winning telehealth solution (video conferencing for outpatient appointments) has delivered over 2500 appointments across 60 specialty areas, helping to reduce the risks for patients by the prevention of unnecessary visits to the hospital
- Finalist for the collaboratively produced carer passport at the Patient Experience Network National Awards 2022 in the 'support for caregivers, friends & family' category
- Continued to achieve over 95% inpatient recommendation rate for Friends and Family Test responses

Clinical effectiveness

- **Cancer Services**

The Cancer Services Team have been widely recognised during this year winning the following awards:

  - Excellence in Healthcare at the NHS Parliamentary Awards for establishing the Surgical Cancer Hub, which provided a rapid, coordinated response to the delivery of essential and urgent cancer surgery during the COVID-19 pandemic
  - Innovation Excellence at the Macmillan Excellence Award 2022 and winner of Nursing Times Awards Cancer Nursing category for the ground-breaking brain tumour optimisation pathway established in collaboration with patient representatives and local neurology oncology centre
  - Quality Improvement Excellence at the Macmillan Excellence Awards 2022 for launch of the Cancer Advice Line during COVID-19
  - Outstanding team at the first ever St Helens Cares Recognition Awards

- **Research, Development and Innovation**
  - Liverpool School of Tropical Medicine and St Helens and Knowsley Teaching Hospitals NHS Trust Research Team won the COVID-19 Research and Innovation award at the 2022 North West Coast Research and Innovation awards
  - Burns and Plastics team successfully recruited to the Re-Energize trial

which was accepted for publication in New England Journal of Medicine
- Burns and Plastics team submitted 23 presentations to the British Burn Association meeting, held in Bristol in May 2022, winning two out of the three poster prizes

1.3. Celebrating success

The Trust has continued to share positive comments from patients and carers via the weekly Thank You Thursday email sent to all members of staff. In addition, the Employee of the Month Award recognises and rewards the ongoing dedication and commitment of staff throughout the year.

The Annual Staff Awards were held for the first time in three years in July 2022, where the Trust celebrated the many achievements of staff, including the Employee of the Year. Community Services were voted the winner of the St Helens Star People's Choice Award.

2. Section 2

2.1. About us

2.1.1. Our services

St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) provides a range of acute and specialist healthcare services including, inpatient, outpatient, community, primary care, maternity and emergency services. The Trust provides the Mid-Mersey Hyper-Acute Stroke Unit (HASU) and the Mersey Regional Burns and Plastic Surgery Unit, which provides this specialist service for people in the North West of England, North Wales and the Isle of Man. In addition, the Trust hosts the Mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital.

The Trust has 723 core overnight general and acute beds, which includes paediatrics. At times of escalation this can be increased to 760 beds which are used to accommodate patients needing admission. There are also 37 maternity beds and 60 intermediate care beds, including 28 at Newton Community Hospital. Most of the services are provided from two main hospital sites at Whiston and St Helens, both of which are purpose-built modern facilities that are maintained to a high standard. Whiston Hospital houses the Emergency Department, the Maternity Unit, Children and Young People's Service and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, rehabilitation beds, the Lilac Centre (a dedicated cancer unit, linked to Clatterbridge Centre for Oncology) and Marshalls Cross Medical Centre (primary care services). St Helens Hospital is a Community Diagnostic Hub, providing increased diagnostic capacity for the whole of NHS Cheshire and Merseyside to reduce the waiting times for patients as the NHS recovers from the impact of COVID-19.

The Trust also provides an Urgent Treatment Centre (UTC) from the Millennium Centre in St Helens and intermediate care and community services at Newton Community Hospital. In addition, the Trust delivers a range of community services, including adult community nursing (for St Helens), Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy, plus outpatient and diagnostic services from a range of other community premises.

The Trust Board is committed to delivering safe services and high-quality care, set within the context of the on-going increases in demand for urgent and emergency care and the increased waiting times for patients as the NHS continues to recover its elective activity position in the aftermath of the COVID-19 pandemic. The Trust continues to be one of the busiest acute hospital trusts in the North West of England. It has an excellent track record of providing high standards of care to its population of over 360,000 people across St Helens, Knowsley, Halton, and South Liverpool, as well as further afield, including Warrington, West Lancashire, Wigan and the Isle of Man.

2022-23 was an extremely busy year as COVID-19 continued to be present. This impacted on the Trust's activities, however not to the same extent as the previous two financial years. The Trust has continued to maintain access to services and has made steady progress in reducing the waiting list for patients waiting more than 12

months.

	2021-22	2022-23	% change 2021-22 to 2022-23
Outpatient attendances (seen)	470,392	491,083	4.40%
Non-elective admissions (less Obstetrics)	54,166	61,254	13.09%
Elective admissions	48,706	52,375	7.53%
Births	3,995	3,770	-5.63%
Emergency Department attendances (as reported)	121,809	116,603	-4.27%
Emergency Department attendances (excluding General Practitioner (GP) Assessment Unit)	116,728	111,216	-4.72%

The average length of stay for non-elective admissions was 7.4 days for 2022-23 compared to 6.3 days for 2020-21 and 6.8 days in 2021-22.

2.1.2. Our staff and resources

The Trust's annual total income for 2022-23 was £586 million.

St Helens and Knowsley Teaching Hospitals NHS Trust employs over 7000 members of staff. In addition, the Trust is the Lead Employer for Health Education North West, Midlands, East of England, South West, Thames Valley Region and Palliative Care London and is responsible for over 12,000 specialty doctors, dentists and public health trainees based in hospitals, general practice, dental and Local Authority placements throughout England. From 1st May 2023, the Trust will become the Lead Employer for over 150 GP trainees in Yorkshire and Humber.

The Trust's average rolling 12 months' staff turnover rate in 2022-23 was as follows:

Q1 – 15.80%
Q2 – 15.58%
Q3 – 15.40%
Q4 – 14.31%

The average is 10.06% for acute teaching hospitals in the North West and 9.00% for acute teaching hospitals nationally (data to December. The strategic resourcing and corporate nursing teams are working collaboratively to understand, monitor and reduce this turnover.

The Trust strives to meet the best standards of professional care whilst being sensitive and responsive to the needs of individual patients. Clinical services are organised within four care groups; clinical support services, surgery, medicine and primary care and community, working together to provide integrated care. A range of corporate services contribute to the efficient and effective running of all our services, including human resources, education and training, informatics, research anddevelopment, finance, governance, estates and facilities management.

Significant recruitment challenges remain within specific specialties and for specific roles, in particular, within nursing and medical staff. The Trust has a successful and well-established international recruitment programme, which brings on average 50 new international nurses into the Trust per year to supplement the existing nursing workforce. Despite the recent challenges of COVID, the Trust recruited 100 additional nurses via this route during 2022-23.

The Trust is constantly looking for new ways to address workforce gaps and continues to work, as a founding member, with the Pan Merseyside International Nurse Recruitment Collaboration programme, which aims to deliver international nurses across most of the Merseyside region. This pipeline will continue to bolster existing recruitment plans with a total of 50 new international nurses expected to start within the Trust during the 2023-24 financial year. The Trust is also a member of the North West Regional International Midwifery Collaboration programme, the North West International Radiography Collaboration programme and the North West Occupational Therapist Collaboration Programme, all of which are intended to bolster the NHS workforce over the next 12 months with 7 new starters planned to date. In addition, the Trust continues to proactively work towards ensuring there are no Healthcare Assistant (HCA) vacancies and providing a “new to care” induction, training and career pathway for those without care experience who wish to become a healthcare assistant in the NHS. Since the new induction commenced in 2022, retention of HCAs has improved significantly within their first 12 months in role due to the enhanced support and training available.

The average medical and dental vacancy rate for 2022-23 is 43.77. There were 42.64 medical gaps across the Trust in April 2023. A number of actions have been taken to address these, including developing new roles such as advanced clinical practitioners. In addition, the Trust hosts regular recruitment events and uses international recruitment to ensure vacancies are filled. The Trust has collaborated with Masaryk University, Brno, Czech Republic, in the recruitment of newly qualified doctors who trained in Brno using the English syllabus since 2014. The Trust has made offers to an additional 103 doctors through these means since 2016. These new recruits join the Trust for two years as Clinical Fellows at foundation year one and two, to support the wards and fill the gaps and vacancies resulting from reduced numbers of allocated posts from the North West Deanery. The scheme saw 17 newly qualified doctors successfully join the Trust in August 2022 following a 4-week clinical induction process. This programme provides the opportunity to reduce agency spend and maintain continuity of care for our patients. The doctors have the same opportunities to access further training in the North West, which keeps the talent pool local. They are a valued asset to the Trust and our delivery of patient care.

The Trust is aligning workforce plans to the NHS People Plan to ensure sustainable pipelines to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals (AHPs), including:

- On-boarding and retention of new and existing staff including the band 5 transfer scheme**,** with 29 requests in 2021 (26 approved) and nearly double that in 2022 to 54 (30 confirmed, 9 pending) assisting us to retain staff within the organisation where possible

- Time to hire (TTH) continues to be monitored, with active analysis of the recruitment pathway, reducing barriers and delays to enable people to be deployed safely and efficiently
- The Trust continues to explore other retention options and has recently piloted a new exit interview in ED, Bevan and frailty ward areas focussed on improving data quality and understanding reasons for leaving. We have made improvements in "would you work for us again" from 46% in January 2022 to 60% in December 2022. Encountering violence and aggression in the workplace from patients does not feature in top 5 reasons for leaving now whereas it did in January 2022
- The Trust's Healthcare Academy has had huge success in recruiting and onboarding HCAs to the Trust and reducing turnover of those within the first year of service, including the new to care programme for HCAs with no previous caring experience and the additional designated support during on-boarding, training and first 12 months
- The Trust also has a programme of work to reduce barriers to employment, including, flexible working requirements and mapping vacancies to those staff considering substantive roles
- Delivering apprenticeship programmes, as the Trust continues to offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles. This is a key route into a variety of careers in the NHS, giving individuals the opportunity to earn and gain work experience while achieving nationally recognised qualifications
- Implementation of the nursing associate role – during this financial year 15 employees have completed the Nurse Associates apprenticeship level 5 and are new Nursing Associates, a further 21 are currently enrolled. An additional 3 staff members are enrolled on the BSc Honours Registered Nurse degree apprenticeship
- Implementation of e-rostering is now at 99% of the organisation. E-job planning is being taken forward for other staff groups to include medics
- The new online appraisal and personal development plan system has been very successful and we achieved our 85% target for staff appraisals

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours for registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with the guidance. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can have an impact on the quality of care provided.

The acceptable monthly fill rate is 90% and over, which throughout the COVID-19 pandemic has been very challenging to achieve. Senior nurses, led by the Director of Nursing, Midwifery and Governance held twice daily staffing meetings at times of increased pressure to redeploy staff across the Trust to maintain patient safety. . The average registered nurse (RN)/midwife safer staffing fill rate for the year was 94.18%, above the 90% target and slightly higher than the 92.1% rate achieved last year.

The Trustalso reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total inpatients in the ward at midnight. The Trust's position is reported monthly as part of the mandated safer staffing report.

The Trust continues to work incredibly hard to maintain patient safety at all times, using a range of approaches to ensure available staff are deployed effectively across the whole Trust. The actions taken include:

- Ward managers cancelling management days to work clinically
- Matrons/specialist nurses working clinical shifts
- Increased the daily matron staffing meetings to twice daily when required, led by the Director of Nursing, Midwifery and Governance, with members of the temporary workforce resourcing team attending. Staffing levels across the Trust are reviewed at each meeting, with every area identifying any gaps identified for the following 24 hours and the number of patients requiring supplementary care (1-1 or bay tagging) on each ward. Staff moves are then jointly agreed to provide the safest care possible
- A plan for further moves, should this be required for unexpected absence, is communicated by the matrons covering the late shift to the operational site managers and the general manager on call each day
- Worked with the Trust's staff bank and external agencies to provide a pool of staff to cover each shift for areas experiencing last minute gaps due to sickness
- Block booked agency staff to provide continuity where possible
- Approached off framework agencies to cover any unfilled shifts (subject to Executive approval)
- Successfully secured £389k funding from NHSE/I to support the recruitment of international nurses
- 293 bank HCAs offered positions and 194 substantive HCAs joined the Trust between 1st April 2022 and end of March 2023
- 100 international nurses commenced their training for the national Nursing and Midwifery Council's (NMC) Objective Structured Clinical Examination (OSCE) test
- Proactive support for staff who are absent to ensure they were able to return to work as soon as possible
- Plans developed to ensure safe staffing during recent periods of industrial action

Ensuring safe staffing levels remained a priority for the Trust throughout the year, with concerns escalated to the thrice daily bed meetings.

2.1.3. Supporting our staff

The Trust continues to appreciate the ongoing impact of the COVID-19 pandemic on our staff and more recently the turbulence of the economy creating the cost-of-living crisis, which is affecting staff and the wider organisation. To help support staff and limit the impact of this a bespoke and dedicated staff extranet site and cost-of-living guide to help staff were developed.

The support focused on how to access support, where to get help with household bills including energy, food, childcare and discounts for NHS staff.

Further to this a winter wellbeing event took place in November 2022 which was themed around cost-of-living support, as well as health and wellbeing support throughout winter and beyond. The event hosted around 30 stalls providing a range of information and resources for staff, as well as practical and informative sessions, attended in-person or virtually. On the day over 300 staff attended in-person and engaged with services such as Citizen Advice Bureau and money saving and advice experts. Staff took part in exercise sessions such as Pilates, tai-chi and sort advice and support from other local experts in health and wellbeing.

The Health, Work and Wellbeing Department (HWWB) continues to provide a wide range of supportive services, including Occupational Health (OH) and those listed below:

- The Wellbeing Hub which supports staff affected by physical or non-physical health matters that can have an impact both in and outside of work. Support is available for all staff, including those that have been affected by COVID-19:
    - **Mental wellbeing** – stress, anxiety, depression and other diagnosed conditions – delivered by counsellors, mental health nurses, and psychologists
    - **Physical wellbeing** – targeted support for musculoskeletal conditions, injury, or other diagnosed conditions, delivered by PhysioMed, physiotherapists and OH clinicians
    - **General health** – any other health related condition(s) that staff feel may be impacting on their work – delivered by OH clinicians or onward referrals to specialist support
    - **Financial wellbeing** - key resources and top tips to help staff limit the impact of rising living costs
- Trust staff engagement application (app) and the staff COVID website which have specific wellbeing sections
- Wellbeing apps (free to use and access) including meditation, mental health in the workplace, mindfulness and sleep aides
- Staff wellbeing events and engagement sessions to promote and support wellbeing and resilience, including mindfulness, sleep hygiene, stress, relaxation

and building resilience
- Rugby League Cares (RLC), which is a charity commissioned by NHS England as a pilot for three NHS organisations in the North West, to provide support via engagement sessions for staff. These include mental fitness and team building. RCL also support with recruitment via community engagement programmes

The Trust's Wellbeing Network continues to grow and consists of champions for the health and wellbeing agenda for the greater good of our people. There are currently over 90 Health and Wellbeing Champions, 30 Mental Health First Aiders and a Wellbeing Guardian all driving the network forward with support from the Wellbeing Lead and Wellbeing Coordinator.

The Wellbeing Network publishes monthly newsletters, which are disseminated throughout the organisation to help promote the health and wellbeing service and support available to staff.

2.1.4. Our communities

The Trust provides services to the communities of St Helens, Knowsley and Halton, as well as attracting some patients from Liverpool and parts of Warrington, Wigan, and West Lancashire. Some specialist services, such as the Regional Burns and Plastics Unit, provide services to a much larger population, across Cheshire and Merseyside, North Wales and the Isle of Man.

The communities served by the Trust are characterised by high levels of deprivation, with the local population being generally less healthy than the rest of England, with a higher proportion having at least one long-term health condition.

Our local communities are not ethnically diverse, but do experience high levels of health inequalities, leading to reduced life expectancy, poorer health and higher demands for health and social care services. Rates of obesity, smoking, cancer, and heart disease remain higher than the national average. Our local communities were hit hard by COVID-19, with some of the highest community infection rates in the country. The impact of the pandemic continues to be felt as people have had to wait longer for outpatient referrals, diagnostic tests and elective procedures or have delayed presenting. The Trust has made progress with its elective backlog in 2022-23, but extreme operational pressures in December and January and the impact of industrial action taken by many health unions in the last quarter of the year, leading to the cancellation of elective activity to protect urgent and emergency care have meant that there are still many patients waiting longer than 18 weeks.

2.1.5. Our partners

The Trust is part of the NHS Cheshire and Merseyside Integrated Care System, and works with the Integrated Place Partnerships in St Helens, Knowsley and Halton. In addition, the Trust is a member of both the provider collaboratives in Cheshire and Merseyside, the Cheshire and Merseyside Acute and Specialist Trust provider collaborative (CMAST) and the Mental Health, Learning Disability and Community Services Trusts provider collaborative. The provider collaboratives coordinate activities between providers to maximise capacity and capability to respond to both

urgent and emergency and elective pressures.

The Trust continued to provide a COVID-19 vaccination service during 2022-23, which mainly focused on staff vaccinations in the second half of the year, when the mass vaccination centres closed.

During 2022-23 the Trust has continued to work in partnership with Southport and Ormskirk Hospital NHS Trust and in September 2022 the boards of both Trusts agreed to formalise the partnership by stating the intention to come together as one organisation. The transaction business case was submitted to NHS England in December 2022 and was followed by statutory consultation with the staff side organisations representing staff at Southport and Ormskirk Hospital NHS Trust and with Healthwatch representing the populations of Sefton and Lancashire.

2.1.6. Technology and information

Considerable progress has been made on the roadmap outlined in the Hospital's Digital Strategy over the last 12 months and the Trust continues to move ever closer towards its digital maturity ambitions.

The Trust will now be assessed against a new NHS Minimum Digital Foundation (MDF) standard that trusts are expected to achieve by March 2025. The Trust is expecting to receive financial support from national funding of £2.658m over the next three financial years to support it in achieving this standard.

Our clinicians now have even more digital capability, less paper-based processes, improved access to patient information and increased security, stability and performance of the infrastructure, supporting consistency and safety of patient care. As always, the achievements in 2022-23 were a collective effort across all teams within the Informatics Department, working alongside clinical and administrative colleagues to improve patient experience, safety and outcomes, in line with the Trust vision for 5-star patient care.

2.1.6.1. Systems

The Trust continued to maximise functionality in its Careflow Electronic Patient Record (EPR) System:

- **Careflow Connect** – has now become a key component of patient care co-ordination across the Trust, with the fast-paced roll-out across clinical teams to facilitate specialist referrals. This helps a clinician request advice and support from a specialist team, with all patient information and notes instantly visible to the specialist team. Advice from the specialist team is provided in a timelier manner and patients receive specialist care and advice sooner

- **Nursing documentation -** Digitisation of the nursing admission form, which previously took about 45 minutes to complete per admission, has saved staff about 50% of this time as digital information is entered just once and is then available online for all those who need to review it. Digitisation of the paper social history and the paper activities of daily living forms into one social history

and activities of daily living (SHADL) form has also been completed. This form removes a lot of duplication of data collection and means our patients only need to provide their information once, which is then available in real time for those who provide care for a patient during their stay and those involved in their discharge planning

- **Careflow Workspace** – Workspace brings a range of patient information from the EPR together into one single view. One click opens the patient information that individual clinicians need in context of their patient, providing easier and faster access to patient information. Clinicians no longer need to switch between different places of patient information within the EPR and always have the right patient's information in the EPR in front of them

- **Mobile Order Comms and Results** – has streamlined the clinician's access to orders and results from any location within the Trust, including the launch of the digitised histology catalogue. Almost 90% of orders for inpatients across the Trust are now placed electronically, removing the need for paper order forms, representing a major contribution to the Trust's ambition of removing paper from clinical processes and improving patient safety with information accurately captured

- **Digital intrapartum notes on Careflow Maternity** - Intrapartum notes are used when a patient arrives in the delivery suite up to the point of discharge. Digitising these notes has reduced reliance on paper-based information, enhanced the privacy and security of patient data and ensures no information is missed. It means notes will always be legible and, importantly, this information is instantly available to others who need access to it

- **Careflow Vitals and noting form digitisation** - to further support clinical workflows, digital versions of the adult bed rails risk assessment and vision test form were launched across inpatient areas within Careflow Vitals. This means that these assessment forms can be completed on a device at the patient's bedside, with alerts given to nursing staff if the assessment is overdue, which ensures our patients are thoroughly and routinely risk assessed to identify any increased risks of falling. If a risk of falling is identified, nursing teams can put into place processes to prevent falls and reduce risk of injury from falls, such as falls alarms, low rise beds and closer monitoring. The assessment results form part of the EPR and are visible to any staff who may need to review it.
  In addition, a digitised discharge planning checklist and food/fluid chart were launched across medical and surgical wards in Clinical Noting

2.1.6.2. Infrastructure

The past 12 months have also seen a concentrated effort to provide an even better user experience for our staff who use digital technology, with security of the infrastructure continuing to be a priority.

- The infrastructure that Careflow resides on has been completely replaced, resulting in much improved performance and better user experience for our staff including faster log on times
- Secure email accreditation on our Microsoft 365 tenant allowing us to collaborate with other organisations more effectively and securely. A good example of this is that Southport and Ormskirk Hospital NHS Trust staff can now be messaged directly by Trust staff using Microsoft Teams
- Significant improvement of the Windows 10 build to ensure log ons/performance are improved. This ensures staff can access systems quickly and reliably
- Upgrades to the wired, wireless and telephony network infrastructure, providing a solid reliable foundation for all digital systems that rely on the network, along with increased speeds across the network which provides improved performance for staff who use these systems

The infrastructure has undergone tremendous improvements in the past 24 months, meaning our staff are able to securely access the right information, at the right time, in the right place and we can be proactive in our response and resolution of issues before they impact a user and their ability to carry out their work. Overall service improvements have been delivered with vastly reduced log in times for staff, a reduction in the calls to the service desk, with a positive impact on the achievement of service levels to the Trust.

2.2. Summary of how we did against our 2022-23 Quality Account objectives

Every year, the Trust identifies its priorities for delivering high quality care to patients, which are set out in the Quality Account. The section below provides a review of how well the Trust did in achieving the targets set last year.

2.2.1. Progress in achieving 2022-23 quality objectives

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
Continue to ensure the timely and effective assessment and care of patients in the Emergency Department	Patients triaged within 15 minutes of arrival	For 2022-23 20.6% of patients were triaged within 15 minutes, with the following improvement initiatives in place to improve performance and maintain safety: • Two senior nurses allocated to triage on late shift at peak times • Triage improvement group has been established and overseeing move from Manchester Triage system to the emergency severity index which reduces the time required for triage without impacting on the quality of the triage. This will also support front door streaming • A health care assistant and medical support worker are assigned to the waiting room to undertake pre-triage observations and also to take bloods if necessary which reduces delays • An additional consultant is allocated to triage (when possible due to staffing levels) to support streaming and to see patients who require rapid head injury assessment/assessment of chest pain	Measure has not been fully achieved, however there are robust mitigating actions in place to maintain patient safety during what is a period of unprecedented pressure across NHS services
	First clinical assessment median time of <2 hours (120 minutes) over each 24-hour period	For 2022-23, the median time from arrival, to be seen by a clinician, was 123 minutes just slightly over the target of 120. This is a marked improvement from 140 minutes in 2021-22.	Virtually achieved
	Compliance with the Trust's Policy for National Early Warning	Matron and Senior Quality Nurse complete weekly audits and report to the Patient Safety Council. The latest audit from Q2 noted 100% compliance with repeated observations for those scoring 0 on NEWS and 88% for	Achieved

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
	Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits	those triggering, with 100% completion of repeat observations within one hour for those missing the initial deadline.	
	Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring	ED achieved 87% Q2 2022-23 for screening (latest data available) and remains below the 90% target at 81% for treatment compliance. Actions are in place to improve compliance • ED staff are allocated to attend sepsis training • Sepsis training is provided on the ED preceptorship program • Sepsis is discussed in morning safety huddles to prioritise sepsis patients and administer antibiotics within the hour. • Monthly audits to be completed by senior quality nurse and fed through nursing highlight report to monitor compliance monthly Sepsis team to support the teams in department on a daily basis	Measures are below 90% target with improvement actions in place
	Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	• Matron for Emergency Department and Quality and Senior Quality Nurse complete weekly audits with the latest audit demonstrating 78% compliance • Generic triage documentation has been reviewed to ensure duplication of information removed • Bristol Emergency Care Safety checklist included in page 2 in generic triage documentation • Education with all nursing teams completed to ensure all staff aware of the correct completion process of the tool • Quarterly audits will be completed by quality nurse in ED and reported to the Patient Safety Council	Measure has not been fully achieved, however nursing documentation confirms that risk assessments and appropriate treatment is delivered
Reduce avoidable harm by preventing falls	Reduction in the number of inpatient falls per 1,000 bed days by 10%	A reduction in total falls per 1000 bed days for 2022-23 to 7.29, decreasing from 8.67 in 2021-22. This demonstrates a 15.89% reduction in falls per 1,000 bed days compared to 2021-22	Achieved

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
	compared to previous year		
	95% of patients to have a documented falls risk assessment within 6 hours of admission measured through quarterly audit of sample of patients	For 2022-23 88.8% of patients had falls risk assessment completed within 6 hours of admission on Tendable audit completed.	Measure not fully achieved, however actions in place to improve
	Audit demonstrating that patients at risk of falling have a completed falls prevention care plan in place as per hospital policy	90% of patients audited in 2022-23 had a completed falls prevention care plan and appropriate interventions in place.	Achieved

Quality Domain: Clinical Effectiveness		Update	Achievement
Objective	Measurement		
Ensure patients in hospital remain hydrated	Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place	Monthly Nursing Care Indicators for compliance with red jugs in place has consistently been above 90% throughout the year, with average of 94.33%. In addition, the audits show 99.28% of all patients were identified as a risk of dehydration. Audit results discussed at the Trust Nutrition and Hydration Steering group. Local improvement plans at ward level.	Achieved

	Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately	Nursing Care Indicators highlight that 75.57% compliance with the requirement for all sections of the fluid balance chart being completed, including input and output. The results are discussed at the Trust Nutrition and Hydration Steering group, with local improvement plans at ward level. Highlighted at Patient Experience Council and Senior Nursing weekly meeting as an area for continued focus, with planned engagement events with wards	Measure not achieved with actions in place to improve
	Reduced rates of hospital acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	The number of Lab Test Acute Kidney Injury Triggers reduced each month from July 2022 to September 2022, a reduction of 12.9% July 2022 to August 2022 and 10.5% August 2022 to September 2022. There were increases for October (15.5%), November (6.8%) and December 2022 (8.1%), however, January 2023 and February 2023 are both showing reductions, 0.8% and 13.5% respectively. The latest individual month (December 2022) indicates a reduction in standardised mortality ratio (SMR) to 79.0 and the lowest since April 2022 (67.1). Please note the observed deaths each month are low numbers. The latest 1, 3, 6 and 9 months (to December 2022) are all below 100 with the latest 12 months showing 107.3, indicating an improvement.	Achieved

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
Improve the effectiveness of the discharge process for patients and carers	85% of take-home medications to be dispensed within 2 hours of prescription being received in pharmacy	Turnaround time is running at approximately 71% within two hours. This is below the target, however, the Trust has implemented different processes to ensure discharges are not delayed due to patients waiting for to take out (TTOs) medication, which include: • Ward-based dispensing has increased by 76% compared to 2019-20. This is almost exclusively related to TTOs. • There are a number of satellite dispensaries located across the Trust, including one on the second floor servicing wards 2A, 2B, 2C, 2D, one	Measure not achieved however mitigating actions in place to reduce discharge delays

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
		on ward 1B/1C and one on Bevan Court. This enables the pharmacy technicians to dispense directly without the need to access the pharmacy department, ensuring more local and timely delivery of TTOs for patients. There are plans for an additional one on the fifth floor. • Pharmacy technicians actively transcribing discharge medication in advance of the date the TTO is required. This allows the TTOs to be ready for the day of discharge on a more regular basis than previously • The pharmacy technicians work closely with ward discharge co-ordinators and are, therefore, aware of the patients' anticipated discharge date • In addition, the pharmacy technicians attend twice daily Medical Care Group meetings with the Assistant Director of Operations and discharge co-ordinators, to reallocate pharmacy staff to areas that may need further support with TTOs to ensure timely discharges	
	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	11 questions in the survey relate to discharge experience, one of which is new. Although only 2 scores improved on the previous year's score, with 3 remaining the same, the Trust scored the highest score for the discharge section compared to other acute trusts in the region and ranked second (when specialist trusts were removed) for discussing with patients if they may need any further health or social care services after leaving hospital, ranked second for patients knowing what would happen next before leaving hospital and ranked third nationally for receiving enough support from health and social care services and understanding care after leaving hospital.	Measure not achieved, however performed better than peers for a number of questions
	Achievement of 20% target for patients discharged before noon during the week with achievement of 30% at	Daily and weekly data provided to monitor current performance of discharges before noon. Current performance is below all measures with an average of 18.6% for the year, with 20% being achieved in three individual months, due in part to infection control risks where patients have to wait on wards and cannot be supported in the communal discharge	Measure not achieved with actions in place to improve

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
	least once each week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards	lounge. Additional monitoring of monthly trends is taking place and will be put into the quarterly patient experience report.	
	Implementation of standardised patient equipment ordering process for aides required at home	A clear process for how therapies can order equipment has been devised and information shared via a booklet. This will be extended to all equipment and further roll out planned by May 2023. Due to the multiple boroughs involved and various commissioners and budgets, it is not possible to implement a fully standardised process	Partial achievement with clear process in place

2.3. Quality objectives for improvement for 2023-24

The Trust's quality objectives for 2023-24 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff, commissioners and patient representatives, as well as being placed on the Trust's website for public participation. In addition, the Patient Participation Group were asked about the proposed objectives during the meeting in January 2023.

The consultation was undertaken using SurveyMonkey with 58 responses received, a decrease from 129 received in the last year's survey. There was overall a high level agreement with the proposed objectives, all receiving over 93% positive responses, with the highest being 98% support for timely and effective assessment of patients in the Emergency Department and for improving the effectiveness of the discharge process. The lowest scoring question was ensuring patients remain hydrated with 93%, with the rationale for one negative response noting that this is already carried out very well.

Further suggested objectives covered the following areas, cancer/end of life patients, deteriorating patients, nutrition, fluid balance recording, improvements to communications (including deafness/hearing loss and access to video interpreting), reducing length of time patients are in ED, waiting times for prescriptions in outpatients, increased use of digital systems, liaison with GPs, involvement of patients in their care, eco-friendly and care and training for staff. These were not included in the final list for this Quality Account, however, all responses were shared with the Executive Committee and relevant leads for wider consideration and inclusion in Trust workstreams.

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Implement and embed the national Patient Safety Incident Response Framework (PSIRF)	PSIRF will replace the current Serious Incident Framework and will result in a significant change to the way in which the Trust and NHS as a whole responds to patient safety incidents to establish a comprehensive safety management system. It will support the delivery of four key aims: • Compassionate engagement and involvement of those affected by patient safety incidents • Application of a range of system-based approached to learning from patient safety incidents • Considered and proportionate responses to patient safety incidents • Supportive oversight focused on strengthening response system functioning and improvement	Director of Nursing, Midwifery and Governance	• 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	Quality Committee

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Continue to ensure the timely and effective assessment and care of patients in the Emergency Department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety, whilst also responding to increased demand for services	Director of Operations and Performance	• All patients waiting longer than 15 minutes for triage have a baseline set of observations recorded, with appropriate escalation action taken in a timely manner • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's 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 • Documented evidence that patients have had timely risk assessments and relevant related actions confirmed by regular audits	Quality Committee

Quality Domain: Clinical Effectiveness				
Objective	Rationale	Lead Director	Measurement	Governance Route
Ensure patients in hospital remain hydrated	Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls	Director of Nursing, Midwifery and Governance	• 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 Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
Improve the effectiveness of the discharge process for patients and carers	A continuing theme from patient feedback is the need to improve the discharge experience for patients and their carers	Director of Operations and Performance	• 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 was the primary factor in the delay, with target to reduce this in subsequent quarterly audits	Quality Committee

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
Improve the overall experience for women using the Trust's Maternity Services	The Trust remains committed to providing the best possible experience for all the women accessing our Maternity Services, particularly in the following areas which were rated lower that we would like in the most recent national survey: Ormskirk Maternity Services • Increasing involvement of women and their partners in their care • Increased access to medical	Director of Nursing, Midwifery and Governance	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys of women receiving maternity care	Quality Committee

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
	history of the mother and baby • Increased information about induction and labour • Increased information about physical recovery after birth Whiston Maternity Services • 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			

2.4. Statements of assurance from the Board

The following statements are required by the regulations and enable comparisons to be made between organisations, as well as providing assurance thatthe Trust Board hasconsidered a broad range of drivers for quality improvement.

2.4.1. Review of services

During 2022-23, the Trust provided and/or sub-contracted £470m NHS services.

St Helens and Knowsley Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2022-23 represents 97% of the total income generated from the provision of NHS services by St Helens and Knowsley Teaching Hospitals NHS Trust for 2022-23.

The above figures relate to income from patient care activities. The remaining total operating income arose from other sources such as NHS North West Deanery for the education and training of junior doctors and services provided to other organisations, such as Information Technology (IT), Human Resources (HR) and Pathology Services.

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2022-23

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items.

The Trust participates in two national confidential enquiry programmes, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the United Kingdom (UK) (MBRRACE–UK). It should be noted that some audits are listed as one entity on the published list, but involve a number of individual projects being undertaken under this single heading, for example, NCEPOD had 6 audit projects undertaken.

