Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 31 January 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (December 2023 and January 2024)** *Purpose: To **note** the Employee of the Month presentations for December 2023 and January 2024*	Verbal	Chair *(15 mins)*
10.15	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Verbal	Chair *(15 mins)*
10.30	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**MWL TB24/003 Minutes of the previous meeting** 5.1. 29 November 2023 5.2. 23 January 2024 (Extraordinary Board) *Purpose: To **approve** the minutes of the meetings held on 29 November 2023 and 23 January 2024*	Report	
	6.	**MWL TB24/004 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.40	7.	**MWL TB24/005 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators	Report	 S Redfern

		7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*		R Cooper obo L Neary A-M Stretch G Lawrence *(30 mins)*
Committee Assurance Report				
11:10	8.	**MLW TB24/006 – Committee Assurance Reports** 8.1. Executive Committee *8.2.* Charitable Funds Committee 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*	Report	 A Marr G Appleton G Brown G Appleton obo L Knight G Appleton *(30 mins)*
Other Board Reports				
11.40	9.	**MWL TB24/007 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register for assurance*	Report	N Bunce *(10 mins)*
11.50	10.	**MWL TB24/008 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
12.00	11.	**MWL TB24/009 Aggregated Incidents, Complaints and Claims Report** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for assurance*	Report	S Redfern *(15 mins)*
12.15	12.	**MWL TB24/010 Learning from Deaths Quarterly Report (Quarter 2)** 12.1. STHK sites 12.2. S&O sites *Purpose: To **note** the Learning from Deaths Quarterly Report for assurance*	Report	P Williams *(10 mins)*
12.25	13.	**MWL TB24/011 Freedom to Speak Up** 13.1. MWL Self-Assessment *Purpose: To **approve** the MWL Freedom to Speak Up Self-Assessment*	Report	S Redfern *(15 mins)*

Concluding Business				
12.40	14.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
12.45	15.	**Any Other Business** *Purpose: To* ***note*** *any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 28 February 2024 at 09:30		**13.00 close**

15 minutes lunch break

Chair: Richard Fraser

The Title of Meeting	**Trust Board**			**Date**	31 January 2024
Agenda Item	**MWL TB24/000**				
Report Title	Patient Story, Dementia and Delirium Team				
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance				
Presenting Officer	Michelle Kitson, Matron Patient Experience				
Action Required		**To Approve**	X	**To Note**	

Purpose

The patient story is to highlight the positive impact of the Dementia and Delirium team at Southport and Ormskirk Hospital sites, with specific reference to the patient and carer experience.

Executive Summary

The patient story demonstrates the positive impact of the Dementia and Delirium team on the patient and their family who live abroad.

The story acknowledges the challenges of being involved in a loved one's care whilst living abroad and the difficulties that have been previously encountered with regards to communicating with the NHS when living so far away.

The positive involvement of the Demetia and Delirium team is highlighted with specific regard to supporting patients and family members when making important life changing decisions.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to note the content of the patient story and the positive impact of the Dementia and Delirium team on the patient and carer experience.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Held at Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 29 November 2023
(Approved by the Trust Board on Wednesday 31 January 2024)

Name	Initials	Title
Richard Fraser	RF	Chair
Ann Marr	AM	Chief Executive Officer
Anne-Marie Stretch	AMS	Deputy Chief Executive Officer & Director of Human Resources
Geoffrey Appleton	GA	Non-Executive Director & Deputy Chair
Gill Brown	GB	Non-Executive Director
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director
Rob Cooper	RC	Managing Director
Paul Growney	PG	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Jeff Kozer	JK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Sue Redfern	SR	Director of Nursing, Midwifery and Governance
Hazel Scott	HS	University Non-Executive Director (via MS Teams)
Rani Thind	RT	Associate Non-Executive Director
Christine Walters	CW	Director of Informatics
Peter Williams	PW	Medical Director (via Teams)

In Attendance

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative)
Lynne Barnes	LB	Director of Nursing, Salford, Salford Care Alliance, Northern Care Alliance NHS Foundation Trust (observer) (via MS Teams)
Darren Buckley	DB	Regional Director, Siemens Healthineers (observer) (via MS Teams)
Lynda Clarke	LC	Bereavement Coordinator (Agenda Item 2) (via MS Teams)
Christine Kelly	KC	Deputy Director of Informatics, Mid Mersey Digital Alliance (observer) (via MS Teams)
Yvonne Mahambrey	YM	Quality Matron, Patient Experience (Agenda Item 2) (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)

Apologies

Name	Initials	Title
Richard Weeks	RW	Corporate Governance Manager

Agenda Item	Description
Preliminary Business	

1. Employee of the Month

1.1. The Employee of the Month for November 2023 was Clare Andrew, Movement Disorder Specialist Practitioner, Whiston Hospital, and the Board watched the film of RC reading the citation and presenting the award to Clare.

RESOLVED:
The Board **noted** Employee of the Month film for November 2023 and congratulated the winner.

2. Patient Story

2.1. RF welcomed YM and LC to the meeting.

2.2. YM presented the patient story video, which focused on Ian and Sue's story about the end-of-life care that Ian received whilst he was an inpatient within the Medical Care Group. It was noted that the story was narrated by Sue, Ian's widow. Sue spoke about how, during the first few days of his stay, he had not wanted Sue to stay overnight and how both she and her daughter had struggled to contact the ward via telephone overnight to receive updates on Ian's condition and how this had made them feel distressed and isolated. She felt that the caring side of nursing had been missing and there had been very little interaction with the ward-based staff. Sue reported on the lack of daily checks about the level of involvement she wanted in Ian's care. Sue reflected that the little things, like being offered a cup of tea, would have made a big difference to her experience. Sue spoke about how this should have been a time for saying goodbye and sharing good memories, however, she was unable to look back at this time without feeling like she had failed Ian. Sue stressed the importance of the little things and the impact that these made on the experience for the patient and their relatives.

2.3. YM commented that everyone would, at some point, be in a position to require end-of-life care, and it was important to ensure that patients and their relatives received the right level of care. YM added that she had been disappointed to hear about Sue's experience and advised that the Operational Matron had met with Sue to discuss her concerns. Additionally, the Patient Experience Matron contacted the family and arranged a face-to-face meeting with Sue to apologise and to capture their journey in Sue's own words so this could be shared with staff and the board. There had also been a study day and the Butterfly Champion initiative had been re-launched to increase awareness of end-of-life care. The study day had been attended by 46 delegates from a range of specialities including representatives from the ward where Ian and Sue had their experience. A 'Butterfly Volunteer Coordinator', had now been recruited and eight volunteers had opted to be Butterfly Volunteers, supporting

patients and their relatives at the end of life. A piece of work was also being piloted on four wards to reduce the number of unanswered calls.

2.4. Sue and her family had been updated on the actions the Trust had taken as a result of her feedback.

2.5. RT reflected on a situation where clinical intervention was no longer indicated and the balance between giving the patient and their family privacy when providing care and intervening, commenting that sometimes it was difficult to get the balance right. RT asked how the Butterfly Champions would operate and YM explained that the Butterfly Champions came from a range of specialities and departments, and this would help ensure their success in supporting patients and relatives.

2.6. GB agreed with RT's comment about the fine balance between privacy and intervention. Additionally, GB commented that she had found Sue's story upsetting to hear and reflected on the contrast with her own experience at another hospital. GB was concerned that it appeared the patient had been on the ward for 12 days with very little interaction with ward nursing staff and sought assurance that Ian had received the correct medical /palliative care. AM stated that she felt the Executive Committee should review the investigation report and action plan.

2.7. IC reflected on his own experience of hospitals and commented that the unanswered patient facing telephone numbers were a universal issue. IC asked how this was being addressed. YM advised that the four wards with the highest number of unanswered calls had been identified and a piece of work was being undertaken with ward management and the IT department to develop an improvement plan, and this included changing how telephones rang on the ward. YM advised that initial reports following the changes had been positive and, if an improving trend was demonstrated, this would be rolled out to all wards.

2.8. RF advised that he would write to Sue on behalf of the Board to express the Board's thanks to Sue for sharing their story and raising her concerns. RF commented that, as a Board, this was taken very seriously as there was only one chance to get end-of-life care right. Additionally, RF requested a review of the changes made to the delivery of palliative care on the wards as a result of the patient and their family's experience, with a report to be presented at a future Board meeting.

ACTION
The Executive Committee to review the investigation and action plan and provide a further report to Board, detailing the changes made to end of life provision as a result.

2.9. HS commented that Sue's story had resonated with her recent bereavement experience and recognised that working in a busy general medicine ward setting how difficult it was to have both palliative care and normal care on the

same ward. HS commented that other trusts had specific palliative care ward capacity set aside and asked if, based on the number of patients that were receiving palliative care across the hospital sites, whether this was something that could be considered. RC commented that having listened to Sue's story, he felt this was about getting end-of-life care right for everyone regardless of where they were in the organisation. RC advised that the Trust had several side rooms on all wards across all sites which were more conducive to end-of-life care and wherever possible patients receiving end of life care were moved into these rooms. RC added that there was a possibility of cohorting these patients, however, there should not be a need to move patients to an area that was specific for end-of-life care as a patient should receive good quality care across all wards.

RESOLVED:
The Board **noted** the Patient Story

3. Chair's Welcome and Note of Apologies

3.1. RF welcomed all to the meeting and in particular LB, CK and DB who were attending the meeting as observers.

3.2. RF acknowledged the following awards and recognition that the Trust had recently received:

Award	Category	Team / Hospital
Macmillan Professional Awards	Integration Excellence	Upper GI Team
Myeloma UK	Clinical Service Excellence Programme (CSEP)	St Helens and Whiston Haematology Teams
Disability Confident Accreditation	Disability Confident Leader	MWL
Armed Forces Covenant		MWL
North West Bloom Award	Best NHS Garden Gold Award	Whiston Hospital St Helens Hospital
Healthcare People Management Association's (HPMA) Brown Jacobson Award	Excellence in Employment Engagement	Equality, Inclusion and Diversity Team
Nursing Times Award	Critical and Emergency Care Nursing	Critical Care Unit – Southport Hospital
Sams Diamonds	Unsung Heroes	Lilac Centre Volunteers

Apologies for absence were **noted** as detailed above

4. Declaration of Interests

4.1. There were no declarations of interests in relation to the agenda items.

5. MWL TB23/053 Minutes of the previous meeting

5.1. The meeting reviewed the minutes of the meeting held on 25 October 2023 and approved them as a correct and accurate record of proceedings subject to the following amendment:

5.1.1. 15.1.5 to be amended to read '*RT commented about the metric indicating patients responsible for staff discrimination/bullying/harassment and that this was not addressed in the action plan.'*

RESOLVED:

The Board **approved** the minutes from the meeting held on 25 October 2023 subject to the amendment detailed

6. MWL TB23/054 Action Log and Matters Arising

6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions.

6.2. SR provided an update on MWL TB23/043 Integrated Performance Report, Quality Indicators, Clostridium difficile (C.Diff) and the following was noted:

6.2.1. A reduction in the number of C.Diff cases as part of the national strategy. SR advised that for 2023/24 C.Diff cases tolerance levels would continue to be reported separately for each legacy Trust. For legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) this was no more than 46 cases and for legacy Southport and Ormskirk (S&O) Hospital NHS Trust this was no more than 39 cases.