During 2022-23, 54 national clinical audits and 7 national confidential enquiries covered relevant health services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

During that period, St Helens and Knowsley Teaching Hospitals NHS Trust participated in 96% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust was eligible to participate in during 2022-23
- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in during 2022-23
  - The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2022-23, are listed below

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Status
1.	Breast and Cosmetic Implant Surgery	Yes	Yes	Continuous monitoring
2.	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Yes	Yes	Continuous monitoring
3.	NCEPOD Transition from Child to Adult Health Services	Yes	Yes	Completed
4.	NCEPOD Crohn's disease	Yes	Yes	Completed
5.	NCEPOD Epilepsy	Yes	Yes	Completed
6.	NCEPOD Community Acquired Pneumonia	Yes	Yes	Active
7.	NCEPOD Testicular Torsion	Yes	Yes	Active
8.	NCEPOD Endometriosis	Yes	Yes	Active
9.	Elective Surgery National Patient Reported Outcome Measures (PROMs) Programme	Yes	Yes	Continuous monitoring
10.	Royal College of Emergency Medicine (RCEM): Pain in Children	Yes	Yes	Completed
11.	RCEM Consultant Sign Off	Yes	Yes	Completed
12.	RCEM Infection Control	Yes	Yes	Active
13.	RCEM Mental Health Self Harm	Yes	Yes	Active
14.	Epilepsy 12 - (round 3) Paediatrics	Yes	Yes	Continuous monitoring
15.	National Audit of Inpatient Falls	Yes	Yes	Continuous monitoring
16.	National Hip Fracture Database	Yes	Yes	Continuous monitoring

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Status
17.	National Gastro-Intestinal Cancer Programme: Bowel Cancer (NBOCA)	Yes	Yes	Continuous monitoring
18.	National audit oesophago-gastric cancer (NAOGC)	Yes	Yes	Continuous monitoring
19.	Inflammatory Bowel Disease (IBD) Programme (registry)	Yes	Yes	Continuous monitoring
20.	Learning disability mortality review (LeDeR) - learning from lives and deaths of people with a learning disability and autistic people	Yes	Yes	Continuous monitoring
21.	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE–UK) – Maternal Infant and New-born	Yes	Yes	Continuous monitoring
22.	Transurethral Resection and Single Instillation Intravesical Chemotherapy Evaluation in Bladder Cancer Treatment (RESECT)	Yes	Yes	Completed
23.	National Mitre Study: Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE) (BAUS)	Yes	Yes	Completed
24.	National Diabetes Core Audit (NDA)	Yes	Yes	Continuous monitoring
25.	National Pregnancy in Diabetes Audit	Yes	Yes	Continuous monitoring
26.	National Diabetes Foot Care Audit	Yes	Yes	Continuous monitoring
27.	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Continuous monitoring
28.	National Diabetes Inpatient Safety Audit	Yes	Yes	Continuous monitoring
29.	National Asthma & Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Paediatric Asthma Secondary Care	Yes	Yes	Continuous monitoring
30.	NACAP Adult Asthma Secondary Care	Yes	Yes	Continuous monitoring

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Status
31.	NACAP Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	Continuous monitoring
32.	National Audit - Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Active
33.	National Audit of Cardiac Rehab	Yes	Yes	Continuous monitoring
34.	National Audit of Care at the End of Life (NACEL) Round 4	Yes	Yes	Completed
35.	National Audit of Dementia	Yes	Yes	Active
36.	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous monitoring
37.	National Cardiac Audit Programme (NCAP) (includes the Myocardial Infarction National Audit Programme - MINAP)	Yes	Yes	Continuous monitoring
38.	National Heart Failure Audit	Yes	Yes	Continuous monitoring
39.	National Clinical Audit Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Continuous monitoring
40.	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring
41.	National Joint Registry (NJR)	Yes	Yes	Continuous monitoring
42.	National Lung Cancer Audit (NLCA)	Yes	Yes	Continuous monitoring
43.	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Continuous monitoring
44.	National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous monitoring
45.	National Ophthalmology Audit (NOD)	Yes	Yes	Continuous monitoring
46.	National Perinatal Mortality Review Tool (PMRT)	Yes	Yes	Continuous monitoring
47.	National Prostate Cancer Audit (NPCA)	Yes	Yes	Continuous monitoring
48.	National Vascular Registry (NVR)	Yes	Yes	Continuous monitoring
49.	British Thoracic Society (BTS) National Smoking Cessation Audit	Yes	Yes	Completed
50.	BTS Adult Respiratory Support Audit	Yes	Yes	Active
51.	Sentinel Stroke National	Yes	Yes	Continuous monitoring

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Status
	Audit Programme (SSNAP)			
52.	Serious Hazards of Transfusion: (SHOT) UK National Haemo-Vigilance Scheme	Yes	Yes	Continuous monitoring
53.	Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	Completed
54.	Trauma Audit & Research Network (TARN): Major Trauma Audit-ED	Yes	Yes	Continuous monitoring
55.	UK Cystic Fibrosis Registry	Yes	Yes	Continuous monitoring
56.	UK Parkinsons Audit	Yes	Yes	Completed
57.	Fracture Liaison Service Database	Yes	No	No capacity to participate
58.	Perioperative Quality Improvement Programme	Yes	No	No capacity

The following audit was on the 2022-23 Quality Account list, however, the Royal College of Emergency Medicine changed the programme and did not undertake this audit:

- RCEM Assessing for Cognitive Impairment in older people

2.4.2.2. Other National Audits participated in during 2022-23 (not on Quality Account list)

National audits
Chip 4: coronavirus and hip fractures a multicentre audit of mortality in post vaccine era
National prosthetic hip dislocation study
UK national comparative audit of acute upper gastrointestinal (GI) bleeding
Sepsis review health & care partnership for Cheshire & Merseyside through the Advancing Quality Alliance (AQuA)
Rapid Access Chest Pain Clinic (RACPC) audit programme
AQuA acute kidney injury focus area
British Association of Dermatologists (BAD) national clinical audit 2022 (joint)
National dermatology nursing audit
Diverticular abscess management: a snapshot collaborative audit study (Damascus)
2022 national comparative audit of blood sample collection and labelling
Orthopaedic trauma hospital outcomes
Texas: Tranexamic acid in elective colorectal surgery
Growth Assessment Protocol (GAP) score missed case audit
Emergency ureteric injury management: a year-long national audit (re-join)
National children and young people diabetes and quality programme

National 3rd corrective jaw treatment audit
Mandatory surveillance of Healthcare Associated Infections (HCAI)
Mandatory surgical site infection (SSI) surveillance service (total hip and knee replacements)
Breast ONCA: breast surgery training opportunities national collaborative audit
EVOLVE- End of life care in adVanced chrOnic LiVEr disease

The reports of 52 national clinical audits were reviewed by the provider in 2022-23 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Intensive Care National Audit & Research Centre	
ICNARC (CMP) Case Mix Programme	The latest report showed that from April -Sept 2022 the Quality Indicator dashboard of 11 quality indicators were all green across the board for our Trust.
NELA	
National Emergency Laparotomy Audit (NELA)	The Trust continues to participate in this national audit and results are within the expected parameters. Regular reports are shared with staff at the Clinical Effectiveness Council and local QI-Clinical Audit meetings.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Surgical & Medical/Child Heath Programme	
Completed studies during 2022-23: • Epilepsy (adults) • Transition from Child to Adult Health Services • Crohn's	Active studies during 2022-23: • Community Acquired Pneumonia • Testicular Torsion • Endometriosis
Reports received and disseminated during 2022-23 for studies undertaken in previous years: • 'A Picture of Health' Physical Healthcare in Mental Health Hospitals – May 2022 (The Trust was not eligible to participate in this study) • 'Disordered Activity' Epilepsy Care' (adults) – December 2022	
Studies under development:	• End of Life Care
NCEPOD Dysphasia Care in Parkinson's Disease Study *2021 Report 'Hard to Swallow'*	A plan is to be implemented to address some of the issues. The services are there but an overall admission document for Parkinson's Disease inpatients which is easily accessible to staff on the staff intranet needs to be developed.
NCEPOD Out of Hospitals Cardiac Arrest (OHCA) Study *2021 Report 'Time Matters'*	The report was reviewed and disseminated at the Trust Quality Improvement (QI) Medical Audit Meeting and Emergency Department Education Meeting. The Trust was compliant with all the eligible recommendations of the

Audit Title	Outcome/actions
	report – no further actions required.
NCEPOD Epilepsy Care (adults) 2022 *Report 'Disordered Activity'*	The report was reviewed and disseminated at the Trust QI Emergency Department Audit Meeting. Any actions needed from the results of the findings will be undertaken.
National Pregnancy in Diabetes Audit	
National Pregnancy in Diabetes Audit 2018-20 report	The report found: some good results, being in line or above the regional or national average for: • Initial engagement with pregnant women who have Type 2 Diabetes in the first 10 weeks of pregnancy. • Women with Type 1 Diabetes taking Folic Acid 5mg up to 12 weeks prior to conception. The Trust had a slightly lower percentage of babies admitted to the Neonatal Unit in women with Type 1 & 2 Diabetes compared to regional and national data The Trust was below regional & national average for women with: • HbA1c <48 in early pregnancy in women with both Type 1 & Type 2 Diabetes • Type 2 Diabetes to be on Folic Acid 5mg up to 12 weeks prior to conception. • Type 1 & Type 2 Diabetes who have a HbA1c <48 in third trimester Babies whose birthweights are large for gestational age (LGA) (above 90th centile) Actions: • Full-time diabetes specialist nurse (DSN) appointed for antenatal care to increase clinic capacity for pre-pregnancy planning: • Pre-pregnancy appointment capacity has been increased • Review appointment slots for women on continuous glucose monitoring (CGM) has increased from 15 to 45 minutes to review technology data (pumps, CGM)
NACEL (National Audit into Care at the End Of Life)	Demonstrated excellent use of the one chance to get it right guidance and consistent levels of effective communication with next of kin (NoK) – (above national average). Staff confidence in delivery of end-of-life care was reported above the national average. Received positive feedback from NoK/families in

Audit Title	Outcome/actions
	relation to their experience of care provided (again above national average). The audit found: • Uptake of individual care plan was lower than anticipated. • Low uptake of quality survey (due to next of kin details being absent). Actions completed: • Promotion of the use of the Individual Care and Communication Record (ICCR) for all expected deaths • Contact made with relevant team/departments to ensure compliance with next of kin details being completed on Careflow system.
Urology	
RESECT: An International Collaborative Study	The results were above target for 1 of the 4 of the transurethral resection of bladder tumour (TURBT) key indicators measured and just below for the other 3. The Trust results were also above the national average for 3 of the 4 indicators. Actions: Theatre staff are now fully trained to do Mitomycin C (MMC) instillation New pro forma has been introduced to improve documentation of resection completeness and tumour details.

2.4.2.3. Local clinical audit information

The reports of 125 local clinical audits were reviewed by the provider in 2022-23 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Burns & Plastics	
Audit of Referrals: Mersey Regional Burns Unit	Significant improvement in the content of referrals. The referral system has been streamlined making the referral process easier. Gap in educational material for patients who do not attend the Burns centre identified. Actions Planned: Devise a leaflet to include in all referral emails aimed at patients who have been given advice only or have declined a clinic appointment. The leaflet will aim to provide information on our Scar Clinic

Audit Title	Outcome/actions
	service and education on burn wound healing times.
A closed loop clinical audit to assess current time to surgery trends for flexor tendon injuries	Successful completion of complete audit cycle including the intervention. Communication locally and peripherally to stress the importance of early flexor tendon repairs – use of audio-visual mediums. Reduction in number of mean days to surgery for flexor tendon repairs in re-audit cycle (4 days vs 11.2 days)
Emergency Department (ED)	
Audit of the management of new suspected Irritable Bowel Disease (IBD) and flares in known IBD	Actions completed include: Creation of an IBD ED guide for the management of suspected IBD and flares. IBD order set was added onto the Careflow system to ensure all the correct investigations are undertaken early in the patient's journey.
Monitoring and management of Clozapine (Joint with Whiston Mental Health Liaison Team & ED)	Actions planned: ED consultants to request Pharmacy Department to place an alert on every patient on Clozaril. Aim to prescribe this from ED during the patient's journey.
Improving care of patients with electrolyte disturbance in the ED	Actions: Creation of a new evidence-based guidance for use in the ED. Combine all electrolyte guidance into one document which is easy to access.
Audit on management of eye presentations in ED	Actions: Triage processes to be reviewed. Process for dealing with chemical injuries discussed at nursing huddles and during triage training. Pro forma to be amended to include a second page for better diagrams and more free text. Annual Emergency Nurse Practitioner teaching.
Coagulation screens in the emergency department; are we doing unnecessary tests?	The audit showed that 66% of coagulations screens analysed in the audit were deemed inappropriate Actions: Improved education and training regarding coagulation screens to ED staff
General Medicine	
Intermittent pneumatic compression (IPC) compliance in stroke patients (second round)	The audit found an increase in compliance with IPC stockings. There was also a reduction noted in the frequency of patients awaiting doctor review of IPC stockings. Improvements are still needed.

Audit Title	Outcome/actions
	Actions: • Introduction of an IPC checklist with thrice daily (TDS) checks • the number of available IPC pumps has been increased • Continue to raise awareness of the importance of IPC stockings and re-audit following implementation of the above recommendations
Short term steroid use in acute hospital along with gastro-protective and monitoring of glucose	There was improvement in use of gastro protectives (proton pump inhibitors (PPI)/H2 blocker) in acute hospital patients started on short term steroid therapy and in monitoring glucose in those prescribed steroids but there is significant scope to improve further. Actions: Distribution of flyer with information to wards as a reminder
Department of Medicine for Older People (DMOP)	
Rationalise use of antibiotics in end of life patient	Actions: Introduce mandatory notes about indication and review date for antibiotics on electronic Prescribing and Medicines Administrations (ePMA). Training sessions about advance care planning (ACP) for healthcare staff. Support the implementation of the deteriorating patient pro forma is in progress. Develop a patient information leaflet about rationale of antibiotics in the last days of life.
Audit of PPI prescribing	Actions include: Development of guideline for initiation and deprescribing PPI
Respiratory Medicine	
Audit of long-term Azithromycin prescribing	Actions include: Introduction of a local prescribing pathway including checklist of monitoring requirements.
Improving the pneumonia care bundle at Whiston Hospital **CURB-65** score estimates mortality of community-acquired pneumonia to help determine whether inpatient vs. outpatient management is best for the patient.	The audit found a good awareness of most components of acute pneumonia care as per National Institute of Clinical Excellence (NICE) & British Thoracic Society (BTS) guidelines. Chest X-ray was performed within 4 hours and CURB-65 score was used appropriately in most cases. Some of the sampling results audited seemed lower than expected. Actions: • Create/update the pneumonia care bundle into electronic format to replace paper version • Highlight sputum sampling as an important aspect of community acquired pneumonia work-up on the electronic pneumonia care bundle

Audit Title	Outcome/actions
	• Discussions with oxygen lead consultant on ways to improve oxygen prescribing rate in current ePMA prescribing context
Haematology	
Febrile neutropenia: to improve out of hours assessment of unwell haematology patients	The audit showed improvement in number of patients with febrile neutropenia being examined out of hours (OoH) from 67% to 94% Improvement in assessment of such patients by "Direct contact" foundation year 1 (FY1) junior doctor reviews from 50% to 92% Actions: Continue the delivery of a short teaching session to the FY1 cohort, about management of febrile neutropenia OoH
Monitoring, management and follow-up of steroid-induced hyperglycemia in the inpatient setting (second cycle of quality improvement programme)	Blood glucose monitoring (BM) significantly improved after the interventions from cycle 1, 80% of the patients prescribed steroids had their BMs monitored. Further improvements are needed: Actions: • Awareness raised of guidelines and need for emergency steroid cards. • To clarify in the guidelines given BM monitoring is necessary for patients on all steroids, regardless of the route of administration • Patients identified with steroid induced hyperglycaemia, to ensure GP follow-up 3 months after discharge to screen for diabetes • Round 3 of the audit has been undertaken.
Histopathology	
A review of reporting of gastric mucosa-associated lymphoid tissue (MALT) lymphoma biopsies	Majority of cases with initial diagnosis of MALT lymphoma are being dual reported locally or referred to Haemato-Oncology Diagnostic Service (HODS) appropriately. Recommended GELA (grading system to evaluate lymphoma response to therapy) classification for reporting of post-treatment biopsies is being used in majority of cases still improvements needed. Actions included: Algorithm/flow chart has been developed and disseminated. Consultation with haematologists and GELA reporting document has been disseminated to local pathologists.
Orthopaedics	
Compliance of preoperative fascia iliaca block (FICB) for neck of femur fractures (NoF) (joint audit with Anaesthetics)	Actions: Educate ED and orthopaedic juniors regarding FICB documentation in NoF pathway. Teaching the FICB block technique to all FY1 and foundation year 2 (FY2) to improve FICB delivery rate in pre-operative period

Audit Title	Outcome/actions
Palliative Care	
Ward based end of life care	The audit underpins that improvement continues to take place following the findings of the National Audit of Care at the End of Life (NACEL). Actions: Ongoing education to ward staff and preceptorship of the importance of using the Individual Care and Communication Record (ICCR) and prescribing of 'just in case' medication.
Paediatrics	
Re-auditing the occurrence of contaminated blood culture in paediatrics after blood culture pack being introduced	Actions include: Make all the practitioners be aware of the importance of providing the information in order to identify the personal factors affecting blood culture contamination. Compulsory training for aseptic non-touch technique (ANTT) and strict implementation of local protocol.
Annual paediatric record keeping audits 2021-22	Some good results noted throughout the year with record keeping standards met in most cases. Actions: Results shared with team at the Trust Quality Improvement Audit Meeting Emails sent to all staff and discussed in safety huddles to remind clinicians of all the key record keeping standards.
Current local practice for neonatal abstinence syndrome (NAS)	The audit found local practice is compliant with the local guidelines, no readmission due to NAS/no missed cases and no serious events. There was some variation in practice found. Actions include: • Reinforce Midwife/Student Midwife/Midwife Support workers in NAS scoring • Train community midwives for NAS detection in low risk babies • Update local guideline in face of other units & British Association of Perinatal Medicine (BAPM) • Disseminate guidelines for appropriate identification of high-risk patients (green plan)
Re-audit of paediatric surgical outcomes	Surgical care of children is safe as there is no mortality or morbidity reported. Length of stay was prolonged in some cases as per the previous audit. This reaudit confirmed that the length of stay had improved (lesser duration) when compared to previous cohort. Patients were completely satisfied with the care - no complaints. Despite COVID-19 restrictions, none of the surgeries were cancelled during the period. No actions needed
Obstetrics & Gynaecology	

Audit Title	Outcome/actions
Review of antenatal care and perinatal outcomes in twin pregnancies pre- and post-twin clinic	The audit found that twins are being seen by specialist obstetrician earlier in pregnancy, better information provision (Trust twins' information booklets), earlier birth plans made (adhering to NICE guideline), ultrasound quality and documentation of discordance vastly improved. Actions: • Audit presentation shared to help raised awareness. liaison with lead sonographer to highlight need to refer twins to Ante-natal Clinic (ANC) for 16 weeks. • Fetal Medicine Unit (FMU) now scanning majority of monochorionic twins (shared placenta), which will become all scans once new scan room available and fetal medicine consultant appointed. • Training delivered to sonographers and aid memoir produced and placed in scan rooms
Audit to evidence a risk assessment is documented at each antenatal visit and appropriate intended place of birth documented according to the risk status. All women are reviewed by the most appropriate health professional	Audit showed that care was being given by the appropriate health professional. Referrals to the most appropriate team were made as the clinical picture developed. Risk assessments were performed although on occasion the risk status was not documented due to the incorrect workflow use. It was however, evident in the clinical narrative that a risk assessment had been done and care provided dependent on the clinical picture. Actions: • Discussed in the QI-Audit meeting and Obstetric & Gynaecology Governance meeting • A reminder added in the screenshot prior to accessing workflows on Medway. • Audit newsletter produced to reinforce the importance of using correct workflows for all episodes of antenatal care assessments and identifying the correct intended place of birth according to risk unless the woman chooses otherwise as part of maternal choice and discussion about the risks has taken place, as demonstrated in the audit.
Review of maternal and neonatal outcomes in women with pre-existing diabetes	Improvement in HbA1c value over the span of pregnancy with much lower values in 3rd trimester compared to 1st. Improved pregnancy outcome with improved diabetes control seen. Poor uptake of pre-pregnancy clinic. High miscarriage with poor diabetes control. Planned Actions: Organise a teaching session for junior doctors and in primary care if possible. Education of staff in Bleeding in Early Pregnancy (BEP) and infertility clinic. Design referral forms for various clinical areas to make the process of referral to pre-pregnancy clinic easy.

Audit Title	Outcome/actions
Orthopaedics	
Venous thromboembolism (VTE) prophylaxis prescription and documentation audit among orthopaedic inpatients	Actions include: • Handout and mini-presentation about importance of electronic (eVTE) completion at induction. • eVTE/prescribing checklist on orthopaedic office whiteboard. • Warning message on ePMA enoxaparin entries to adjust dose for weight/estimated glomerular filtration rate (eGFR) • Induction presentation (as above)/whiteboard checklist • Notice on Careflow to prescribe anti-embolism stockings when mechanical prophylaxis ticked
Quality Improvement & Clinical Audit	
Compliance against the Trust Record Keeping Policy (RK)	Generally good compliance with the Trust Record Keeping Policy found, with staff following the processes; although it was noted that due to the pandemic, data submissions and dissemination dates varied in some cases, which was to be expected at this time. • New record keeping infographic has been added to the quarterly QICA activity report for Quarters 1&2 2022-23 • Record Keeping Policy has been reviewed/updated (V8) and the compliance audit tool has also been updated with additional questions to reflect working practices • Further community specialties are joining for 2022-23. A review of workload: which now stands at 108 individual quarterly audits per annum for the record keeping programme has been undertaken and a streamlined way of disseminating the results will start from April 2023. • Record keeping audit action plans will continue to be requested from specialties and escalated as per the (action plan monitoring escalation process) in place for non-receipt.
Cancer Services	
Counselling & help to overcome problems effectively (HOPE) course waiting time audit	Actions: • New electronic referral form to be created by IT digital team to help with referrals. • Triaging clients, offer other ways of support if on waiting list for a while. • Clients to be contacted on receipt of referral form and informed of potential waiting time.
Resuscitation Services	
Lots of work has been undertaken during 2022-23 with some new initiatives being developed, including the implementation of a new do not attempt cardiopulmonary resuscitation (DNACPR) Steering Group, looking at having difficult conversations with patients and family and plans to introduce a neonatal life support course.	

Audit Title	Outcome/actions
Task and finish group being arranged regarding patients attending radiology with DNACPR decisions	
uDNACPR audit	An audit also saw some further actions to be planned: Creation of a video on how to fill out a unified DNACPR (uDNACPR) form and podcasts to discuss some of the issues and subjects around uDNACPR discussions.
Health Work & Wellbeing (HWWB)	
Record Keeping Audit of HWWB consultation notes 2022	All five standards were achieved There has been an increase to 100% compliance in three of the standards, recording employee details, conclusions and actions and legibility and consent. Further actions: Updating training for clinicians.
HWWB-Counselling Attendance and Outcome: Service Review 2022	Actions to include: • Development of an initial counselling letter for clients prior to their first session. • Monthly counsellor meetings to review trends & strategies • Review annual statistics & reassess service provision
Urology	
Urology record keeping quarterly audit 2022-23	The audit found some good standards of record keeping with compliance being met is several areas. Actions: • Consultants give formal talk at FY1 induction on the importance of accurate record keeping at the start of new rotation. • Findings to be disseminated to FY1 cohort with reminder about accurate record keeping including particular emphasis on key areas not meeting targets.

2.4.3. Participation in clinicalresearch

Great research in a great environment

Patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery. 'Research-active' hospitals have lower mortality rates, with benefits not limited to those patients who participate in research (NHS Long Term Plan, 2018). St Helens and Knowsley Teaching Hospitals NHS Trust is committed to ensuring that patients have access to and are aware of opportunities to participate in research that is of relevance to them.

The past year has seen several exciting changes/additions to our Research, Development and Innovation (RDI) Department. In July 2022 we welcomed Dr Peter Williams as the new Medical Director and at the same time Dr Ascanio Tridente was appointed as our first ever Clinical Director of Research. Their aims for the RDI Department are to build upon and expand our existing clinical research strengths, and to attract, promote and deliver commercial research.

In July 2022, as a result of patient feedback, we opened two dedicated Research Clinics, which have allowed us to offer more patients a safe and friendly environment to take part in essential research. Participants are reviewed for screening, randomisation, study procedures and follow-up visits. Altogether, this enhances the quality of the patients' research journey, ensuring that our participants have the best experience possible, which is something that we are extremely passionate about.

As part of the plan to grow research, in November 2022 a review of the Trust's RDI Income Distribution Plan (IDP) was conducted. The IDP was produced to provide a transparent and consistent approach to the utilisation of income from research studies. The IDP was updated to allow and encourage the flow of research income to be reinvested back into research in a timely manner, thus enabling growth and expansion.

In January 2022, the Trust employed a dedicated Commercial Research Nurse, for 12 months, to expand and increase the number of new commercial studies. This has proved to be extremely successful. In addition, we have introduced a new role to our Research Team, the Associate Clinical Research Practitioner, which is an essential post that works alongside Principal Investigators, research nurses and the wider research teams to assist in the delivery of high-quality research.

The number of research studies (portfolio) open to recruitment at the Trust during 2022-2023 was 90 compared to 99 in 2021-2022. This includes the Huawei Watch trial which is a study looking at whether the use of a smart watch (Huawei smart band) can detect atrial fibrillation (AF) (an abnormal heart rhythm) in patients following a stroke. This study is important because having untreated AF after a stroke may increase the likelihood of another stroke. The stroke team were the top recruiter to this study and have been a shining example to other trusts on how to set up and run the study.

The number of studies that the Trust sponsored increased from 7 in 2021-2022 to 8 in 2022-2023. This is an important role for the Trust, as the sponsor organisation is the company, institution or organisation that takes on the ultimate responsibility for the initiation, management (or arranging the initiation and management) and/or financing (or arranging the financing) for that research

An Award Winning Team

The North West Coast Research and Innovation awards took place on the 23rd June 2022 at Edge Hill University and were hosted by the Innovation Agency, the National Institute for Health and Care Research (NIHR) Clinical Research Network North

West Coast (CRN NWC) and Applied Research Collaboration North West Coast (ARC NWC). These awards were an opportunity to celebrate success and the excellent work being undertaken in health and care across the region during an unprecedented time. We were extremely proud that the Liverpool School of Tropical Medicine Plus Partners (St Helens and Knowsley Teaching Hospitals Research Team) won the COVID-19 Research and Innovation award. The Trust has continued to support the Liverpool School of Tropical Medicine by following up participants on the Oxford Vaccine Study. We are proud to have played our part in this important study as it has led the way in fighting the battle against COVID-19.

In 2022-2023 one of the main priorities for the Trust was to increase the amount of commercial research. Dr Ascanio Tridente forged links with Astra Zenca and other commercial companies, which has led to an increase in the number of commercial studies open to recruitment, from 9 in 2022-2023 compared to 8 in 2021-2022. The whole research team set up and opened commercial studies swiftly and efficiently. The following feedback was received from a commercial partner:

> "Working with St Helens and Knowsley Teaching Hospitals NHS Trust has been a breath of fresh air. Since receiving the expression of interest form, everyone involved has worked so efficiently to get the study up and running. The set-up time has easily been one of the fastest and seamless I have been involved with recently which has made it a pleasure and therefore a site we would approach to do further studies in the future".

The Trust also recruited the first patient in Europe and the first patient in the UK to two important commercial research studies:

- In January 2023, Dr Jennifer Marlow recruited the first patient in Europe (out of 34 sites) to the commercial Connect 3 trial
- In February 2023, Dr Ascanio Tridente recruited the first patient in the UK to the TILA trial. The purpose of this international clinical study is to evaluate the effect of tozorakimab as an add-on to standard of care treatments in patients with viral lung infection requiring supplemental oxygen on the prevention of death or progression to Invasive Mechanical Ventilation (IMV) or Extracorporeal Membrane Oxygenation (ECMO).

Both studies were supported by our outstanding research nurses and support staff. This is a huge achievement for the research staff at the Trust and puts us on the map both in the UK and internationally as a site with an excellent reputation for setting up and delivering commercial research.

Our commercial portfolio also includes the HARMONIE study; this is a research study that looks at how strongly babies can be protected from serious illness due to Respiratory Syncytial Virus (RSV) infection by giving them a single dose of antibodies. The Research Team have worked hard to get this study up and running and were the third highest recruiter in the CRN NWC.

Between 01-09-21 and 30-11-2022 our Cancer Research Team were the highest recruiting Trust in the country with the Melmart 2 study (Melanoma Wide Excision Trial). The hard work of the Research Team placed the UK in second position internationally behind the USA. The success of this study can be attributed to

excellent team working, with several trained registrars recruiting to this important study. They were also second top recruiters to the ROSETA trial. The ROSETA study aims to test combinations of four different interventions which have been designed to support women who have been prescribed hormone therapy medication as part of their treatment for breast cancer.

The Cancer Research Team is the only research team to be Macmillan adopted. This is an exceptional achievement and demonstrates our commitment to delivering the best support and treatment for our cancer patients.

The cancer portfolio at the Trust has remained stable with 14 studies open to recruitment. There was an increase in the number of patients recruited, from 62 in 2021-2022 to 126 in 2022-2023.

Our Burns and Plastics team successfully recruited to the Re-Energize trial which was accepted in New England Journal of Medicine, one of the world's top-ranked journals with the highest impact factor. The team also submitted 23 presentations to the British Burn Association meeting, held in Bristol in early May 2022, winning two out of the three poster prizes.

We have supported research in the primary care sector and are pleased to report that Marshalls Cross Medical Centre were the top recruiter in the CRN NWC and fifth in the UK, to the Panoramic study, a study which investigates treatments that can help people in the community with COVID-19 to get better earlier and to reduce the need to be admitted to hospital.

It has been recognised that although the number of patients recruited to research studies is important, there is a shift towards ensuring that the Recruiting to Time and Target (RTT) metric is met. This is the number of research studies closed to recruitment during 2022-23 that met the study target. In 2022-23, 19 studies closed to recruitment and 84% of these met the RTT.

The number of patients receiving relevant health services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2022-23 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 865. Currently the Trust ranks 12th out of 19 trusts across the CRN NWC.

The 19 principles in the UK Policy Framework for Health and Social Care Research (2017) serve as a benchmark for the conduct of research. Adhering to these standards is a must and ensures the health and safety of research staff and participants. The RDI Department has a suite of Standard Operating Procedures (SOPs) which are reviewed every three years unless there are any changes to the guidance. The SOPs cover all aspects of the set up and conduct of a research project. The suite of SOPs were reviewed and brought up to date in December 2022.

The Participant in Research Experience Survey (PRES) is conducted annually by the NIHR. In 2022-23, the Trust received the highest number of responses across the CRN NWC. The PRES continues to be a priority, as participant experience is at the heart of research delivery by providing an opportunity for as many research

participants as possible to share their experience of taking part in research. It was encouraging to note the following feedback:

> "All the staff involved were very positive, friendly, and professional. I really felt I was doing something worthwhile and useful."
>
> "During the initial meeting, I had ample time to ask lots of questions and was never rushed. Answers were provided so that I truly understood. The care and the treatment I received and continue to receive is exceptional. For me personally the thoroughness of the care gave me confidence that I was being looked after and made me less anxious about my cancer diagnosis as I felt any further tumours would have been picked up."
>
> "I am positive about being involved with the research, I have children and want to help them in the future and if this research helps then that's the positive for me."

All the comments were positive, however there was a request from a participant asking to be informed of the results of the trial. This is something that the NIHR are keen to deliver and encourage sponsors of studies to inform participants of the outcome of the study.

In addition, the results from The National Cancer Patient Experience Survey (2021), published in July 2022, placed the Trust in first position across all the Cheshire and Merseyside acute trusts for discussing cancer research opportunities with our patients.

2.4.3.1. Research aims for 2023-24

Our aims for 2023-24 are to:

- Continue to increase the number of commercially sponsored studies as these are a valuable source of support for NHS trusts. This income can be used to encourage key stakeholders to develop capacity for new research within the Trust and increase the volume and, therefore, future income generation
- Collaborate with other NHS organisations and Universities, which is high on the agenda as we prepare to merge with Southport and Ormskirk Hospital NHS Trust (in 2023) and the merge of the North West Coast Clinical Research Network with Greater Manchester Clinical Research Network (in 2024). We will include this in our new strategy which will be released in June 2023
- Look at options to expand our workforce to support the successful delivery of both commercial and non-commercial trials
- Increase our patient recruitment into NIHR adopted clinical trials
- Explore research options in specialities which are not research active
- Carry out thorough feasibility assessments so that studies reach targets
- Submit business cases to the Research Network for additional income when opportunities arise
- Ensure that there are robust structures in place to initiate, deliver and manage research, thus increasing opportunities for patients to participate in high quality clinical research
- Engage and communicate with patients and service users. It is of great value to know about the opinions and experiences of the participants. We will ensure that

the NIHR patient research experience survey is embedded into the patients' research journey. We will also feed back both positive and negative experiences, so that we can put action plans in place if necessary
- Continue and update our social media and website platforms to help promote research

2.4.3.2. Research Summary

In summary, it has been a successful year, we have opened our new dedicated research clinics, expanded the team to include the new Clinical Director of Research. We have increased the amount of commercial research undertaken at the Trust and recruited the first patient in the UK and the first patient in Europe to two important studies. We have also reached out to more patients than ever before for feedback on their experience of taking part in research.

Our ambition as a team is to keep growing and expanding clinical research and health sciences research, to improve our patients' opportunity to be involved in cutting edge projects and improve the health of the region and the nation.

2.4.4. Clinical goals agreed with commissioners

A proportion of St Helens and Knowsley Teaching Hospitals NHS Trust income in 2022-23 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework (CQuIN). The Trust was required to report on all CQuIN Indicators, but only five had payments attached to their delivery, with four for Community Services and one for Specialised Commissioning. The full list is shown in the table below below:

[DN: update full year performance when received after 25th May 2023

Ref	Description	Payment basis*	Q1	Q2	Q3
CCG1	Flu vaccinations for frontline healthcare workers	Minimum: 70% Maximum: 90%	n/a	n/a	58%
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Minimum: 20% Maximum: 60%	100%	100%	100%
CCG4	Compliance with timed diagnostic pathways for cancer services	Minimum: 55% Maximum: 65%	Meeting being arranged to discuss with NHSE		
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery	Minimum: 45% Maximum: 60%	95%	94%	94%
CCG8	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Minimum: 60% Maximum: 70%	88%	87%	85%

CCG2	Appropriate antibiotic prescribing for UTI in adults aged 16+	Minimum: 40% Maximum: 60%	65%	63%	64%
CCG5	Treatment of community acquired pneumonia in line with BTS care bundle	Minimum: 45% Maximum: 70%	70%	23%	18%
CCG7	Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Minimum: 0.5% Maximum: 1.5%	34%	36%	34%
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Minimum: 20% Maximum: 35%	27%	84%	96%

* Payment Basis percentages indicate levels required to gain all or no CQUIN funding.

Community indicators will only report at end of quarter 4.

Reference	Provider Type	Indicator
CCG13	Community	Malnutrition screening in the community
CCG14	Community	Assessment, diagnosis and treatment of lower leg wounds
CCG15	Community	Assessment and documentation of pressure ulcer risk
PSS2	Specialised	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery

2.4.4.1. CQuIN proposals2023-24

The table below reflects the CQuINs currently being finalised between the Trust and its commissioners. The Director of Nursing, Midwifery and Governance will confirm the final five acute CQuINs linked to financial payments once agreed with commissioners.

Reference	Contract Type	Title
CQUIN01	Acute & Community	Flu vaccinations for frontline healthcare workers
CQUIN02	Acute	Supporting patients to drink, eat and mobilise (DrEaM) after surgery
CQUIN03	Acute	Prompt switching of intravenous to oral antibiotic
CQUIN04	Acute	Compliance with timed diagnostic pathways for cancer services
CQUIN05	Acute	Identification and response to frailty in emergency departments
CQUIN06	Acute	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
CQUIN07	Acute	Recording of and response to NEWS2 score

		for unplanned critical care admissions
CQUIN08	Acute	Achievement of revascularisation standards for lower limb ischaemia
CQUIN09		n/a
CQUIN10	Specialised Commissioning	Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway
CQUIN11		n/a
CQUIN12	Acute & Community	Assessment and documentation of pressure ulcer risk
CQUIN13	Community	Assessment, diagnosis and treatment of lower leg wounds
CQUIN14	Community	Malnutrition screening for community hospital inpatients

2.4.5. Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where these fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information and assesses services against five key questions to determine the quality of care a Trust provides, asking if services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

The latest comprehensive CQC inspection took place in July and August 2018. The Use of Resources review was undertaken on 5th July, the unannounced inspection took place during the week commencing 16th July, the inspection of Marshalls Cross Medical Centre was completed on 14th August and the planned well-led review was completed during the week commencing 20th August.

Teams of inspectors visited Whiston, St Helens and Newton hospitals and the Trust's directly provided community and primary care services during the inspection period to talk to patients, carers and staff about the quality and safety of the care provided. They reviewed care records and observed the care provided. The Trust was able to demonstrate to the inspection team the high standard of work that is undertaken on a daily basis to ensure patients receive excellent care.

A further inspection of Marshalls Cross Medical Centre took place in October 2022 and was rated good for each of the five domains, with an overall rating of good, improving from the previous requires improvement rating.

St Helens and Knowsley Teaching Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2022-23.

St Helens and Knowsley Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2022-23.

St Helens and Knowsley Teaching Hospitals NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in July/August 2018. The CQC's assessment of the Trust following that review was outstanding. There was a follow up inspection of Marshalls Cross in October 2022 which was rated as good overall.

2.4.5.1. CQC ratings table for St Helens and Knowsley Teaching Hospitals NHS Trust, March 2019

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Outstanding	Good	Outstanding	Outstanding

The Trust's Emergency Department was rated as requires improvement for the responsive and safety domains, with action plans implemented to address the recommendations.

The Marshalls Cross inspection report highlighted just two should do actions which are being addressed.

The Trust is taking the following action to address the points made in the CQC's assessment:

- Delivery of comprehensive action plans in continuing attempts to achieve key national targets to enable timely care of patients in ED, including arrival to initial assessment times and the decision to admit, transfer or discharge target
- Development of action plans for the two should do actions for Marshalls Cross to continue to:
    - Improve uptake for cervical screening and childhood immunisations
    - Monitor patient medication reviews

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2023 in taking such action:

- Delivery of action plans to address areas where the Trust requires improvement in the ED, including clarifying and monitoring the quality and completion of ligature and clinical risk assessments to ensure they are completed as appropriate for all patients requiring them in ED

During 2022-23 the CQC continued with transitional monitoring arrangements with no concerns raised.

2.4.6. Learning from deaths

2.4.6.1. Number of deaths

During Quarters 1-4 2022-23, 1,913 of St Helens and Knowsley Teaching Hospitals NHS Trust's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:
443 in the first quarter
418 in the second quarter
531 in the third quarter
521 in the fourth quarter

By end of Q4, 149 case record reviews and 3 investigations (reds and ambers) have been carried out in relation to the 1,913 deaths included in item 2.4.6.1.

In 3 cases (reds and ambers), a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
2 in the first quarter
1 in the second quarter
0 in the third quarter
0 in the fourth quarter

0 representing 0.00% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient (red rated).
In relation to each quarter, this consisted of:
0 representing 0% for the first quarter
0 representing 0% for the second quarter
0 representing 0% for the third quarter
0 representing 0% for the fourth quarter

These numbers have been estimated using the St Helens and Knowsley Teaching Hospitals NHS Trust's Royal College of Physicians Structured Judgement Review (SJR).

75 case record reviews and 0 (reds and ambers) investigations completed after 31-12-2021 which related to deaths which took place before the start of the reporting period.

0 representing 0% (reds) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the St Helens and Knowsley Teaching Hospitals NHS Trust's Structured Judgement Review (SJR) (which uses NCEPOD quality score and red, amber, green (RAG) rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance. This represents the final position for Quarter 4 of 2021-22.

1 representing 0.05% (reds) of the patient deaths during 2021-22 are judged to be more likely than not to have been due to problems in the care provided to the

patient. This represents all four quarters of 2021-22.

2.4.6.2. Summary of learning from case record reviews and investigations

The Trust has focussed on one or two key learning priorities for each report to the Trust Board. The key lessons shared are listed below:

- **Alerts**

The alert status for COVID risk and shielding is to be removed from electronic records. This reiterates the need to check the alert status in every clinical interaction. When highlighted, be aware of any additional needs/risks

- **Recognition of the deteriorating patient**

This starts at the patient's bedside, adhering to the NEWS2 policy and escalating accordingly. Everyone plays a role from the speciality teams, in hours and out of hours, from junior doctors (FY1) through to consultants, further supported by the Medical Emergency Team and Intensive Care Unit

- **Abnormal results**

When checking a patient's results, please be aware once reviewed, it may not appear on someone else's check list and, therefore, go unmanaged. It is vital that anything abnormal is duly actioned or escalated according to need

- **Recognition of new confusion with sepsis**

New confusion (or a worsening confusion from a patient's baseline) may be a first sign of sepsis at initial presentation or as an in-patient (think hospital acquired pneumonia, etc) with an early opportunity to treat and reverse. Please be suspicious, think sepsis and arrange appropriate investigations to evaluate further

- **Availability of hospital post-mortems**

A hospital post-mortem may be requested for any patient not requiring a Coroner's post-mortem. Written consent must be obtained from the next of kin and the Trust consent form 5 completed from the Policy for Consent to Examination or Treatment (appendix11); also available from the Bereavement Office. A death certificate must be issued before the post-mortem is performed. Hospital doctors involved with the patient's care can attend the post-mortem and if requested, they will then be contacted by the mortuary staff

- **Chronic Liver Disease Care Bundle**

Following a patient review, in line with Learning from Deaths, staff are reminded to use the Decompensated Chronic Liver Disease Care Bundle, which is available on the intranet. Also, staff are reminded to use Careflow for an urgent gastroenterology opinion/review

2.4.6.3. Actions taken resulting from learning

The Trust's Learning from Deaths Policy is due for review and is currently out for consultation. This incorporates the principles laid down in the National Quality Board

document “Learning from Death: Guidance for NHS trusts on working with bereaved families and carers”.

Lessons identified from the structured judgement reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, intranet home page, global email, Care Group governance and directorate meetings.

As learning generated from SJRs continues to be shared, evidence of changes to practice can be seen. In addition to sharing the learning, as outlined above, the following work streams have been initiated and are ongoing:

- Trust level project to evaluate and determine the best course of action in the management of the deteriorating patient at Whiston site, including aggregated, comprehensive review of patients who have required multiple calls to the Medical Emergency Team (MET)
- Case review sharing with junior doctors in line with the Royal College of Physicians Lessons Learned Programme https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6616793/
- Recognition of exceptionally good care, which is acknowledged by the Mortality Surveillance Group in writing and used by individual clinicians to support appraisal and revalidation
- Task and finish group to highlight within the organisation the benefits and challenges of “Feeding at Risk” in line with recommendations from the Royal College of Speech and Language Therapists’ eating and drinking with acknowledged risks. Leaflets are being developed to share with patients, carers and staff to hopefully encourage choice and remove fear.

In addition, there is a Medical Examiner service at the Trust that will refer cases that require a review, providing further opportunities to learn lessons and make improvements to the care provided.

2.4.6.4. Impact of actions taken

The effectiveness of learning is assessed by audit of Datix, serious incidents, complaints, Patient Advice and Liaison Service (PALS) contacts, litigation and mortality reviews for evidence of failure to deliver these priorities. Systematic assessment of effectiveness is necessarily two quarters behind priorities, allowing time for sharing and then time to establish that learning has become embedded.

2.4.7. Priority clinicalstandardsfor seven-day hospital services

There are four priority seven-day services clinical standards which are outlined in the list below.

- Clinical Standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties (eg. acute medicine) consultant presence into the evening is likely to be needed every day

- Clinical Standard 5 states that emergency and urgent access to appropriate Consultant-led diagnostic tests should be available every day. Relevant diagnostic tests include computerised tomography (CT), magnetic resonance imaging (MRI) and ultrasound imaging, endoscopy and echocardiography
- Clinical Standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions and typically should include emergency theatre, intensive care, interventional endoscopy, percutaneous coronary intervention (PCI) for acute myocardial infarction, emergency cardiac pacing and thrombolysis for stroke
- Clinical Standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway

The Trust has a list of consultant job plans to deliver these standards covering each speciality, including on call arrangements. There are arrangements in place to provide access to consultant delivered diagnostic tests and the majority of interventions onsite, with the remaining available via the network, that is, interventional radiology, stroke thrombectomy and PCI for myocardial infarctions.

In summary, the job planned consultant presence is available to deliver the 4 priority 7 Day Clinical Standards for the majority of patients admitted to hospital. Specialities which do not currently have job planned consultant time to deliver consistent early (<14h from admission) review (haematology and urology) are responsible for a small proportion of the patients admitted to hospital non-electively.
Structures are in place to deliver the emergency consultant delivered diagnostic tests and interventions across weekdays and weekends.

2.4.8. Information governance and toolkit attainment levels

Information Governance (IG) is the way in which the Trust manages its information and ensures that all information, particularly personal and confidential data, is handled legally, securely, efficiently and effectively. It provides both a framework and a consistent way for employees to deal with the many different information handling requirements in line with Data Protection legislation.

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG and IT security controls, also known as the IG Assessment Report. The DSPT is an annual online self-assessment tool that allows health and social care organisations to measure their performance against the National Data Guardian's 10 Data Security Standards (covering topics such as staff responsibilities, training and continuity planning) and reflects legal rules relevant to IG. The Trust must address all mandatory requirements within the DSPT in order to publish a successful assessment.

St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall submission position for 2021-22 was published in June 2022. To provide assurance that the Trust's DSPT for 2021-22 was of a good

standard, it was audited by Mersey Internal Audit Agency and achieved substantial assurance.

The Trust has assigned specific roles to ensure the IG framework continues to be adhered to and remains fully embedded:

- Christine Walters, Director of Informatics – Senior Information Risk Owner (SIRO)
- Mr Alex Benson, Assistant Medical Director - Caldicott Guardian
- Camilla Bhondoo – Head of Risk Assurance and Data Protection Officer

All three staff are appropriately trained.

The Trust has a Data Breach Management Procedure in place which is adhered to when a personal data breach/incident occurs. All incidents are risk assessed and scored and if an incident is scored highly, it must be reported to the Information Commissioner's Office (ICO). The incidents that were reported throughout the year did not score highly and, therefore, no further escalation was required and these incidents were managed locally.

2.4.9. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2022-23 by the Audit Commission.

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security & Protection Toolkit (DSPT) 2022-23. The error rates reported in the latest published audit for that period of diagnoses and treatment coding (clinical coding) were:

Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
Data Security & Protection Toolkit	9%	8.91%	9.87%	12.14%

In this year's DSPT audit, the error rate on Primary Diagnosis, Primary Procedure and Secondary Procedure has increased. It should be noted that, as a result of staffing gaps, there was a coding backlog that needed to be resolved and a third party company was secured to support the Trust in reducing the coding backlog. This contract was in place from September 2022 and finished at the end of December 2022. The DSPT is based on a random audit of finished consultant episodes (FCE), so this includes FCEs coded by the third party company. When analysing the results for those completed by Trust staff the error rate was significantly lower and similar to previous Trust performance for DSPT.

2.4.10. Dataquality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care

to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of this process. Audit outcomes are monitored to ensure that the Trust continues to maintain performance in line with national standards. The data quality work plan is reviewed on an annual basis ensuring any new requirements are reflected in the plan.

There are a number of standard national data quality items, which are routinely monitored, including:

- Blank/invalid NHS numbers
- Unknown or dummy practice codes
- Blank or invalid registered GP practices
- Patient postcodes

The Trust implemented a new Patient Administration System (PAS), Careflow, in 2018 which has the functionality to allow for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier.

The Careflow configuration restricts the options available to users. Validation of this work is on-going and forms part of the annual data quality work plan.

2.4.10.1. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during 2022-23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which includes the patient's valid NHS number and registered GP practice contributes to the overall Data Quality Maturity Index (DQMI) scores, which are shown in the table below:

DQMI	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Trust Score	92.2	93	92.8	92.7	93	93.1	93.3
National Average	81.0	80.7	82.2	81.0	80.0	79.8	79.5

(Source: DQMI)

The Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

The Trust will be taking the following actions to improve data quality:

- Data Quality team will monitor the nationally mandated submissions via the NHS digital toolkit and a formal report will be presented at the Information Steering Group meeting. Any elements requiring action will be agreed at this meeting
- Data Quality Team will continue to monitor data quality throughout the Trust via

the regular suite of reports
- Provide data quality awareness sessions about the importance of good quality patient data and the impact of inaccurate data recording
- Data Quality Forum will be established to provide oversight to ensure the timely completion of data quality checks across departments in the Trust

2.4.11. Benchmarking information

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS trusts. The Trust has more up-to-date information for some measures; however, in the main only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

2.4.11.1. Benchmarking Information

Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data sources. Any internal figures included are displayed in purple font.

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Summary Hospital-level Mortality Indicator (SHMI)	NHS Digital	Dec-21 to Nov-22	1.025	1.000	0.717	1.222	Data for Jan-22 to Dec-22 to be published early May 2023
SHMI	NHS Digital	Nov-21 to Oct-22	1.032	1.000	0.623	1.247	
SHMI	NHS Digital	Oct-21 to Sep-22	1.027	1.000	0.645	1.234	
SHMI	NHS Digital	Sep-21 to Aug-22	1.038	1.000	0.698	1.225	
SHMI Banding	NHS Digital	Dec-21 to Nov-22	2	2	3	1	
SHMI Banding	NHS Digital	Nov-21 to Oct-22	2	2	3	1	
SHMI Banding	NHS Digital	Oct-21 to Sep-22	2	2	3	1	
SHMI Banding	NHS Digital	Sep-21 to Aug-22	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Dec-21 to Nov-22	52.0%	39.8%	12.6%	66.0%	
% of patient deaths having palliative care coded	NHS Digital	Nov-21 to Oct-22	51.4%	40.1%	11.9%	65.4%	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
% of patient deaths having palliative care coded	NHS Digital	Oct-21 to Sep-22	39.9%	50.6%	11.8%	64.6%	
% of patient deaths having palliative care coded	NHS Digital	Sep-21 to Aug-22	49.9%	39.8%	11.5%	65.1%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (NHS Digital). St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by: Monthly monitoring of available measures of mortality. Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned as noted in section 2.4.6.							
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-20 to Mar-21 (final)	N/A	N/A	N/A	N/A	The mandatory varicose vein surgery and groin-hernia surgery national PROMs collections have ended In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-19 to Mar-20 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-20 to Mar-21 (final)	0.430	0.472	0.393	0.574	
EQ-5D adjusted health gain:	NHS Digital	Apr-19 to Mar-20	0.406	0.459	0.352	0.539	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Hip Replacement Primary		(final)					between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.428	0.465	0.348	0.557	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-20 to Mar-21 (final)	0.314	0.315	0.181	0.403	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-19 to Mar-20 (final)	0.252	0.335	0.215	0.419	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.309	0.338	0.266	0.405	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-20 to Mar-21 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-19 to Mar-20 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:							

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation (Quality Health). St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: Delivering a number of actions to improve patient experiences following surgery. PROMs data was monitored at the Trauma and Orthopaedic bi-monthly clinical effectiveness meeting.							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-11 to Mar-12	12.73	11.45	0.00	17.15	2011-12 still latest data available. Date of next version to be confirmed. Lowest and best national performance based on acute providers
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	12.60	11.43	0.00	17.10	
(Indirectly age, sex, method of admission, diagnosis,	NHS Digital	Apr-11 to Mar-12	11.39	10.01	0.00	14.94	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	10.66	10.01	0.00	14.11	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The data was consistent with Dr Foster's standardised ratios for re-admissions. The readmissions: 30 day relative risk score is monitored monthly by the Trust Board. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by: Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient	NHS Digital	2021-22					Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
survey focussing on the responsiveness to personal needs.							Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed. As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding score regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2020-21	76.0	74.5	67.3	85.4	
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2019-20	66.2	67.1	59.5	84.2	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does.
The Trust was rated outstanding overall for caring by the CQC following their latest inspection undertaken in 2018.
The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website.
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by:
Promoting a culture of patient-centred care.
Responding to patient feedback received through national and local surveys, Friends and Family Test results, complaints and Patient

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning.							
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	NHS staff surveys	2022	77.6%	61.9%	39.2%	86.4%	Data for 2020 onwards is for acute and acute & community providers Data for 2018 and 2019 is for acute providers only
If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2021	79.4%	66.9%	43.6%	89.5%	
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2020	88.1%	73.4%	50.0%	92.0%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2022	15.1%	20.0%	25.9%	12.3%	Low scores are better performing trusts
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2021	15.1%	19.5%	27.2%	12.3%	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2020	12.2%	19.8%	26.3%	12.2%	
% believing there are opportunities to develop their career in this organisation	NHS staff surveys	2022	58.2%	53.4%	42.9%	63.6%	Note – new wording to this question in 2021 survey
% believing there are opportunities to develop their career in this organisation	NHS staff surveys	2021	52.5%	52.1%	64.6%	38.8%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2020	93.2%	84.9%	66.5%	94.3%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons; The Trust provides a positive working environment for staff with a proactive Health, Work and Wellbeing Service. An independent provider (Quality Health) provides the data. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Engagement of staff at all levels in the development of the vision and values of the Trust. Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.							
Friends & Family Test - A&E -	NHS England	Mar-23					

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Response Rate							National response rates no longer published Data for Mar-23 to be published early May 2023
Friends & Family Test - A&E - Response Rate	NHS England	Feb-23					
Friends & Family Test - A&E - Response Rate	NHS England	Jan-23	2.6%				
Friends & Family Test - A&E - Response Rate	NHS England	Dec-22	6.4%				
Friends & Family Test - A&E - % positive	NHS England	Mar-23					
Friends & Family Test - A&E - % positive	NHS England	Feb-23	78.4%	79.7%	37.5%	94.7%	
Friends & Family Test - A&E - % positive	NHS England	Jan-23	91.2%	83.0%	43.3%	100.0%	
Friends & Family Test - A&E - % positive	NHS England	Dec-22	75.3%	72.9%	20.0%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Mar-23					
Friends & Family Test - Inpatients - Response Rate	NHS England	Feb-23	34.8%				

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Friends & Family Test - Inpatients - Response Rate	NHS England	Jan-23	24.0%				
Friends & Family Test - Inpatients - Response Rate	NHS England	Dec-22	22.0%				
Friends & Family Test - Inpatients - % positive	NHS England	Mar-23					
Friends & Family Test - Inpatients - % positive	NHS England	Feb-23	95.8%	94.6%	66.1%	100.0%	
Friends & Family Test - Inpatients - % positive	NHS England	Jan-23	96.7%	94.6%	78.5%	100.0%	
Friends & Family Test - Inpatients - % positive	NHS England	Dec-22	97.0%	94.1%	73.4%	100.0%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes the Friends and Family Test across all areas. The data was submitted monthly to NHS England. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology, supported by volunteers in key areas. Actively working with ward staff to improve levels of engagement with the system, to ensure the latest results are shared at local level and actions are delivered to respond to the feedback.							
% of patients admitted to hospital	NHS England	Quarter 3 2019-20	96.24%	95.25%	71.59%	100.00%	All data is for Acute Providers only

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
who were risk assessed for VTE							All data is for Acute Providers only Data for Q4 2019-20 onwards is suspended
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2019-20	95.23%	95.40%	71.72%	100.0%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2019-20	95.23%	95.56%	69.76%	100.0%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Adult admitted patients with a stay over 24 hours have a venous thromboembolism (VTE) risk assessment undertaken to ensure that they receive the most appropriate treatment. Data collection has been suspended nationally since 2020 due to the impact of the pandemic. Root cause analysis (RCA) investigations undertaken on VTEs are recorded on Datix to ensure best practice is followed. The clinical reviews completed to date found the patients to have received appropriate care. COVID-19 related VTE has been identified nationally and internationally as a complication of the virus and, therefore, the Trust developed and implemented appropriate guidance for clinicians to consider in planning VTE prophylaxis. St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Developing IT systems and pathways to facilitate VTE risk assessment and prescribing of thromboprophylaxis. Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed. Sharing any learning from these reviews and providing ongoing training for clinical staff.							
Clostridium Difficile (C Difficile) rates per 100,000 bed-days	GOV.UK	Apr-21 to Mar-22	10.9	16.2	0	53.6	

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
for specimens taken from patients aged 2 years and over (Trust apportioned cases)							
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-20 to Mar-21	9.6	15.4	0	80.6	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-19 to Mar-20	15.7	13.6	0	51.0	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-18 to Mar-19	10.2	12.2	0	79.7	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
Infection prevention remains a priority for the Trust.
All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
mandatory external reporting. The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea. Cases are thoroughly investigated using RCA, which is reported back to a multidisciplinary panel to ensure appropriate care was provided and lessons learned are disseminated across the Trust. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: Focussing on ensuring staff compliance with mandatory training for infection prevention. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.							
Incidents per 1,000 bed days	Internal	Apr-22 to Mar-23	52.39				
Incidents per 1,000 bed days	NHS Improvement	Apr-21 to Mar-22	60.56	55.96	30.18	120.59	
Incidents per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	37.20	57.63	27.20	118.70	
Incidents per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	35.31	49.70	27.52	110.21	
Number of incidents	Internal	Apr-22 to Mar-23	14530				
Number of incidents	NHS Improvement	Apr-21 to Mar-22	0.18	0.22	0.02	0.63	
Number of incidents	NHS Improvement	Apr-20 to Mar-21	0.14	0.25	0.03	1.08	
Number of incidents	NHS Improvement	Oct-19 to Mar-20	0.04	0.15	0.00	0.52	Data now published once a year.
Incidents resulting in severe harm or	Internal	Apr-22 to Mar-23	0.28				

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
death per 1,000 bed days							Next data to be published in Sept-2023 Data for Apr-21 to Mar-22 and Apr-20 to Mar-21 is based on acute (non-specialist) trusts with complete data (12 months data) Data for Oct-19 to Mar-20 is based on acute (non-specialist) trusts with complete data (6 months data)
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-21 to Mar-22	0.18	0.22	0.02	0.63	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	0.14	0.25	0.03	1.08	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	0.04	0.15	0.00	0.52	
Number of incidents resulting in severe harm or death	Internal	Apr-22 to Mar-23	78				
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-21 to Mar-22	50	58	5	216	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-20 to Mar-21	31	54	4	261	
Number of incidents resulting in severe harm or death	NHS Improvement	Oct-19 to Mar-20	5	19	0	93	
Percentage of patient safety	Internal	Apr-22 to Mar-23	0.54%				

Indicator	Source	Reporting Period	STHK	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
incidents that resulted in severe harm or death							
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-21 to Mar-22	0.3%	0.4%	0.0%	1.3%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-20 to Mar-21	0.4%	0.4%	0.0%	2.8%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-19 to Mar-20	0.1%	0.3%	0.0%	0.9%	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust actively promotes a culture of open and honest reporting within a just culture framework.
The data has been validated against National Reporting and Learning System (NRLS) and NHS Digital figures. The latest data to be published is up to March 2022. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.3%
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by:
Undertaking comprehensive investigations of incidents resulting in moderate or severe harm.
Delivering simulation training to enhance team working in clinical areas.
Providing staff training in incident reporting and risk management.
Monitoring key performance indicators at the Patient Safety Council, Quality Committee and the Trust Board.
Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.

2.4.11.2. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2022-23 is shown in the table below:

Performance Indicator	2021-22 Performance	2022-23 Target/threshold	2022-23 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Not Achieved	100.0%	99.6%	Apr22-Feb23
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Not Achieved	92%	62.1%	Apr22-Feb23
Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	97.4%	Apr22-Feb23
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	86.5%	Apr22-Feb23
- anti-cancer drug treatments	Achieved	98%	100.0%	Apr22-Feb23
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	81.0%	Apr22-Feb23
- from consultant upgrade	Achieved	85%	88.9%	Apr22-Feb23
- from urgent screening referral	Achieved	90%	98.1%	Apr22-Feb23
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Not Achieved	93%	78.1%	Apr22-Feb23

Performance Indicator	2021-22 Performance	2022-23 Target/threshold	2022-23 Performance	Latest data
- symptomatic breast patients	Not Achieved	93%	86.8%	Apr22-Feb23
Emergency Department waiting times within 4 hours - All Types	Not achieved	95%	70.7%	Apr22-Mar23
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	87.3%	Apr22-Dec22
Clostridium Difficile	Achieved	56	57 of which 26 deemed unavoidable to date with 6 cases to be reviewed	Apr22-Mar23
MRSA bacteraemia	Not achieved	0	1	Apr22-Mar23
Maximum 6-week wait for diagnostic procedures: % of Diagnostic Waits who waited <6 weeks	Not achieved	99%	76.0%	Apr22-Feb23

3. Additional information

3.1. Equality, Diversity and Inclusion (EDI)

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally underserved groups are not disadvantaged when accessing the services that the Trust provides.

The Trust's EDI Steering Group meets regularly to ensure compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and members of the Trust staff networks.

The Trust is a member of the following external charter marks, accreditations and commitments, which are used to further our equality strategy:

- Disability Confident Scheme, Leader (Level 3)
- Rainbow Badge Accreditation, Bronze (LGBT, 2022)
- Veterans Aware (Armed Forces, 2021)

3.1.1. Human Resources Equality, Diversity & Inclusion Operational Plan

The Human Resources EDI Team has developed an updated Equality, Diversity & Inclusion Operational Plan setting out the Trust's key objectives and activities to advance equality through 2022 to 2025. A key action to enable this has been the appointment of a dedicated EDI Team to embed equality within the workforce. The plan identifies three key priority areas:

- Inclusive and compassionate leadership
- Culture of inclusion
- Diverse workforce

The plan builds on our previous successes and activities and pulls together key actions and activities in response to the Staff Survey results, the Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and the Equality Delivery System 2 (EDS2).

The Staff Disability Reasonable Adjustment Passport was approved and the Trust have introduced an Accessibility Passport which further supports employees and managers in agreeing workplace reasonable adjustments

External providers have been commissioned to deliver a suite of EDI training and development courses. The training programmes will continue to be delivered to the end of March 2023, with 300 staff to date having attended one of the courses. The course topics/titles included:

- Managing disability with confidence

- Lessons learned from Employment Tribunals – discrimination, ill health & reasonable adjustments
- Discrimination law and reasonable adjustments
- Flexible working requests
- Employment rights in the workplace
- Parental leave and right to request flexible working

The Trust has continued to support six staff networks:
- Armed Forces
- Building Abilities (disability)
- Building a Multicultural Environment
- Carers
- Menopause
- Proud@STHK

Events organised by or in support of the networks included participation in the Liverpool Pride march and a series of menopause cafes on a wide variety of topics including emotional wellbeing and mindfulness and testosterone and its role in menopause.

The Trust continues to meet is legal and regulatory obligatory to complete the:
- EDS2
- Gender Pay Gap
- Workforce Disability Equality Standard
- Workforce Race Equality Standard

3.1.2. Patient Experience and Inclusion Strategy

The Patient Experience and Inclusion Team launched the new Patient Experience and Inclusion Strategy in 2022 following consultation with internal and external stakeholders. The strategy brings together objectives for equality, diversity, inclusion and engagement for the first time, rather than having separate strategies. Additional information about the strategy is provided in section 3.5 below.

3.1.3. Equality objectives 2019-23

In February 2023, the Trust held its Equality Delivery System (EDS2) panel assessment, which was attended by senior leaders in the Trust and from Southport and Ormskirk Hospital NHS Trust, representatives from local Healthwatch groups, St Helens Deafness Resource Centre, Unison and the Senior Governance Manager from the Integrated Care Board (ICB). Progress on EDS2 goals and the Equality Objectives 2019-23 action plan were presented and the approved grades are outlined in the table below.

2023 EDS2 approved grades

Goal	Outcome	2018	2019	2021	2023
Better health outcomes	1.1	Developing	Achieving	Achieving	Achieving
	1.2	Developing	Achieving	Achieving	Achieving
	1.3	Developing	Achieving	Achieving	Achieving
	1.4	Achieving	Achieving	Achieving	Achieving
	1.5	Developing	Achieving	Achieving	Excelling

Improved patient access and experience	2.1	Achieving	Achieving	Achieving	Achieving
	2.2	Developing	Achieving	Achieving	Achieving
	2.3	Achieving	Achieving	Achieving	Achieving
	2.4	Developing	Achieving	Achieving	Excelling
A representative and supported workforce	3.1	Achieving	Achieving	Achieving	Achieving
	3.2	Excelling	Excelling	Excelling	Excelling
	3.3	Developing	Developing	Achieving	Achieving
	3.4	Achieving	Achieving	Achieving	Developing
	3.5	Achieving	Achieving	Achieving	Achieving
	3.6	Excelling	Excelling	Excelling	Excelling
Inclusive leadership	4.1	Achieving	Achieving	Achieving	Developing
	4.2	Achieving	Achieving	Achieving	Developing
	4.3	Developing	Achieving	Achieving	Achieving

All parties present at the assessment approved the Trust's self-assessment of their grades and congratulated the Trust on the work that had been carried out to support both patients and staff during the last few years, which had been challenging for everyone.

The patient facing goals have moved to excelling for outcomes 1.5 and 2.4 following the work undertaken relating to vaccination services which reached and benefitted all local communities (1.5) and regarding the handling of complaints about services respectfully and efficiently (2.4). On reviewing the workforce outcomes, the workforce team assessed three as developing rather than achieving, due to the differential impact felt by some groups of staff with protected characteristics in the respected domains. Detailed action plans are in place to address these areas.

Progress in delivering the equality objectives for 2019-23 are detailed in the sections below with the areas for focus for 2023-27 outlined in section 3.1.3.3.

3.1.3.1. Improving access and outcomes for patients and communities who experience disadvantage

Communication support for those with disabilities
We have further increased the number of patients who told us they had additional communication needs due to their disability (in line with the Accessible Information Standard (AIS)) by:

- ✓ Additional training for appointments/admissions staff to 'ask'
- ✓ Publicity via social media, posters, GPs and Healthwatch
- ✓ Regularly audit alerts on patients' records
- ✓ Training with team from Deafness Resource Centre (DRC) for our doctors in training
- ✓ Trust website asking people to tell us their needs
- ✓ Webform on communication needs for patients to tell us if they have additional communication needs due to disability
- ✓ Ongoing awareness training delivered by St Helens DRC to multiple groups of 25 staff
- ✓ Currently looking at how we can cleanse Careflow so the AIS alerts are kept specific to patients who need communication support relating to disability

Increasing accessibility

- ✓ Introduction of carer passport
- ✓ Virtual clinics
- ✓ Cancer symptoms advice line set up (2020)
- ✓ Virtual British Sign Language (BSL) interpreting available through DRC
- ✓ Piece of work in ED focussing on their access to interpreting services when they are needed at short notice
- ✓ Looking at app for BSL interpreters for ED and out of hours/short notice requests
- ✓ Learning Disability Nurse Specialist able to assist with reasonable adjustments and completion of health passports
- ✓ Fully accessible website with accessibility functions on it
- ✓ Internal and external review of all polices and departments as part of the Rainbow Badge Accreditation (scored bronze)
- ✓ Patient information leaflets checked internally and by a group of lay readers to ensure they are clear and can be understood by patients (reading age of local populations taken into consideration)
- ✓ Patient information leaflets have content checked to ensure they are inclusive (both language and content)

Collaborative working

- ✓ Worked together to develop formal guidance for reasonable adjustments for patients and staff, which has been built into the electronic patient record and into our policies and procedures (patients and staff)
- ✓ Joint reasonable adjustments action plan with other NHS trusts
- ✓ Joint deafness action plan with other trusts to address issues the deaf community encounter
- ✓ Standards for interpreting services developed and embedded into all trusts' interpreting contracts; staff from DRC worked with us, particularly around minimum qualifications and experience needed
- ✓ Transgender task and finish group established to identify issues affecting trans patients and staff; this group developed a workforce policy for use in all trusts in Cheshire and Merseyside
- ✓ Worked with Liverpool University Hospitals NHS Foundation Trust and patient representatives to develop the carer passport which was introduced across Cheshire and Merseyside in 2021, with other areas of the country interested in introducing it in their areas
- ✓ Armed forces and veterans task and finish group worked collaboratively on the Veterans Accreditation, making sure policies are in place to support veterans (particularly workforce policies for veterans seeking employment in the Trust)

3.1.3.2. Engagement and consultation

- ✓ Patient Participation Group was reinstated early in 2022 and members were involved in the development of the new Patient Experience and Inclusion Strategy, carers' passport and quality objectives for 2023-24. Dates in diary for 2022-23 included meetings on different days/times with some held virtually and some face to face to allow more flexibility for participants to join in
- ✓ Access audits and PLACE inspections restarted following the pandemic and

patient representatives from our local communities and local Healthwatch groups participated alongside Trust staff

- ✓ Have engaged and consulted on policies and standard operating procedures from specialist groups eg trans polices with Lesbian and Gay Foundation (Rainbow Badge)
- ✓ Widely consulted on Patient Experience and Inclusion Strategy 2022-25
- ✓ Patient groups joined focus groups on the Trust's new website for advice around accessibility
- ✓ Engaged with patient groups regarding the new name for the Trust following the transaction with Southport and Ormskirk Hospital NHS Trust

3.1.3.3. Patient equality objectives 2023-27

The following objectives will be the focus for the coming years:

- Improve all methods of communication with patients, ensuring they are inclusive and accessible to all:
  - Patient app
  - Patient letters
  - Accessible formats
  - Alternative ways to contact patients eg emails
  - Information in alternative formats
- Review accessibility of Trust areas/services across all sites
  - Lay out/estate
  - Accessibility
  - Patient call systems
  - Booking systems
- Change the way interpreting services are delivered in the Trust
  - 20% face to face
  - 40% telephone
  - 40% video

3.2. People Strategy

The Trust's People Strategy brings together the key themes from the supporting operational plans which align with the national People Strategy and the Trust's vision for five star patient care. The strategy has been translated into specific, meaningful and achievable actions which are reviewed annually in line with the Trust objectives. In addition, the Trust has a cycle of continuous improvement to ensure strategies, policies and other governance documents continue to align with national guidance and regulatory compliance.