6.2.2. SR advised that all C.Diff cases had to be reported, irrespective of whether a lapse in hospital or community care had been identified during the Root Cause Analysis (RCA). Therefore, the reported figures reflected the total number of cases and the number that had resulted for a lapse in care, that could be influenced by the Trust.

6.2.3. The Cheshire and Merseyside (C&M) ICB figures for Quarters 1 and 2 were published in November 2023 and the rate per 1,000 bed days for C&M was 22.7 cases. STHK and S&O trusts had the lowest number of cases per 1,000 bed days in the ICB.

6.2.4. For the period April to October 2023/24 STHK had reported 31 cases, and for the RCAs completed to date 21 had been unavoidable and seven were due to lapses in care. In the same period in 2022/23 STHK had 33 cases of which 11 had been assessed as unavoidable.

6.2.5. SR was therefore assured that there had been an improvement.

6.2.6. There were two wards on the Southport site that currently had increased incidents of C.Diff and SR noted that specimens had been sent off and the results were currently outstanding. It was noted that the main cause of outbreaks was due to environmental transmission and the fact that there was a limited number of side rooms at Southport to be able to isolate infected

patients. SR advised that work was ongoing to declutter wards. Additionally, work was ongoing with staff on the importance of Personal Protection Equipment (PPE) as well as infection, prevention, and control precautions. A back-to-basics workshop had also been held with staff on the Southport site.

6.2.7. An Infection, Prevention and Control (IPC) summit would be held on 08 December and regular IPC meetings had been reinstated, following appointments to the IPC team.

6.2.8. SR commented that all trusts were experiencing similar challenges with patients on corridors, an increased length of stay (LOS), however, MWL had now increased the number of beds in a bay to cope with the urgent and emergency care demand and this would increase these challenges.

6.2.9. SR noted that Knowsley had the highest number of community acquired cases followed by Southport, which meant there was a higher prevalence in the population.

6.3. RF commented that as the Trust now had five hospital sites and asked whether it was possible to move infected patients. SR advised that this was a challenge because patients still needed speciality care.

RESOLVED:

The Board **approved** the action log.

Performance Reports

7. MWL TB23/055 Integrated Performance Reports

GL introduced the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for October 2023.

7.1. Quality Indicators

7.1.1. SR presented the Quality Indicators and advised that the Care Quality Commission (CQC) rating for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) remained as Outstanding. SR advised that maternity services across both sites were preparing for an imminent CQC inspection.

7.1.2. SR highlighted the following:

7.1.2.1. The Hospital Standardised Mortality Ratio (HSMR) rate for April to June 2023 was 89.6 against the average of 100.

7.1.2.2. The Family and Friends Test (FTT) inpatient score was 94.75% against a target of 90% and the Emergency Department (ED) was an area of focus, particularly with the increase in the number of patients waiting to be admitted as well as the increase in corridor care as this had impacted on the FFT feedback.

7.1.2.3. The staffing fill rate had remained consistent throughout the year at 97.5% against a target of 90%. The requirement for supplementary care and the levels of bank and agency staff were currently being reviewed to ensure a consistent approach across the two legacy organisations.

7.1.2.4. The Trust had reported one case of gentamicin-resistant Methicillin-Resistant Staphylococcus Aureus (MSRA) in October 2023 and SR noted that this was an avoidable infection and lessons learnt had been identified.

7.1.2.5. Escherichia coli (E.coli) remained a challenge both regionally and nationally and the Trust was part of a health economy collaborative to reduce the number of Urinary Tract Infections (UTI) as most of the cases related to either abdominal sepsis or UTIs. It was noted that there was an action plan in place to reduce the number of infections and SR advised that the Trust was one of the better performing trusts. There had been seven reported cases of E.coli in October.

7.1.2.6. There had been 12 moderate or more severe harm falls in September 2023 across all hospital sites and SR noted that, as agreed, these were being reported retrospectively once reported at the Falls Panel to be graded and identify lessons learnt. SR noted that there had been an increase in supplementary care as well as an increase in the number of patients being admitted with cognitive impairment, confusion and delirium over the preceding year which increased the risk of falls. In several cases patients, were medically optimised for discharge, but delays in the discharge process and mobility constraints meant they still required a high level of monitoring and support. There had been patients who despite being independent and mobile, with a risk assessment in place, had still fallen and SR advised that a full analysis would be undertaken, but this highlighted the risks of delayed discharge for some patients.

7.1.2.7. Pressure ulcers continued to be monitored closely through the Hospital Acquired Pressure Ulcers (HPAU) Panel. The Trust continued to see patients being admitted from Care Homes with pressure ulcers that were pre-existing, and a piece of work was being done with PLACE commissioners to identify any care homes that would benefit from further education. The rate of Hospital acquired pressure ulcers from April 2023 was 0.1 per 1,000 bed days.

7.1.2.8. There had been no never events reported year to date (YTD).

7.1.2.9. Compliance with the MWL 60-day complaints turnaround time ambition was 61.8% in October against the target of 90%, which was a slight deterioration.

7.1.3. RT commented on the C.Diff score of 12 cases in month and 61 cases YTD against a target of 85 and thought that this should be highlighted as red not green. SR responded that the trajectory was not evenly spread across the year and reflected the previous profile of infections, and there were usually fewer cases in the winter months. On this basis 12 cases in October were in line with the expected trajectory for the time of the year and was therefore rated as green. AM commented that it was counter intuitive that the numbers decreased in winter instead of increasing, but this had been the pattern for a number of years.

7.1.4. JK commented that there had been several questions raised at the Finance and Performance (F&P) Committee about the format of the report and noted that it was still evolving and developing as board members became familiar with the new format and performance metrics for MWL.

7.1.5. JK asked about the action plan that was being developed to reduce the number of E.Coli infections and whether this would include the expected outcomes. SR provided an overview of the actions taken which included work around the diagnosis of infection, nutrition, and hydration as well as the appropriateness of taking samples. SR advised that a 10% reduction in infections had been set as the target and agreed to share the action plan and expected outcomes with the Quality Committee.

ACTION
SR agreed to provide a summary of the action plan that was being developed as well expected outcomes to the Quality Committee.

7.1.6. GB asked if it would be possible to split the complaints into ED and non-ED as there was a possibility that the non-ED complaints could be lost in the volume of complaints received. SR advised that a full breakdown was included in the quarterly complaints reports and the IPR metric was about overall response time for all complaints.

7.1.7. RF commented that the Trust's Friends and Family Test (FFT) was 94.7% against a target of 90.0%, however, the Trust was benchmarked as being in the worst 50% nationally. SR responded that most trusts scored very highly on the FFT. The Trust continued to try and encourage high response rates from patients particularly in ED and maternity postnatal which were typically quite low.

RF reflected on the upcoming CQC inspection of the Trusts maternity units and commented that he had been informed that there was a new approach to the inspections. SR advised that this inspection was for maternity only as a result of the Ockenden report and would be conducted via the old CQC inspection regime. The CQC was currently trailing its new inspection approach, and this was expected to be rolled out in 2024.

7.1.8. SR reported that the Trust had been successful in appointing a new Maternity Voices partner.

7.2. Operational Indicators

7.2.1. LN presented the Operational Indicators and provided an update on the actions taken to mitigate some of the performance risks. LN highlighted the following:

7.2.1.1. The Accident and Emergency (A&E) mapped performance was 73.9% against the 2023/24 target of 76%. Mersey and West Lancashire NHS Teaching Hospitals (MWL) was the second best performing acute Trust in the C&M region.

7.2.1.2. Bed occupancy averaged 106.4% in October 2023 (104.3% in September 2023) (the equivalent of 72 additional patients) in general and acute beds, escalation areas and those waiting for admission for A&E. LN noted that this remained a challenge nationally.

7.2.1.3. At one stage, there had been 90 patients waiting for admission in Whiston and 56 patients at Southport.

7.2.1.4. A Winter Summit had been held with PLACE directors to address the ongoing challenges with bed occupancy and delayed discharges and further discussions would be taking place with the Integrated Care Board (ICB).

7.2.1.5. Work was ongoing internally to encourage discharges earlier in the day as there had been a reduction in the number of discharges completed before noon.

7.2.1.6. Other work included the conversion of paediatric and surgery bedspace to create an additional medical ward at the Whiston site which would provide 24 more medical beds and recruitment was underway to staff the ward, and the extension of the Same Day Emergency Care (SDEC) at Whiston site to include weekends.

7.2.1.7. Work was ongoing with Chase Heys to increase bed numbers to 16 to support discharges from Southport.

7.2.1.8. Elective Recovery and Long Waits had been impacted by industrial action in October 2023. The 52-week waiters had decreased from 2,480 in September to 2,420 in October (3.2%). It was noted that the Trust represented 11.5% of all C&M long waiters.

7.2.1.9. A detailed diagnostics plan that focused on three modalities, namely Endoscopy (STHK), Obstetrics (STHK) and DEXA scans (S&O), had been presented at the Finance and Performance Committee in October 2023 and LN advised that there had been an improvement across all three modalities. LN advised that a paper was also being prepared for the Executive Committee, that would set out the recovery plan for each tumour site pathway.

7.2.1.10. Performance against the two-week Cancer standards was 75.8% against a target of 93% (nationally performance was 74%), with S&O sites at 93.3% and STHK sites at 62.8%.

7.2.1.11. Performance against the 62-day Cancer standard was 73.3% against a target of 85% (nationally performance was at 59.3%), with STHK sites at 72.3% and S&O sites at 74.7%. LN noted that the Trust had treated the highest number of patients on the 62-day pathway in C&M.

7.2.1.12. There had been an improvement in the discharge letters response times and urgent letters were being produced within one day of an appointment and routine letters within eight days, this had been 12 days in September. LN noted that there had been a reduction in the backlog of letters from 8,599 in October 2023 to 6,766 in November 2023.

7.2.2. JK commented that during the industrial action in October 2023 a larger percentage of diagnostics services were impacted, and this would have affected the reporting of results.

7.3. Workforce Indicators

7.3.1. AMS presented the Workforce Indicators and highlighted the following:

7.3.1.1. The appraisal compliance rate was 82.4% against a target of 85% and it was noted that the lower compliance on the legacy S&O sites has been

impacted by the lengthy appraisal paperwork and, following discussions with staff groups, S&O will transition to the STHK paperwork which would make the appraisal process easier.

7.3.1.2. The mandatory training compliance rate was 86.4% against a target of 85%. AMS advised that this was an area that required harmonisation as the legacy trusts had different approaches to mandatory training and work was underway to review this to introduce a standardised system from April 2024.

7.3.1.3. In month sickness remained above target at 6.21% with stress, anxiety and depression remaining the highest causes for sickness and AMS noted that this was the same nationally. It was noted that there had been a seasonal increase in September and October. Additionally, there has been an increase in the number of Covid-19 cases. Health and Wellbeing (HWB) continued to provide support to staff and there had been a good uptake of the services by staff. It was noted that staff groups in the clinical areas had the highest rate of sickness, and this was mainly in the qualified nurses, midwifery, and Health Care Assistants (HCAs) staff group.