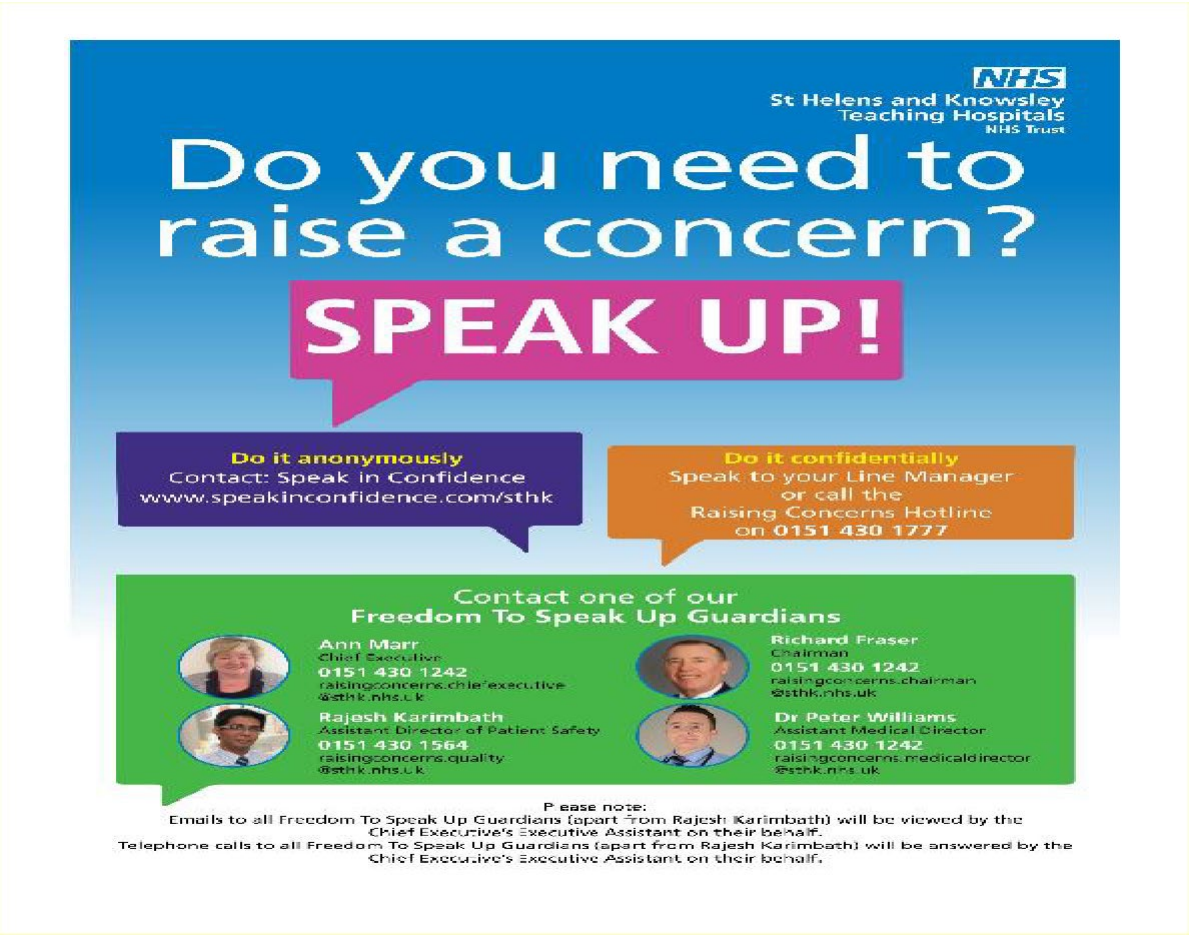
To deliver five star patient care, the Trust must put our staff at the centre of everything we do and the People Strategy sets out what we will do to achieve this. The plan focuses on how we must look after each other and foster a culture of inclusion and belonging, as well as actions to grow and train our workforce, working together differently to deliver patient care.

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

The NHS People Promise shown below is central to the plan and will help to embed a consistent and enduring offer to all staff in the NHS:

The Trust's People Strategy and associated action plan provides assurance to the Strategic People Committee and the Trust Board regarding progress against achieving the Trust objectives relating to workforce and delivering against the four pillars of the NHS People Plan.

3.2.1. Freedom to speak up



The Trust has continued with its commitment and support to ensure a culture where all staff feel empowered to speak up or raise concerns. The Trust values include being open and honest and listening and learning. There are a number of supportive facilities in place across the Trust for staff to raise concerns, including:

- Freedom to Speak Up

All staff members across the organisation, including sub-contracted staff, have access to any of the Trust's four appointed Freedom to Speak Up Guardians, to raise concerns. The Guardians are representative of various staff groups and backgrounds. They provide an alternative way for staff to discuss and raise concerns and they act as an independent and impartial source of advice to staff at any stage of raising a concern.

The work of the Guardians has a direct impact on continuously improving safety and quality for our patients, carers andfamilies, as well asenhancing the experience of our staff, by acting on the concerns raised. The Guardians have continued to engage with staff members who have raised a concern, in a manner that is supportive, whilst ensuring that there are no repercussions for the person raising a concern. The Guardians have received very positive feedback on the help provided.

Staff members are encouraged and supported to raise concerns, either personal or service-related, to the Guardians or to use alternative raising concerns portals

available. Improvements and changes have been made based on the concerns raised.

The Trust works in partnership with the National Guardian's Office and North West Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns. The Trust recorded a mean Freedom to Speak Up index score of 82.3% in 2020 (published in 2021), an increase from 81.9% for the previous year. The Trust score is significantly higher than the national mean score for acute trusts of 77.9%, confirming the positive culture for raising concerns. Due to changes in the national staff survey, the index measurement was discontinued by the National Guardian's Office in 2021-22. There were 25 concerns raised in 2022-23, compared with 24 in 2021-22.

- Speak in Confidence system

The Trust has continued to provide staff members with access to an anonymous reporting system, Speak in Confidence, which enables all staff, irrespective of their role, to raise concerns without disclosing their identity. The system uses a browser-based interface to ensure anonymity so that the concern raiser remains anonymous at all times. However, the manager receiving the concern is able to provide a response to the concern, to request further information and/or to provide assurances of actions taken to mitigate the risks associated with the concern raised via the online system. The system has been used by staff members to raise concerns, which have been addressed.

- Raising concerns hotline

The Trust also has a telephone hotline, which provides access to report any concerns, which are reviewed and actioned by the Medical Director.

- Health, work and wellbeing hotline

Staff members have access to adedicated helpline, to provide advice and support regarding health and wellbeing aspects relating to work or impacting on the individual. Bespoke support can be offered depending on the needs and circumstances. Concerns about the workplace can be raised through the hotline.

- Hate crime reporting

A hate crime is when someone commits a crime against a person because of their disability, gender identity, race, sexual orientation, religion, or any other perceived difference. The Trust, in partnership with Merseyside Police, continues to support staff members with the first ever Hate Crime Reporting Scheme based at an NHS Trust. This is a confidential online reporting service thatenables anyone fromacross our organisation and local communities to report, in complete confidence, any incidents or concerns around hate crime to Merseyside Police.

- Policies and procedures

There are a number of Trust policies and procedures that facilitate the raising of staff concerns, including Grievance Policy and Procedure, Respect and Dignity at Work Policy and Being Open Policy. Staff are also encouraged to informally raise any concerns to their manager, nominated HR lead or their staff-side representative, as well as considering the routes listed above.

All concerns are taken seriously and changes made where appropriate, including making changes to the working environment, providing individual support and information available to staff and reviewing staffing levels in key areas. The Trust has made available nationally recommended Freedom to Speak Up training to all staff members on its e-learning platform.

3.2.2. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. For the 2022 survey, reported in 2023, the Trust conducted a full census staff survey for the second time. There were 2691 completed questionnaires returned giving a 40% response rate, which is 3% higher than last year.

As the survey saw many changes between 2020 and 2021, plus the fact that the Trust conducted a full census for the first time in 2021 comparisons are only valid for most questions over the last two surveys. The questions are still related to the themes and sub themes of the NHS People Promise with additional themes of staff engagement and morale retained from earlier surveys. The results give a wide picture of satisfaction across the organisation and a good comparison with the 2021 data.

For the first time eligibility to participate in the NHS Staff Survey was extended to bank only workers in NHS organisations, using a tailored version of an online questionnaire, with 72 organisations invited to take part. The survey was sent via an online link to 576 people who were eligible to take part at the Trust. Eligibility was based on bank workers who had worked in the six months between 1st March 2022 and 1st September 2022 and who did not have a substantive or fixed term contract. Out of the 576 people the survey was sent to, 125 people responded providing a response rate of 21.7%

We are able to make comparisons with the Trust's benchmarking group, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. The Trust's benchmarking group will be of 126 organisations, 2 less than 2021 .

Results are reported both as individual question responses, sub themes, two engagement themes and the ten themes aligned to the NHS People Promise. Overall, the Trust reported the highest national score for the following theme:

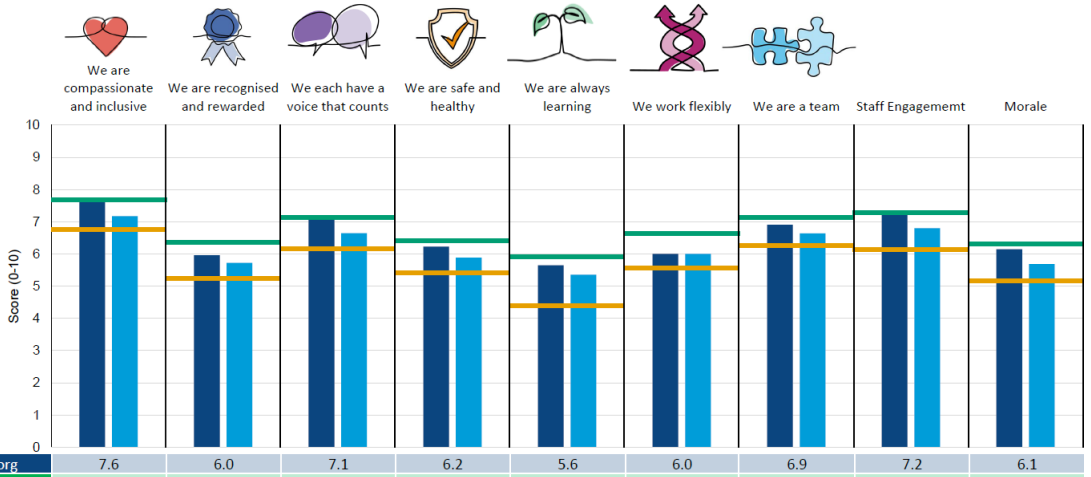
- We each have a voice that counts

And the second highest national score for:

- Staff engagement
- We are compassionate and inclusive

These results are shown in the chart below:

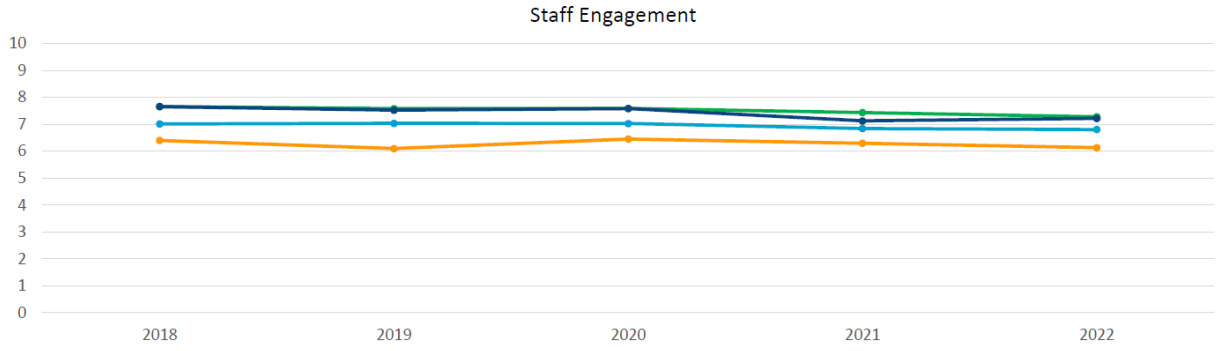
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.6	6.0	7.1	6.2	5.6	6.0	6.9	7.2	6.1
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2673	2660	2632	2630	2541	2642	2665	2677	2677

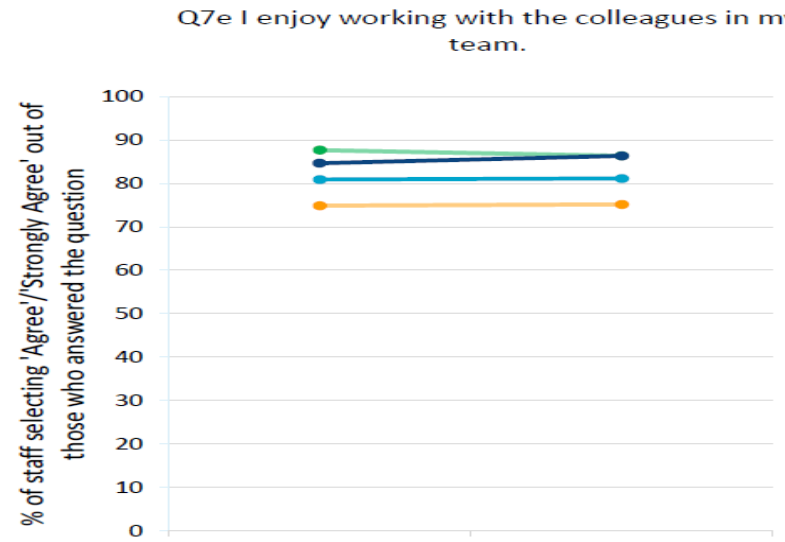
The Trusts achieved the best scores in the region for all themes other than one theme, that is we work flexibly.

Overall staff engagement is measured as an average across three themes, advocacy, motivation and involvement. Staff engagement scores fall between 0 and 10, where the higher the score, the more engaged the staff. Although 2021 saw a decline an improvement was recorded in 2022, which was just below the highest score.



	2018	2019	2020	2021	2022
Your org	7.7	7.5	7.6	7.1	7.2
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	619	564	508	2381	2677

STHK secured the national highest score for staff reporting that they enjoy working with colleagues in their team.



	2021	2022
Your org	84.6%	86.3%
Best	87.6%	86.3%
Average	80.9%	81.1%
Worst	74.8%	75.1%
Responses	2365	2664

Areas of focus for 2023 onward include addressing issues relating to sufficient staffing, work pressures, dissatisfaction with levels of pay, acting on staff and patient feedback, continued development of staff and opportunities for career progression, training and appraisals and supporting staff to balance work and home life.

3.2.3. Clinical education and training

In March the Trust was awarded the National Preceptorship for Nursing Quality Mark, following the introduction of the preceptorship framework in July 2022, which is outlined in the section below.

In April 2022 the Clinical Education Team implemented Health Education England's (HEE) post COVID education recovery plan, which consisted of three phases:

- Phase 1: Support learners/trainees and educators
- Phase 2: Optimise innovations
- Phase 3: Deliver long-term education improvements

Firstly, the team explored supporting the wellbeing of trainees/learners. This was achieved by developing and increasing engagement and exploring service pressures impacting on learning, including via focus groups and data from the Genera Medical Council survey, the national education training survey and locally sourced feedback.

By increasing service/learner engagement and mapping educational provision against service delivery, the team set out to increase training opportunities, with several new education interventions proposed, developed and implemented. The above phases have been achieved following the development and implementation of the education projects as outlined in the sections below.

Implementation of the STHK Preceptorship Pathway
The Trust's 12-month preceptorship programme is designed to support our newly qualified staff within their first 12-months of registration. The aim of this preceptorship period is to aid the transition of newly qualified practitioner to autonomous professional through developing confidence and competence. Together with core clinical skills and competencies that preceptees are expected to achieve, behavioural skills such as leadership, communication, delegation and time management are also developed during this time. For 2023, the core clinical skills will be blood glucose monitoring, blood product collection, blood administration, blood sampling for a transfusion (group & save training), venepuncture, cannulation, catheterisation and an introduction to the intravenous medications examination. In order to support the implementation of the pathway, the Trust has recruited seven Preceptorship Champions on a secondment/fixed term basis until January 2025. The Champions will work with the ward managers, preceptors, practice-based educators and Clinical Education Team as an additional level of support to identify areas of development and put action plans in place to support this. Each Champion will have a hub area which they will be responsible for but as the need for support will vary among preceptees, Champions will also assist other Champion areas where necessary as part of a hub and spoke model.

Implementation of the preceptorship programme aligned to the new RCN preceptorship framework:
Utilising the regional and national frameworks for preceptorship, published in 2022, alongside feedback from preceptees and their departments, 2023 will see a new Preceptorship Programme being introduced, called the STHK Preceptorship Pathway. This new pathway has been designed and implemented with the aim of improving staff satisfaction and aiding retention.

Recruitment and training of 100 international nurses
100 internationally educated nurses (OSCE nurses) have been recruited to the Trust since April 2022, of which 81 (82%) have now passed their OSCE examination and have received/are in the process of receiving their Nursing and Midwifery Council (NMC) PIN and 18 nurses are resitting the examination in early March. The final nurse who arrived late due to circumstances outside everyone's control is currently undertaking their OSCE preparation course. All of these 100 nurses are employed at the Trust and those who have received their NMC PIN have moved onto the 12-month preceptorship programme. The 18 nurses who are awaiting resits are being supported by the Clinical Support Team and have been provided with opportunities for refresher study days.

Establishment of a new Healthcare Support Worker Academy
In August 2022, the Trust's Clinical Education Support Tutor, along with colleagues from the Trust's Healthcare Academy devised a new training programme for all new Healthcare Support Workers (HCSWs). The first aspect of this training is a 5-day induction programme, which covers a range of different topics, such as, practical clinical skills and human factors training. The incorporation of human factors training, specifically relating to stress and mental health wellbeing, was based on the feedback provided from HCSWs, who completed a health and wellbeing questionnaire. Feedback suggested HCSWs were not necessarily mentally prepared

for the challenges of the role, therefore, the Trust wanted to ensure this was incorporated into the new training programme.

Each new starter is included on a 12-week tracker and the Trust Clinical Education Support Tutor undertakes ward visits to each clinical area. The care certificate is used as a framework for induction and, once the care certificate is complete, the HCSW is then provided with a further 12 weeks to embed it into their new role. After 6 months, the Healthcare Academy Team contact the HCSW to ascertain if they want to complete their level 1 and level 2 NVQ. It was felt providing this opportunity to staff would further improve staff retention.

Edge Hill School of Medicine
September 2022 saw the first rotation of medical students from the newly established Edge Hill Medical School in the Trust. The Trust has worked closely with Edge Hill Medical School since 2018, providing advice and support on the development of the medical school's quality and governance frameworks requested by the General Medical Council.

HEE North West recovery funds.
The Trust was invited to bid for additional education monies to support postgraduate medical trainees. Postgraduate speciality leads submitted seven bids totalling £85,780. HEE have confirmed the bids have been successful and the monies will be allocated in quarter four of the education tariff. Following the allocation of the above bids, collaborations are underway to develop a multi surgical speciality laparoscopic education programme. This will initially focus on the Trust's surgical trainees and going forward the vision is to develop the programme as a regional/national offer creating opportunities for income generation.

3.3. Patient safety

One of the Trust's continuing priorities in 2022-23 was to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. There was a particular focus on reducing avoidable harm by preventing falls.

3.3.1. Falls

The Falls Team continues todevelop strategies to minimise the occurrence of inpatient falls and in 2022-23, the Trust reported:

- 16% reduction in inpatient falls per 1000 bed days, decreasing from 8.667 falls per 1000 bed days in 2021-22 to 7.290 in 2022-23
- 20% reduction in inpatient falls of moderate harm or above per 1000 bed days, decreasing from 0.253 falls per 1000 bed days in 2021-22 to 0.202 in 2022-23
- 14% reduction in Moderate harm or above patient incidents, decreasing from 65 during 2021-22 to 56 during 2022-23

The Trust continued to implement its Falls Prevention Strategy 2022-25 with a focus on 5 key areas for improvement:

- Embedding a culture of safety improvement that reduces harm caused by falls
- Improvement in communication of patient risk factors between wards/areas and

the Falls Team
- Providing assurance of improvements and learning
- Education and development
- Equipment and environment

The Hospital Falls Team have provided staff with various methods of support, education and guidance to ensure the action plan associated with our strategy is completed within the specified timeframes. Some examples of this work include daily falls walk rounds by Falls Nurse Specialist, daily snapshot audits of falls care and ward based training.

Falls prevention training is provided to newly qualified nursing staff, junior doctors and healthcare assistants new to the Trust as part of the induction programmes. The Team also host a North West regional falls nurse forum. The group now meets bi-monthly and is a valuable opportunity for all members to share practice and news on national and local initiatives. Falls nurses, therapists and patient safety colleagues across the region attend and the membership has grown from 9 to 13 trusts during 2022-23. The forum has also been asked by the NHS England Cheshire and Merseyside Falls Prevention Steering Group chair to support as an operational group where decisions made or suggested by the Steering Group can be discussed with staff who work operationally in falls prevention roles across the region.

3.3.2. Pressure ulcers

The Trust has continued to focus on reducing the risk of patients developing hospital acquired pressure ulcers, as a result of lapses in care. During 2022-23, there was 1 incident of a hospital acquired category 3 or above pressure ulcer with lapse in care reported. This is a reduction of 50% compared with 2021-22, where 2 incidents of category 3 or above pressure ulcers with lapses in care were identified. A thorough and in-depth investigation was commissioned to identify the root causes, with improvement actions taken, including education for staff members to improve risk identification and appropriate care planning to prevent the development of a pressure ulcer. The Trust also developed a new visual display board with an electronic risk assessment tool and is developing electronic documentation to improve information about the care of pressure ulcers and wounds, which supports more effective handover of care.

The Trust is continuing with improvements to reduce the number of Trust-acquired category 2 pressure ulcers with lapses in care. In recognition and response to the high number of patients in the Emergency Department, clinical pathways have been redesigned with improved access to preventative devices and specialist mattresses.

3.3.3. Venous thromboembolism (VTE)

VTE covers both deep vein thrombosis (DVT) and its possible consequence, pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. However, if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE) that could lead to death.

The risk ofhospital-acquired VTE can begreatly reduced by risk assessing patients on admission to hospital and taking appropriate action. This might include prescribing and administration of appropriate medication to prevent blood clots and application of specialisedstockings.

National reporting for VTE risk assessment compliance has been suspended since April 2020, however the Trust has continued to maintain appropriate prevention interventions by:

- Using an electronic VTE risk assessment tool, which is integrated into the patient administration system (PAS)
- Sharing risk assessment compliance through daily dashboards
- Undertaking a root cause analysis investigation of all cases of hospital acquired thrombosis in order to reduce the risk of it happening again
- On-going VTE training including Moodle based online learning for all clinical staff

3.3.4. Medicine safety

In October 2022, the electronic prescribing and medicines administration system (ePMA) underwent a major upgrade to Careflow Medicines Management Version 8. This removes the need for accumulated patches and work-arounds due to issues identified in the old version. Significantly, the new version now includes mobile device functionality and use of 2 dimensional (2d) bar codes. An ongoing programme of ePMA system development and rollout is managed by a joint project board with Southport and Ormskirk Hospital NHS Trust. Priorities for 2023-24 include roll-out of ePMA across Southport and Ormskirk hospitals and progressive reduction in the use of paper prescriptions for specialist prescribing, including palliative care, paediatrics and anticoagulants.

During 2021-22 we reported the development and launch of our innovative and invaluable ‘live’ clinical pharmacy dashboard which enables clinical pharmacy staff to review the medicines status of patients on each ward at a glance. This takes feeds from multiple systems including ePMA, laboratory results, alerts and the dispensary systems. During 2022-23 the dashboard has undergone substantial background development as a result of the upgraded ePMA system and also to minimise the burden on IT servers which had been slowing other systems down. Visible developments of the dashboard this year have included colour coding for the time since patients were last weighed, creation of a dashboard for pharmacy staff working in ED, new alerts for patients on specific intravenous (IV) antibiotics who may be candidates for the Outpatient Parenteral Antimicrobial Treatment (OPAT) service and the supply status of medicines ordered from pharmacy. Recently, a new printable summary of jobs for doctors on ePMA for each ward has been produced which clinical pharmacy staff can hand over and discuss with the doctors on their wards.

Within ED following the success of the new clinical pharmacist and pharmacy technician input during the winter of 2021-22, we have now established this service on an ongoing basis. An additional pharmacist post has been added to this team since summer 2022. Innovations introduced by the Team include the use of ePMA records to assist in prioritisation of patients who have previously been admitted. Joint work with medical and nursing staff within ED has been ongoing to focus on time-

critical medicines to minimise delays in their administration. The Team focusses on patients being admitted as inpatients and performing medicines reconciliation to ensure an accurate drug history is obtained and that all prescribed medicines are appropriate on an individual patient basis. During the intense pressure on inpatient beds and patient flows during winter 2022-23, the input of this pharmacy team in ED has been especially important to support the prompt, safe treatment of patients with medicines in ED, especially for those whose onward transfer to wards has been delayed.

In early 2023, a multi-disciplinary team (MDT) OPAT service was established following new investment. Feedback from the initial MDT rounds in early 2023 indicate that they have speeded up the identification of patients who can have their treatment deescalated from IV to oral treatment and also have identified more patients who are candidates for management of their intravenous antimicrobial therapy at home. This is similar to a virtual ward and patients under the care of the OPAT team are monitored and reviewed to ensure they are managed safely and effectively.

New automated dispensing robots within pharmacy were commissioned in April 2022 and have been optimised during the last year. Work is ongoing to enable them to automatically pick ward medicines requisitions once they are authorised by pharmacy staff on wards.

An upgraded version of the pharmacy prescription tracking system has been implemented. This provides patients with an automated text message to their mobile phones when their outpatient prescriptions have been dispensed and are ready to collect. This spares patients from waiting in the pharmacy waiting rooms. Considerable work has been performed to enable this functionality for electronic proof of delivery of medicines supplied to wards from the dispensaries. Nurses on wards can track prescriptions and requisitions sent to pharmacy to see if they have been received, are being dispensed, are ready, are out for delivery and whether they have been delivered and who has signed for receipt. The system captures electronic signatures of authorised recipients on wards now we have equipped pharmacy porters with iPads. This provides additional security and also saves useful time for nurses and pharmacy staff by reducing the need for phone calls to check the status of take home medication prescription dispensing and inpatient medicines supply.

Medicines storage and security audits remain ongoing and continued improvement in performance have been reported from the previous year when Tendable was introduced. Targeted support has been provided to areas as identified in the audits which had led to improvements.

Feedback on Trust-wide pharmacy-led audits and sharing of key messages through safety huddles, Care Group quality meetings and Team Brief have been performed during the year. The audit pro forma for controlled drugs (CD) in clinical areas has been set up within Tendable in early 2023. This platform will be used for audits going forwards. This will enable faster analysis of results and subsequent feedback and support for areas which require this. A capital bid has been submitted for Careflow CD Manager, an electronic system to replace paper CD registers. In the meantime the pharmacy technical team is about to trial new pre-printed CD book indexes which

will help address some shortfalls in CD audits. High level reporting and assurance for management of CDs will be combined with the general medicines storage and security audit reports from Tendable and presented to Quality Committee in future.

During the year, notable work has been completed to implement/update guidance on steroid emergencies and valproate in female patients. Additional safety alert-related work included implementation of the alert on inadvertent oral administration of potassium permanganate. We have continued a campaign to alert clinical staff of the importance of obtaining up to date weights for patients on weight-sensitive medicines doses such as both IV and oral paracetamol.

Work is currently ongoing to formulate and deliver a new annual medicines safety training package (including CDs) to clinical staff. This will be informed by incidents, risks & alerts and take advantage of modern platforms for e-learning to allow the training to be better targeted than previous training.

Following a proof of concept using simulation by an MDT enhanced care trollies were introduced during 2022 in the Acute Medical Unit (AMU) to reduce the time to treatment for emergency conditions including status epilepticus, diabetic ketoacidosis, hyperkalaemia, hypoglycaemia (severe) and anaphylaxis.

Experienced hospital clinical pharmacists have been required to review clinically vulnerable patients' current medicines for harmful interactions with the first-choice oral antiviral for COVID, Paxlovid. Additionally, our dispensary team ensure the prompt supply of COVID antivirals for community patients, making arrangements for collection or delivery. Demand for these treatments continued strongly into spring 2023.

Other medicines safety and quality-related work has included:

- Regular input into the Trust's safety huddles and quality & risk newsletters
- Critical medicines guidance cards supplied for attachment to lanyards
- Falls reviews of patients by clinical pharmacists
- De-prescribing guidance approved in early 2023
- Medicines safety event during September with stands in foyers at both Whiston and St Helens hospitals
- Discharge medicines service to prompt follow up of patients by community pharmacists after discharge, which now includes targeting for smoking cessation support
- Capital bids pending for automated 24 hour prescription collection machines to reduce need to attend pharmacy to collect repeat medicines, electronic CD registers, updated temperature monitoring system, additional Omnicell cabinets for ED and AMU
- Revenue bids developed in early 2023 for additional staff to support increased workload in outpatients and for homecare delivery of medicines
- Aseptic dispensing unit establishment of additional funding stream to enable recruitment of extra staff
- Initiatives to maximise recruitment and retention of pharmacists and pharmacy technicians such as over-recruitment, increased intake of trainees, redesign of posts
- Sharing of work with Southport and Ormskirk Hospital NHS Trust, with further

plans to work together when the two Trusts come together formally
- COVID vaccines – experienced pharmacy staff continued to provide direct support for trust-run vaccination clinics
- Chemo-care electronic prescribing for haematology oncology medicines, with the successful upgrade of the system in the second half of the year
- Increased development of the clinical pharmacy technician service, with the establishment of a new senior technician post to lead in training ward-based technicians. Expansion continuing of ward-based dispensing with a new dispensary on the 5th floor to be launched in spring 2023
- Sustaining of a wide range of key extended services despite major challenges due to continued waves of COVID and exceptional operational pressures

3.3.5. Theatre safety

The Trust Operating Theatre Department has continued to develop and refine patient safety initiatives in keeping with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures.

The department has not had any never events for the last two years.

The World Health Organisation (WHO) surgical safety checklists continue to evolve in response to learning from incidents and other improvement work. Completely redesigned charts were implemented in quarter 3 2022-23, which are clearer and provide more space for additional checks, in particular relating to recording of surgical implant details.

3.3.6. Being open – duty of candour

The Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty on trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

- The Trust's incident reporting system has a mandatory section to record duty of candour
- Weekly incident review meetings are held, where duty of candour requirements are reviewed on a case-by-case basis allowing timely action and monitoring. This

allows the Trust to ensure that it meets its legal obligations
- The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings
- Duty of candour training is also included as part of mandatory training and root cause analysis training for staff

3.3.7. Never events

Never events are described by NHS England in its framework published in 2018 as serious incidents that are wholly preventable. Each never event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a never event. never events include incidents such as, wrong site surgery, retained foreign object post-surgical procedure and chest or neck entrapment in bedrails.

The Trust reported two never events in 2022-23; one relating to wrong site surgery within the plastic surgery department and one relating to retained foreign body (wire) during an invasive procedure. The Trust remains committed to understanding the cause of these incidents and utilises comprehensive root cause analysis. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and to feed back in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

Improvement actions have been implemented to minimise the chance of any recurrence. Actions from wrong site surgery included the development of a Standard Operating Procedure (SOP) to ensure consistency and correct identification of surgical site and the revision of the surgical checklist to include higher levels of details regarding confirmation of the procedure.

A number of actions were identified and implemented following the retained foreign object post procedure including revision of the care pathway and changes in clinical practice by utilising X-ray during clinical interventions.

3.3.8. Infection prevention

The Health and Social Care Act 2008 requires all trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). The Trust's Director of Infection Prevention and Control (DIPC) is the Director of Nursing, Midwifery and Governance. She has Board level responsibility for infection control and chairs the Hospital Infection Prevention Group.

The Infection Prevention Team undertake a rolling programme of infection prevention audits of each ward and department, with individual reports discussed with ward managers and teams for action.

The Trust's infection prevention priorities are to:
- Promote and sustain infection prevention policy and practice in the pursuit of patient, service user and staff safety within the Trust
- Adopt and promote evidence-based infection prevention practice across the Trust

- Identify, monitor and prevent the spread of pathogenic organisms, including multi-resistant organisms throughout the Trust
- Reduce the incidence of HCAI by working collaboratively across the whole health economy

During the reporting period April 2022 to March 2023, the Trust reported the following:

- MRSA bacteraemia (MRSAb): one bacteraemia case against a threshold of zero
- NHS Improvement (NHSI) set a threshold for Clostridium Difficile Infection (CDI) cases for 2022-23 as 56 cases and the Trust has reported 57 in total with 23 cases deemed unavoidable
    - Root cause analysis (RCA) executive reviews were held for 46 cases, with no lapses in care or lessons learned identified in 23 of these cases; 23 cases had lessons to be learned and 11 cases are awaiting an RCA
- Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb): The Trust had 43 cases of (MSSAb), of which 32 were hospital onset healthcare associated and 11 were community onset healthcare associated. RCAs were carried out on 23 hospital onset healthcare associated cases and 12 were deemed unavoidable
- Lessons learned from the post infection reviews (PIRs) of MRSAb and CDI cases are shared Trust-wide via a monthly infection prevention report. Lessons learned include good practice identified, as well as areas for improvement. Lessons learned are shared at ward safety huddles and directorate governance meetings

The latest surgical site infection (SSI) rates related to elective hip and knee procedures from July 2021 to June 2022 are shown below:

- Hips 0.9%% against a national average of 0.8%
- Knees 0.3 % against a national average of 0.8%

In May 2016, the Government announced its ambition to halve gram-negative bloodstream HCAI by 2021. Approximately three-quarters of E. coli bloodstream infections (BSIs) occur before people are admitted to hospital and, therefore, reduction requires a whole health economy approach. The Trust, in collaboration with the ICB and partners, has developed a health economy action plan particularly focusing on a 10% in-year reduction in urinary tract infections and to learn and share lessons. The Trust continues to work closely with the infection prevention, patient safety and quality teams in the wider health economy, attending collaborative meetings across the region in order to improve infection prevention and control practices and monitoring.

The Trust has 24 consultant infection prevention champions and over 146 link nurses who attend education and training and complete local audits to monitor compliance.

Key achievements for 2022-23 were:

- 341 Aseptic Non-Touch Technique (ANTT) key trainers in the Trust who are responsible for ensuring all staff are compliant with ANTT
- 100% compliance with carbapenemase-producing enterobacteriaceae (CPE) and MRSA screening
- Infection prevention input into environmental monitoring systems and implementation of national standards for cleanliness and validation of standards

- Infection prevention input into new builds and building modifications
- Bristol Stool Chart observations and CPE risk/screening assessment undertaken electronically via vitalpac
- Continued bi-weekly multi-disciplinary ward inspections with estates and facilities, Medirest, Vinci and new buildings to monitor ward cleanliness and estates and facilities provision
- Changes to the RCA processes to improve and prioritise cases that require oversight and input from the Executive Team and clinical teams. The timely RCA review for CDI cases has improved the dissemination of lessons learned and enabled the infection prevention team to target input to ward areas that required support
- 74.4% of frontline staff received their flu vaccination, an increase of 2.3% from last year

3.3.9. Safeguarding

The Trust is committed to ensuring safeguarding responsibilities are carried out in line with legislation and national and local policy. The dedicated Safeguarding Team ensures appropriate measures are in place to protect children, vulnerable adults, patients with a diagnosis of learning disability and/or autism, as well as those who may require support in decision making or a deprivation of liberty safeguard due to concerns relating to lack of mental capacity. The team maintain a visible presence on site and are available to offer advice and support to all Trust staff and community partners.

The Trust safeguarding key performance indicators (KPIs) are submitted on a quarterly basis and quality assured by the Integrated Care Board (ICB) Designated Nursing Team (St Helens Place). During 2022-23, a red/amber/green (RAG) rating of green was given in all areas except safeguarding training compliance and completion of Looked After Children (LAC) initial health assessments. There has been a steady increase in training compliance with the 90% required compliance received in some but not all levels. The expectation in relation to initial health assessments is that 100% of children will receive their assessment within 20 days of entering the care system; this continues to prove challenging due to external processes, particularly late notifications from the Local Authority and children not being brought to appointments. The Trust Developmental Paediatric Team, who complete the assessments, have taken steps to increase appointment capacity and provide weekend appointments to support attendance.

The ICB continue to express assurance in relation to safeguarding activity which has risen consistently across all areas, particularly numbers of referrals and evidence of good multi agency working.

Safeguarding reports are presented quarterly to the Quality Committee, Patient Safety and Patient Experience Councils. The Safeguarding Assurance Group meets quarterly to provide safeguarding updates in all areas of safeguarding activity and process, with external stakeholder representation provided by the Designated Nurses and Healthwatch partners for the purpose of external scrutiny and information sharing. An annual report is completed and presented to the Quality Committee.

The Trust provides representation at three local safeguarding partnership boards for adults and children and to associated subgroups. When required, there is additional representation and contribution to adult and children multi-agency reviews, domestic homicide reviews and theme specific multi-agency audits.

Due to the increase in activity a business case was submitted in 2022 to increase staffing within the Safeguarding Team; this was successful and additional staff have been recruited.

3.3.10. Clinical harm reviews

There continue to be high numbers of patients awaiting elective procedures as we focus on recovering from the pandemic. Each patient is listed with a clinical priority code (Priority 2 (P2) – Priority 4 (P4)) which guides the timing of the procedure according to the level of clinical need. P2 indicate procedures to be undertaken in less than a month, P3 within three months and P4 being the most routine.

The challenges of post pandemic elective recovery mean there are a significant number of patients waiting beyond the target timescale. In order to ensure that these patients are managed appropriately, and the risk of harm is reduced, the Trust has developed a framework by which patients with excessive waiting times are reviewed by their clinician to identify any evidence of clinical harm and to confirm that the level of prioritisation is still appropriate (similar to the process already in place for patients delayed on cancer treatment pathways).

This requires a review of all P2 patients waiting longer than 10 weeks, P3 patients waiting longer than 22 weeks and P4 patients waiting longer than 52 weeks.

To support this process and ensure we are identifying the patients at the highest risk of clinical deterioration on the waiting list we are utilising artificial intelligence software (C2AI), which can provide patient level risk data. The system is also able to validate the priority code assigned to each patient. Where significant risk of clinical harm due to surgical delay is identified by AI, a formal review of the case is requested by the clinical team to validate and action a new priority if indicated. Pilot validation of the C2AI data quality has provided assurances that the system identifies the highest risk patients and procedures. This approach reduces the requirement on clinician time.

A system is also in place for retrospectively reporting any evidence of clinical harm due to prolonged waiting times identified at the time of treatment.

3.4. Clinical effectiveness

The Clinical Effectiveness Council meets monthly, is attended by representatives from all care groups and is chaired by the Medical Director. It monitors key outcome and effectiveness indicators, such as mortality, nationally bench-marked cardiac arrest data, critical care performance, hip fracture performance, readmissions, clinical audit performance, departmental performance and application of National Institute for Health and Care Excellence (NICE) guidance. The Clinical Effectiveness

Council reports monthly to the Quality Committee through its chair.

3.4.1. Clinical Speciality Presentations

Each speciality in the Trust is invited to give a presentation to the Clinical Effectiveness Council outlining their achievements, challenges, research/audit activity and patient feedback from the previous year. This gives them an opportunity to showcase the good work that they have been doing in their speciality and to raise with the Council any challenges they have, which may require Executive or Board support.

3.4.2. Research, Development and Innovation Group

Clinical research is vital to the NHS as it means we can continually improve the healthcare we provide to our patients and develop new and improved treatments and medications. St Helens and Knowsley Teaching Hospitals NHS Trust has a successful and busy research department which supports clinical staff to carry out research projects in the Trust to help improve patient care. The Research, Development and Innovation Group (RDIG) presents regular reports to the Clinical Effectiveness Council on the annual plans for clinical research within the Trust, provides assurance that research projects are being successfully completed and gives updates from RDIG meetings.

3.4.3. Quality Improvement and Clinical Audit

Clinical audit is a key process in the Trust's cycle of continuous quality improvement, through the review of care provided against evidence based standards. In order to assist this process, the Quality Improvement & Clinical Audit (QICA) Department provides a wide range of support and advice to Trust staff, both clinical and non-clinical, who are involved with audit projects at national, regional or local/Trust level. QICA present regular updates on compliance with mandatory national audits, the progress of ongoing audit projects within the Trust and compliance with action plans

3.4.4. Non-Elective Laparotomy Audit

This is a national audit which is carried out to monitor the outcomes of emergency abdominal surgery. The results are presented to the Clinical Effectiveness Council by the Clinical Director for Surgery to provide assurance that safe care is being provided to patients undergoing emergency laparotomy and to identify any areas where improvements could be made.

3.4.5. National Institute forHealth and Care Excellence (NICE)guidance

St Helens and Knowsley Teaching Hospitals NHS Trust has a responsibility for implementing NICE guidance to ensure that:

- Patients receive the best and most appropriate treatment
- NHS resources are not wasted byinappropriate treatment
- There is equity through consistent application of NICE guidance/quality standards

The Trust must demonstrate to stakeholders that NICE guidance/quality standards are being implemented within the Trust and across the health community. This is a regulatory requirement that is subject to scrutiny by the CQC. The QICA Teamare responsible for supporting the implementation and monitoring NICE guidance compliance activity. The Trust has a robust NICE compliance policy.

A total of 180 pieces of new or updated NICE guidance were released to date during 2022-23. 94 of these were identified as applicable to the Trust by the Assistant Medical Director. There is a system in place to ensure all relevant guidance is then distributed to the appropriate clinical leads to assess its relevance and the Trust's compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance is rigorously assessed by mandatory departmental compliance audits reportable through the Trust audit meetings. The Trust received compliance returns for 65 of the relevant guidance issued, with 44 reported as fully compliant and 13 partially compliant. Further there are 3 pieces of guidance which are reported as not implemented/not compliant and 5 are terminated appraisals. The team is working towards achieving the remainder. Compliance reporting is 99% for last year, with 1 piece of guidance awaiting response.

3.4.6. Promoting health

The Trust continues to actively promote the health and wellbeing of patients by undertaking a holistic assessment on admission that looks at physical, social, emotional and spiritual needs. Patients are referred or signposted to relevant services, for example, dieticians, stop smoking services and substance misuse. In addition, the Maternity Service actively promotes breast-feeding and treatment and support for tobacco dependencyfdi.

The initial review of patients includes a numberof risk assessments that are used to highlight specific concerns that are acted upon, including nutrition, hydration and falls. The Trust has a Smokefree Policy in place that promotes a healthy environment for staff, patients and visitors, with measures in place to support staff and patients to give up smoking. Patients are asked on admission about smoking and alcohol intake and then provided with support and guidance as required. The Trust is the third biggest provider of nicotine replacement therapy to patients compared to Cheshire and Merseyside hospitals (excluding mental health, community and paediatrics trusts). The two better performing trusts received funding in previous years to implement The CURE Programme - Smoking Cessation in Secondary Care. The Trust is looking to implement its inhouse tobacco dependency service in 2023-24, which will see further support for patients.

The Trust works in partnership with other agencies to provide holistic services throughout thepatient'sjourney toensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the work of our Community Falls Team, who work collaboratively with the local council, primary and community care and our Infection Prevention Team who liaise closely with community teams and GP services.

3.4.7. Non-medical prescribing

Department of Health policy has extended prescribing responsibilities to a range of professions to deliver the following benefits:

- Improve patient care without compromising patient safety
- Make it easier and quicker for patients to get the medicines they need
- Increase patient choice in accessing medicines
- Make better use of the skills of health professionals
- Contribute to the introduction of more flexible team working

The Non-Medical Prescribing (NMP) workforce, which is nurses, pharmacists and dietitians support the Trust to deliver high quality care and respond to the quality agenda. There has been an increase of 160% of registered NMPs in the Trust over the last four years, with 265 registered NMPs in 2023. This skilled workforce continues to grow year on year and now delivers high quality care across forty different specialities.

The role of the NMP within the Trust has offered solutions to address capacity, quality, efficiency and effectiveness within clinical pathway. The focus has been on developing staff within emergency and urgent care services, frailty services, the Medical Emergency Team, out-of-hours care within the Urgent Treatment Centre and for care pathways for long term conditions such as diabetes, cancer, chronic obstructive pulmonary disease, specialist palliative care and finally supporting patient flow and discharge via community nursing teams.

The use of NMPs allows the range of healthcare professionals to contribute to service improvement and efficiency in several ways:

- Improving access to services
- Extending patient choice
- Making it easier for patients to access medicines they need
- Improving quality and care, especially across the range of long-term conditions
- Improving productivity
- Reducing waiting times
- Reducing hospital admissions
- Responding to reduced junior doctor hours
- Delivering cost savings

There is a Trust framework for the supporting NMPs, which ensures that appropriate staff are trained so that investment both by the Trust and staff in gaining this qualification is maximised. There is a designated part time NMP Lead Nurse and a dedicated part time administrator, who oversee the application and approval process and the annual updates which all registered NMPs are required to complete.

Documentation for application and annual updates has been updated to reflect the Royal Pharmaceutical Society Framework and has had input from senior nursing and HR leads, furthermore, learning from any incidents locally and nationally is reflected in this process.

Registered NMPs can access a suite of continuing professional development (CPD) both externally through HEE funding to the value of £150 each annually and internally via the monthly Professionals Forum, which delivers focussed education

events from a range of specialist leads including clinical, legal and academic. These monthly forums have been well attended and had positive feedback.

> *"I have just finished watching the lectures on the forum. They are all good. However, the one on diabetes is exactly what I needed. So informative and interesting"* Nurse Clinician Surgery

The Trust's NMP webpage has been updated and directs staff to up to date online resources to support them pre and post qualification, including a free 6-month trial with the Health and Education Cooperative. The page has been well received by staff and was visited 120 times in February 2023. In addition in January 2023 an NMP teams peer support group was established.

The average cost for NMP training is £1800 and is a six-month course. The Trust NMP lead nurse has secured £92,000 in HEE funding over the last two years to fund staff training and the 2023-2024 application was submitted on the 17th March 2023 for £80, 000. The trust will know if has been successful in April 2023. If successful staff have already been identified for funding.

There is a Trust professional leads group, including the Chief Pharmacist, Assistant Director of Workforce, Therapies Manager, Assistant Director of Patient Safety, corporate matron, NMP Lead Nurse and administrator. The group will define the strategic aims of the Trust for sustainability and ongoing safe practice.

3.5. Patient experience

The Trust acknowledges that patient experience is fundamental to the quality of healthcare and that a positive experience leads to better outcomes for patients, as well as improved morale for staff. Patient experience is at the heart of the Trust's vision to provide 5-star patient care.

Extensive collaboration with our patients, key stakeholders, local communities and our staff on the new Patient Experience and Inclusion Strategy for 2022-25 took place during the year, culminating in a Trust wide launch of the strategy in July 2022. The purpose of the Strategy is to set out the Trust's commitment to improve patient experience by meaningfully engaging with our patients, key stakeholders and local communities, to remove any barriers to access, by building on our current engagement activities and ensuring people from all our local communities are included and able to shape our services. The Strategy consists of three commitments supported by a number of objectives and a detailed implementation plan that describes how the Trust will monitor itself against each commitment, with progress made in each area.

The Trust promotes patient and family engagement through several forums, many of which have continued during the year. These include the Trust-wide Patient Participation Group, which consists of patients, carers and members of the public who have met both virtually and face to face. Additional patients continue to be recruited to the membership of the group. The Group met quarterly in 2022-23, as planned and welcomed many guest speakers to disseminate initiatives and provide updates on service improvements. The Group also discussed the Trust quality objectives for 2023-2024. The Patient Experience and Inclusion Team report on the progress of the group to the Patient Experience Council via regular written reports.

The Trust's collaborative work on the Carer Passport, with Liverpool University Hospitals NHS Foundation Trust and 13 other trusts was a finalist at the Patient Experience Network National Awards 2022 in the 'Support for Caregivers, Friends & Family' category. Our entry also stood out to the Picker Institute and was commended as an innovative project that captured what co-production is all about (treating all stakeholders as equal partners in the design, development and rollout of new or improved healthcare services). The Trust were one of three trusts selected from all entries to present at a national seminar to other Heads of Patient Experience.

The Trust is committed to learning from patient, service user and carer experiences,

to drive improvements and share best practice. Listening to patient stories is one way to achieve this. Patient stories continue to be a fundamental part of the patient experience agenda, with stories shared in their own words in several forums across the Trust. Patient stories have been presented to the Board by patients remotely this year, as well as being shared by the Quality Matron at the Patient Experience Council. To improve the accessibility of stories and their inclusion to reinforce learning, there has been a move to a digital story telling platform that uses a patient's own voice put together with images to create short authentic videos. The library of digital stories has continued to grow in number and variety since its creation and is accessible for staff to view on the Trust intranet so that it can be used to reinforce education and training. The library includes digital stories relating to our Trust values, patient centred care, communication and multidisciplinary team collaboration. A feedback form for viewers has been created to reinforce and consolidate learning and will be used by the Patient Experience and Inclusion Team to refine and improve the library. A patient story nomination form has also been created.

Patient stories have directly contributed to several service improvements including the provision of a bespoke deaf awareness course for Trust staff and a new and improved method to log an interpreter request. There is also ongoing development of an information leaflet for patients about future hair care following medical hair loss. A dedicated patient experience session is now delivered within the HCA training programme to reinforce the organisational culture that patient experience is everyone's responsibility.

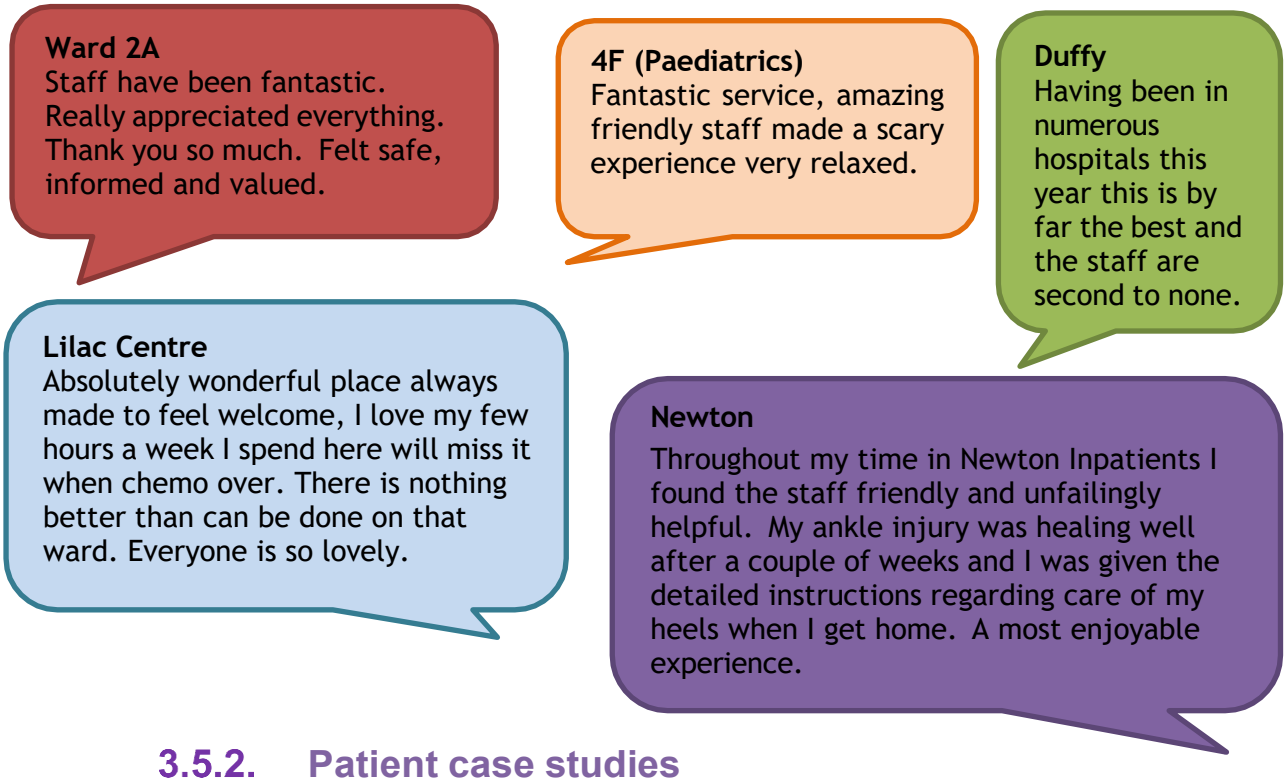
The five a day programme is face to face contact with inpatients, outpatients, carers and families. This enables direct contact with the Patient Experience and Inclusion Team and provides an opportunity for real time experiences to be shared. It is about actively listening and acting on immediate concerns if any are raised. It also provides the opportunity to inform patients of services and campaigns and gain specific feedback about different areas within the Trust. A number of changes have been made throughout the year as a result of this direct patient feedback, including, reinstatement of cash payment for food and drink in the hospital restaurant, the provision of bedside entertainment through the purchase of large communal televisions for three patient bays and the upgrade of all televisions in single rooms to SMART TV at our Newton Community Hospital. Other improvements include the implementation of a hot meal service for those patients transitioning home through the discharge lounge and the re-introduction of free bedside television to allow patients to follow coverage of the Queen's lying-in-state and funeral. Additional funding has been identified to enable members of the acute pain team to undertake a non-medical prescribing qualification which will eliminate possible delays between pain management plans being created and medication being prescribed and administered.

Additional feedback is gained in many ways, through everyday interactions, local and national surveys, social media platforms, independent statutory bodies and regulators, Patient Advice and Liaison Services (PALS) and complaints. Fundamental to feedback is that we gather, analyse, share and demonstrate learning. To increase the number of comments, the Trust has welcomed external partners such as Healthwatch and the Deafness Resource Centre back into the hospital premises following the removal of social distancing to undertake regular

outreach visits. This allows the additional collection of comments from patients and visitors and enables a quick resolution to queries, as well as assisting with awareness raising.

The Patient Experience and Inclusion Team launched the yearly appeal for school aged children to send in seasonal pictures and messages to cheer up our patients who were unfortunately in hospital during the Christmas period. The team received nearly 2000 pictures and messages, which were added to the Christmas packs for our inpatients that included a festive message from the Trust and quizzes for patients. This year the team launched the packs for paediatric inpatients, and we successfully created Christmas packs for 30 children. A total of 834 packs were created with the support of PALS and the volunteers helped deliver them to all the inpatient areas at Whiston, St Helens and Newton hospitals. The Patient Experience and Inclusion Team has written to every school and child who sent pictures/messages with a thank you from the Trust.

3.5.1. What our patients said about us in 2022-23



3.5.2. Patient case studies

The three case studies described below provide anonymised examples of changes made as a direct result of patient feedback.

Care and treatment accessible to all.
A patient who is profoundly deaf and uses British Sign Language (BSL) as their first language was admitted to hospital and did not receive the communication support required for procedures and communicating clinical information. This caused them additional loneliness, worry and distress. With the aid of charitable funds and the support of facilitators from the Deafness Resource Centre, the Trust now provide a bespoke deaf awareness course for Trust staff. The training covers a range of topics,

including deaf awareness, deaf culture, working with deaf people and effective communication, as well as teaching the BSL alphabet, numbers and greetings. The course is aimed at raising awareness of the barriers that deaf people face. In addition, we have made it easier to make requests for foreign language and BSL interpreters with the help of our digital team.

Inclusion – co-production and involving experts by experience.
Following the suboptimal experience of one of our patients living with a learning disability and autism in our Emergency Department the Trust Learning Disability Specialist Nurse worked hard with the patient and family to restore trust and ensure that reasonable adjustments to support the patient during future hospital admissions were in place. The patient and family were then invited to participate in the interview process for the recruitment of a second Learning Disability and Autism Practitioner for the Trust. They were very pleased to be asked to be involved and they both agreed. Patient participation in the interview process is an excellent example of inclusion and co-production in involving experts by experience in our staff recruitment process.

Providing holistic care.
During a Healthwatch outreach visit comments were provided by a bereaved parent about the missing entry of their child in the Trust's baby remembrance book. This omission had caused the family additional distress. The error was immediately rectified and the opportunity was taken to perform a review of the remembrance book referral process. As a result, improvements were made to bring the referral process up to date and make the process more robust. At the time of the feedback the memorial was provided for babies that die within our obstetric service, which has now been extended to baby and child deaths occurring in the Emergency Department and paediatric wards.

3.5.3. Friends and FamilyTest

The Friends and Family Test (FFT) asks patients if they would recommend the ward or department where they recently received healthcare to their friends or family if they needed similar care or treatment. It is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback in real-time about their experience.

The feedback gathered is used to identify themes or trends, stimulate local improvement and empower staff to carry out changes that make a difference to patients and their care.

The Trust uses a variety of survey options, with inpatient ward areas and maternity services providing patients with a postcard and Emergency Department andoutpatient areas use texting and interactive voice mail service.

The Trust's inpatient recommended care rate for 2022-23 was 95.3% compared to 95.7% in the previous year. Wards and departments across the Trust monitor the patient feedback and create 'you said, we did' posters for display to highlight the actions being taken to continuously improve the care we provide, as well as maintaining staff motivation and influencing change.

You Said	We Did
Very long waiting times with poor communication regarding waiting times. ***(Emergency department)***	We have purchased an announcement communication system which will give information regarding waiting times and health promotion along with general hospital information
Was told be there for 8am and should have been 12:00 I was afternoon patient. Had to wait ***(Sanderson Suite)***	Please accept our apologies for this error in communication. The admissions team have been contacted and informed of this error and the team leader has spoken to the team about accuracy in admission letters as it causes much inconvenience and stress to the patient. Matron for the area is monitoring these incidents to ensure improvements.
Check in for children should not be at adult section **(Emergency department)**	We now have a receptionist in the paediatric department within ED for children to be booked in and we are in the process of having building work completed and aim to have this service available 24hrs as at present this is in working hours.
Only comment - very rarely staff member seemed unsure how to lift my injured leg ….. only happened twice I think and soon corrected by another staff member, not a serious complaint ***(Ward 3B)***	Thank you for raising this concern. I will speak to the moving and handling link nurse to ensure all staff are trained appropriately on using the ward equipment. Occasionally we use agency/bank nurses, I will organise a checklist to ensure these staff are trained to use the equipment.
All staff friendly and helpful, did feel at times a bit more communication could be helpful with what was happening and where we were up to. Other than that, everything was fine. Thank you to the staff who looked after me. ***(Ward 2A)***	Thank you for your comments, this information will be fed back to staff. We have recently changed our handover which will help in improving communication between the whole team.

3.5.4. Our volunteers

Our volunteers play a vital role in supporting our patients, carers, visitors and staff seven days a week. We are incredibly grateful to them for the time they give, the support they offer and the contribution they play as part of our workforce. The Trust has 270 volunteers, some who have been fulfilling this role for more than 15 years. Our volunteers contribute more than 25,000 hours every year to provide 5 star patient care.

There are over 19 different volunteer roles in place, with a focus on recruiting to roles that have the most impact on patients and services, including meet and greet, dining companions and supporting the Emergency Department.

Our dining companion service was reintroduced in December 2021 with the help of

NHS England and NHS Improvement (NHSEI) funding. The income was used to recruit an administrative assistant for one year to support restoring volunteer services within the Trust following the pandemic and to focus on training and re-establishing the dining companion service. A multi-disciplinary team created a new programme of training for the dining companions and feedback forms which has allowed us to measure the impact of the service. We understand from the data that has been collected that this role is not suitable for everyone, however we currently have 25 active dining companions who have assisted 440 patients at mealtimes. Volunteers have a form for each patient interaction, which gains feedback from the patient, volunteer and member of staff. Having a bespoke member of staff to support the dining companions with recruitment, training, placements and liaising with ward staff has helped to embed this role.

Staff comments:
"Volunteer was absolutely brilliant and a delight to have on the ward"
"Volunteer chatted to patient about old Liverpool. An excellent service."

Volunteer comments:
"I assisted the patient in cutting up his food. Enjoyed speaking to him about his walking."
"Patient really appreciated the company"

Patient comments:
"I enjoyed having a companion there, it was like having a friend with me"

Meet and greet volunteers provide high visibility and improve the experience of our patients, visitors and staff at the front door of our hospitals. The minimum age for volunteering is 16 years old and this group of volunteers start their journey on meet and greet, as well as buddying up so they can learn about the role and find their way around. Feedback has been that this role has helped many to gain confidence and meet new friends. Reception staff really value this volunteer role as they direct patients around the hospital so that they do not need to queue up at reception for help. In addition, they are an invaluable resource when it comes to delivering items to wards and departments.

Our Emergency Department volunteer role description has been revised in consultation with the ED matron to incorporate more volunteer activity which enhanced the role and focused it more on the patient. With several existing, experienced volunteers we resumed the volunteer service in ED rolling out the new duties and worked to improve the integration of volunteers into the department, continuing to grow and support volunteers and to embed the role. Recent volunteer feedback indicates that they feel appreciated and more welcome. When we asked volunteers to tell us about three things they liked about being an ED volunteer this was what they said:

- Being a companion to patients who are on their own, listening to their stories, patients love a chat
- Feeling appreciated by the staff especially the Co-ordinator/Consultant
- I love the variety, diversity and how busy I am on each shift

3.5.5. Complaints

The Trust takes patients' complaints extremely seriously. Staff work hard to ensure that patients and carers' concerns are acted on as soon as they are identified and that there is a timely response to rectify any issues that are raised either at a local level, through the Trust's PALS Team, or through the AskAnn email: askann@sthk.nhs.uk. Ward and departmental managers and matrons are available for patients and their carers to discuss any concerns and to provide timely resolution to ensure patients receive the highest standards of care. Each area has a patient experience notice board to highlight how patients and carers can raise a concern and this is also included on the information table placemats available for patients. At times, however, patients and their carers may wish to raise a formal complaint, which is thoroughly investigated so that complainants are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust internet. Over the course of the last 12 months the Trust has begun to be able to offer more face-to-face meetings to try and resolve complaints both formally and informally.

In 2022-23, the Trust received 211 new first stage complaints that were opened for investigation. This represents a 21.6% decrease on 2021-22, when the Trust received 269 and is also less than 2020-21, when the Trust received 251. This is significantly below the figures for 2019-20 (325 complaints) which was the last year largely unaffected by the pandemic.

There were 38 complainants who were dissatisfied with the initial response and raised a stage two complaint in 2022-23. This is an increase of 11.9% (4 compared to 2021-22).

In total the Trust received 285 complaints in 2022-23 (including second stages, out of time complaints, complaints primarily against other organisations etc.). This compares to 328 in 2021-22.

The challenges of working within the COVID-19 pandemic and the significant workload pressures across the year has affected the timeliness of responses to those who highlighted concerns about their care. The percentage of new complaints responded to within the agreed timescale decreased slightly from 79.9% in 2021-22 to 76.8% in 2022-23. It should be noted that the Trust installed a target of 6 months for responses to complaints during the pandemic, moving to a target of 100 working days from 1 August 2022; the first of these fell due after 21 December 2022. In the final quarter of 2022-23 (including the 100 day target) the Trust achieved 79% of complaints responded to in agreed timescales.

The Trust has continued to take steps to try and address the backlog of complaints, with 99 open first stage complaints at1 April 2022, reducing to 85 on 31 March 2023.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2022-23, with a copy of the survey sent out with all response letters. Unfortunately the response rate this year has been relatively low, with 10 responses in total received, which is a 4.8% response rate. It should be noted that not all respondents

answered all of the questions as shown in the summary below:

- 6 respondents found it very or fairly easy to complain, 3 found it very difficult and 1 did not answer
- 3 said their complaint was responded to within 3 working days (a legal requirement) and 4 said it was not. Our own data shows every 1st stage complaint received in 2022-23 was responded to within 3 working days
- 7 respondents said they were given information about the local advocacy services; 2 said they were not, although this forms part of the response template
- 4 respondents said they were contacted directly by the person dealing with their complaint, but 4 said they were not; 1 respondent did not answer and 1 could not remember
- 3 said they were given the opportunity to clarify their concerns; 4 said they were not and 3 did not answer
- 5 said they were given contact details for the team dealing with their complaint; 3 said they were not, which is also included in the template response
- 4 respondents said their complaint was responded to in a reasonable timescale; 5 said it was not
- Those 4 people said that the reasons for the decisions made in the complaint response were made clear to them. 4 of the 5 who said the timescale was not reasonable said that the reasons were not made clear. The other indicated “the department was busy” in the comments section.
- 5 complainants said the complaint process left them feeling like an individual “all of the time” but 4 respondents said “not at all”.

The Complaints Team are continuing to work hard on reducing the time taken to provide complaints responses, whilst maintaining the quality of the investigations and responses. As indicated above the Trust is moving back towards their previous timescales with a move to 100 working days from 1 August 2022, with 45.7% of the Trust’s responses sent out within 100 working days by 31 March 2023. The Trust responded to 65.5% of complaints responded to within 100 working days in the last quarter or 2022-23. The Trust intends to move to a target of 60 working days in 2023-24.

A number of actions were taken as a result of complaints made in 2022-23:

- Changes to laboratory processes and contact with an external supplier of equipment to ask them to change the sample vials we use in order to reduce the risk of cross contamination by splashing
- Information regarding coeliac disease has been shared via a lessons learned newsletter for staff. The catering team have confirmed that the cornflakes are gluten free and a decision has been made to ensure that cornflakes are now available in the department overnight. Individually wrapped gluten free snacks have now been placed in a sealed lidded container, located in the relevant department
- Staff were reminded of the correct process for ensuring patients are appropriately transferred when a decision has been taken not to dress a pressure sore
- It was reiterated that if staff are unsure whether relatives can remain, they should discuss the circumstances with the senior team for additional clarity. Nursing huddles take place twice a day and are a method of communicating with the ED nursing team on shift to ensure consistency of the approach to relatives being allowed to visit

- A designated full time Pharmacist has been appointed to the ED department.
- Body maps now go with all patients on discharge. This has also been discussed in ward meetings and safety huddles which take place daily. In addition, for high-risk patients who suffer trauma or damage to their skin staff have been reminded to document and complete body maps on admission and updated on discharge. Staff have also been reminded that any wounds identified should be recorded on Careflow in the form of photographic evidence
- One to one teaching and reflection for the clinicians involved have taken place to highlight the importance of the safety netting and best practice in the management of headache in children and presentations of paediatric brain tumour. Best practice in the management of headache in children was circulated, with a teaching session at the junior doctors' teaching and teaching to the triage nurses

3.6. Care Group summary

3.6.1. Surgical Care Group

2022-23 has continued to present unprecedented challenges for the NHS nationally, for the Trust and, particularly, for surgical care services. However, despite the ongoing challenges, all urgent and cancer surgery has continued to be maintained during this period, enabling patients to receive their surgical treatment in a timely manner. In addition, the focus has also been on the restoration and recovery of elective activity and the management of our longest waiting patients. The Trust was successfully able to clear all patients waiting at or above 104 weeks and all efforts are now concentrated on those patients waiting at or above 78 weeks.

In the determination to return to pre-pandemic levels of activity, a number of initiatives have continued. These included 'Mega Weekends', where resources were consolidated at weekends on one type of surgical procedure in order to treat patients who have been identified as being at higher clinical risk due to treatment delays. These highly productive weekends have been highlighted nationally as model initiatives, have been published in recognised surgical journals and other trusts have been in contact to learn from these experiences. A similar model has also been recently introduced in plastic surgery at St Helens hospital, where Sunday operating has enabled large numbers of high volume, low complexity surgical procedures to be undertaken.

2022-23 also saw the Trust introduce robotic surgery for major colorectal procedures. This programme required a great deal of planning to ensure it was safely implemented. The first robotic colorectal procedure was undertaken on 26th April 2022 with great success. Urology and more recently gynaecology, are now also utilising this state-of-the-art technology. Surgeons and anaesthetists, as well as theatre teams, have all undergone in-depth training to enable this programme to be established. A number of patient benefits are associated with robotic surgery, including reductions in post-operative complications, reduced admissions to critical care post-operatively and length of stay reductions. Early indications are that these identified benefits are all very much on track to deliver.

In addition to maximising the available in-house capacity and productivity, the Trust

has continued to transfer suitable procedures from theatres to outpatient settings to release theatre capacity and to undertake more procedures as day cases rather than inpatients. The appropriate utilisation of the independent sector for specialties such as orthopaedics, general surgery and plastic surgery has also continued, as well as maintaining the focus on the clinical prioritisation of surgical patients across all specialties. This has included the priority coding of all patients and the introduction of a cutting-edge artificial intelligence (AI) system of risk stratification of patients. This has been introduced in conjunction with regular clinical harm reviews for those patients identified as being at higher risk due to lengthy delays for surgery. Further work is also underway to clinically optimise patients prior to surgery through the AI pre-habilitation programme for those deemed to be at higher risk, in order to ensure that patients are fit and well enough to undergo their surgery and to reduce the risk of cancellations.

In January 2023, during the height of winter pressures, surgery transferred an elective theatre of orthopaedic activity (hip and knee replacements) to Ormskirk Hospital. This move included the transfer of consultant surgeons, anaesthetists, ward staff, theatre staff and equipment. This enabled 5 clean-air theatre canopies to be replaced, all of which were in need of life cycle works across both St Helens and Whiston Hospitals. This also enabled the elective beds to be re-provided to help manage the medical non-elective pressures. Despite the challenges, this project was very successful and enabled 70 patients who may not have been able to have their surgery, to successfully undergo their hip and knee replacements.

The anaesthetic department has also embarked on a new initiative involving Anaesthetic Associates and has recently recruited to two such posts. Both Anaesthetic Associate trainees will commence their training on 27th March 2023 and once qualified, will support the provision of anaesthesia in the future.

During 2022-23, outpatient activity has continued through a mixture of face to face and virtual appointments, with all clinic templates back to pre-pandemic levels and activity well above that of 2019-20.

3.6.1.1. Maternity Services

In December 2020, the first Ockenden report was published, following a clinical review of care provided at the maternity unit at the Shrewsbury and Telford Hospital NHS Trust. The report detailed a number of clinical priorities and immediate and essential actions for maternity services. In March 2022, the final Ockenden report was published with further recommendations and immediate and essential actions to support ongoing improvements.

In response to the report, the Trust completed assessments of compliance against the requirements in both reports, which were reported to the Quality Committee and the Board. Comprehensive action plans to address any areas of partial or non-compliance are monitored by the Board and the Quality Committee, as well as the external Local Maternity and Neonatal System (LMNS).

An external Regional and System Insight visit was undertaken on 15th August 2022 to review the assurance against the seven immediate and essential actions,

workforce planning and guidelines from the interim Ockenden report. Compliance was confirmed with 41 of the 47 recommendations following the visit, with eight recommendations/points for consideration. An update was provided to the LMNS in March 2023, confirming that four of the actions have been completed and four ongoing.

The Trust has reviewed the current delivery of Continuity of Carer (CoC) within the context of the requirements of the Ockenden reports and has a revised action plan in place, based on a mixed risk model for all eligible women that enables the delivery of CoC at full scale. The plan sets out the phased approach to achieving this and identifies the significant resource implications, recruitment, estate, training and consultation requirements. It identifies the building blocks and actions required to relaunch the revised model when these are in place, including safe staffing. The phasing of the implementation has considered the national drive to prioritise CoC for women from ethnic minorities and/or vulnerable backgrounds, in line with published evidence regarding poorer clinical outcomes.

Work commenced in 2022 and is scheduled for completion later in 2023 for the birthing hub in St Helens that will provide the facility for two freestanding birthing suites and enhancements to the antenatal/postnatal care provision within this facility incorporating ultrasound and physiotherapy support.

The Trust received the best quality improvement award at the Maternity and Neonatal Safety Improvement Programme Optimisation Celebration event in March 2023 for effective teamwork in keeping babies less than 32 weeks gestation warm, achieving significantly higher results than the national average for two consecutive years. This involved members of the neonatal team, theatres and maternity services.