7.3.2. RT asked about the increase in the 'did not attends' (DNA) rate referenced in the Strategic People Committee (SPC) Assurance Report and commented that she had recently attended a Quality Ward Round and a staff member had advised that the waiting time for HWB appointments was 15 weeks and asked if the DNA rate was based on last minute cancellations and if the HWB team had sufficient capacity. AMS responded that, as discussed at the SPC, the DNA rate mainly applied to pre-employment checks which was impacting on the Time to Hire rate and a deep dive was being undertaken to understand the reasons for this. AMS agreed to follow up on the QWR comment with RT to understand if this was for the management referral or a self-referral. AMS commented that there was an issue with DNA for staff attending appointments as they did not always get time off the wards to attend, and this was always fed back to the relevant manager to gain an understanding of why it had happened.

7.4. Financial Indicators

7.5. GL presented the Financial Indicators and highlighted the following:

7.5.1. The approved MWL financial plan for 2023/24 had included a £7.6m surplus which assumed the delivery of £7.0m non-recurrent Cost Improvement Plans (CIP) as well as the delivery of the 2023/24 activity plan.

7.5.2. The Trust was reporting a £1.8m surplus in line with the plan at Month 7.

7.5.3. The Trust remained on plan to deliver the CIP target of £38.8m at Month 7 with schemes delivered or at the finalisation stage totalling £30.2m (78%) and £19.8m (62%) recurring.

7.5.4. The cash balance at the end of Month 7 was £2.5m with a forecast of £2.5m at the end of the financial year.

7.5.5. The Trust had received £9m of the £10m revenue cash in line with the transaction support agreement.

7.5.6. Capital expenditure at month 7 was £8.5m, against the plan of £10.8m.

RESOLVED:
The Board **noted** the Integrated Performance Report.

Committee Assurance Reports

8. MWL TB23/056 Committee Assurance Reports

8.1. Executive Committee

8.1.1. AM presented the Executive Committee Assurance report for September 2023 and highlighted the following items:

8.1.1.1. The Committee approved the Electronic Patient Record (EPR) Outline Business Case (OBC) and noted the amendments to the cost modelling, which would not impact the overall cost of the new EPR system.

8.1.1.2. The Committee approved the annual membership of the Institute for Health and Social Care Management.

8.1.2. RT reflected on the Copelands' Risk Adjusted Barometer (CRAB) and fluid balance monitoring, and the additional work required to understand the data and noted that this was presented regularly at the Quality Committee and asked if this was a high-level action plan or a ward-based action plan. AM advised that this had been presented at the Executive Committee as this had been raised on several occasions and had become an operational management issue which required further review for assurance. SR advised that a hydration and nutrition group had been established and regular audits were being carried out on fluid balance charts at ward level. Additionally, SR advised that two checklists had been developed to ensure that the right interventions were in place. PW advised that CRAB data was useful in the surgical setting to identify the expected risks as well as the actual outcomes, however, the use in a medical setting was not as clear., although the data could be useful in identifying patients who came into hospital with a low risk of Acute Kidney Injury (AKI) and then developed AKI whilst in hospital. PW noted that the CRAB data would not be able to assist with the fluid balance issue as this was down to day-to-day nursing care on the wards, however, it might be able to highlight areas that required additional support.

The remainder of the report was **noted.**

8.2. Audit Committee

8.2.1. IC presented the Audit Committee Assurance Report for the meeting held on 15 November 2023 and advised that the External Auditors had presented an unqualified report on the STHK 2022/23 financial statements, however, work was ongoing to finalise the Value for Money (VFM) report.

8.2.2. IC highlighted the following:

8.2.2.1. The International Fraud Awareness Week took place from 12 to 18 November 2023.

8.2.2.2. The NHS Counter Fraud Authority (NHSCFA) had issued a new product called ‘learning reports’ and the lessons learnt would be presented at future Audit Committee meetings.

8.2.2.3. The Committee received an update on Conflict of Interest and, whilst compliance remained a risk the committee was assured by the processes in place and the progress that had been made when following an alert to the S&O Audit Committee.

8.2.3. RF asked how the Trust compared to other trusts in terms of fraud. GL advised that there was not any national benchmarking but noted the number of cases was very small. IC commented that this also linked to cyber security and noted that there had been an increase in phishing fraud which included emails and mandate fraud. It was noted that work was ongoing to raise staff awareness of this risk. JK commented that he had been surprised to find out that one of the biggest areas of fraud in the NHS was people masquerading as doctors. AMS commented that the most common fraud being dealt with was staff working whilst off sick.

The remainder of the report was **noted.**

8.3. Quality Committee

8.3.1. GB presented the Quality Committee Assurance report and highlighted the following:

8.3.1.1. The Committee had requested that the Corporate Performance Report (CPR) be updated to include incidents being investigated using the Patient Safety Incident Response Framework (PSIRF).

8.3.1.2. The Patient Story presented at the meeting highlighted the excellent care by the Dementia and Delirium Team at the Southport site.

8.3.1.3. The Committee received the 2022 Inpatient Survey results for S&O, and it was noted that six of the seven areas targeted for improvement in the previous year had shown an increase in scores. The remaining area that required continued focus was patient information leaflets about discharges, and an action plan had been developed to address this.

8.3.1.4. The Committee received an assurance report from the Clinical Effectiveness Council including the plans for updating the pharmacy robots at Southport and Ormskirk sites. Additionally, the Council had received an update on the Histology outsourcing project to reduce the backlog.

8.3.1.5. The NICE Compliance Report for STHK for 2022/23 had been received and it was noted that 92% of guidance issued had been assessed by the relevant service, with 61% fully compliant and 21% partially compliant and any outstanding returns were being followed up. It was noted that the next report would include additional information about the risks and mitigations and would be presented via the Executive Committee.

8.3.1.6. The Core Mandatory Training and Essential Skills Training reports were discussed, and GB noted that these were two separate reports. The compliance rate for Essential Skills Training was not as good as the Core Mandatory Training and the Quality Committee had recommended that

both should be presented to the Executive Committee on a monthly basis to drive further improvements.

8.3.1.7. The Patient Safety Council Assurance report highlighted the ongoing impact of operational pressures on patients.

8.3.1.8. The Maternity Services Update Reports for Whiston Hospital and Ormskirk Hospital were discussed, and the following was noted:

8.3.1.9. Whiston Hospital - detailed the ongoing work to meet the ten safety actions required for the latest Maternity Incentive Scheme (MIS) Year 5. It was noted that the majority of the ten areas were compliant and action plans had been presented for those areas which were not yet fully compliant. The report also included an update on the two reportable neonatal deaths. GB noted that the report had included four Red Flag Events in Quarter 2 compared to 17 in Quarter 1. The Committee had been assured by the report presented.

8.3.1.10. Ormskirk Hospital – GB advised that the report presented had not been as in depth as the Whiston report and the Committee had requested additional information and evidence for assurance purposes to ensure that the Quality Committee and Trust Board would be in a position to sign off the Clinical Negligence Scheme for Trusts (CNST) submission.

8.3.2. SR confirmed that the CNST report was due to be signed off and submitted by the end of January 2024. SR outlined that timeframe and noted that the Local Maternity and Neonatal System (LMS) had set a timetable for the reports to be submitted to the ICB by 24 January and suggested that a special meeting be convened after the January Quality Committee, as the Board was not scheduled to meet until 31st January. The Board supported this proposal.

8.3.3. SR advised that the biggest challenge for CNST was in meeting the transitional care standards and she was working with GL and the specialist commissioners to agree the necessary resources to fully implement the transitional care pathway at both units.

8.3.4. GB noted that the Committee had received the Freedom to Speak Up (FTSU) Quarter 1 legacy reports for STHK and S&O. RF reflected on the different approaches to FTSU that had been taken by the legacy organisations and asked if the best aspects from both trusts would be incorporated into the MWL approach. AM agreed that this was an opportunity to include the best from both legacy organisations.

The remainder of the report was **noted**.

8.4. Strategic People Committee

8.4.1. LK presented the Strategic People Committee Assurance report and advised that a HWB deep dive was planned for a future SPC meeting.

8.4.2. LK highlighted the following items from the report:

8.4.2.1. The Ward Dashboard provided a detailed analysis into the sickness/absence rates for HCAs and a deep dive was underway.
8.4.2.2. The vacancy rate for HCA and Allied Health Professionals (AHP) was above target, however there was a strong pipeline of HCA applicants. Additionally, there were 16 new starters who were due to join the Trust to fill the AHP vacancies.
8.4.2.3. The Trust had 150 wellbeing champions and ambassadors of hope.
8.4.2.4. The MWL Leadership Programme 'Leading through Change' was being developed.
8.4.2.5. The Committee had received the Workforce Development Assurance Plan Update and discussed the work being done to grow our own future talent with the expansion of the Healthcare Academy.
8.4.2.6. The Committee had received a Staff Story in which an Advanced Clinical Practitioner (ACP) spoke about her career path from a Band 5 Registered Nurse to a Band 8a ACP. The member of staff shared the challenges of balancing studying, working in the Emergency Department (ED) and family life.
8.4.2.7. The Committee had received the Employment Services/Payroll Annual Assurance Update which provided an overview of Employment Services and the Payroll and Pension services provided.

The remainder of the report was **noted**.

8.5. Finance and Performance Committee

8.5.1. JK presented the Committee assurance report and alerted to the meeting that the financial position included £3.7m costs which related to industrial action as well as £0.7m API overperformance and this remained a risk to the planned position if the Trust did not receive formal written agreement from the Commissioners. JK also highlighted that the Trust's response to the NHSE Letter addressing the significant financial challenges created by industrial action in 2023/24 had been discussed and noted that the ICB was looking to providers to improve the position before the end of the financial year.

8.5.2. JK highlighted the following:
8.5.2.1. The Committee had reviewed the Integrated Performance Report for month 7
8.5.2.2. The committee had been briefed about the Winter Summit held with PLACE partners.
8.5.2.3. The Committee reviewed the Finance and Operational Performance Reports, noting the financial positional at month 7 and the risks to the delivery of the 2023/24 plan.
8.5.2.4. Agency costs were £11.4m to date and this equated to 4.0% of total pay spend, against a target of 3.7%. It was noted that mitigating actions were being taken to address this.
8.5.2.5. Capital expenditure year to date (YTD) was £8.5m and a significant amount of capital was due to be spent in the second part of the year.

8.5.2.6. The Cash balance at the end of Month 6 was £2.5m and the Trust had submitted the request for cash in line with the transaction support agreement which had been approved.
8.5.2.7. The 2024/25 Planning and Budget setting process had been presented and reviewed.
8.5.2.8. The Commercial Finance reports were reviewed, and it was noted that the forecast contribution for HR Commercial services was £1.5m for 2023/24.
8.5.2.9. The Trust's response to the NHSE Letter addressing the significant financial challenges created by industrial action in 2023/24 was discussed and it was noted that the Trust's response was in the process of being reviewed.

8.5.3. The Terms of Reference for the Estates and Facilities Management Council had been approved.

The remainder of the report was **noted**.

RESOLVED:
The Board **noted** the Committee Assurance Reports

Other Board Reports

9. MWL TB23/0057 Trust Objectives 2023/24 Mid-Year Review

9.1. AM presented the Trust Objectives Mid-Year Review which provided an update on the progress in delivering the 2023/24 Trust Objectives and noted that:
9.1.1. One objective had been assessed as being delivered (green),
9.1.2. 28 objectives were assessed as being on track and expected to be completed by the end of the financial year (amber)
9.1.3. Two objectives were assessed as being behind plan and at the risk of not being fully delivered (red).

9.2. AM advised that the two objectives that had been assessed as being behind plan were:
9.2.1. Improve the effectiveness of the discharge process for patients and carers.
9.2.2. Improving the complaints response times and the quality of the responses.

9.3. SR advised that the complaints response target had been reduced from 90 days to 60 days in July.

9.4. RT asked whether the Patient Advice and Liaison Service (PALS) presence in A&E at the Southport site had made a difference to the number of complaints received. LN advised that the PALS team had been able to address any concerns or issues before they became a formal complaints. SR clarified that this arrangement had been time limited as part of the 2022/23 winter plan. RT suggested this could be rolled out on both sites on a permanent basis. RC commented that there needed to be a better understanding of the difference that this service made before a decision was

made to continue with it. GB commented that many issues appeared to be about communications and RC agreed but noted that the teams already in place in the A&E should be able to do this.

9.5. RT reflected on the maternity service objectives and wanted to make the Board aware that there had been an application at the Ormskirk site for partners to stay overnight as they were currently only allowed to stay until 21:00. RT noted that pre-Covid partners were allowed to stay overnight post-delivery. Additionally, this was also allowed at the Liverpool Womens NHS Foundation Trust NHS Hospital. RT advised that she had spoken to several patients who had indicated that it would be helpful if their partner was allowed to stay overnight post-delivery. The Chair of the Maternity Voices Partnership (MVP) had been asked to undertake a survey of all the women to gain their views. LK commented that the majority of women would have a partner, but we need to take into consideration those women who did not have partners with them to support them overnight. SR clarified that partners could stay with women in the delivery suite where there were single rooms, but on the post-natal wards women were often in bays, and the privacy and dignity of all the women sharing the bay had to be considered.

9.6. PW commented that his best friend's wife recently had a baby at the Ormskirk site and was in hospital for five days and the partner was allowed to stay with her before, during and after the birth. PW noted that the feedback received was exemplary.

RESOLVED:
The Board **noted** the progress in achieving the 2023/24 Trust Objectives

10. MWL TB23/08 Digital Strategy Review of Progress for STHK sites

10.1. CW presented the IT Strategy Update which provided an update on the progress made on the STHK Digital Strategy since the last update in November 2022. CW noted that S&O had a separate legacy Digital Strategy in place and a new MWL strategy was being developed and would be presented to the board in early 2024.

10.2. CW highlighted the four main areas:
10.2.1. EPR Programme
10.2.2. Digital Maturity
10.2.3. A new Digital Strategy
10.2.4. Foundations

<u>EPR Programme</u>
10.3. Work had continued on the development of the EPR and other clinical systems and this included:
10.3.1. This included Careflow Workspace which provided a single login for clinicians to key clinical systems.

10.3.2. Electronic ordering for diagnostic tests which had removed the paper process. This facilitated a quicker turnaround time for test results and had a direct impact on patient care.

10.3.3. Electronic Prescribing and Medicines Administration (EPMA) had been implemented in the ED .

10.3.4. Patient Portal - £1.3m tech funds had been secured to support the creation of a patient portal for the whole of MWL and this had recently gone live for the waiting list module.

10.3.5. Clinical Narrative was due to go live in December and would further support the aim of having paperless clinical records.

10.3.6. Careflow Optimisation – additional funds had been received from the national Frontline Digitisation Programme to enable STHK sites to achieve the national Digital Capability Framework Core Standard by March 2025. CW noted that nationally this deadline had subsequently been delayed to March 2026 to allow for trusts to progress their business cases for the capability to deliver the new standards, however, the STHK sites remained on track to achieve the standards by March 2025.

10.3.7. The implementation of the new Maternity solution (Badgernet) was underway and would enable the Trust to meet the digital maternity record and safety standards.

10.3.8. Plans were developed for the use of voice recognition to replace digital dictation, and this would reduce the clinical administration burden. An interim solution has been agreed for digital dictation, until the voice recognition business case was approved.

10.3.9. Work continued to optimise clinic structures, including the redesign of workflow, and improving the outpatient letters functionality. CW noted that this was a more complex piece of work than had originally been anticipated and had been impacted by industrial action.

10.3.10. The development of the digital shared care records has continued and supported more teams in the delivery of out of hospital care.

<u>Building Foundations</u>

10.4. CW advised that work has been ongoing to build the foundations for the new MWL digital strategy and these included:

10.4.1. Major technical infrastructure developments including a network refresh and cyber security improvements on S&O sites.

10.4.2. The joining together of the STHK and S&O networks, to enable staff to be able to access all the clinical systems regardless of their location.

10.4.3. Email migration and the creation of a new MWL email address. It was noted that staff based at all S&O sites had now migrated over to the new MWL email addresses and STHK staff would do so in the new year.

10.4.4. Funding of £22.6m for the single EPR system has been secured.

10.5. As a result of the work undertaken so far, the number of calls to the S&O IT Helpdesk had reduced by 33%

10.6. Despite the pressures on national technology funds, to support the overall financial position, CW remained hopeful that the Trust outstanding £19.5m of

funding for the single EPR would still be allocated because the ICB had placed the Trust in the highest priority category i.e. Level 0.

Digital Maturity

10.7. A lot of work has been carried out during the last 12 months to address not only the infrastructure and clinical systems but also how staff interacted with them.

10.8. There was a national digital maturity framework which consisted of seven domains and STHK scored 3.3 out of 5 compared to a national average score of 2.7. CW noted that STHK was ranked as the highest acute provider in the North West and in the top 20% nationally for digital maturity.

Priorities for 2024

10.9. CW advised that the new MWL Digital Strategy, was in development and the draft would be presented at the strategy board in February.

10.10. IC reflected on the low Empower Citizens score in the digital maturity assessment and asked whether there was a reason for this. CW advised that this was the score for C&M and noted that the ICB had decided to implement a single patient portal where patients (the citizens) would go to access their information, to make and amend appointments. But this had not been delivered in the agreed timescales and this was one of the reasons why the Trust had received funding for the development of a local patient portal and CW anticipated that there would be an improvement in the score when the next digital maturity assessment was completed.

10.11. LK asked whether patient's participation in clinical trials was recorded in the EPR record. CW advised that, whilst this was currently not recorded in EPR, the system could be updated to include this as a flag in the patient record.

10.12. IC asked how clinicians would be involved in developing the new Digital Strategy and CW advised that an independent company was assisting the development of the strategy, and they would be holding interviews with a wide range of staff, including clinicians to understand user needs. Also, there would be a communications and engagement programme with a wide range of opportunities for staff to contribute to the development of the strategy.

10.13. IC asked if there were any plans to develop further virtual wards and services. CW advised that the functionality to support virtual services would be covered in the strategy.

10.14. GA commented on the great legacy that CW was leaving the organisation when she left the Trust in 2024 and noted his appreciation of her work.

RESOLVED:

The Board **noted** the Digital Strategy Review of Progress for STHK sites

11. MWL TB23/059 Research and Development Annual Reports and Capability Statement

11.1. STHK Research and Development Annual Report 2022/23

11.1.1. PW presented the STHK Research and Development Annual Report for 2022/23 and noted that the 2023/24 report would be for MWL. PW explained that the research team at STHK was a bigger team with 18 Whole Team Equivalent (WTE) staff members compared to six WTE staff members in the S&O team.

11.1.2. PW highlighted the following:

11.1.2.1. The STHK team won the Covid-19 Research and Innovation award alongside the Liverpool School of Tropical Medicine for their work on the Oxford Vaccine Study.

11.1.2.2. Having dedicated research space in the new unit that opened in 2022/23 allowed the Trust to offer more patients a safe and friendly environment to take part in essential research.

11.1.2.3. STHK was ranked first on the Clinical Research Network (CRN) North West Coast (NWC) dashboard for the number of responses to the Patient Research Experience Survey.

11.1.2.4. The Trust was looking to increase its commercial research in line with the national policy and this would result in increased funding and would allow the Trust to expand its research portfolio.

11.1.2.5. STHK was one of the top recruiters to several studies in 2022/23 including the Huawei watch study "Evaluation of Huawei Smartwear for Detection of Atrial Fibrillation in a Post-Stroke Population".

11.2. S&O Research and Development Annual Report 2022/23

11.2.1. PW presented the S&O Research and Development Annual Report which provided an overview of activity during 2022/23 and PW highlighted the following:

11.2.1.1. S&O had not met the target of national studies in 2022/23, however, the results of the research patient experience survey had been positive. The survey had highlighted the lack of dedicated space for research and PW noted that following this there had been approval to convert clinical space at the Ormskirk site to be used for research, which would address this issue.

11.2.1.2. The S&O team had made progress in growing its National Portfolio research activity and recruited a total of 401 participants into NIHR CRN portfolio research studies against the NIHR target of 533.

11.2.1.3. Ormskirk was the first recruiter to world-wide Paediatric Diabetes study, with the patient identified at the Whiston site and referred to the research team at S&O for inclusion in the study.

11.2.2. The STHK and S&O Research teams were now working closely together, and it was noted that STHK had previously managed research on behalf of S&O so many key relationships were already in place. An away day had

been held and there were regularly joint meetings chaired by PW. Work was underway on creating a Research Strategy for MWL and this would build on the work already being undertaken by the two departments.

11.3. MWL Research Capability Statement

11.3.1. PW presented the MWL Research and Capability Statement and noted that this must be published on the Trust's website. The report provided an overview of the resources available to support Research and Development in the organisation as well as an overview of the research collaborations and partnerships with other organisations.

11.3.2. JK commented on the amount of work done within the Research and Development teams and congratulated them on their achievements. PW commented that the majority of the STHK team were funded by the research networks and there were any opportunities to expand the research portfolio across MWL, building on the areas of strength that came from the legacy trusts.

11.3.3. GB commended the teams on the quality of the reports and suggested that the creation of a Research, Development and Innovation Committee could assist in elevating research. PW agreed that this was something to think about and noted that, he attends the Research and Development Group which currently reports via the Clinical Effectiveness Council.

RESOLVED:
The Board **noted** the 2022/23 STHK and S&O Research and Development Annual Reports and **approved** the MWL Capability Statement

12. MWL TB23/060 Trust Board Meeting Arrangements (including Work Plan)

12.1. NB presented the proposed Trust Board Meeting Arrangements for 2024/25 which included the proposed dates for meetings and the workplan. It was proposed that the Board meeting be held on the last Wednesday of every month.

12.2. AMS suggested an amendment to the work plan noting the six-monthly HR indicators report was no longer required at Board as this was now presented at the monthly Strategic People Committee (SPC) meeting, however, the Workforce Strategy Update would still need to be presented at Board.

12.3. IC asked if Freedom to Speak Up reports should be presented at Board. NB advised that legacy STHK Board only received the Freedom to Speak Up Annual Report with the detailed reports being presented to the SPC, however, the legacy S&O Board had received regular reports.

12.4. RT asked if maternity performance reports should be included on the workplan. SR commented that in light of the Ockenden Report as well as the

Lucy Letby case the Board might require additional information. SR noted that quarterly reports were currently presented at the Quality Committee. RF reflected on the Ockenden Report as well as the Lucy Letby case and that it was important for the Board to reflect on its governance and reporting arrangements. NB commented that the current governance arrangements enabled the Board to be sited on issues via the Quality Committee Assurance Reports which was designed for the escalation of concerns and risks and did not necessarily have to receive a duplicate report. AM commented that whilst NB was technically correct, given the current high profile of maternity and neonatal services it would be sensible to include two reports per annum on the Board workplan.