3.6.2. Medical Care Group

The Trust continued to face many challenges in 2022-23, however staff have continued to deliver a number of service improvements and initiatives, with examples given in the sections below.

The Medical Care Group has prioritised supporting and managing the demands in the ED by gaining new investment to provide additional sessions to ensure timely consultant review of patients in the department waiting for a medical bed. This is provided seven days per week and includes junior doctor support.

Recovery of clinical activity continued to be a focus for outpatient and day case areas such as dermatology, cardiology and endoscopy, with new and innovative ways of working for clinical, managerial staff and administration staff required to reduce backlogs.

Gastroenterology
Gastroenterology has successfully introduced faecal immunochemical testing (FIT) reducing the need for invasive diagnostics requests. The service also supports the Faster Diagnosis Pathway (FDP) triaging to ensure more effective and timely response of referrals and that patients are treated early in the management pathway.

Endoscopy successfully introduced further weekend lists to reduce the surveillance backlog.

Haematology
Collaboration with Southport and Ormskirk Hospital NHS Trust's haematology is now in its second year with successful alignment within the NICE guidance. The team have recently transferred all chemotherapy prescribing to a web based system (Chemocare v6) that allows clinicians to easily track patients treatments across most of the Cheshire and Merseyside portal at the Southport and Ormskirk sites.

Diabetes
The Diabetes Team have delivered a number of initiatives, including the appointment of a dedicated nurse to support all new patients that qualify for continuous glucose monitoring (CGM) to ensure patients can optimise their diabetes control through support and training. They have increased the level of support for community-based health care practitioners, including provision of an emergency advice line to reduce the number of hospital related diabetes admissions.

The Diabetes Insulin Pump service has participated in a national hybrid closed loop 12 month project with insulin pumps and CGM, which has improved patients' average blood glucose levels (HbA1c) and overall quality of life. The pump service is also taking part in a national project with other hospital teams to improve the quality of insulin pump training and accessibility of service provision.

The commencement of a Diabetes Specialist Nurse who focuses on pregnancy and antenatal care has led to an increase in the use of technology related diabetes equipment in pregnancy care and a significant reduction in patients' HbA1c and pregnancy related outcomes.

The diabetes young adults service have participated in a national transition programme which has supported improved working and collaboration with the paediatric diabetes team in improving the transition process for young people with diabetes.

Rheumatology
In November 2022 the Trust's rheumatology service started to work collaboratively with colleagues from Southport & Ormskirk Hospital NHS Trust, which has provided improved access for patients.

In addition, a new nurse advice line has been introduced which provides timely specialist advise for patients, as well as providing ongoing support to long term patients and enabling them to manage their condition appropriately without the need to attend hospital.

Dermatology
Over the last year we have been working collaboratively with commissioners in St Helens, Knowsley and Halton on a project called Telederm. This will enable primary care colleagues to send pictures of lesions using a dermatascope via the Accenda app. This will enable consultant review of the pictures to determine appropriate care pathway. Tele-triage enables consultants to reply directly to GPs, discharge if

appropriate and provide advice. This optimises outpatient capacity and improves patient access.

Stroke

The Sentinel Stroke National Audit Programme (SSNAP) is a health improvement programme that measures the quality and processes of care provided to stroke patients up to 6 months post stroke against evidence based standards, which encompass 10 domains covering 44 key stroke indicators. The scores from each of the domains are combined and each indicator awarded a score to determine the overall reported Trust performance, A to E, which is benchmarked nationally. The Trust belongs to the "Mid Mersey and Cheshire Stroke Integrated Delivery Network" and we are the largest stroke unit in the network reporting 1027 strokes in 2020-2021 and are on trajectory to report an increase for this year.

The Trust is the top performing Trust in the network and one of the top performing trusts in the country, reporting a SSNAP score of A in Quarter 2 and sustaining this performance in Quarter 3 for the Hyper Acute Stroke Unit (HASU).

The table below shows the Trust's performance against organisations in the Cheshire & Merseyside Network

Routinely Admitting Teams		Number of patients		Overall Performance				Patient Centred Data											Six Month Assessment*			
Trust	Team Name	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	PC KI Level	Number Applicable	% Applicable	Number Assessed	% Assessed
North of England - Cheshire and Mersey																						
Countess of Chester Hospital NHS Foundation Trust	Countess of Chester Hospital	111	107	D	A	B↓	D	C↓	E	D↑	B	C↑↑	D↑	E	C	A↑	A	D	100	65%	57	57%
Liverpool University Hospitals NHS Foundation Trust	Royal Liverpool University Hospital	142	128	D↓↓	A	A	D↓↓	B	E	E↓	C↓	A	B↓	D↓	D↓	C↓	A	C↓	141	69%	101	72%
Liverpool University Hospitals NHS Foundation Trust	University Hospital Aintree	128	133	C↑	A	A	C↑	B↑	E	D	C↑	B↑	B↑	C↑	C↑	B	A	C↑	193	96%	29	15%
Southport and Ormskirk Hospital NHS Trust	Southport and Formby District General	93	102	D	A	B	D	B	E	C↑	D	B↑	B	E	D	B	A	C↑	148	100%	34	23%
St Helens and Knowsley Teaching Hospitals NHS Trust	Whiston Hospital HASU	282	252	A↑	A	A	A↑	B	C	B↑	B	A↑	B↑	A↑	A	B↑	A	A↑	342	81%	151	44%
Wirral University Teaching Hospital NHS Foundation Trust	Wirral Arrowe Park Hospital	169	158	C↓	A	A	C↓	B	E	D	B	C↓	D↓↓	E↓	A	A	A	C↓	189	89%	187	99%

We have developed links with Liverpool University Department of Medicine and Cardiac Science and have recruited an academic research consultant post along with two research clinical fellow posts and a dedicated stroke research nurse. Our research department is now a leading organisation in stroke trials and care and continues to expand.

The Trust and North West Ambulance Service (NWAS) have collaborated with the Cheshire and Mersey Integrated Stroke Delivery Network to develop video triage for patients presenting with suspected stroke or transient ischaemic attack (TIA). The pilot aims to reduce the time to scan at ED and improve the time to treatment for patients presenting with symptoms of stroke. The pilot started on 6th March 2023 and will run for 9 months.

Further developments include dedicated room to support therapeutic psychology service for stroke patients, tone management service, including the administration of inpatient Botox and improvements in post stroke ambulatory cardiac monitoring to ensure rapid turnaround and identification of abnormal results.

Resuscitation services

There is a bespoke resuscitation service and a deteriorating patient programme in place. The Trust performs extremely well compared to most other hospitals and has a low rate of cardiac arrests, that is, 0.42 per 1000 hospital admissions, due in part to early identification and treatment of patients at risk of deterioration. Resuscitation services provide tailored training programmes that support staff to feel more confident at recognising patient deterioration and in managing these patients, resulting in better patient care.

In addition, the Trust has recently re-established a do not attempt cardiac pulmonary resuscitation (DNACPR) Steering Group to further improve the patient and family care and experience.

Deteriorating patient project

The deteriorating patient programme has been in place since May 2021, with a focus on collaborative working to recognise deteriorating patients early, providing individualised patient-centred care to achieve the right outcome.

In 2022 the programme was further enhanced with the establishment of a Deteriorating Patient Collaborative to ensure coherent leadership and management in areas related to the prevention, recognition, management and response to patient deterioration, in order that the patients are provided with expert, evidence-based care and staff are provided with training appropriate to their roles. In recognition of the importance of this key project two new key deteriorating patient roles have been introduced, Deteriorating Patient Clinical Lead and Deteriorating Patient Quality Lead, both providing clear, visible leadership to support the Trust's objective of embedding a culture of safety improvements that reduces harm and improves patient outcomes and experience.

The programme is supported by training for the identification of patient deterioration and best practice responses to this deterioration. This includes training for newly appointed health care assistants (HCAs) via the STHK Healthcare Academy, training on the electronic system by the digital training team, ensuring staff can correctly input patient observations to determine the right national electronic warning score (NEWS2) protocol and exciting new plans for an education and training pilot, including bedside emergency assessment course for healthcare staff including HCAs (BEACH) and awareness why anticipation and reacting is essential (AWARE) training for HCA staff and acute life-threatening events, recognition and treatment (ALERT) and immediate life support (ILS) training for nursing staff.

A deteriorating patient pro forma has been piloted to support high quality decision making and escalation planning for patients who begin to deteriorate.

As part of a Trust-wide focus on improving the timeliness of patient observations, an in-house dashboard was developed by the Service Improvement Team to help to drive visibility of observation compliance and reduce the proportion of patient

observations that breach. The Deteriorating Patient Collaborative set target improvement measures for March 2023 with further stretch targets by September 2023. Current data is already demonstrating improvements across the organisation for timely observations compliance, with 29 ward areas across the Trust reducing the proportion of patient observations that breach by 5% when comparing February with January 2023.

Palliative Care
The STHK End of Life Strategy draws upon the national document, Ambitions in Palliative and End of Life Care where education and training are an intrinsic part of improving the quality of care at the end of people`s lives. The Trust's Palliative Care Consultant leads on providing virtual teaching sessions weekly, with a focus on a wide range of staff across the hospital, community and hospice to provide a platform for joint learning and insight into challenges in the other settings.

Palliative Care has currently been trialling a clinical nurse specialist based in the ED, which has enhanced the care of patients across the department. This innovative new role has had national interest and been recognised as leading the way forward. The Team are also working towards enhancing the transitional care of palliative paediatric patients to adult care, which will support children and their families who are living with life limiting illnesses.

In addition, the team are looking to introduce a Volunteers Butterfly Project, which will provide invaluable support for dying patients, whereby volunteers will spend time with patients and provide families with the opportunity to have some time away from the hospital.

Frailty services
The service has funded experienced Frailty Advanced Nurse Practitioners (ANP) in ED to case find appropriate patients, assessing their frailty and then, where appropriate, facilitating a discharge back home, with the support of the Urgent 2-hour Community Response Team. The Team has recently been commissioned by the Integrated Care Board to identify suitable patients who would benefit from care at home, rather than being admitted into hospital. Patients identified include end of life patients with advance care plans specifying home as place of death, patients that could be cared for at home that need intravenous (IV) therapy or dressings, as well as patients that are at risk of falling. The ANP can deploy a therapist to the patient's home, preventing further admissions. Social care packages are also put in place for the patient to enable them to stay at home for longer.

3.6.3. Urgent and Emergency Care Group

Emergency Department (ED)
The ED continues to see the highest number of attendances across Cheshire and Merseyside, for both walk-in and ambulance attendances and is the third busiest single ED in the North West, seeing approximately 121,000 patients per year.

As part of the response to the national restoration plan for UEC services, initiatives to improve and reduce front-door demand have been implemented, including introduction of a Triage Consultant, a multidisciplinary team primary care streaming

hub, urgent community 2-hour response (UCR) and North West Ambulance Service (NWAS) and care home engagement events to reduce ambulance conveyances.

To improve patient care and experience in the ED, there has been investment into senior nurse posts, with a new Head of Nursing and Quality for UEC, Quality Lead Nurse and a second Practice Educator. The impact of these new posts can be seen in the reduction of complaints and instances of harm occurring in the department compared with previous years. This is despite increased attendances and patients spending longer in the department awaiting an inpatient bed.

The department is also undergoing significant estate works, expanding the size of the Paediatric ED by over 300%, doubling the size of the Ambulance Assessment Area and creating a dedicated ED Same Day Emergency Care (SDEC) zone, which will all contribute to an improved overall patient experience and support improved assessment times.

Intensive Therapy Unit (ITU)
Following a challenging period through the COVID pandemic and the impact on the ITU workforce, a programme of wellbeing and support was developed, tailored for ITU. This supported the reduction of sickness levels and the retention of staff. The results for the 2022-23 staff survey also demonstrated significant improvements to staff feeling valued and listened to.

In addition, the recruitment of three new ITU Consultants, all previous trainees, is positive news in demonstrating the on-going improvement work, focusing on medical trainee feedback and recruitment challenges within the medical workforce.

Paediatrics
Recovery post-pandemic for Paediatrics was not such a challenge as the overall impact of COVID on children and young people was much reduced, so the service maintained pre-COVID clinical activity levels throughout, albeit via new ways of working such as telephone and virtual clinics.

Different challenges did however arise, including a significant increase in referrals from local GPs, attributed to both a deflection from the local tertiary centre and an increase in activity post-pandemic for the local catchment area and some out of area. Waiting times increased and 'Waiting List Initiative' sessions were necessary to manage the increased activity which continue at much higher levels than pre-COVID. There was also an increase in demand for phlebotomy services, which again remain much higher that pre-COVID activity levels and rely on additional sessions to maintain the necessary short waiting times. Other challenges included a huge rise in the number of children and young people admitted with mental health and eating disorders crises and a spike in newly diagnosed Type 1 and Type 2 diabetes cases.

Despite these challenges, the team sustained many ongoing service developments, including:

- An Advanced Paediatric Nurse Practitioner (APNP) led service on the Children's Observation Unit (paediatric SDEC); providing a single point of contact for advice/referrals from community and embedding a robust ambulatory care

pathway to avoid ED attendances and reduce hospital admissions
- Transfer of consultant led outpatient and phlebotomy clinics to Lowe House, the Women and Children's Community Hub in St Helens providing care closer to home
- Development of a GP with Extended Remit in Paediatrics community provision (first of its kind in England)
- A consultant led GP advice & guidance service, ensuring only clinically appropriate patients are booked into clinics
- Initiation of Patient Initiated Follow Up (PIFU)
- Programme of seamless transition to paediatric diabetes to adult service
- Collaboration with Cheshire & Merseyside Paediatric Network regarding Paediatric NHS 111 pilot and mutual aid)

3.6.4. Primary and Community Services Care Group

The Primary and Community Services Care Group were very honoured to win the People's Choice Award for Community Services in 2022. The Care Group deliver a wide range of services which are outlined below.

St Helens Urgent Treatment Centre (UTC)
The UTC continues to experience high numbers of attendances, with 62,642 in 2022, an average of 177 per day. The centre has seen a 36% increase in patients requiring urgent treatment compared to 2021. Over 95% of patients were seen and treated within 4 hours, with 61% of these triaged within 15 minutes of arrival.
Winter fund monies were secured to provide an additional GP, and regular bank and agency staff were sourced in the latter part of the year to support the increase in acuity. Capacity and demand work is in progress to review the current workforce model to ensure we meet the needs of the population.

St Helens Community Matron team
The team work closely with Primary Care Networks to ensure a holistic approach to the care of our St Helens residents. The exciting Care Communities work in progress in St Helens will further develop and strengthen partnership working across primary care, social care, secondary care and the 3rd sector.

Contact Cares Nursing team
The team demonstrate the integration developed with our Local Authority partners, providing valuable input into this single point of access and in reach into Brookfields Care Unit.

Duffy Suite and Newton Community hospitals
Our intermediate care services continue to provide short term rehabilitation and sub-acute care to improve patients' functional abilities, facilitate complex discharges and support patient flow through the Trust. They have achieved over 90% bed occupancy, with Newton Community hospital demonstrating a lower than the national average length of stay as detailed in the national intermediate care audit. Participation at daily intermediate care huddles and system discharge tracking list meetings with key partners across our health and social care services continues to strengthen relationships and whole system working.

District Nursing Service
The District Nursing Service continues to provide a frontline role in supporting patients in their own homes, supporting patient flow, helping to avoid inappropriate admissions and timely discharges from hospital to home, often picking up social care packages to help facilitate a patient's wishes regarding their preferred place for end-of-life care. Over the past year the District Nursing Service has been part of planning a pilot study to support enhanced collaboration of care between the upper GI cancer nurse specialists and the District Nursing Service. This pilot is initially for 20 patients diagnosed with pancreatic cancer. A collaborated approach to their care will involve the district nurses having access to specialist advice, joint service patient consultations and joint clinical care planning with the aim of supporting patients to remain in their own home, avoid hospital admission and ED attendances.

Community Cardiac Rehabilitation
The team have been successfully chosen as one of two pilot sites for a mental health beacon study. It is a Meta-Cognitive Therapy group based psychological support programme where techniques are delivered by a community specialist physiotherapist and a community cardiac nurse who facilitate changes to behavioural patterns that prolong anxiety and depression. This effective evidence-based psychological intervention has been found to reduce anxiety and depression compared to cardiac rehabilitation alone. This has been demonstrated in patients that have completed the course, showing a reduction in their Hospital Anxiety and Depression Scale (HADS) scores in both the anxiety and depression components.

Community IV Therapy service
The service has provided a pivotal role in support for vulnerable patients who were COVID positive, in delivering lifesaving neutralising monoclonal antibodies (nMABs) medication to this group of patients across the St. Helens and Knowsley footprint. This has been in conjunction with the delivery of Outpatient Parenteral Antimicrobial Treatment (OPAT) to patients in their own homes and supporting the hospital team with venous line insertion to allow delivery of IV medication and support patient flow by facilitating discharge into the community. The service has also trialled an innovative new way to deliver IV antibiotics in the community via a device called elastomeric. This method of delivery helps to reduce the need for multiple daily visits from nurses and some patients are able to independently assist in the use of these devices. The ICB have recognised this innovative practice and are looking to roll this out across the Cheshire and Merseyside footprint.

Community Heart Failure Service telehealth pilot
The team commenced the telehealth pilot in September 2021 which has been extended for another 12 months to support patient care. This is a joint initiative and provides daily monitoring of inputted observations such as blood pressure, heart rate, oxygen saturations and weight, which are all significant markers to highlight early detection of any deterioration in heart failure. This early detection of any deterioration can help to prevent acute hospital admissions. The pilot is designed for a group of up to 75 patients suffering from decompensating heart failure in the community setting. Feedback to date from service users and staff has been positive with patients feeling more in control of their long-term condition and assurance that their health is being closely monitored. There has been a reduction in the requirement for patients to attend a clinic appointment and staff reporting increased

assurance in prescribing safety.

Paediatric Continence Service
The team has undertaken sleep training to enable them to improve support for the children and young people with night wetting within the service. The development of discharge packages has been completed and is now in place to support families to feel confident in their onward plan when children and young people leave the service. We have also developed new feedback tools for patients and their families and carers to enable them to contribute their views and give feedback to the service to enable us to make future improvements that are service user led.

Developmental Paediatric Service
Two new pathways have been devised to support families in flowing through the service and being safely transitioned to the care of other services. These pathways include the patient initiated follow up (PIFU) which empowers families to contact the service if they need support and the transfer of melatonin medication to Primary Care services in line with pan-Mersey guideline changes. The service also undertook a restructure of the Attention deficit hyperactivity disorder (ADHD) appointment pathway to make the diagnostic process more effective and efficient and ensure every appointment is optimised to support a reduced waiting time for diagnosis of ADHD. Education, health and care plan (EHCP) training has been provided to all nursing staff within the team to enable them to complete EHCPs for children and young people within the service.

Marshalls Cross Medical Centre (MC)
The practice has continued to see a growth in registrations, with the practice list increasing from 5327 patients in January 2021 to 6373 patients in January 2023 which is an average increase of 80 new patient registrations per month. The service currently supports 6373 registered patients with a weighted population of 7,133.

Same day appointments are provided for urgent care and routine appointments are currently offered within 2 weeks. Approximately 1,222 appointments are delivered each week by the service from Monday to Friday 9am to 5pm. The practice has become a training practice and is now supporting training for junior doctors and speciality trainee doctors. In addition to this the practice is also a research and development practice with a dedicated GP aligned to support research and development in primary care.

On 6 October 2022 CQC undertook an inspection of the practice which confirmed an increase in rating from ‘requires improvement’ in August 2018 to an overall rating of ‘good’ in all areas.

Treatment Room Service
The service currently supports 1790 patients and on average the weekly number of referrals is 150 patients. The service is delivered across eight locations within St Helens borough and offers 72 clinic sessions per week.

GP with Extended Roles (GPwER) in community services
The Care Group provides GPwER services for ear, nose, and throat (ENT), dermatology and gynaecology. Each of the services provide diagnosis, treatment,

and care to patients whose conditions do not need to be managed within an acute service but are more complex than what can be managed within primary care. Without the services, the patients would be referred into the hospital outpatient services and therefore would increase caseload sizes and waiting times for hospital services. There are on average monthly patient clinic capacities of 120 patients for dermatology, 160 patients for ENT and 112 patients for gynaecology at Newton Hospital site.

3.6.5. Clinical Support Services Care Group

The Clinical Support Services Care Group includes Therapy Services, Clinical Psychology, Neurophysiology, Pathology, Radiology, Cancer Support Services, Patient Access Services (comprising of the Patient Booking Service (PBS) and outpatient nursing) and the Community Diagnostic Centre (CDC). These services have been integral to the Trust's recovery and optimisation plans to deliver against key targets.

The Care Group will continue to rise to the challenges of meeting the new care demands and reducing backlogs that are a direct consequence of the pandemic, increasing demand and the ongoing requirement to increase capacity and resilience to deliver safe, high-quality services that meet the full range of people's health and care needs.

Therapy Services
Electronic Careflow referrals have been implemented for those clinical areas who activate referrals to therapy. This has led to the ability to easily screen referrals and request further information as appropriate ensuring timely intervention is provided to support patient flow. Therapy demand can now be established and analysis is underway to look at working hours to support these times of peak demand.

A flexible workforce approach has been maintained via the introduction of a therapy morning huddle. This allows the service to collectively respond to maintain patient safety, provide high-quality care and support flow.

Close working relationships and practices with community therapy colleagues have been maintained providing timelier and seamless transfers of care building on models of Discharge to Assess. The introduction of the 2-hour Urgent Community Response (UCR) Team providing integrated health and social care has served to maximise patient flow and strengthen community partnerships.

Involvement in international recruitment for Occupational Therapists to support our workforce is ongoing, which is a new concept in therapy for our Trust that we hope to be able to roll out further.

Therapy Services continue to host the Cheshire and Merseyside Allied Health Professionals (AHP) Faculty. Focus has been continuing to support workforce issues encountered by all professions and support both the registered and non-registered workforce. Early careers and preceptorship have been a significant focus over the last 12 months with the Trust hosting a secondment in therapy to scope a student support role and embedding the previously developed student placement toolkit to

ensure support for both students and educators to gain the best from placement time. The AHP Faculty has supported the development of preceptorship across Cheshire and Merseyside, assisting to embed the national framework and link trusts to support learning with each other. The Trust rolled out the newly developed collaborative preceptorship programme across nursing, midwifery and AHPs in September 2022 with huge success and work continues to grow and develop these programmes across Cheshire and Merseyside. A large piece of work has just been completed pulling together all Cheshire and Merseyside trusts' AHP workforce plans which will then be shared to further the work and strengthen AHP workforce strategies.

Clinical Psychology
The Clinical Health Psychology service was successfully awarded Health Education England (HEE) recovery funding in October 2022, which is enabling the service to offer Compassion Focused Therapy (CFT) and Acceptance and Commitment Therapy (ACT) after receiving accredited training by March 2023. Skills sharing with the broader workforce is also anticipated. The service is implementing preceptorship opportunities to grow-our-own Senior Clinical Psychologists and improve recruitment opportunities. The service continues to support specialist Trainee Clinical Psychologist placements to ease clinical pressures. These trainees are 6-12 months away from qualifying as Clinical Psychologists and recruitment pressures are starting to ease because of this offer. The service has completed participation in a national research project improving breast cancer recovery pathways. Waiting list initiatives have been in action since December 2020 and waiting lists remain low compared to other comparable services outside of the Trust. Outpatient referrals are 30% higher compared to pre-pandemic and the service continues to strive for clinical excellence and efficiency to match demand.

Pathology
Pathology continues to work with our Cheshire and Merseyside colleagues towards a combined pathology network. The Trust has undergone and maintained ISO15189:2012 accreditation and is currently undergoing a full assessment.

Staff investment and development has continued, with upskilling, recruitment to vacancies, professional registrations, completion of apprenticeships and placement degrees and awards including masters level and British Blood Transfusion Society qualifications.

Developments within the service include the installation of a new track system in Haematology and automated embedding and tissue processing equipment installed in Cellular Pathology. In Microbiology service improvements include front end automation and improvements to antimicrobial sensitivity testing. Transfusion has supported the filming of a major haemorrhage training video in collaboration with the clinical teams to comply with a national Central Alerting System (CAS) alert. There was a national blood supply shortage which was extremely well managed with no patient harm and minimal disruption to elective services.

Several new tests were introduced on site rather than being referred to other laboratories and a demand optimisation module activated in the laboratory information system to appropriately reduce repeat requests.

In excess of 250,000 COVID requests were processed, including rapid testing for Infection Prevention and Control and COVID-19 antibody testing and Consultant Microbiologist Dr Kalani Mortimer was named as Employee of the Year for her remarkable efforts during the pandemic.

The Pathology team worked with Cancer Services and engaged with an external company, Pinpoint Datascience. The PinPoint test uses an artificial intelligence algorithm to detect early cancer and support appropriate patient triage.

Radiology
Radiology Services have retained their Quality Standard for Imaging (QSI) accreditation and are due a full review in March 2023. This accreditation allows the department to benchmark itself against national quality standards and promotes continuous improvement. Radiology achievements for 2022-23 include:

- Successfully training a new reporting radiographer, a new assistant practitioner, an advanced practitioner in fluoroscopy and a member of staff in nuclear medicine
- Recruitment of new breast radiologist and head and neck radiologist
- Successful recruitment of an international recruit for magnetic resonance imaging (MRI)
- Successful recruitment of band 6 MRI radiographers
- New installation of an additional computerised tomography (CT) scanner
- Supporting improved patient pathways for same day elective care and brain, abdomen and prostate conditions
- Supporting the faster diagnostic pathways
- Increased working hours and capacity at the CDC
- Successfully trained and recruited new sonographers
- Put into place a pathway to support claustrophobic patients who require an MRI scan with the help of the psychology team.
- Utilising new technology in CT and MRI to improve image quality and reduce scan times
- Continual education of staff in post graduate studies in all modalities.

The priority going forwards is to build on these efficiencies to support the care groups to optimise service delivery, improve patient flow and to deliver truly integrated patient pathways to support recovery, faster diagnosis programme (FDP), development of the CDC and Integrated Care System (ICS) agenda.

Cancer Services
Cancer services has had an outstanding year having won six prestigious awards for innovation and excellence in cancer care. In July 2022, the Trust was honoured with a Parliamentary award for the development of a cancer surgical hub during the pandemic to ensure cancer patients could continue to have timely access to life saving surgery. The Trust's FDP has continued to evolve and progress, ensuring that the Trust is working to best practice timed pathways across all tumour groups. The groundwork has been set to further roll out the Faecal Immunochemical Test (FIT) test and develop referral triage models for both upper and lower gastrointestinal cancers so that prioritisation and effective diagnostic capacity utilisation can continue to ensure that patients have early access to endoscopy considering ever-increasing

numbers of referrals. The non-specific symptoms pathway is now well established and has been included in the commissioning intentions for 2023-24. A unique pathway for patients with brain cancer has been developed with regional partners and the Brain Tumour Charity. This pathway has been adopted across the Cancer Alliance and is now being extended to other organisations, improving and co-ordinating patient journeys in a way that has never been done before. The Trust continued to rank very highly in the National Cancer Patient Experience Survey (NCPES) with an overall score of 9.2/10.

Outpatients
Led by the Patient Access Team, outpatient transformation has been fundamental in supporting the elective recovery planning. Expansion of Advice & Guidance, Virtual Communications and Patient Initiated Follow Up (PIFU) across specialties has championed this agenda. This has supported patient education to facilitate self-care and enhance health and wellbeing, as well as supporting remote monitoring of conditions, to enable a reduction in unnecessary hospital follow up appointments across specialties. Transforming care in this way is a key commitment set out in the NHS Long Term Plan.

Community Diagnostic Centre (CDC)
This has seen significant progress, investment and achievement over the last 12 months. As of December 2022, the CDC at St Helens Hospital has achieved 50,000 additional tests (the highest number in Cheshire & Merseyside). This is across a plethora of services that have diagnostics within their clinical pathways. The CDC through extra diagnostic capacity continues to align and support the FDP from a cancer perspective. The aim of the CDC is to provide additional capacity with a vision to provide access 7 days per week, 12 hours per day and, where possible, in a 'one-stop' fashion, that is providing multiple diagnostic tests in one visit to the hospital, therefore, speeding up diagnosis.

The CDC was successful in achieving circa £24 million of investment in September 2022 for a 3-year period to the end of March 2025. This is a collective amount in terms of revenue (staffing), capital (for building/estates construction) and capital in the form of equipment. The successful areas were radiology, endoscopy, cardio-respiratory and phlebotomy.

In December 2022 the Trust successfully bid for further capital funding. This covered a much wider service base that included gynaecology, urology and ear, nose and throat (ENT) services and many key pieces of equipment such as a DEXA scanner, ambulatory analysis equipment in addition to the MRI scanner from the successful bid in September. Funding will also enable the upgrade of the site itself with such projects as car park improvements and the electrical supply to the hospital. Work is underway to recruit a substantive workforce that can deliver this additional activity on a permanent and sustainable basis.

3.7. Summary of national patient surveys reported in 2022-23

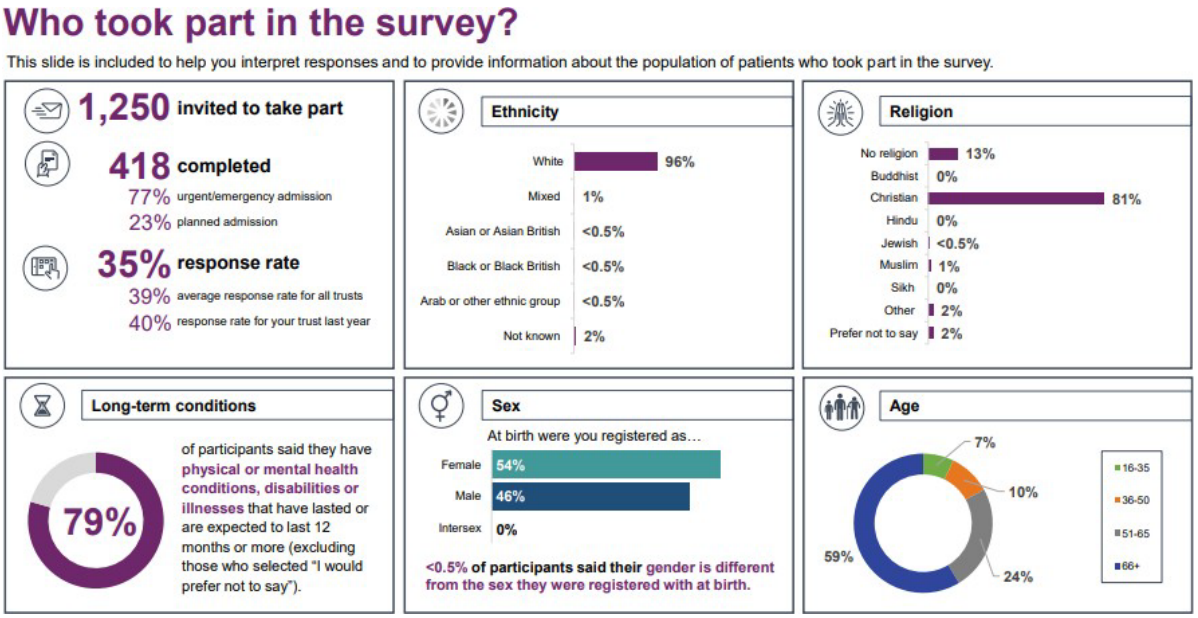
The full results for all the latest Care Quality Commission's national patient surveys can be found on their website at www.cqc.org.uk

3.7.1. National inpatient survey

The Trust participated in the annual national inpatient survey 2021 coordinated by the Care Quality Commission. The results from the survey are used in the regulation, monitoring and inspection of NHS trusts in England and were published in September 2022.

The adult inpatient 2021 survey built on the new 2020 survey methodology and result reporting. The survey was sent to those who were inpatients during the month of November 2021.

Trust statistics:



The Trust's results were:

- Better than expected in 7 questions – relating to hospital cleanliness, privacy, communication before and after operations/procedures and support following discharge
- Somewhat better than expected in 3 questions – relating to questions before operations/procedures, involvement and notification of discharge
- Somewhat worse than expected in 1 question – relating to the wait for a bed on a ward
- Banded about the same as other trusts for the remaining 36 questions

Comparison with 'like for like' trusts (12 specialist trusts removed from sample) highlights that for 80.8% questions the Trust was in the top 50 trusts (of 122 Trusts in total). The Trust was ranked 1st nationally for the question regarding communication following operation/procedure and ranked in the top 10 for 13 questions (covering cleanliness, confidence in staff, communication, involvement in care/decisions, privacy and discharge planning).

Themes for improvement have been identified including ensuring support for patients for washing/keeping clean, access to staff when needed and discharge medications.

Other issues are Trust-wide, including waiting for a bed on arrival to the hospital and ensuring enough nurses on duty. An action plan has been developed focusing on the main priorities and actions for improvement from the survey.

3.7.2. National maternity survey 2022

The CQC annual national maternity survey was undertaken in 2022 where women aged 16 years or over who had a live birth between 1st and 28th February 2022 at Whiston Hospital were asked to participate. The findings of this survey were released in January 2023 with some comparisons to the previous maternity survey which was undertaken in 2021. The response rate for STHK was 34% with 109 women responding to the survey which contained 51 questions.

The overall findings identified that the maternity service was about the same as other trusts for 42 questions, with the following questions below average:

- During your antenatal check-ups, did your midwives listen to you?
- During your pregnancy did midwives provide relevant information about feeding your baby?
- Thinking about your care during labour and birth, were you involved in decisions about your care?
- On the day you left hospital, was your discharge delayed for any reason?
- In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?
- If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- Were your decisions about how you wanted to feed your baby respected by midwives?
- Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?
- Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

Within these 42 responses, five questions were new or had changed from the previous survey; of the remaining 37 questions, six questions scored better compared to the 2021 survey and 14 had a significant reduced scoring. The report acknowledges that COVID-19 may still have had an impact, requiring consideration of the changes and continued restricted visiting within the maternity services when interpreting the results is required.

A series of focus groups and presentations have been undertaken to share the results with staff and to enable the development of an action plan for maternity and obstetric staff to understand their own results and enable engagement in actions on areas where improvement will be undertaken.