12.5. RT queried if there needed to be a more formal route for the Maternity Champions update. The Board felt that the current updates in the quarterly maternity reports to the Quality Committee provided a governance route for escalation, if RT had a specific concern. RF reminded the Board that any Director with a concern could escalate this to the Board for discussion.

12.6. CW noted that the Cyber Security and MMDA performance report needed to be included on the Closed Board workplan.

12.7. It was agreed NB would update the workplan to include the changes discussed.

12.8. RF reflected on the importance of having an agreed workplan, which helped ensure Board papers were circulated in a timely way so that as Chair he had time to read the papers and raise any queries ahead of the meetings and commented that it was important that the Committees were dealt with in the same way as Board to ensure high quality meetings.

RESOLVED:
The Board **approved** the Trust Board Meeting Arrangements for 2024/25 (including Work Plan) subject to the amendments discussed.

Concluding Business

13. Effectiveness of Meeting

The members reflected on the effectiveness of the meeting.

14. Any Other Business

14.1. RF advised that it was JK's last public Board meeting and thanked him for his commitment to and support for STHK, S&O and now MWL, and wished him well for the future. JK responded that he had been disappointed when his term of office could not be extended further by NHSE but reflected on how quickly the last six years had gone as well as the talented and professional people he had worked with during this time.

There being no other business the meeting closed at 13.28.

The next Board meeting would be held on **Wednesday 31 January 2024 at 09.30**

Meeting Attendance 2023/24												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)				✓		✓	✓	✓				
Ann Marr				✓		✓	✓	✓				
Anne-Marie Stretch				✓		✓	✓	✓				
Geoffrey Appleton				✓		✓	✓	✓				
Gill Brown				✓		✓	✓	✓				
Nicola Bunce				✓		✓	✓	✓				
Ian Clayton				✓		✓	✓	✓				
Rob Cooper				✓		✓	A	✓				
Paul Growney				A		✓	✓	✓				
Lisa Knight				✓		✓	✓	✓				
Jeff Kozer				✓		✓	✓	✓				
Gareth Lawrence				✓		✓	✓	✓				
Lesley Neary				✓		✓	✓	✓				
Sue Redfern				✓		A	✓	✓				
Rani Thind				✓		✓	✓	✓				
Christine Walters				✓		✓	✓	✓				
Peter Williams				✓		✓	✓	✓				
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball				✓		A	✓	✓				
Richard Weeks				✓		✓	✓	A				
✓ = In attendance A = Apologies												

Minutes of the Extraordinary Trust Board Meeting
Held via Microsoft Teams
Tuesday 23rd January 2024 at 1pm
(Approved by the Trust Board Meeting, Wednesday 31st January 2024)

Present

Name	Initials	Title
Gill Brown	GB	Non-Executive Director, Chair
Rani Thind	RT	Associate Non-Executive Director
Ian Clayton	IC	Non-Executive Director
Ann Marr	AM	Chief Executive Officer
Anne-Marie Stretch	AMS	Deputy CEO/Director of HR
Nicola Bunce	NB	Director of Corporate Services
Peter Williams	PW	Medical Director
Gareth Lawrence	GL	Director of Finance & Information
Sue Redfern	SF	Director of Nursing, Midwifery & Governance

In Attendance

Name	Initials	Title
Denise Baker	DB	Executive Assistant (Minutes)
Catherine McClennan	CM	Local Maternity and Neonatal System (LMNS)
Debby Gould	DG	LMNS
Sue Orchard	SO	Head of Midwifery, Whiston
Dawn Meredith	DM	Associate Director of Midwifery, Nursing & AHPs, Ormskirk

Apologies

Name	Initials	Title
Richard Fraser	RF	Chair
Geoffrey Appleton	GA	Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Paul Growney	PG	Associate Non-Executive Director
Hazel Scott	HS	Non-Executive Director
Rob Cooper	RC	Managing Director
Christine Walters	CW	Director of Informatics

Agenda Item	Description
Preliminary Business	
1.	**Chair's Welcome and Note of Apologies**
	1.1. GB welcomed everyone to the meeting which had been convened to review and approve the legacy STHK sites and the legacy S&O sites CNST submissions.
	1.2. GB welcomed CM and DG to the meeting, who were attending on behalf of the LMNS
	Apologies for absence were as noted above.
2.	**Declaration of Interests**
	2.1. There were no declarations of interests in relation to the agenda items.

Papers

3. MWL TB24/001 – Legacy STHK sites CNST Submission

3.1. The Chair noted that the compliance report and supporting evidence for legacy STHK sites had been extensively reviewed during the preceding Quality Committee meeting and the recommendation of the Quality Committee had been that the Trust Board approve submission of the legacy STHK sites CNST.

3.2. AM confirmed that prior to consideration at the Quality Committee the Executive had also reviewed the evidence supporting the submissions.

RESOLVED:
The Extraordinary Trust Board **approved** the submission of the legacy STHK sites CNST declaration.

4. MWL TB24/002 – Legacy S&O sites CNST Submission

4.1. The Chair noted that the compliance report and supporting evidence for legacy S&O sites had been extensively reviewed during the preceding Quality Committee meeting and the recommendation of the Quality Committee had been that the Trust Board approve submission of the legacy S&O sites CNST.

RESOLVED:
The Extraordinary Trust Board **approved** the submission of the legacy S&O sites CNST declaration.

Concluding Business

5.

5.1. CM outlined the next steps, advising that once the Trust CEO had signed off the reports, they would be presented to the ICB for approval. Following ICB approval, the Trust would then complete the declaration for CNST. The deadline for submission to the ICB is 24th January 2024 and the deadline for the final declaration to CNST was 1st February 2024. CM acknowledged the challenges of complying with this year's process and thanked the Trust for all the work that had been completed across the two units.

5.2. CM requested any feedback from the Trust regarding the CNST process that could be fed back to the ICB. AM stated that the approval process was overly convoluted, given the LMNS oversight throughout.

5.3. GB thanked the maternity teams at Whiston and Ormskirk for their hard work in delivering CNST, this was echoed by SR.

As there were no other items for discussion, GB thanked everyone for their attendance and closed the meeting.

Trust Board (Public)

Matters Arising Action Log

Action Log updated 26 January 2024

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
6	25/10/2023	**MWL TB23/043 Integrated Performance Report** 6.2 Operational Indicators	AM commented that the STHK sites had prioritised the 62 day diagnosis to treatment pathway, rather than the two week referral pathway. It was agreed that the Executive Committee would review the cancer two-week referral target performance and potential improvements.	LN	Feb-24		
7	25/10/2023	**MWL TB23/044 Committee Assurance Reports** 7.1 Executive Committee	Safe Staffing report - GB commented on the increase in medication errors noted on the neonatal ward and requested an update at the Quality Committee.	SR	Feb-24		**Delegated to the Quality Committee**
2	29/11/2023	**Patient Story**	The Board requested a review of the actions taken as a result of this patient story to provide assurance that a similar situation could not happen again.	SR	Feb-24		
7	29/11/2023	**MWL TB23/055 Integrated Performance Reports** 7.1 Quality Indicators	The Board asked for a report on the actions being taken to reduce E.Coli infections to acheive the Trust target for 2023/24.	SR	Feb-24		

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
6	25/10/2023	**MWL TB23/043 Integrated Performance Report** 6.1 Quality Indicators	AM noted that the Trust's position on the league table for Clostridium difficile (C.Diff) had deteriorated and asked what the reason for this was. SR advised that she had received feedback via the Infection Prevention and Control (IPC) network that other Trusts were also struggling to achieve the C.Diff target and would request additional data from the C&M ICB and would provide an update at the next meeting Update SR to provide verbal update at meeting	SR	Nov-23	29/11/2023 - SR provided a verbal update at the meeting. **Action closed**	**Completed**
11	25/10/2023	**MWL TB23/048 Aggregated Incidents, Complaints and Claims Report** 11.1 STHK	SR to include additional detail in the next report on PALs contacts converted to formal complaints and a deep dive into the increase in complaints received about general surgery	SR	Jan-24	26/01/2024 - Update included in report **(Action closed)**	**Completed**

Title of Meeting	Trust Board			Date	31 January 2023
Agenda Item	MWL TB24/005				
Report Title	Integrated Performance Report				
Executive Lead	Gareth Lawrence, Director of Finance and Information				
Presenting Officer	Gareth Lawrence, Director of Finance and Information				
Action Required		To Approve	X	To Note	

Purpose
The Integrated Performance Report provides an overview of performance for MWL across four key areas: 1. Quality 2. Operations 3. Workforce 4. Finance
Executive Summary
Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.
Financial Implications
The forecast for 2023/24 financial outturn will have implications for the finances of the Trust.
Quality and/or Equality Impact
The 10 metrics for Quality provide an overview for summary across MWL
Recommendations
The Trust Board is asked to note the Integrated Performance Report for assurance.

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Integrated Performance Report

Board Summary

Overview

Mersey and West Lancashire 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	Aug-23	100.7	100	93.3	Best 40%
FFT - Inpatients % Recommended	Dec-23	94.0%	90.0%	94.8%	Worst 50%
Nurse Fill Rates	Dec-23	97.5%	90.0%	97.4%	
C.difficile	Dec-23	14	85	89	
E.coli	Dec-23	14	121	127	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-23	0.08	0.00	0.08	
Falls ≥ moderate harm per 1000 bed days	Nov-23	0.32	0.00	0.21	
Stillbirths (intrapartum)	Dec-23	0	0	0	
Neonatal Deaths	Dec-23	2	0	5	
Never Events	Dec-23	1	0	1	
Complaints Responded In 60 Days	Dec-23	67.7%	80.0%	47.9%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Nov-23	68.2%	75.0%	69.4%	Worst 40%
Cancer 62 Days	Nov-23	81.0%	85.0%	79.0%	Best 10%
% Ambulance Handovers within 30 minutes	Dec-23	52.9%	95.0%	64.2%	
A&E Standard (Mapped)	Dec-23	73.1%	76.0%	75.2%	Best 20%
Average NEL LoS (excl Well Babies)	Dec-23	4.4	4.0	4.1	Best 30%
% of Patients With No Criteria to Reside	Dec-23	24.8%	10.0%	26.4%	
Discharges Before Noon	Dec-23	18.3%	20.0%	17.8%	
G&A Bed Occupancy	Dec-23	90.0%	92.0%	90.0%	Worst 50%
Patients Whose Operation Was Cancelled	Dec-23	0.7%	0.8%	0.9%	
RTT % less than 18 weeks	Dec-23	59.3%	92.0%	59.3%	Best 40%
RTT 65+	Dec-23	783	0	783	Best 40%
% of E-discharge Summaries Sent Within 24 Hours	Dec-23	83.6%	90.0%	81.9%	
OP Letters to GP Within 7 Days	Nov-23	54.6%	90.0%	42.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Dec-23	84.6%	85.0%	84.6%	
Mandatory Training	Dec-23	86.7%	85.0%	86.7%	
Sickness: All Staff Sickness Rate	Dec-23	6.3%	5.0%	5.9%	
Staffing: Turnover rate	Dec-23	0.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Dec-23		21,613	11,700	
Cash Balances - Days to Cover Operating Expenses	Dec-23	1.9	10		
Reported Surplus/Deficit (000's)	Dec-23		4,063	3,044	

Board Summary - Quality

Quality

Never Events - 1 never event was reported in December. An initial review has been undertaken and immediate actions have been implemented. This is subject to a wider investigation under the PSSI process.

Pressure Ulcers - Whilst the Trust is reporting validated pressure ulcers up to August, there remains one outstanding complex case for this month. Work is ongoing to review all pressure ulcers reported. Ward teams are now supporting the RCA process to ensure more timely validation going forward.

Patient Falls - Any wards where moderate or above harm falls are reported have daily walkabouts to review falls documentation, alongside supported education for ward staff.

MRSA - S&O reported 2 MRSA. PIR investigations have been completed. The formal review meeting for one of the cases has identified the case was unavoidable, with examples of exemplary care, there were no lapses in care. The formal review for the second case is due later in January.

C.Diff - The Trust is over trajectory. All cases have been reviewed by the IPC Team and RCAs have been requested of clinical teams, formal feedback is awaited.

MSSA bacteraemia - The majority of cases are linked to wound and chest sources. No cases have been linked to vascular access devices. 1 case was cannula related and was avoidable.

E coli - The majority from urinary sources of infection. An action plan is in place.

Stage 1 Complaints closed within 60 working days - There has been a 20% improvement from November to December, with improvements noted on both sites. An action plan in place to achieve 80% by quarter 4 and to improve quality of complaint responses.

Friends & Family Test - The A&E ratings have been affected by waiting times but remain above the NHSE average of 79% (Nov data). Maternity results are influenced by low response rates, for example Maternity antenatal at StHK had 17 responses with 1 very poor/poor, resulting in 5.9% rating the service very poor/poor, and Maternity – Birth had 39 responses, with, 3 very poor/poor resulting in 7.7% rating the service very poor/poor. Similarly, the 12.5% for SOHT Maternity Postnatal related to just 2 responses. All feedback is shared with individual teams. Wider improvements are being implemented as part of national in-patient experience survey results.

Neonatal Deaths - Two were reported in December, both cases were unavoidable.

Mortality - YTD the HSMR remains low at 93.3 however there has been an in month (Aug-23) rise in the HSMR. This appears to be due to a fall in palliative care coding at the Southport site. Further analysis is underway. Ongoing analysis by diagnosis group continues to monitor and investigate any diagnosis group that exceeds 100. There are no diagnosis groups of concern. The SHMI remains within expected levels.
Rapid Reviews into the perinatal and neonatal deaths has been undertaken. Care to be reviewed as part of the PMRT process.

Integrated Performance Report

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Aug-23	100.7	100	93.3	Best 30%	
FFT - Inpatients % Recommended	Dec-23	94.0%	90.0%	94.8%	Worst 50%	
Nurse Fill Rates	Dec-23	97.5%	90.0%	97.4%		
C.difficile	Dec-23	14	85	89	Best 50%	
E.coli	Dec-23	14	121	127	Best 40%	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-23	0.08	0.00	0.08		
Falls ≥ moderate harm per 1000 bed days	Nov-23	0.32	0.00	0.21		
Stillbirths (intrapartum)	Dec-23	0	0	0		
Neonatal Deaths	Dec-23	2	0	5		
Never Events	Dec-23	1	0	1		
Complaints Responded In 60 Days	Dec-23	67.7%	80.0%	47.9%		

Board Summary - Operations

Operations

Bed occupancy across MWL averaged 105.7% in December equating to 65 patients - a decrease from 108.1% in November. There was a peak of 154 patients (68 at S&O, 86 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. There is an increased number of admissions sustaining this high occupancy level, with admissions 8% higher than last December driven mainly by a 23% increase in 0-day LOS activity. Average length of stay for emergency admissions is similar across both main sites with an overall average of 8.6 days, the impact of non CTR patients being 25% at Organisation level, slightly lower than November - (26% StHK and 23% S&O). 4-Hour performance dipped slightly in December achieving 67.7% (all types), national performance 69.4% and providers across Cheshire & Merseyside averaging 64.8%. The Trusts mapped 4-Hour performance achieved 73.1%, national performance 69.4% with providers across Cheshire & Merseyside averaging 67.4%. Winter plans have been enacted as agreed with all escalation capacity in use to support demand.

The Trust had 2,775 52-week waiters at the end of December (209 S&O and 2,566 StHK) with 31 x 78+ week waiters (S&O 1 x Cardiology, 1 X Urology; StHK 4 x gen Sur, 1 X Urology, 9 x Trauma & Orthopaedics, 2 x ENT, 13 x Plastics)). The 52 week position is an increase of 191 from November with 3 days Industrial Action in the month. 18 Week performance in December for MWL was 59.3%, S&O 63.7% and StHK 57.6%. National Performance (latest month November) was 58.3% and C&M regional performance was 56.1%

Cancer performance for MWL in November was 79.9% for the 14-day standard (target 93%), National performance was 75.1% and Cheshire & Mersey 79.2%. The 62-Day standard achieved 81% (target 85%), National 59.6%, Cheshire & Mersey 67.6%. St Helens performance was 71.9% for 14-day and 83% for 62 Day. Southport achieved 91.4% for the 14 -day standard and 75.3% 62-day.

Diagnostic performance in December for MWL was 79.0%, S&O 77.3% and StHK 79.7%. National Performance (latest month November) was 76.7% and C&M regional performance was 84%.

There were 3 days of industrial action in December for Junior Doctors. MWL cancelled 6 elective or day case admissions and 350 outpatient appointments (S&O 0 inpatients and 58 outpatients, 6 inpatients and 292 outpatients for StHK). However, the inpact of the industrial action was much greater than this due to reduced scheduling of activity having had notice of the forthcoming IA. On average over the strike period 229 out of 444 junior doctor shifts (51.5%) chose to strike when due on.

Challenges continue with the production of letters following an outpatient appointment. However, urgent letters are being produced within 48 hours of appointment and routine within 14 days, which is line with internal targets. An interim solution has been approved for letter production, whilst the strategic voice recognition solution is developed.

Integrated Performance Report

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Nov-23	68.2%	75.0%	69.4%	Worst 30%	
Cancer 62 Days	Nov-23	81.0%	85.0%	79.0%	Best 30%	
% Ambulance Handovers within 30 minutes	Dec-23	52.9%	95.0%	64.2%		
A&E Standard (Mapped)	Dec-23	73.1%	76.0%	75.2%	Best 30%	
Average NEL LoS (excl Well Babies)	Dec-23	4.4	4.0	4.1	Best 30%	
% of Patients With No Criteria to Reside	Dec-23	24.8%	10.0%	26.4%		
Discharges Before Noon	Dec-23	18.3%	20.0%	17.8%		
G&A Bed Occupancy	Dec-23	90.0%	92.0%	90.0%	Worst 50%	
Patients Whose Operation Was Cancelled	Dec-23	0.7%	0.8%	0.9%		
RTT % less than 18 weeks	Dec-23	59.3%	92.0%	59.3%	Best 40%	
RTT 65+	Dec-23	783	0	783	Best 30%	
% of E-discharge Summaries Sent Within 24 Hours	Dec-23	83.6%	90.0%	81.9%		
OP Letters to GP Within 7 Days	Nov-23	54.6%	90.0%	42.1%		

Board Summary - Workforce

Workforce

Appraisals - The Trust has not achieved the appraisal target, achieving 84.6% against a target of 85%, a 0.9% increase on the previous month. The lower compliance on the legacy S&O sites has improved in month (from 76.5% to 78.1%) however continues to be impacted by lengthy appraisal paperwork. S&O are in the process of transitioning to the STHK paperwork which will make the appraisal process easier.

Mandatory Training - The Trust is exceeding its mandatory target at 86.5% against a target of 85%.

In-month sickness remains above target, at 6.3% against the 5% target.
The top reason for absence is Anxiety, Stress and Depression. This is consistent with the top reason for absence across the NHS. The Trust continues to focus on supporting all employees who are absent due to Anxiety/Stress/Depression by ensuring that all supportive actions have been undertaken. Further targeted work has also been undertaken as part of our overall absence management approach:

- Ensuring that welcome-back conversations (renamed from return to work), welfare meetings and trigger meetings are being undertaken
- Carrying out internal audits of areas to ensure the processes are being followed and providing support and training to line managers
- Delivering Attendance Management training sessions to new and existing managers.
- Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
- Facilitating early engagement of all employees who are absent due to musculoskeletal problems.

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Dec-23	84.6%	85.0%	84.6%		
Mandatory Training	Dec-23	86.7%	85.0%	86.7%		
Sickness: All Staff Sickness Rate	Dec-23	6.3%	5.0%	5.9%		
Staffing: Turnover rate	Dec-23	0.9%	1.1%	1.0%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 23/24 (combining agreed STHK and S&O plans) gives a surplus of £7.6m, which assumes:

- Full achievement of CQUINs
- Delivery of £31.8m recurrent CIP
- Delivery of £7.0m non-recurrent CIP
- Delivery of the 23/24 activity plan, in order to achieve planned levels of income including ERF/API variable funding

Surplus/Deficit – At Month 9, the Trust is reporting a year to date surplus of £3m, which is a £1m deterioration from plan. This variance is in relation to industrial action costs of £1m over and above those funded earlier in the year of £4m. The position also includes ongoing pressures currently being mitigated internally, including £6.2m non pay inflation above plan and a £3.0m YTD pay award pressure.

CIP - The Trust's 2023/24 CIP target is £38.8m, of which £31.8m is to be delivered recurrently and £7.0m non-recurrently. As at Month 9, schemes delivered or at finalisation stage totalled £34.9m in year (90%) and £22.9m (72%) recurrently.

Cash - At the end of M9, the cash balance was £4.0m, with a forecast of £2.5m at the end of the financial year. The Trust has received cash in line with the transaction support agreed with NHS England and C&M ICS.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £11.7m. No PDC funding (provided by Department of Health & Social Care) has been used. There is significant capital spend profiled in Q4.