The priorities to focus upon for 2022-23 are:

- Continued dissemination of findings and shared learning
- A focus upon communication and ensuring women and their families are provided with adequate information to ensure they have continued and improved involvement in their care to empower them to make informed choices
- Collaboration with the Maternity Voices Partnership (MVP) to seek service user

views and opinions to identify specific areas for improvement on which to focus in the forthcoming year and ideas to address any areas of improvement
- Explore ways to encourage more women to complete the survey including social media platforms
- A review of current infant feeding training facilities including practical skill support assessments
- Raising awareness with staff about the importance of ensuring birth partners are involved as much as a woman wishes
- Review of ward processes to improve and reduce delayed discharges
- Development of a postnatal ward welcome pack to support communication regarding the discharge process, as mothers and babies may not be fit for discharge at the same time, which can be perceived as a delay
- Review of current digital services to enhance documentation and ensure appropriated medical history is fully available
- Development and undertaking of internal trust surveys based on the inpatient survey questions to receive regular feedback and progress with the action plan, as well as enabling more detailed feedback indicating the reasons for the responses provided to allow for more targeted action to improve the care and services within maternity

Some key actions that have already been achieved following the 2022 survey include:
- Reintroduction of a support partner onto the antenatal and postnatal ward between 9am and 9pm and a restricted visiting time for additional visitors
- Recommencement of parent education sessions which were previously suspended due to the COVID-19 pandemic. These sessions include discussions regarding personalised care, information provision and shared decision-making processes
- Infant feeding drop-in sessions have recommenced to offer advice and ongoing support to women
- Infant feeding workshops have recommenced aiming to increase staff knowledge and provide ongoing advice and support

3.7.3. National children and young people's (CYP) Survey

There has been no further national CYP inpatient survey since the one that was reported in last year's Quality Account, with the next survey due to start with fieldwork in August to November 2023 and publication anticipated for April 2024. The most recent survey covered inpatients discharged during November/December 2020 and January 2021, with three different questionnaires depending on the patient's age, 0-7 (completed by the parent/carer), 8-11 and 12-15 years (completed by the child and the parent/carer). All surveys were postal or telephone due to poor online uptake in previous years.

The Trust's response rate was 15%, with 610 questionnaires sent out and 89 completed and returned; a slight improvement on the 13% response rate for the previous survey in 2018. There was a 24% average response rate for all trusts.

The overall report indicated excellent feedback in relation to the experience of parents/carers and CYP. The Trust scored amongst the top scoring 20% of trusts for

63% of questions and within the intermediate 60% of trusts for the remaining 37% of questions. The Trust had no scores within the lowest scoring 20% of trusts and scored in the top 20% for the overall experience question in that parents/carers felt their child was well looked after by the hospital staff (this score was much better than the national average score and a significant increase on the Trust's 2018 survey results). Patients and their families scored their experience as 9/10 with 10 being the maximum score.

Areas of note where the Trust scored amongst the highest scoring 20% of trusts were:

- The high quality and choice of the hospital food provided (this has been an area of concern in previous surveys, so this indicates a significant improvement)
- The ability to sleep uninterrupted when needed in the hospital and the cleanliness of the hospital room/ward (always score very highly)
- The privacy afforded when receiving care and treatment
- Parents/carers felt involved in agreeing a plan for their child's care, that they could ask questions and had confidence/trust in the staff treating their child
- Parents/carers felt involved in decisions about their child's care and treatment and felt they were kept well informed
- Parents/carers felt staff worked well together (much better than national average score and improvement on 2018 survey results)
- Different members of staff were aware of the child's medical history and did not give conflicting advice/information
- Parents/carers felt listened to by staff looking after their child (significant improvement against 2018 survey result)
- CYP said hospital staff talked with them about how they were going to be cared for
- Parents/carers were given information about their child's care and treatment in a way that they could understand
- Parents/carers felt looked after by the staff and highly rated the overnight facilities with access to hot drinks facilities and ability to prepare food in the hospital
- Parents/carers felt that staff did everything to help their child if they felt pain
- CYP knew who to talk to if they were worried about anything when they got home
- Parents/carers were given advice about caring for their child when they went home and knew what was going to happened next with their child's care

As always, there were some areas requiring improvement based on the feedback, noting that the survey took place during the COVID pandemic, when there were a lot of unavoidable restrictions in place to maximise patient safety, including the closure of playrooms, strict social distancing and visiting restricted to one parent at a time. As a result of this feedback the Trust looked at:

- Ways to ensure age-appropriate playthings were available and that play specialists adapted their ways of interacting with CYP so that they were aware of the wide variety of play options that are available to them. Fortunately, the playrooms are again fully operational now that all COVID restrictions have been lifted and so the barriers to play that were noted in this survey are no longer in place. Also play specialists can again now fully interact with CYP during their hospital stay to ensure they have every opportunity to use the wide choice of age appropriate play options that are available to them
- How to provide younger children with a more age-appropriate environment,

which, where possible, should be separate from older CYP. Due to physical space constraints on the wards, it has proven challenging to provide separate play environments/relaxing rooms for both young and older CYP. The team are currently exploring the option of splitting one of the two playrooms into two or potentially modifying the sensory room to create a specific adolescent area
- Reviewing methods by which staff can involve CYP in decisions about their care and treatment, where appropriate. CYP are routinely asked to share their thoughts and views to ensure their voices are heard and acted on. The recently reintroduced Paediatric Patient Experience Group (paused during COVID) which has a number of patient and parent members will further embed this ethos (such members being recently canvassed for their views in relation to a new CYP privacy notice being introduced across the Trust)
- Completing an audit of the communication skills and competencies of staff to identify any training (include induction) required given that some CYP did not always fully understand what staff were saying about their care. The paediatric audit nurse has developed an audit tool for this purpose which is currently being rolled out across the unit
- Reviewing information and advice given on discharge to ensure that parents/carers know who to talk to if worried about their child when they get home and that CYP have appropriate advice on how to look after themselves after they go home. There is a discharge checklist which is always completed by the nurse in charge of the CYP when they leave hospital and therein is a very detailed sub-section in this respect (the team are also currently exploring the viability for incorporating into the paediatric Nursing Care Indicator dashboard). There is also a rolling programme to review all patient information/advice leaflets given to patients and families on discharge

3.7.4. National urgent and emergency care survey

There has not been a further survey since the previous one that was published in September 2021 and reported in last year's Quality Account, which focused on the experiences of patients using the service in September 2020. The Trust's response rate was 22%.

The overall section for environment and facilities put the Trust amongst the best performing trusts and the Trust scored better than other trusts for the following questions:
- For doctors and nurses not talking in front of patients, as if they were not there
- For being able to access suitable food and drink while in A&E, if they wanted to
- For being told about any symptoms to watch for regarding their illness or treatment after going home, if this information was needed

All the other responses were rated about the same as other trusts, with none scoring worse than other trusts.

The Trust has produced an action plan to focus on key areas of improvement and where the score fell from the previous survey in 2018, including ongoing work to reduce the waiting time in the department.

3.7.5. National cancer patient experiencesurvey(NCPES)

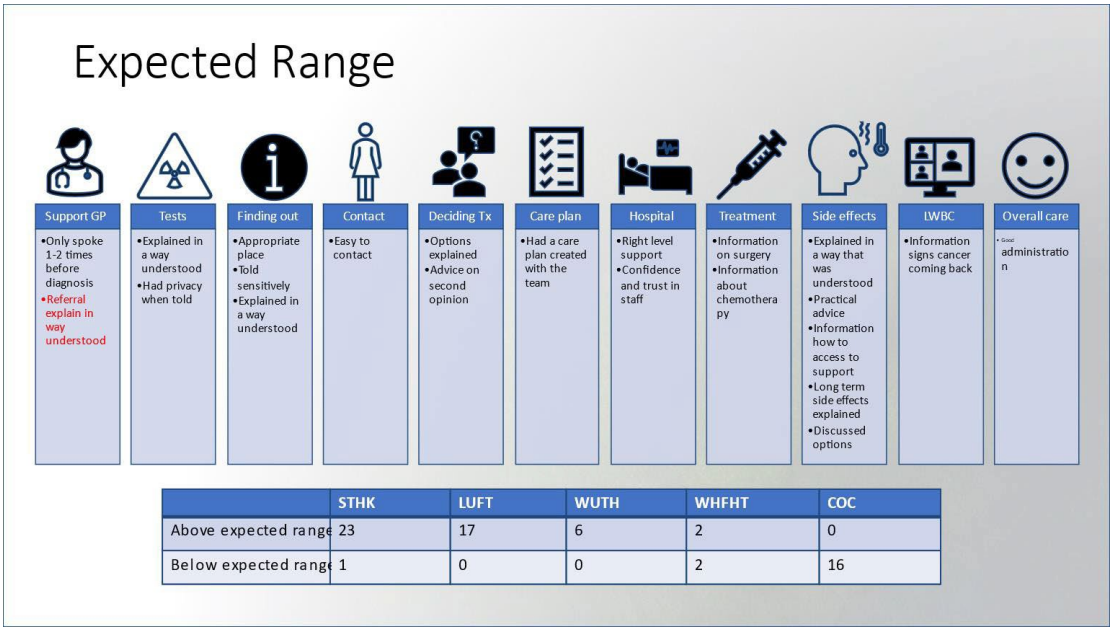
The Trust participated in the latest National Cancer Patient Experience Survey (NCPES), which was the 11th iteration of the survey that the Trust has participated in. The NCPES is overseen by the national Cancer Patient Experience Advisory Group, who set the principles and objectives of the survey programme and guide questionnaire development.

The 2021 NCPES was carried out from 29th April to 8th July 2022. The survey was in a new format and, therefore, cannot be compared with previous year's results. The Trust had a 51% response rate (269 patients responded out of a total of 530), slightly below the national rate of 55%.

When asked how patients rated their overall care on a scale 1-10, 259 (96%) patients responded, giving a positive rating of 9.2 out of 10, above the national average of 8.9 and consistent with previous year's results demonstrating how the staff have maintained a high standard of care.

The expected range charts in the report show the lowest and highest score received for each question nationally. The Trust are positive outliers for 23 (38%) of the questions asked, providing assurance that as an organisation we are delivering care that is better than what trusts of the same size and demographics are expected to perform.

The table below shows the areas across the patient pathway that STHK exceeded the expected range and includes an overview of results for similar trusts within Cheshire and Merseyside Cancer Alliance.

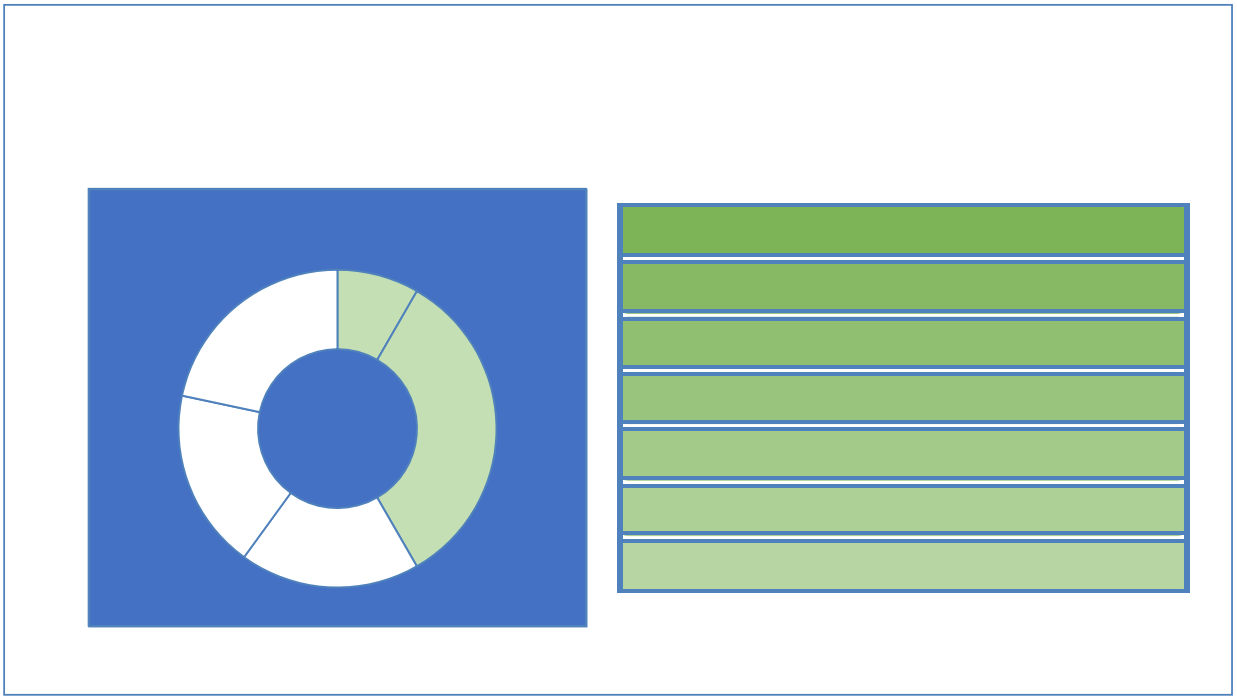


	STHK	LUFT	WUTH	WHFHT	COC
Above expected range	23	17	6	2	0
Below expected range	1	0	0	2	16

One question was reported as below the expected range relating to the explanation given to patients when being referred by their GP and this is being addressed as part of the faster diagnosis pathway work that is underway.

To understand areas for improvement the Trust was benchmarked against the

national highest score and local trusts. Patients have rated the Trust in the highest in the country and in the top ten for 42% of the areas covered in the survey, including from diagnosis through to living with and beyond cancer This is outlined in the chart below:



The Trust is always looking to improve and has identified areas for improvement linked to the following survey questions:

- Referral for diagnosis was explained in a way the patient could completely understand and the patient received all the information needed about the diagnostic test in advance
    - The teams are working closely with primary care colleagues to improve the level of information required as part of the Cancer Diagnostic Centre and faster diagnosis pathway
- Care team gave family, or someone close, all the information needed to help care for the patient at home and the patient received the right amount of support from their GP practice during treatment
    - The upper gastrointestinal (GI) tract cancer team is piloting an enhanced communication project, looking at the communication between district nurses, site specific teams and the patient. The pilot is due to start March 2023 and includes enhanced verbal communication between teams, a single point of access and virtual working with patients and district nurses
- After treatment, the patient could get enough emotional support at home from community or voluntary services and the right amount of information and support was offered to the patient between final treatment and the follow up appointment and patients have had a review of cancer care by GP
    - During the pandemic health and wellbeing events which support patients in the transition into follow up care and links into community services were ceased and teams are delivering bespoke smaller session for those patients who are on supported self-management programmes, which have been well received. For 2023 cancer services will be relaunching the

health and wellbeing events with the specialist teams and are currently scoping different models, as we need to be able to offer patients an option for the type of event they wish to attend. There will also be bespoke events for patients with a palliative diagnosis

- Cancer services are also working in collaboration with our partners at Macmillan and the ICB on a community model which will deliver information and support to local communities within their own areas. This is in discussion now with further work ongoing around the role of cancer champions with St Helens Place. This will be one of seven pilots nationally looking at cancer champions in the community, if agreed and implemented. For the St Helens project Macmillan have worked with our Place partners and cancer services and it has been agreed to focus on those most deprived areas
- Personalised supported self-management is now embedded in five pathways across the Trust and we are working with the respiratory team to role this out for lung cancer patients. There are 2740 patients who have their follow up care proactively managed by a dedicated cancer support worker through a patient portal. The portal also offers patients access to a range of resources, including information on local support groups and community services that they can access following their diagnoses

The full report can be found at www.ncpes.co.uk

3.7.6. National general practice (GP) patient survey

Marshalls Cross Medical Centre participates in the national GP patient survey each year. In 2022, 119 surveys were returned from a total of 447 resulting in a response rate of 27%. The results showed that of the 18 questions, the number of responses above or the same as the local average and national average were 6, with the remaining 12 below. An action plan was devised to address areas below the average, which includes working with a local practice that received higher scores, conducting inhouse surveys to replicate the national survey, reviewing appointment availability and capacity and demand and increased recognition of mental health needs.

It was pleasing to see that there were positive scores for areas that were in the previous year's action plan relating to contacting the practice by telephone, helpful receptionists and receiving support from local services.

4. Statement of directors' responsibilities in respect of the Quality Account

The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2022-23
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Richard Fraser, Chairman

Ann Marr OBE, Chief Executive

5. Written statements by other bodies

5.1. Commissioners

5.2. Healthwatch Halton

5.3. Healthwatch Knowsley

St Helens and Knowsley Teaching Hospitals NHS Trust – Quality Account Commentary 2022-23

Healthwatch Knowsley welcomes the opportunity to provide this commentary on the St Helens and Knowsley Teaching Hospitals NHS Trust Quality Account for 2022/23.

We would like to express our thanks to the Trust for the continued opportunity to work together to discuss patient experience issues and trends, and to contribute to the work of the Patient Experience Council, Cancer Patient Experience and Quality Assurance Group, Equality, Diversity and Inclusion Steering Group and the Patient Participation Group. This collaborative working has been a consistent theme over many years and is very much appreciated.

It is encouraging to see that the Trust has retained its outstanding Care Quality Commission (CQC) rating and has also been recognised for quality achievements across a wide range of operating areas, including around equality with the receipt of the Rainbow Badge Bronze Accreditation.

It is clear that pressure across NHS services has impacted on the Trusts ability to achieve a number of its 2022/23 quality objectives and we are pleased that the objective around timely and effective assessment and care of patients in the Emergency Department remains a priority for 2023/24. Our own feedback from patients highlights that Access to Services (both waiting times and lack of access) remain high areas of concern. In relation to other quality objectives identified for improvement for 2023/24, we would agree that these are suitably challenging and appropriate. However, we may have expected to see a further priority around improving communication as this is another area that our independently gathered feedback suggests is of concern to patients.

Healthwatch Knowsley
April 2023

5.4. Healthwatch St Helens

Healthwatch St Helens Response to the St Helens & Knowsley Hospital Trust Quality Account for 2022-2023.

A very thorough, clear and detailed Account that contains a lot of information, is well written and reads well.

We are pleased to see some direct quotes from patients in there, as this give a 'human' touch.

It is very positive to see how the Trust is offering a high level of support for staff, particularly given the additional pressure that staff have been under during the past few years. The wellbeing of staff will ultimately impact the quality of care that is delivered to patients.

It was very interesting to read about the advancements in IT systems. Anything that can improve the fast and efficient treatment of patients, by offering better access to patient records for example, can only be a good thing.

It's always good to see the commitment to improving communication and it was interesting to see the variety of ways in which the Trust plans to communicate with patients, listed in the report. Also good to see are the responses to various survey questions, particularly around communication and checking patients' understanding of information they are given, as communication continues to be the biggest issue that people speak to Healthwatch about.

It is positive to see what has been achieved in the quality objectives for 2022-23 and while there are some areas that still need to be improved, it is hardly surprising, in the current climate and with the pressures the Trust are under, that not all have been met. We look forward to seeing objectives around patient hydration and falls being fully met in the near future.

It was very good to see, in the patient case studies section, the acknowledgement of where the patient experience has not been as good as it could have been, and what has been done to address issues. Also impressive is the patient story about a patient being involved in the recruitment of a Learning Disability and Autism practitioner.

We were pleased to see the work around creating Care Communities in St Helens mentioned in the report as we are only too aware of the level of effort that has gone into this by all involved.

Healthwatch St Helens continues to be committed to working with the Trust to ensure that the feedback we receive from patients helps the Trust understand what patients believe is working well and where improvements could be made.

5.5. Amendments made to the Quality Account following feedback and written statements from other bodies

The following amendments were made following feedback from other bodies:

Section	Amendment/addition
3.1.3.3	Response provide to Healthwatch Knowsley in relation to request to prioritise communication, confirming this is included as part of the patient equality objectives for 2023-27, outlined in section 3.1.3.3

6. Abbreviations

ACP	Advance care planning
ACT	Acceptance and commitment therapy
ADHD	Attention deficit hyperactivity disorder
AF	Atrial fibrillation
AHPs	Allied Health Professionals
AI	Artificial intelligence
AIS	Accessible Information Standard
AKI	Acute kidney injury
ALERT	Acute life threatening events, recognition and treatment
ALTC	Agreement for long term collaboration
AMU	Acute Medical Unit
ANC	Ante-natal Clinic
ANP	Advanced Nurse Practitioner
ANTT	Aseptic non-touch technique
App	Application
AQuA	Advancing Quality Alliance
ARC NWC	Applied Research Collaboration North West Coast
AWARE	Awareness why anticipation and reacting is essential
BAD	British Association of Dermatology
BAPM	British Association of Perinatal Medicine
BAUS	British Association of Urological Surgeons
BEACH	Bedside emergency assessment course for healthcare staff including Healthcare Assistants
BEP	Bleeding in early pregnancy
BM	Blood glucose monitoring
BSI	Blood stream infection
BSL	British Sign Language
BTS	British Thoracic Society
CAS	Central Alerting System
CaSH	Contraception and Sexual Health Services
CCGs	Clinical Commissioning Groups
CCS	Clinical Classifications Service
CD	Controlled drugs
CDC	Community Diagnostic Centre
CDI/C diff/C difficile	Clostridium difficile infection
CFT	Compassion focused therapy
CGM	Continuous glucose monitoring
CHPPD	Care hours per patient per day
CMAST	Cheshire and Merseyside Acute and Specialist Trust provider collaborative
CMP	Case mix programme
CoC	Continuity of Carer
COPD	Chronic obstructive airways disease
CPD	Continuing professional development
CPE	Carbapenemase-producing enterobacteriaceae

CQC	Care Quality Commission
CQuIN	Commissioning for quality and innovation
CRAB	Copeland risk adjusted barometer
CRN NWC	Clinical Research Network, North West Coast
CT	Computerised tomography
CYP	Children and young people
DAMASCuS	Diverticular abscess management: a snapshot collaborative audit study
Datix	Integrated risk management, incident reporting, complaints management system
DIPC	Director of Infection Prevention and Control
DMOP	Department of Medicine for Older People
DNACPR	Do not attempt cardiopulmonary resuscitation
DQMI	Data quality maturity index
DRC	Deafness Resource Centre
DrEaM	Drink, eat and mobilise
DSN	Diabetes Specialist Nurse
DSPT	Data Security and Protection Toolkit
DVT	Deep vein thrombosis
ECMO	Extracorporeal membrane oxygenation
ED	Emergency Department
EDI	Equality, diversity and inclusion
EDS or EDS2	Equality Delivery System
eGFR	Estimated glomerular filtration rate
EHCP	Education, health and care plan
ENT	Ear, nose and throat
ePMA	Electronic prescribing and medicines administration
EPR	Electronic patient record
EVOLVE	End of life care in adVanced chrOnic LiVEr disease
eVTE	Electronic venous thromboembolism (recording)
FCEs	Finished consultant episodes
FDP	Faster diagnosis programme
FDS	Faster diagnosis standard
FFT	Friends & Family Test
FICB	Fascia iliaca block
FIT	Faecal immunochemical test
FMU	Fetal Medicine Unit
FY1 or FY2	Foundation year 1 or 2
GAP SCORE	Growth assessment protocol standardised case outcome review and evaluation
GELA	Grading system to evaluate lymphoma response to therapy
GI	Gastrointestinal
GP	General Practitioner
GPAU	General Practitioner Assessment Unit
GPSI	GP with special interest
GPwER	GP with extended role
HADS	Hospital Anxiety and Depression Scale
HASU	Hyper-Acute Stroke Unit

HbA1c	Haemoglobin A1c - average blood glucose (sugar) levels for the last two to three months
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HCSW	Healthcare Support Worker
HEE	Health Education England
HES	Hospital Episode Statistics
HODS	Haemato-Oncology Diagnostic Service
HOPE	Help to overcome problems effectively
HR	Human Resources
HWWB	Health, Work and Well-being
IBD	Inflammatory bowel disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICB	Integrated Care Board
ICCR	Individual care and communication record
ICS	Integrated Care System
IDP	Income distribution plan
IG	Information governance
IMV	Invasive mechanical ventilation
IPC	Intermittent pneumatic compression
IPR	Integrated performance report
IT	Information technology
ITU	Intensive Therapy Unit
IV	Intravenous
KPI	Key performance indicator
LAC	Looked after children
LeDeR	Learning disability mortality review
LGA	Large for gestational age
LGBT	Lesbian, gay, bisexual, transgender
LGBTQI+	Lesbian, gay, bisexual, transgender, questioning and intersex
LMNS	Local Maternity and Neonatal System
LocSSIPs	Local safety standards for invasive procedures
MALT	Mucosa-associated lymphoid tissue
MBRRACE-UK	Mothers and babies - reducing risk through audits and confidential enquiries across the UK
MC	Medical Centre
MDF	Minimum Digital Foundation
MDT	Multi-disciplinary team
MET	Medical Emergency Team
MINAP	Myocardial infarction national audit programme
MITRE	Muscle invasive bladder cancer at transurethral resection of bladder
MMC	Mitomycin C
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant staphylococcus aureus
MRSAb	Methicillin-resistant staphylococcus aureus bacteraemia
MSSA	Methicillin-sensitive staphylococcus aureus

MVP	Maternity Voices Partnership
NABCOP	National audit - breast cancer in older patients
NACAP	National asthma and COPD audit programme
NACEL	National audit of care at the end of life
NAOGC	National audit oesophago-gastric cancer
NAS	Neonatal abstinence syndrome
NatSSIPs	National safety standards for invasive procedures
NBOCA	National bowel cancer audit
NCAA	National cardiac arrest audit
NCAP	National cardiac arrest programme
NCEPOD	National confidential enquiry into patient outcome and death
NCPES	National cancer patient experience survey
NDA	National diabetes audit
NELA	National emergency laparotomy audit
NEWS	National early warning score
NHS	National Health Service
NHSE	National Health Service England
NHSEI	National Health Service England/Improvement
NHSI	National Health Service Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National joint registry
NLCA	National lung cancer audit
NMC	Nursing and Midwifery Council
NMP	Non-medical prescribing
NMPA	National maternity and perinatal audit
NNAP	National neonatal audit programme
NOD	National ophthalmology audit
NoF	Neck of femur
NPCA	National prostate cancer audit
NPDA	National paediatric diabetes audit
NRLS	National Reporting & Learning System
NVR	National Vascular Registry
NWAS	North West Ambulance Service
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OH	Occupational Health
OHCA	Out of hospital cardiac arrests
ONCA	(BreaST ONCA: Breast Surgery Training) Opportunities National Collaborative Audit
OoH	Out of hours
OPAT	Outpatient Parenteral Antimicrobial Treatment
OSCE	Objective structured clinical examination
OT	Occupational Therapist/Therapy
P2, P3, P4	Priority 1, 2 or 3
PALS	Patient Advice and Liaison Service
PAS	Patient administration system
PBS	Patient Booking Services

PCI	Percutaneous coronary intervention
PE	Pulmonary embolus
PIFU	Patient initiated follow up
PIN	Personal identification number
PIR	Post infection review
PLACE	Patient-led assessments of the care environment
PMRT	Perinatal mortality review tool
PPI	Proton pump inhibitor
PRES	Participant in research experience survey
PROMs	Patient reported outcome measures
QCAT	Quality Care Accreditation Tool
QI	Quality improvement
QICA	Quality Improvement and Clinical Audit
QSI	Quality standard for imaging
RACPC	Rapid Access Chest Pain Clinic
RAG	Red, amber, green
RCA	Root cause analysis
RCEM	Royal College of Emergency Medicine
RDI	Research, development and innovation
RDIG	Research, Development and Innovation Group
RESECT	Transurethral resection and single instillation intravesical chemotherapy evaluation in bladder cancer treatment
RLC	Rugby League Cares
RN	Registered Nurse
RTT	Recruiting to time and target
RSV	Respiratory syncytial virus
SAMBA	Society for Acute Medicine (SAM) benchmarking audit
SARS-CoV1/SARS-CoV	Severe acute respiratory syndrome coronavirus 1
SDEC	Same Day Emergency Care
SDI	Service Desk Institute
SHADL	Social history and activities of daily living
SHMI	Summary hospital-level mortality indicator
SHOT	Serious hazards of transfusion
SIRO	Senior Information Risk Owner
SJR	Structured judgement review
SMR	Standardised mortality ratio
SOP	Standard operating procedure
SSI	Surgical site infection
SSNAP	Sentinel stroke national audit programme
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TDS	Thrice daily
TEXAS	Tranexamic acid in elective colorectal surgery
TIA	Transient ischaemic attack
TURBT	Transurethral resection of bladder tumour
UCR	Urgent Community Response

uDNACPR	Unified do not attempt cardiopulmonary resuscitation
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
UK	United Kingdom
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WGLL	What good looks like
WHO	World Health Organisation
WRES	Workforce Race Equality Standard
2d	Two dimensional

7. Contact details

Additional information about the Trust is available on the website:

www.sthk.nhs.uk

If you have any queries relating to this Quality Account please direct them to the following email: askann@sthk.nhs.uk.

Alternatively please contact the Executive Office on 0151 430 1371.

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (23)047

Title of paper: Trust Objectives 2022/23 – Review

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

Summary:

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

Rating	Number	Percentage (%)
Achieved	20	65%
Progress made but not fully achieved by 31st March 2023	11	35%
Not Achieved	0	0%

Where objectives have not been achieved this is as a result of operational pressures, including increased demand in some services and the impact of industrial action.

The objectives that have not been fully achieved are either rolled over or incorporated into the Trust objectives for 2023/24, that were approved by the Board in April.

Trust objective met or risk addressed: provides assurance that the Trust has made good progress in delivering the 2022/23 Trust objectives.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff, patients, and all stakeholders.

Recommendation(s): The Board notes the achievement of the 2022/23 Trust objectives

Presenting officer: Ann Marr, Chief Executive

Date of meeting: 31st May 2023.