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Dec-23		21,613	11,700		
Cash Balances - Days to Cover Operating Expenses	Dec-23	1.9	10			
Reported Surplus/Deficit (000's)	Dec-23		4,063	3,044		

Integrated Performance Report

Board Summary

Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-23	116.0	100	99.0	
FFT - Inpatients % Recommended	Dec-23	93.7%	90.0%	94.6%	
Nurse Fill Rates	Dec-23	96.8%	90.0%	96.5%	
C.difficile	Dec-23	6	39	34	
E.coli	Dec-23	3	48	44	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-23	0.07	0.00	0.03	
Falls ≥ moderate harm per 1000 bed days	Nov-23	0.14	0.00	0.13	
Stillbirths (intrapartum)	Dec-23	0	0	0	
Neonatal Deaths	Dec-23	1	0	2	
Never Events	Dec-23	0	0	0	
Complaints Responded In 60 Days	Dec-23	69.2%	80.0%	72.1%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Nov-23	68.8%	75.0%	70.0%	
Cancer 62 Days	Nov-23	75.3%	85.0%	63.0%	
% Ambulance Handovers within 30 minutes	Dec-23	50.0%	95.0%	69.9%	
A&E Standard (Mapped)	Dec-23				
Average NEL LoS (excl Well Babies)	Dec-23	6.2	4.0	5.1	
% of Patients With No Criteria to Reside	Dec-23	22.9%	10.0%	18.7%	
Discharges Before Noon	Dec-23	19.5%	20.0%	19.5%	
G&A Bed Occupancy	Dec-23	81.7%	92.0%	80.5%	
Patients Whose Operation Was Cancelled	Dec-23	0.7%	0.8%	0.7%	
RTT % less than 18 weeks	Dec-23	63.7%	92.0%	63.7%	
RTT 65+	Dec-23	16	0	16	
% of E-discharge Summaries Sent Within 24 Hours	Dec-23	84.1%	90.0%	79.2%	
OP Letters to GP Within 7 Days	Nov-23	76.2%	90.0%	70.3%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Dec-23	78.1%	85.0%	78.1%	
Mandatory Training	Dec-23	90.5%	85.0%	90.5%	
Sickness: All Staff Sickness Rate	Dec-23	6.1%	6.0%	5.7%	
Staffing: Turnover rate	Dec-23	0.9%	1.1%	0.9%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Dec-23				
Cash Balances - Days to Cover Operating Expenses	Dec-23				
Reported Surplus/Deficit (000's)	Dec-23				

Integrated Performance Report

Board Summary

St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-23	94.4	100	91.0	
FFT - Inpatients % Recommended	Dec-23	94.1%	90.0%	94.9%	
Nurse Fill Rates	Dec-23	98.3%	90.0%	98.4%	
C.difficile	Dec-23	8	46	55	
E.coli	Dec-23	11	73	83	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-23	0.09	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	Nov-23	0.43	0.00	0.26	
Stillbirths (intrapartum)	Dec-23	0	0	0	
Neonatal Deaths	Dec-23	1	0	3	
Never Events	Dec-23	1	0	1	
Complaints Responded In 60 Days	Dec-23	66.7%	80.0%	33.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Nov-23	67.8%	75.0%	69.0%	
Cancer 62 Days	Nov-23	83.0%	85.0%	84.3%	
% Ambulance Handovers within 30 minutes	Dec-23	55.4%	95.0%	59.6%	
A&E Standard (Mapped)	Dec-23				
Average NEL LoS (excl Well Babies)	Dec-23	3.8	4.0	3.7	
% of Patients With No Criteria to Reside	Dec-23	25.8%	10.0%	30.6%	
Discharges Before Noon	Dec-23	17.1%	20.0%	16.2%	
G&A Bed Occupancy	Dec-23	96.2%	92.0%	97.0%	
Patients Whose Operation Was Cancelled	Dec-23	0.8%	0.8%	1.1%	
RTT % less than 18 weeks	Dec-23	57.6%	92.0%	57.6%	
RTT 65+	Dec-23	767	0	767	
% of E-discharge Summaries Sent Within 24 Hours	Dec-23	83.4%	90.0%	82.7%	
OP Letters to GP Within 7 Days	Nov-23	42.5%	90.0%	25.6%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Dec-23	88.4%	85.0%	88.4%	
Mandatory Training	Dec-23	85.2%	85.0%	85.2%	
Sickness: All Staff Sickness Rate	Dec-23	6.4%	5.0%	6.0%	
Staffing: Turnover rate	Dec-23	0.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Dec-23				
Cash Balances - Days to Cover Operating Expenses	Dec-23				
Reported Surplus/Deficit (000's)	Dec-23				

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	31 January 2024
Agenda Item	**MWL TB24/006 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the eight Executive Committee meetings held in November and December 2023		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
There were eight Executive Committee meetings held during November and December 2023. At every meeting bank or agency staff requests that breach the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded.		
02 November 2023		
Safeguarding Update following approval of additional resources	• The Assistant Director of Nursing for Safeguarding provided a review of the impact following the approval of a business case for additional resources for the STHK safeguarding team. Recruitment to the additional posts had been completed and the team was now fully functional. • Activity has continued to increase compared to 2022/23. • The additional resources now and two case studies highlighted the impact of this work. • There had been an improvement in safeguarding training compliance, as the team had been able to provide additional support. • The team were now working with the legacy S&O team to align processes and policy across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).	Assurance
Winter Schemes Update	• The Managing Director presented the update on internal schemes and winter surge plans for Whiston and Southport sites. • The escalation plans involved adding ward beds and required a risk assessment and the availability of staff, and it was recognised that	Approval

	reducing bed spaces would potentially have an impact on the effectiveness of IPC policies. • There were also a range of other schemes that would release bed spaces or improve discharge of medically optimised patients, and it was agreed that the priority should be to focus on the schemes to decrease bed occupancy levels and get patients to the most appropriate setting for the care and support they needed. • It was agreed to increase staffing so that the Same Day Emergency Care (SDEC) provision at both Whiston and Southport Hospitals could operate 7 days a week. • Options for further step down beds continued to be discussed with the place and Local Authority Leads and a winter summit was being arranged to discuss the place response to winter pressures to limit hospital bed occupancy levels to 98%. • Ward 4F would be converted to an adult medical ward following the completion of the ChObs scheme and the completion of essential life cycle works, and required additional staffing, and committee agreed to commence recruitment for the nursing, ANP and therapies staff that would be required. • It was noted that if patient flow could be improved then current unplanned escalation costs would reduce.	
Smoke Free Policy	• The Deputy Director of Governance presented the revised Trust Smoke Free Policy which had been updated to include information about vaping. • It was explained that vaping had now been identified as a positive alternative to smoking, but the policy did not encourage or promote vaping. • Committee discussed if there were any further means to discourage patients and visitors from smoking in the grounds of Trust premises.	Assurance
NHS Sexual Safety Charter	• The Deputy CEO/Director of HR briefed the committee on the NHSE Sexual Safety Charter that the Trust had signed up to in October 2023 and had until July 2024 to demonstrate how it was meeting each of the 10 commitments.	Assurance

Winscribe Replacement Business Case	• The Director of Informatics and Managing Director presented the Business Case to evoke a contract change notice (CCN) with the Digital Dictation Supplier for the Southport and Ormskirk sites to replace the current obsolete system at STHK sites and to ensure service continuity. • It was noted that this would be a recurrent cost as well as the set up and implementation costs.	Approval
November Trust Board Agenda	• The Committee reviewed and agreed the draft Trust Board agenda for November. • The Employee of the Month for November was selected from the nominations received.	Assurance
09 November 2023		
East of England Lead Employer Contract	• The Committee supported the request to enter a new 2 year lead employer contract with the East of England NHS for GP and Public Health Trainees. The rate per trainee had been renegotiated to ensure the Trust costs were covered.	Approval
Shaping our Continuous Improvement Journey (Aqua Senior Leadership Journey)	• Representatives from Aqua and the Trust Service Improvement Team attended the committee and led a leadership session to help plan how the Trust would embed a continuous improvement philosophy and approach across MWL. • The outputs from the session would be used by the Service Improvement team to develop an implementation plan.	Assurance
Cyber Report	• The Director of Informatics presented the cyber performance report for the period to the end of September. The report was due to be presented to the Trust Board at the November meeting.	Assurance
16 November 2023		
Theatre Staffing Business Case	• The Managing Director introduced the business case which set out the workforce requirements needed to maximise the capacity created by the 2 additional theatres under construction at Whiston hospital and were due to open in mid-2024. • The committee reviewed the potential configuration of the theatre capacity and the optimal impact that could be achieved for the specialities with the longest waiting list, in	Approval

	conjunction with parallel plans to optimise elective capacity at Ormskirk Hospital. • Committee supported the staff plans, taking account of both the revenue consequences and projected additional PbR tariff income. • It was noted that due to the value of the investment the business case had to be presented at Board for approval.	
Paediatric Staffing	• The Director of Nursing, Midwifery and Governance introduced the business case which detailed the need for additional specialist paediatric nurse staffing across the reconfigured paediatric ward and the new co-located paediatric emergency department and Childrens Observation (ChObs) ward beds to meet the required nursing ratios. • Committee approved the temporary increase in staffing over the winter period, whilst the ChObs beds were open 7 days a week, pending a more in depth review.	Approval
Corporate Benchmarking	• The Director of Finance presented the report which detailed the annual returns on corporate benchmarking for 2022/23 for STHK & S&O and it was noted that most corporate services compared favourably to the national median.	Assurance
Collaborative Bank Update	• The Director of HR/Deputy CEO presented a report on the status of the collaborative staff bank projects the Trust was hosting or advising the ICB/CMAST.	Assurance
Risk Report and Corporate Risk Register (CRR)	• Committee received the Risk Management Council (RMC) assurance report and a summary of the risks escalated to the CRR. • There were 1,011 open risks on the MWL combined risk register at the end of October 2023 and 51 risks were escalated to the CRR.	Assurance
Appraisal and Mandatory Training Compliance Performance	• The Deputy CEO /Director of HR presented the report. • The trust continued to be below target for appraisal compliance, because of the different approaches of the legacy trusts, with STHK being above target and S&O below as they used the appraisal anniversary rather than the 6 month	Assurance

	appraisal window. The approach would be aligned from the start of 2024/25. • Mandatory training compliance remained in line with previous months and was still below target. • There had been no change in the compliance rate for medical and dental staff and the Director of HR/Deputy CEO and Medical Director were meeting to discuss next steps.	
23 November 2023		
Safe Staffing	• The Director of Nursing, Midwifery and Governance introduced the report for September 2023 which provided a full overview of nurse staffing levels. • At the STHK sites the overall Registered Nurses (RN) fill rate was 96.66% in September and the HCA overall fill rate was 122.13% • At the S&O sites the RN overall fill rate was 104.05% and the HCA overall fill rate 99.66% • The report also provided an update on recruitment and absence levels and the work being undertaken to understand the different approaches to supplementary care across the legacy trusts.	Assurance
STHK 6 Month Establishment Review	• The Director of Nursing, Midwifery and Governance introduced the report which set out the results of the nurse establishment review. • It was agreed that the recommendations needed to be supported by robust business cases detailing how demand and acuity had changed. • These business cases needed to be completed before recommendations could be made to the Board.	Assurance
Digital Strategy Review of Progress for STHK sites	• The Director of Informatics presented the report which provided an update on the STHK Digital Strategy ahead of its presentation to the Board in November. • The plans to develop a new MWL Digital Strategy to be presented to Trust Board in February 2024, were also noted.	Assurance
Mid-year review of Trust Objectives	• The Director of Corporate Services presented the draft mid-year review of progress in achieving the 2023/24 Trust objectives.	Assurance

	• Committee agreed some minor changes to the draft assessment for the final report that would be presented to the November Board.	
Equality Delivery System 22 (EDS22) Update	• The Director of Nursing, Midwifery and Governance introduced the report which provided an update on EDS22 policy changes for the 2023/24 submission requirements, and clarification of the governance and approval arrangements. • It was noted that the Integrated Care Board (ICB) would no longer set the parameters for EDS and that this would be the responsibility of individual trusts and reviewed by the Care Quality Commission (CQC) and the Human Rights Commission.	Assurance
University Hospital Status	• The Medical Director gave an update on his discussions with the University of Liverpool Pro Vice Chancellor, which had clarified the number of academic appointments that would be required to pursue an application to achieve University Hospital Status. • The Committee discussed the lengthy process and high costs involved in becoming a University Hospital and what the benefits would be.	Assurance
Winter Planning Summit Update	• The Chief Operating Officer (COO) provided an update on the Winter Planning Summit that had been held on 22nd November and the disappointing attendance of senior leaders from some places.	Assurance
30 November 2023		
Updated Outline Business Case (OBC) for investment in Electronic Patient Records (EPR) and Digital Maturity	• The Director of Informatics presented the report which detailed the changes to the OBC made following the review feedback from the ICB and NHSE North West. • It was noted that the OBC had been formally approved by Trust Board in July 2023 and had delegated authority to the Executive Committee to approve any amendments following review, that were not material to the case, to be able to meet the challenging national timetable that was part of the investment agreement.	Approval