2022/23 Trust Objectives – Full Year Review

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**					
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of hospital-acquired acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee	Monthly Nursing Care Indicators for compliance with red jugs in place has consistently been above 90% throughout the year, with average of 94.33%. In addition, the audits show 99.28% of all patients were identified as a risk of dehydration. Audit results discussed at the Trust Nutrition and Hydration Steering group. Local improvement plans at ward level. Nursing Care Indicators highlight that 75.57% compliance with the requirement for all sections of the fluid balance chart being completed, including input and output. The results are discussed at the Trust Nutrition and Hydration Steering group, with local improvement plans at ward level. Highlighted at Patient Experience Council and Senior Nursing weekly meeting as an area for continued focus, with planned engagement events with wards The number of Lab Test Acute Kidney Injury Triggers reduced each month from July 2022 to September 2022, a reduction of 12.9% July 2022 to August 2022 and 10.5% August 2022 to September 2022. There were increases for October (15.5%), November (6.8%) and December 2022 (8.1%), however, January 2023 and February 2023 are both showing reductions, 0.8% and 13.5% respectively. The latest individual month (December 2022) indicates a reduction in standardised mortality ratio (SMR) to 79.0 and the lowest since April 2022 (67.1). *Please note the observed deaths each month are low numbers. The latest 1, 3, 6 and 9 months (to December 2022) are all below 100 with the latest 12 months showing 107.3, indicating an improvement.*	
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	DoOp	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24 hour period • ~~Implement the new national ED standards to; see and treat~~	Quality Committee	For 2022-23 20.6% of patients were **triaged within 15 minutes**, with the following improvement initiatives in place to improve performance and maintain safety: • Two senior nurses allocated to triage on late shift at peak times • Triage improvement group has been established and overseeing move from Manchester Triage system to the emergency severity index which reduces the time required for triage without impacting on the quality of the triage. This will also support front door streaming	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		~~98% of patients within 12 hours and "clinically ready to proceed"~~ (target was not implemented) • Implement revised safety checklist documentation which includes National Early Warning Score (NEWS) and sepsis screening and undertake regular audits to demonstrate effective monitoring and appropriate escalation		• A health care assistant and medical support worker are assigned to the waiting room to undertake pre-triage observations and also to take bloods, if necessary, which reduces delays • An additional consultant is allocated to triage (when possible due to staffing levels) to support streaming and to see patients who require rapid head injury assessment/assessment of chest pain For 2022-23, the median time from arrival, to be seen by a clinician, was 123 minutes just slightly over the **target of 120**. This is a marked improvement from 140 minutes in 2021-22. Matron and Senior Quality Nurse complete weekly audits and report to the Patient Safety Council. The latest audit from Q2 noted 100% compliance with repeated observations for those scoring 0 on **NEWS** and 88% for those triggering, with 100% completion of repeat observations within one hour for those missing the initial deadline. ED achieved 87% Q2 2022-23 for **sepsis screening** (latest data available) and remains below the 90% target at 81% for treatment compliance. Actions are in place to improve compliance • ED staff are allocated to attend sepsis training • Sepsis training is provided on the ED preceptorship program • Sepsis is discussed in morning safety huddles to prioritise sepsis patients and administer antibiotics within the hour. • Monthly audits to be completed by senior quality nurse and fed through nursing highlight report to monitor compliance monthly Sepsis team to support the teams in department	
1.3. Increase capacity at the Trust and improve clinical adjacencies to optimise patient flow	DoOp/ DoCS	• Continue to progress the strategic site development plans for the Trust and the capital schemes planned for 2022/23 to improve patient facilities and increase capacity • Paediatric Emergency Department and Children's Observation Ward • Additional Theatre capacity at Whiston Hospital	Executive Committee	All planned schemes for the 2022/23 capital programme are progressing to plan, with the Paediatric ED and CHOBs schemes due for completion in spring 2023. The accommodation strategy is also progressing to plan and IT, HR, Lead Employer, Finance and Procurement have now moved to new offsite offices, vacating off site accommodation that was no longer fit for purpose and allowing decant space on site to facilitate the theatres scheme. The Community Diagnostic Centre at St Helens is operational and additional national funding has been secured to create further capacity.	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Implement the accommodation strategy to create space in the main hospital buildings for clinical services • Deliver increased diagnostic capacity in support of the elective recovery plans			
1. STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**					
2.1 Reduce avoidable harm by preventing falls (QA)	DoN	• Reduction in the number of inpatient falls per 1000 bed days by at least 10% compared to 2021/22 (stretch target remains less than 7.2 inpatient falls per 1000 bed days • 95% of patients to have a documented falls risk assessment within 6 hours of admission measured through quarterly audit of sample of patients • When falls do occur the subsequent investigation will identify the root cause so these can be monitored and analysed • Audit demonstrating that patients at risk of falling have a completed falls prevention care plan in place that has been reviewed as per hospital policy	Quality Committee	A reduction in total falls per 1000 bed days for 2022-23 to 7.29, decreasing from 8.67 in 2021-22. This demonstrates a 15.89% reduction in falls per 1,000 bed days compared to 2021-22 For 2022-23 88.8% of patients had falls risk assessment completed within 6 hours of admission on Tendable audit completed. 90% of patients audited in 2022-23 had a completed falls prevention care plan and appropriate interventions in place.	
2.2 Evaluate best practice and develop proposals for improving the Trust wide safety culture	DoN	• Commission an independent diagnostic and cultural survey to inform the development of the "Safe and Sound" strategy and action plan	Executive Committee	The Trust has worked with Aqua and clinical teams to develop a comprehensive Trust falls strategy, this has included observational reviews, focused education and training, review of falls plans and ward-based support. The rate of falls per 1000 bed days has reduced (see 2.1)	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Launch and publicise the agreed strategy and the ways that staff can contribute • Celebrate achievements and successes with regular bulletins and dissemination across all clinical and patient facing staff		PSIRF will replace the current Serious Incident Framework in September 2023 and the Trust is preparing for this change which will establish a comprehensive safety management system. A business case to support the implementation of PSIRF is being developed with S&O The DoN, Assistant, Clinical Directors of Safety and Assistant Director of Patient Safety have participated in the National Patient Safety Specialists programme A weekly patient safety panel has been established to take an overview of all the 72 hour harm reviews. This then feed into a monthly patient safety bulletin The Trust actively promotes a culture of open and honest reporting within a just culture framework. Data is validated against National Reporting and Learning System (NRLS) and NHS Digital figures. The latest data published (March 2022) shows the percentage of incidents that resulted in severe harm or death was 0.3%. The incidence per 1000 bed days in 2021-22 was 60.56% and for 2022-23 this has reduced to 50.39%. The Deteriorating patient programme goal was to improve pathways for patients who deteriorate in hospital and promotes: • Shared decision making by multi-disciplinary Care Teams ensuring right patient, right place, and right treatment first time. • Using technology to drive earlier detection of deteriorating patients by electronically alerting to the right team to assess, manage and stabilise. • Improved visibility of decisions and plans put in place with the development of electronic, standardised documentation accessed via the Trust clinical systems at any time by multiple users. • Trust and ward level centralised summary views to improve planning. • All staff involved in the care of the deteriorating patient empowered to make decisions and feel confident to escalate in line with clearly communicated protocols. • Advanced Care Planning, DNACPR and Ceilings of Treatment protocols fully embedded. • Access to all relevant systems to ensure information is available at the point of decision making	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
				• Standardised Proforma • Exploring the potential for collaborative working of the key deteriorating patient teams; Resuscitation / MET / Sepsis / AKI and formal links with other key teams such as palliative care, cardiorespiratory etc. A Patient safety week was held in March 2023 focusing on VTE, needlestick management, IPC, falls and NEWS	
2.3 Implement the recommendations of the Ockenden Report into the safety of Maternity Services	DoN	• Delivery of the year two action plan to implement the recommendations of the Ockenden Report • Achievement of the CNST maternity safety bundle for 2022/23	Quality Committee	Fully compliant with all the elements of Saving babies lives care bundle (SBL). Ockenden 1, one year review against compliance completed. Insight visit undertaken by the regional team on 15.08.22 to assess against the 7 immediate and essential actions (IEA) of Ockenden 1 and positive feedback was received. Ockenden 2 gap analysis completed and action plan in progress aligned to the further 15 overarching EIAs. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4 submission made on 05.01.23, declaring compliance.	
2. 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)	DoOp	• Continue to improve inpatient survey satisfaction rates for receiving discharge information • In regular audits achieve a minimum 75% of patients who receive the discharge from hospital booklet • Achievement of the 20% target for patients to be discharged before noon during the week and 85% by 5.00pm, consistently across all wards	Quality Committee	TTO - Turnaround time is 71% within two hours. A number of improvement actions have been put in place: • Ward-based dispensing has increased by 76% compared to 2019-20. This is almost exclusively related to TTOs. • Increase the number of satellite dispensaries • Pharmacy technicians actively transcribing discharge medication in advance of the planned discharge date. • The pharmacy technicians attend twice daily Medical Care Group meetings with the discharge co-ordinators, to allocate pharmacy staff to areas that need additional support to cope with the volume of TTOs needed. Of the questions in the inpatient survey relate to discharge experience, one of which was new. Two scores improved on the previous year, with 3 remaining the same. The Trust scored the highest national score for discussing with patients if they need any further health or social care services after leaving hospital, ranked second for patients knowing what	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Achievement of 85% of the weekday average discharges to be achieved at the weekends, consistently across all wards • Implementation of standardised patient equipment ordering process for aides required at home.		would happen next before leaving hospital and ranked third nationally for patients feeling they were receiving enough support from health and social care services and understanding care after leaving hospital. Discharges before noon - an average of 18.6% for the year, with 20% being achieved in three individual months, due in part to infection control risks where patients wait on wards and could not be supported in the communal discharge lounge. The weekend discharge target was not consistently achieved on all wards. An improved process for how therapies can order equipment has been implemented. This will be extended to all equipment by May 2023. Due to the multiple boroughs involved and various commissioners and budgets, it is not possible to implement a fully standardised process	
3.2 Implement the multidisciplinary Community Crisis Response Service for St Helens	DoOp	• Respond to 80% of calls within 2 hours by Quarter 3, increasing to 90% by April 2023 • Reduce ambulance conveyances to the ED • Reduce unnecessary emergency admissions to hospital	Finance and Performance Committee	In September 2022 we went live in St Helens with our integrated Urgent Community Response (UCR) service with St Helens Council. In Q3 the service had 1003 referrals of which 91% were cared for at home without the need for a hospital attendance. In Q4 the service had 971 referrals of which 90%- were cared for at home and did not need to go to hospital. In the majority of cases these patients would otherwise have been admitted to hospital by ambulance. In Q3 and Q4 80% of patients were responded to within 2 hours. Funding has recently been confirmed to support the expansion of this service to deliver Frailty Virtual Wards which will increase the capacity and breadth of offer that can be provided by the UCR team.	
3.3 Improve acute care pathways to ensure optimal configuration of services	DoOp	Agree the optimal configuration of surgery, medical specialities and paediatrics within the Trust to; • Reduced number of patient ward moves • Reduced number of FCEs • Implement direct to specialty pathways	Executive Committee	Bed modelling exercise undertaken. Ongoing work to ensure specialty bed bases are right sized, to include appropriate work force. Direct to specialty pathways in place for Medicine, Surgery, Paediatrics, Frailty as well as other specialist pathways including Plastics Trauma. The Trust has worked to reduce the number of finished FCE and the number of ward moves. Within an extremely challenged environment these have remained on the right trajectory. The continued work between the Trust, NWAS, 111, Primary care and community services, supported by the ED MDT hub initiative, has	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Improve patient satisfaction and experience ratings		resulted in an increasing number of patients being directed to the most appropriate service. See also statements and progress update provided on In Patient survey reported under 3.1	
3.4 Continue to redesign outpatient pathways through transformation and modernisation	DoI/DoOp	• Introduce an electronic room-booking service, so that the capacity in the outpatient departments are optimised to accommodate additional clinics • Reduce DNAs by enabling patients to choose their preferred method of communication for appointments and appointment reminders • Implement electronic requesting for clinicians in outpatient settings e.g., prescribing, request for follow up appointments, diagnostic tests • Reduce the number of cancelled and rearranged appointments by 20% by revising the current clinic structures and piloting shortened booking horizons	Executive Committee	Interim solution in place for main outpatients to facilitate improved room management Procurement for an off-the shelf solution underway in collaboration with S&O Patients are now being asked for their preferred method of communication for appointments and appointment remainders in advance of rolling out Careflow letters, which is scheduled to start in April 2023. Electronic requesting is available in outpatient areas for prescribing and for placing diagnostic orders. Histology, Cardiorespiratory and Urology specialised ordering has recently been deployed. The most recent figures show that 89% of orders are being made electronically. Data collation to facilitate clinic reconfiguration is underway with a number of small specialties. Therapies due to go live shortly.	
3. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1 Improve communications for relatives who need to contact our wards	DoN/DoI	• Develop innovative solutions to enable relatives to be able to contact the clinical team on each ward and be regularly updated about their loved ne • Reduce PALs contacts and complaints relating to communication with wards	Quality Committee	A small group of wards with a higher rate of unanswered calls have formed a task and finish group with the informatics team. Innovative options for contacting wards are being piloted. To date these have included the formation of bespoke “hunt groups”, advice for families and	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Reduce the number of abandoned calls to wards		pre-recorded message. These tests of change will be mapped against ongoing monthly performance. The number of complaints and PALS concerns relating to communication with relatives has decreased to 270 in 2022-23 compared to 630 in 2021/22 32% decrease in number of calls not answered from external numbers in 2022-23 compared to 2021/22	
4.2 Introduction of digital letters and "real time chat" alongside telehealth appointments to support patients in having a choice about how they communicate with the Trust	DoI	• Digital letters that meet the accessibility standards and can easily be shared with other carers or relatives • Improved digital information supported by "messaging" to enable patients to ask questions about their care or condition directly and easily with the clinical team looking after them	Executive Committee	The trust has contracted with a 3rd party print and mail provider who can facilitate digital outpatient appointment letters that meet the accessibility standards. Careflow letters meet the accessibility standards and are scheduled to be rolled out starting with a pilot in Q1/2 2023/24. Messaging capability to be provided as part of the new patient portal and virtual appointment solutions which will be procured by September 2023 A business case for a new Telehealth solution which will also deliver a chat function will be submitted for approval in September 2023.	
4.3 Improve internal processes and communication systems with patients and relatives about patient property	DoN	• Reduction in incidents relating to lost patient property • Reduction in PALs contacts and formal complaints received about patient property	Quality Committee	The number of incidents* on Datix relating to lost property has decreased to 19 in 2022/23 from 20 in 2021/22 *[*Incidents reported where the lost items were subsequently located have not been included in the numbers*] The number of PALS concerns and complaints relating to lost property was 59 in 2022/23 compared to 116 in 2021/22	
4. 5 STAR PATIENT CARE – Systems We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes					
5.1 Deliver the 2022/23 Digital Strategy Objectives and achieve HIMSS Level 5 or greater by Autumn 2023	DoI	• Reduce the amount of paper in nursing and therapies documentation produced, as part of the paper based medical record by 90% • Reduce the amount of paper in medical documentation by	Executive Committee	90% of Nursing and AHP paper documentation digitised. All inpatient wards are now live. Medical documentation has been reduced by 20% to date. On track to achieve 50+% by Winter 2023 Careflow Connect business continuity solution displays patient allergies from the EPR problem/diagnostic lists. The electronic prescribing business continuity solution provides medication information. Lab results	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		50%, aided by in-built clinical decision support • During Careflow downtime ensure clinicians have access to patient allergies, problem/diagnostic lists, medications and lab results		available in Telepath and ICE systems in the event of a Careflow downtime. Complete	
5.2 Implement and electronic bed management and discharge planning system across inpatient wards at Whiston Hospital.	DoI	• Help ensure that the sickest patients are seen soonest by the use of Early Warning Scores (EWS). These are available via the clinical modules within Careflow EPR, specifically Vitals on desktops and handheld devices, Careflow Connect, and Patient Flow, which displays the EWS in a colour coded format. • Roll out electronic whiteboards across Whiston Hospital wards • Improve access to patient information by the implementation and roll out of Workspace and Narrative digital clinical documentation • Reduction in patient LOS by supporting achievement of the national discharge targets • Patient information to be entered electronically only once and used many times.	Executive Committee	Informatics have been working with the Deteriorating Patient Team to improve Vitals compliance by supporting and retraining staff. The desktop version of Patient Flow shows the latest EWS score. Breached observations have reduced from 27.6% in April '22 to 18.2% in February '23. This is within the 20% target set for March '23, and on the way to achieving the 15% target set for September '23. The desktop version of Patient Flow has been deployed to all wards and includes indicators on risk assessment compliance. Touch screen whiteboards are being installed at every nursing station on inpatient wards. Medical wards have been completed, and surgical wards scheduled to be completed during summer 2023. Workspace has been deployed across the organisation. Narrative will be implemented in May/June 2023 The new clinical notes have been designed to record information once and once only. The About Me – SHADL digital form is a good example of one form where information is entered once and used multiple times by Nurses, Medics, AHPs, Discharge Coordinators, Specialist Nurses etc.	
5.3 Implement new Community Electronic Patient Record (EPR) solution	DoI/DoOp	• To improve the management of patients in the community	Executive Committee	66% of community services are live on the new Community EPR solution. The remaining services are scheduled to be on the system by July 2023.	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Reducing the amount of paper that clinicians have to complete, releasing more time to care • Improving the ability to share information in real time with primary and secondary care colleagues. Supporting joined up care.		GP's can now see urgent care records	
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**					
People Plan Pillars – Looking After our People					
6.1 Enhance health and wellbeing support services for staff and promote attendance	DoHR	• Comply with NICE guidance and the NHS People Plan and provide an extended range of support services to improve the health, well-being, and resilience of our staff, including supporting staff who have been impacted by the COVID-19 pandemic • Implement a new person-centred well-being and attendance management policy framework that supports staff to return to work • Develop a leadership development training programme that supports managers deliver the new approach •	Strategic People Committee	The Wellbeing Hub continues to grow from strength to straight with over 120 champions, offering a comprehensive range of services to support staff and managers with their health and wellbeing needs, which includes support for staff impacted by the Covid-19 pandemic. Additional bespoke sessions and events have been created specially in response to cost-of-living crisis, Winter Wellbeing, and Menopause Network. The national and local healthcare worker Covid-19 autumn booster vaccination campaign resulted in a final reportable figure of 42.66% uptake. This is slightly below the national average figure of 47%. The Influenza seasonal vaccination achieved 74% uptake. Wellbeing conversations continue to be offered and form an integral part of the annual staff appraisal process. Wellbeing conversations are also promoted and delivered within the wellbeing hub and network service delivery model, supporting managers with tool kit and resources that under pin healthy leadership practices. The Stress and Wellbeing, and Menopause Policies were approved and launched in 2022 supporting staff and managers in best practice when managing the health and wellbeing of the workforce. The HWWB service now plays an integral role within the leadership and management induction programme by engaging on health and wellbeing services and support, to equip managers in future when supporting staff. The HWWB service played a vital role in supporting STHK to achieve the best in the Northwest and Cheshire and Merseyside for the 2022 staff	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
				survey results, with particular focus on the NHSE People Promise theme ''We are Safe and Healthy''.	
People Plan Pillars - Belonging to the NHS					
6.2 Continue to listen to our staff to ensure we remain an employer of choice	DoHR	• Agree the priority actions from the 2021 staff survey and deliver them in 2022/23	Executive Committee	Staff survey results released and presented to staff. Results dashboard completed and shared across all staff groups. Action plan continually updated and reports to Board, People Council and Strategic People Committee completed. Areas of focus for 2023/24 include a) addressing issues of safer staffing, acting on staff and patient feedback, career progression, development and appraisal and b) in Equality, Diversity & Inclusion, addressing concerns raised over access to flexible working opportunities, discrimination from patients. There are also service specific themes being picked up through the delivery of focussed OD work with specific services/departments.	
6.3. Improve the methods of delivery and ease of access of mandatory training to increase compliance rate recovery	DoHR	• Achieve the COVID-19 recovery improvement trajectory of 85% compliance with mandatory training across all staff groups • Continue to innovate with the subject matter experts to create alternative delivery methods to support staff access to mandatory training	Strategic People Committee	Mandatory training remains slightly below target at 82% compliance. Overall compliance remains a priority, particularly in Fire Safety and the medical workforce. Targeted action being undertaken supported by L&OD. Mandatory training compliance is monitored through the Executive Committee & Quality Committee monthly. Development and deployment of e-learning packages continue into 2023/23 An e-learning developer in now in post and supporting development of bespoke e-learning materials such as the development and deployment of e learning package for Safeguarding Level 2 which replaces workbooks, and widening of access to completion of e-learning through use of ESR/OLM alongside Moodle as an e learning platform	
6.4 Respond to feedback from staff to improve appraisals and appraisal compliance to support staff to deliver high quality patient care.	DoHR	• Continue to embed the new Trust appraisals process and evaluate the impact with staff	Strategic People Committee	Following feedback from staff a new online appraisal and personal development system to support staff in their development and career planning throughout the year has been implemented. Overall staff are finding the new process very positive. Some of the feedback was “It’s spot on! Makes sense, simple format, straight forward, a lot quicker to prepare and compete encouraging and engaging.”. “Clear easy to use. Looks good.” “Definitely a big tick from me, much more concise.” Automated process for recording of appraisal introduced for 23/24 window following further feedback from staff	
People Plan Pillar – New Ways of Working					

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
6.5 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimal design of the workforce and the right number and skill mix of staff	DoHR	• Undertake a benefits realisation review for e-rostering and e–job planning to improve levels of compliance • Improve the management and governance processes that support e-rostering and reduce errors • Restart the specialist nursing job planning project with the aim of having 50% of this staff group with refreshed job descriptions • With the Director of Nursing review opportunities for the development and deployment of the band 2-6 nursing workforce to ensure effective use of resources aligned to patient acuity and the delivery of safe and effective care.	Executive Committee	Benefits realisation from e-rostering solutions and sharing of best practice is now being delivered through the Better Rostering Steering Group The group continues to review roster data and KPIs and have seen an improvement in Filled Duty count and Unfilled Duty Hours. Work continues to improve roster approval times. Safe care census periods have been aligned to the long day hours and will provide the correct compliance. The Long Day Shift Review has been concluded and shifts are now built into rosters. Reporting has now been aligned and Safe care is reported to be operating correctly. Work continues to roster outstanding areas. Final teams (Histopathology, Haematology, Blood Transfusion, Mortuary, and Chemical Pathology). are being approached and supported to ensure they are rostered from May 2023. Roster KPI's are reported on monthly at local roster utilisation groups, roster oversight group and People council and include safe care. The Specialist nursing job planning project has not been completed in 2022/23. In collaboration with Southport and Ormskirk Hospital NHS Trust the specialist nursing job planning project will re-commence in Q2 of 2023/24 to re-establish the job planning cycle with a focus on standardised frameworks and job descriptions. The review of opportunities for the band 2-5 nursing workforce has not been completed in 2022/23. Work will continue into 2023/24 with the support of Service Improvement and the Information Team. Delivery of action is ongoing and monitored through the Workforce Development Operational Plan	
People Plan Pillar – Growing for the Future					
6.6 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Recruit 180 additional new permanent nurses • Recruit 80 of the new nurses and 20 medical and dental staff via international recruitment programmes • In partnership with the Medical Director and Director of Nursing, Midwifery & Governance develop	Strategic People Committee	In 2022/23 120 externally recruited band 5 to 7 registered nurses and 119 student nurses have commenced with STHK. 100 international nurses have now been appointed by April 2023. 52 international medics have been recruited since April 202A further 50 international nurses will be joining STHK between April 2023 and November 2023. Planning for 2023/24 intakes is underway. ACP funding bid successful - 14 ACPs to commence training in September 2023. Review of programme underway alongside the current clinical model review to ensure appropriate budgetary support is in place	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		workforce development plans to achieve a strong pipeline of new clinical roles including 15 TNAs, 6 ACPs and 6 PAs • Support registered nurses to adopt a flexible approach to working, offering all those eligible retire and return conversation • Increase the Healthcare Support Worker use of the internal transfer scheme by 10% and improve staff retention rates for this group of staff by 15% through meeting career aspirations and development opportunities within the Trust • Create opportunities for people who are “new to care” offering the care certificate and apprenticeship programmes • Support more staff to undertake further training in Advanced Clinical Practice and Leadership Development, utilising the apprenticeship levy		Two Trainee Anaesthetic Associates (AA’s) started in post in March 2023. Further work required in the organisation to identify some "early adopter" areas to implement PAs in in 2023/24. Staff retention remains a focus. Retire and Return conversations continue to be held by all Matrons and Directorate Managers and are having an impact – between in 2022/23 12 RN’s retired and of them, 5 returned. Programme of work around flexible working for nurses will continue into 2023/24. 123 HCA leavers in 2021-22, 87 in 2022-23 - reduction of 19%. There has been significant progress made to support Healthcare Support Workers. There has been a 19% reduction of leavers in 2022/23, and a significant uptake in the Internal Transfer Scheme amongst this staff group (12 in 2022/23 compared to 5 in 2021/22). The induction, training, and development pathway for new to care HCSWs “The Healthcare Academy” has been reviewed and amended in collaboration with HR and Nursing colleagues. The revised onboarding and training process has made a high impact on the retention and experience of HCAs. All HCAs are now tracked during completion of the Care Certificate. Delivery of the Talent Management and Leadership Development Strategy is ongoing, STHK is awaiting further guidance on Scope for Growth and continues to be represented on the Regional Scope for Growth Community of Practice to understand what implementation will look like in 2023/24	
7 OPERATIONAL PERFORMANCE - We will meet and sustain national and local performance standards					
7.1 Deliver the elective recovery activity targets to reduce waiting lists	DoOp	• Deliver at least 104% of 2019/20 elective activity levels • By July 2022 no one to have waited longer than two years	Finance and Performance Committee	When adjusted for working days, delivery of elective activity at the end of March was 101.7% when compared to 2019/20 levels This activity was delivered within an extremely challenging operating environment of delayed discharges, congested wards, heightened attendances and acuity and prolonged episodes of Industrial Action in Q4.	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Eliminate waits of over 18 months by April 2023 • Provide mutual aid in specific specialities to support the delivery of system recovery targets •		The trust was able to eliminate all 104+ week waits by the national deadline, when recognising nationally agreed exceptions such as patient choice. By the end of March, the Trust cleared all but 52 of the 78+ week waits, with 30 of these patients being clinically complex (not suitable for mutual aid) and 11 deferring by choice. Work is ongoing to reduce waits to 74 weeks by the end of Q1 2023/24 in line with national targets. Regional mutual aid and independent sector capacity was actively used to maximise opportunities for all C&M patients and STHK also transferred elective orthopaedic joint replacements (with full operating teams) to Ormskirk Hospital for a 6-week period during the height of the winter pressures. Mutual aid for skin, colorectal and urological cancer was provided to the wider region during COVID-19. Further requests for mutual aid are now provided on an individual, case by case basis due to capacity constraints. We continue to assist S&O with pressures in Ophthalmology	
7.2 Implement recovery plans to consistently achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including the new 12 hour see and treat targets • 62-day cancer treatment standard • Diagnostic tests completed within 6 weeks • Ambulance handover times (under 30 minutes) • Working with system partners reduce the % of medically optimised patients with delayed discharges	Finance and Performance Committee	Delivery against this objective continues to be challenging within a congested operating environment, of delayed discharge, high bed occupancy and increased admissions and acuity. 12-Hour from arrival performance 10.25% of patients have waited longer than 12 hours (M 6-12). Which is an increase on H1 which stood at 8.7%. This reflects the increasing pressure in the organisation and across the system through the second half of the year. 62 day cancer standard 78.9% YTD against a target of 85%. This is the best performance of an acute trust in C&M. Diagnostic tests completed within 6 weeks 68.8% YTD against a target of 99%. Ambulance handover times Q4 average for ambulance turnaround time was 37 minutes. Delayed discharges Discharge trajectories have been set per PLACE, with the PLACE Directors being accountable for delivery. In accordance with the ambition to achieve 92% bed occupancy, system plans have now been agreed,	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
				which are set to improve the current position, with further work required at achieve the target. The average daily number of super stranded patient in March was 127, which is an improvement on the previously reported position of 153.	
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g. GiRFT to ensure that all services meet best practice standards	DoOp	• Continued participation in national programme of GiRFT and other reviews and delivery of the resulting action plans • Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery and sustainability of the changes	Finance and Performance Committee	The Trust continues to actively participate in the GiRFT programme, with specialties engaging with the relevant webinars	
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**					
8.1 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaboration at scale to increase efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration at scale with system partners	Executive Committee	The Trust has committed to and is signed up to - Cheshire and Merseyside Acute and Specialist Trust Collaborative (CMAST). The CEO of the Trust Chairs the Collaborative and the Trust hosts its Managing Director. The Trust also signed up to the Joint Working Agreement and established a Committees in Common approach to decision making, in October 2022. CMAST is re-establishing the Collaboration at Scale programme to be led by a CMAST CEO and sponsored by the ICB. STHK is a contributor to all ICS / ICB financial discussions and leads the ICS wide finance ledger programme which reports to the CAS Board. We also host networks for the system which drive pathway innovation, efficiency, and enhanced performance. DOFs, through CMAST, have also agreed to procure once where this fits with strategy to deliver and achieve efficiencies – Imaging being a recent example.	
8.2 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	□ Achieve the approved financial plan for 2022/23 □ Delivery of the agreed Cost Improvement Programme	Finance and Performance Committee	The Trust agreed a final 22/23 financial plan at a deficit of £4.9m in June 2022. The plan included a CIP target of £28.1m (5%) including non-recurrent savings. The Trust finished the financial year with a £7.1m surplus.	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
		• Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.		The financial position includes non-recurrent benefits offsetting the non-achievement of national ERF, non-pay inflation pressures (excluding energy & PFI) and the pay award impact over and above funded levels. The Trust's final CIP target is £28.1m to a profile agreed with the ICS. The Trust delivered the full CIP target in line with agreed plans, with £22.1m recurrently and £6m non recurrently. The Trust finished the financial year with cash balances of £25.5m which exceeds 1.5 working days. Aged debt at the end of the year was £10.5m which equates to 0.9% of cash income. Capital – The Trust delivered the full capital programme in year of £26m, which included £18m of PDC funded schemes.	
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve system success	DoCS	• Meet statutory and regulatory responsibilities • Implement the new performance and accountability frameworks when the ICBs are created in July 2022. •	Trust Board	No regulatory action has been taken against the Trust and it remains at SOF 2 for monitoring. Fully complied with new ICB performance monitoring and accountability framework, as it evolves.	
9.2 Working with health and care system partners implement Place Based Partnerships to improve the health of the local population	DoInt	• Support our local boroughs to establish Place Based Partnership Boards (PBPBs) • Position the Trust as a key partner and anchor institution in each Place	Trust Board	The ICB hold regular review meetings: St Helens Place Partnership continues to be held as an exemplar for C&M. The Trust supports St Helens, Halton and Knowsley at their quarterly Place reviews are also taking place in November/December. The Trust has co-ordinated several Mid Mersey Place meetings with Halton, Knowsley and St Helens to explore joint working for hospital discharge, hospital avoidance, neuro diversity pathway and workforce development. STHK gained accreditation for the Social Value Award in July 2022 and is currently pursuing the Prevention Pledge which focuses on reducing inequalities.	

	Lead Director	Measurement	Governance Route	Mid-Year Progress	RAG
9.3 Provide leadership and direction as part of the C&M ICB to achieve clinically and financially sustainable acute provider services.	EO	• Develop areas for collaboration that bring benefits for patients and partner organisations • Support the development of effective Provider Collaboratives that enhance collaboration and integration of acute services and coordinates the delivery of the elective recovery plans to maximise the capacity available to the system	Trust Board	CMAST governance and shared decision framework has been agreed by all partner trusts. CMAST lead is a member of the C&M ICB CMAST continues to coordinate elective recovery plans and respond to the UEC challenges, brokering mutual aid where appropriate and ensuring optimisation of available capacity and targeted investment to increase capacity for specific areas that are under pressure.	
9.4 Progress the Agreement for Long Term Collaboration (ALTC) with Southport and Ormskirk Hospital NHS Trust	All	• Continue to provide management support to S&O • Continue to develop plans to address the fragile clinical services working with clinicians across both Trusts and other providers as necessary • Develop a plan, with the Shaping Care Together programme that will deliver sustainable clinical services	Trust Board	Transaction application process completed, and transaction approved by NHSE to proceed. The ALTC has operated successfully during 2022/23 with S&O performance improving and new investment secured to tackle backlog maintenance, elective capacity, and IT infrastructure Discussions continue with the ICBs in relation to the development of strategic service reconfiguration options (that will be subject to public consultation)	

END

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)048

Title of paper: Learning from Deaths Quarterly Report May 2023

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

Number of reviews carried out Q1 / 2 2022/23 *

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
	192 **(101)**	65	20	4	2	0

Number of reviews carried out Q3 2022/23

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
October*	31 **(20)**	10	1	0	0	0
November	30	17	6	6	0	0
December	39 **(9)**	16	9	4	1	0

Number of reviews carried out Q4 2022/23

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
January	37 **(19)**	11	8	2	2	1

* delayed reporting subject to an alternative process to assist in retrospective catch up
Corporate objectives met or risks addressed: 5 Star patient care: Care, Safety, Communication
Financial implications: None arising from this report
Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners
Recommendation(s): To approve the report, policy and good practice guide
Presenting officer: Dr Peter Williams – Medical Director
Date of meeting: 25th January 2023

1 EXECUTIVE SUMMARY

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

In Quarter 1 & 2 2022/23

During this quarter there was a backlog in cases where reporting was delayed. This was managed using a new process where the reviewed abbreviates the review in straightforward cases but carries out a full SJR in any cases where there are any concerns. The abbreviated process remains comprehensive enough to identify learning points or concerns. A further 48 have been completed since the last report.

To date 91 cases have been reported: 65 with green outcome, 20 green with learning, 4 green with positive learning and 2 with amber outcome.

In Quarter 3 2022/23

Although October was also subject to delayed reporting as above, November and December are fully allocated to reviewers and heading back on track.

To date the combined quarter has 100 cases reported, 41 are green, 14 green with learning, 9 green with positive learning and 1 amber outcome.

In Quarter 4 2022/23

January's cases have been allocated. To date 37 have been reported of which 11 are green, 8 green with learning, 2 green with positive learning, 2 cases have an amber outcome and 1 case is red (These are subject to further MDT review at Mortality Surveillance Group.

1.1. Shared learning

Observations compliance with increasing NEWS score	**Escalation in the Deteriorating Patient**
Use of NEWS2 and clinical observation in identifying patient deterioration at the earliest opportunity requires compliance with the NEWS2/eVitals policy ensuring observations are updated at the stated intervals.	Increasing NEWS2 scores or other evidence of deterioration need timely escalation via parent or ward team / MET / cardiac arrest team according to need with documentation in the notes on each occasion.

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

1.2 Sharing and embedding learning

This learning points from mortality reviews are shared & evidenced in meeting minutes as per the matrix in appendix 2.

2. ANALYSIS

2.1.1 Total number of reviews completed for Q1 &2 2022/23

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
April – September 2022	192 (101)	65	20	4	2	0

2.1.2 Total number of reviews completed for Q3 2022/23

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
October	31 (20)	10	1	0	0	0
November	30 (0)	17	6	6	0	0
December	39 (9)	16	9	4	1	0

2.1.3

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
January	37 (19)	11	8	2	2	1

2.4 Assurance in safety of Learning from Deaths process

The new SJR process is now fully established with all reviewers. The table below shows a comparison with a three-month period last year with initial SJR Ratings (rating given prior to discussion and further review). This comparison provides us with assurance on the sensitivity of the new process to identify new concerns. Further assurance will be provided through an audit of a random sample of cases which were reviewed using the new process which to date has not revealed any concerns which were not highlighted in the initial review.

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
AMBER	1	3	1	0	1	0	1	1	1	0	0	0	9
RED	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	1	3	1	0	1	1	1	1	1	0	0	0	10

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Total
AMBER	1	1	0	1	0	0	0	0	1	2	6
RED	0	0	0	0	0	0	0	0	1	1	2
Total	1	1	0	1	0	0	0	0	2	3	8

2.5 Delayed reporting

Actions are to be undertaken to address the concerns raised with delayed reporting. A smaller team of experienced reviewers are undertaking an abbreviated review of care with less documentation in the SJR template. However, if concern is identified at any point, this case is then transferred for the usual review process.

So far 121 cases have been reviewed in this way, with 6 transferred for further review (SJR outcomes: 3 GREEN, 2 GWL, 1 AMBER).

3 CONCLUSION AND RECOMMENDATIONS

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

- Learning from Deaths is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised. (Appendix 2)
- Where concerns have been identified these have received further peer review and escalated as appropriate.
- The backlog of cases that resulted over Q1&2 2022/23 are being addressed by a robust process with assurance that concerns when present are being identified.
- The new SJR process has now been distributed to all reviewers, initial assurance has been provided that concerns are detected and reported. We will continue to monitor its reliability and provide the appropriate assurance once we have 12 months of data (April 2024).

Appendix 1

Total Deaths in Scope[1]

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

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

Appendix 2

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

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (23)049
Title of paper: In-depth review of the complaints process and the proposed developments to improve complaint responses.
Purpose: The purpose of this paper is to provide Trust Board with the outcome of the in-depth review of the complaints process and the proposed developments to improve complaint responses.
Summary: At the request of the Trust board an in-depth review of the complaints process was undertaken with the aim to reduce the timeframe of formal written responses. The Trust has currently been working to 100 days' time frame and achieved 77% compliance in terms of timescale in the last financial year. The 100 working day target was commenced on 1 August 2022, as part of the Trust's efforts to return to timescales that closer to our pre-Covid targets of 30 and 60 working days. The intention is to move back to 60 working days from 1st July 2023. The report highlights the actions agreed at the Complaints Summit on 10 May 2023 .to improve the timeliness and quality of complaint responses and provides on overview of this will be monitored.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners,
Recommendation(s): Members are asked to review and approve the actions in place
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 31st May 2023

Introduction

The Trust is committed to ensuring all patients and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate, and compassionate response. Compliments, concerns, and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services. This report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO).

At the request of the Trust board an in-depth review of the complaints process was undertaken with the aim to reduce the timeframe of formal written response.

The Trust has currently been working to 100 days' time frame and achieved 77% compliance in terms of timescale in the last financial year. The 100 working day target was commenced on 1 August 2022, as part of the Trust's efforts to return to timescales that closer to our pre-Covid targets of 30 and 60 working days. The intention is to move back to 60 working days from 1st July 2023, recognising that there will be 2 timeframes in place for a period of time (up to November until the current 100-day time frame ends) however, the aim is to complete the outstanding 100-day response by end of September unless very complex. S&0 timeframe is 40 days, going forward we will need a single agreed target for consistency

Complaint Summit

The Complaints summit was held on 10Th May with MDT representation from all the care groups. The focus was on how we ensure the complainant receives a high quality response to support the philosophy of " Getting it Right First Time" with regards to the complaint investigation and the quality of the responses received but to also understand the challenges to achieving this and agreement of the action to make sustained improvements. The aim of this session to review and streamline the process, propose changes, local resolution, look at resources, and agree training requirements and assistance

Challenges

The challenges identified that were influencing the ability to meet the existing and upcoming targets related to statements, drafts, quality checking, and sign off. On reflection several complaints have needed numerous versions and corrections, some of which on occasions were not corrected at QC stage. This is unnecessary use of people's time, duplication of work, results in delays and is a poor experience for the complainant.

Proposed and agreed actions

- Local resolution and formal complaints are a key priority, - An email has been circulated to inform medical. nursing and operational team that the target time for compliant responses is changing with effect from 1st July 2023.
- Complaint responses are to be prioritised, with the focus of getting it right the first time. i.e., answer the question, offer an apology, demonstrate compassion and empathy, ensure factually accurate and that the response is written plain language that is easy to understand.

- Further Masterclass training for those directly involved in investigating concerns and complaints: matrons, ward managers, directorate manager and heads of dept. This will include investigation, statement writing and quality checking (8th June 2023)
- 1 page guidance has been produced to support writing statements, writing complaints responses and quality checking (Appendix 1)
- There are 2 different systems in place for addressing complaints which need to be aligned. A review of resources to be undertaken in Surgical Care Group and Community to reflect the support provided to Medical Care Group process. Identified that the complaints coordinator in SCG is on long term sick, the role as been supported by ADM however, admin support is required to review complaints, extract key questions, and chase responses, this is the same for Community services (ADOs to address Immediately)
- MCG -The final QC before submission to Exec is reliant on 2 individuals this needs to be a shared responsibility within the MCG senior teams (Rota now in place)
- Matrons to provide cross cover when on leave for their statement QCs which will improve the response time.
- Weekly review of complaints to review progress to be undertaken in care groups and delays to escalated to HoN&Q for immediate actioning (similar to DTL process)
- Statements must be returned within 7 days, 3 days for QC by matrons
- The flow chart included in the Complaints policy, outlining timeframes for each part of the complaint process has been circulated with revised timings
- Reports by the Business Intelligence team will be circulated 3x weekly to highlight complaint time frames and those outstanding
- No extension to 60-day timeframe will be permitted unless under extreme circumstance and approved by Exec
- Complaint response times is now included in monthly IPR for monitoring
- Care Groups will maintain a log of completed and outstanding actions and monitoring their progress against these through their Quality Governance Forums and report this to the complaint group meetings monthly.
- Actions plans related to the complaint will be uploaded to Datix, evidence of actions to reviewed until completed as part of ongoing review.
- A review of the trends arising from complaints will continue to be presented quarterly to ensure all relevant improvements are identified and acted upon.
- identifying and sharing any learning arising from complaints which may benefit other services will be shared across the organisation via the Lessons Learnt forum, Quality Team, and Ward meetings.

Ends

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Review of complaints process