	• Following a discussion of the changes Committee approved the revised document for re-submission along with the letter of support from the CEO.	
Charitable Funds Update	• The Director of Finance and Information gave a presentation detailing the propped arrangements for the management of charitable funds for MWL from the start of 2024/25. • This included rationalising and simplifying the number of funds and re-launching the Hospital Charity. • The MWL Charitable Funds Committee was due to meet for the first time in December and would be chaired by Geoffrey Appleton, Non-Executive Director. • Due to the size of the combined funds, there were different charity commission rules that MWL would need to comply with. • A new Charity Manager was being recruited to spearhead the fundraising strategy for the new organisation.	Assurance
7 December 2023		
Flexible working strategy	• The Director of HR/Deputy CEO introduced a presentation which outlined the Trust's position regarding flexible working and provided comparison data from the 2022 NHS Staff Survey, with other similar organisations. • Learning was taken from listening events and other Trusts that had scored highly in the Flexible Working theme of the NHS Staff Survey to develop next steps. • The committee was assured that suitable flexible working options were in place in the context of providing 24/7, 365-day frontline services, and that the planned promotional awareness raising campaign, training for managers, targeted support and pilots of self-rostering would impact staff perceptions of the opportunities offered by the Trust.	Assurance
MWL Frontline Digitisation Investment Agreement	• The Director of Informatics presented a paper outlining the commitments the Trust must make when signing the investment agreement with NHSE for the allocation of the 2023/24 Frontline Digitisation to MWL.	Approval

	• Following discussion of the commitments, and the delivery programme that must be met the Committee approved the Investment Agreement.	
Approval of updated Outline Business Case (OBC) for investment in Electronic Patient Records (EPR)	• The Director of Informatics presented the updated EPR Outline Business Case with further minor amendments that had been requested by NHS Northwest following the earlier submission. • The Committee reviewed and discussed these changes and retrospectively approved the amendments to the updated EPR OBC.	Approval
Business Case for Additional MRI Scanner at Whiston Hospital	• The Managing Director presented the paper which outlined a proposal to secure a second MRI scanner for Whiston Hospital, by utilising the existing scanner from St Helens Hospital that was due to be replaced as part of the MES contract. • This scanner had recently been upgraded and would provide resilience for the service at Whiston for urgent and emergency patients and reduce the need for the mobile scanner. • A preferred location had been identified adjacent to the current MRI, which would involve some reconfiguration of the imaging rooms. • Committee reviewed the capital and revenue implications alongside the potential additional income that could be generated and approved the business case.	Approval
Cancer Performance	• The Chief Operating Officer presented a report detailing cancer waiting lists and waiting time performance. • The Trust was in line or ahead of national performance for all standards, although was not meeting the national access targets and planned to meet the improvement trajectory by the end of March, assuming there was no further industrial action. • Specific action plans were being developed to address the most challenged tumour group pathways, and these would be presented to the committee in January for review.	Assurance
EPR Pre-Procurement Market Engagement Plan	• The Director of Informatics presented a report seeking approval for the approach to pre-procurement market engagement for the replacement EPR.	Approval

	• The national process would delay the start of procurement by three months and mean the prescribed timetable could not be achieved. Following discussion with the national team, ICB, regional NHSE colleagues and the Trust's specialist procurement advisors a revised process has been developed that would not compromise the expected procurement start date. • The paper set out the risks to this approach and how they would be mitigated, and committee discussed the implications. • Committee approved the revised pre-procurement market engagement plans.	
14 December 2023		
HSMR at S&O	• The Medical Director introduced the report comparing historic Hospital Standardised Mortality Ratios (HSMR) at each of the legacy Trusts. • S&O had experienced a fall in HSMR from 123.8 in 2017/18 (above the national average of 100.0) to 96.8 in 2018/19 which continued to fall to 75.5 in 2021/22. Over the same period the rate at StHK had remained stable. • Analysis of the data suggested patients who were 65+ with an emergency admission resulting in an inpatient stay longer than 5 days contributed most to the difference between S&O, StHK and the national average and outside this cohort of patients S&O HSMR rates were more aligned with national figures. • It appeared that a lower than expected percentage of this cohort of patients were dying in hospital, potentially owing to different model of end of life care enabling patients to be discharged to die at home or at another location. The close links between S&O and Queens Court Hospice were noted, alongside a strong palliative care service. • Analysis of Summary Hospital-level Mortality Indicator (SHIMI), which does not include palliative care, also indicated that out of hospital deaths had been the main driver for the difference in the HSMR. • A comparison of in-hospital vs out-of-hospital deaths showed S&O was 3rd highest nationally for deaths within 30 days of discharge.	Assurance

	• The Committee discussed the data and the possible reason for the change between 2017/18 and 2018/19 and requested further analysis on historic 30 day mortality to try and identify the event or service change that had driven the marked change in HSMR at S&O between 2017/18 and 2018/19.	
Review of S&O sites email migration	• The Director of Informatics presented the lessons learned from the recent migration of S&O email addresses from nhs.net to merseywestlancs.nhs.uk and how these would be applied to the STHK email migration planned for February/March 2024. • It was however noted that this would be a simpler process because STHK had not used nhs.net.	Assurance
Band 2-3 Grievance	• The Director of HR/Deputy CEO briefed the committee on the latest meeting with Unison to try to resolve the dispute. • The briefing included an update of how other trusts were approaching the same issue. • Further regular meetings were planned with Unison.	Assurance
Neonatal Transitional Care Business Case (Whiston Unit)	• The Director of Nursing, Midwifery and Governance presented the business case to implement a full transitional care pathway at Whiston so that mothers and newborn babies would not have to be separated. The pathway required a dedicated staffing model. • Specialised Commissioning were responsible for commissioning of neonatal cots and had not previously funded transitional care costs at the Whiston Unit, which they have now agreed to do. • The Committee approved the proposed staffing model subject to Specialised Commissioning funding being confirmed.	Approval
January Trust Board Agenda	• The Director of Corporate Services presented the draft Trust Board agenda for January 2024 for review. • The Employee of the Month for November was selected from the nominations received.	Assurance
Risk Management Council Assurance	• The Director of Corporate Services presented the Risk Management Council (RMC) assurance	Assurance

Report and Corporate Risk Register (CRR)	report and a summary of the risks escalated to the CRR. • There were 1,063 open risks on the MWL Risk Register at the end of November 2023 and 48 risks escalated to the CRR. • The RMC had received assurance reports from the IG Group, including FOI performance and the Claims Governance Group and an update on progress in completing the Quality Impact Assessments for the 2023/24 Cost Improvement Programme schemes.	
Appraisals/Mandatory Training	• The Director of HR/Deputy CEO presented the monthly performance report on mandatory training and appraisals compliance. • Appraisal compliance continued to be just below the target of 85% • Mandatory training was above target. • Committee discussed the differences in headline reporting between the two legacy trusts and the need for increased visibility of both mandatory training subjects and core clinical skills training. Work was being undertaken to develop standard reports.	Assurance
21 December 2023		
Underlying Financial Position Report	• The Director of Finance and Information presented an overview of the current position against the 2023/24 MWL Financial Plan including risks and mitigation. • The risks identified for 2023/24 include industrial action lost income and costs, transfer of income from PBR to block, consumables spending and a shortfall for pay and inflation. However, if all CIP is delivered there is potential to return to a breakeven position for 2023/24. • The presentation also included the known planning risks and assumptions, ahead of the release of the national planning guidance, for 2024/25, together with the initial CIP opportunities that were being developed with the operational and corporate teams. • The committee agreed to appoint MIAA to review the current CIP process to provide assurance.	Assurance
Bed stock management	• The Director of Corporate Services provided a verbal update on the current arrangements for	Assurance

	managing beds which was different at the two legacy trusts (EBME at S&O and Tissue Viability at STHK). • The Committee approved the work to agree aligned management arrangements and take forward the plans for replacement of both beds and mattresses. • There was agreement to purchase existing hire beds to replace bed stock at STHK sites which had been condemned. This had a pay back of less than six months. • It was also recognised that the expansion of bed capacity in response to winter pressures and to reduce the elective backlog also required an increase in the bed stock.	

Alerts:

None

Decisions and Recommendations:

New investment decisions taken by the Committee during November/December were:

1. Winter plan additional bed capacity schemes
2. Digital dictation software (Winscribe replacement)
3. Theatres Staffing Business Case (subject to Board approval)
4. Temporary paediatric staffing
5. Additional MRI scanner at Whiston
6. Neonatal transitional care staffing model
7. EPR OBC amendments
8. Frontline Digitisation Programme Investment Agreement
9. EPR pre-procurement market engagement plan

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	31 January 2024
Agenda Item	**MWL TB24/006 (8.2)**		
Committee being reported	Charitable Funds Committee		
Date of Meeting	05 December 2023		
Committee Chair	Geoffrey Appleton		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Transformation and Acquisition Arrangements	• The Committee noted the work completed to date and approved the new Expenditure, Fundraising and Treasury Management Policies	Approval
Finance Report	• The Committee noted the STHK and S&O Finance reports	Information
Investment Advisors Report	• The Committee noted the Investment Advisors Reports for Whiston and St Helens Hospitals Charity, and Southport and Ormskirk Hospital Charity	Information
Annual Report and Accounts 2022/23	• The Committee approved the 2022/23 Annual Reports and Accounts and to recommend to Board for approval.	Approval
Approval for Funds Spent or Applications Received	• The Committee approved funding & applications received since the last meeting – including allocation of funds for the Christmas Patient gifts in 2023	Approval
Terms of Reference and Work Plan	• The Committee noted Board approval of the Terms of Reference, and approved the work plan	Approval
Fundraising update	• The Committee received the latest fundraising update	Information

Alerts:

No alerts were raised.

Decisions and Recommendation(s):

- The Committee approved the 2022/23 Annual Reports and Accounts for both Charities and recommend to Board for approval.
- The Committee recommends to the Board the formal removal of Southport and Ormskirk NHS Trust from the Charity Commissions Register as well as the consolidation Whiston and St Helen's Hospital 14 linked charities.

- The Committee approved the new Expenditure, Fundraising and Treasury Management Policies.
- The Committee approved funding & applications received since the last meeting.
- The Committee noted Board approval of the Terms of Reference and approved the work plan.

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	31 January 2024
Agenda Item	**MWL TB24/006 (8.3)**		
Committee being reported	Quality Committee		
Date of Meeting	23 January 2024		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	**Description**	**Purpose**
Minutes of the previous meeting	• Minutes of the meeting held on 21 November were approved as a correct and accurate record of proceedings, following a minor correction.	Approve
Matters arising/action log	• Seven actions were discussed with three closed and four carried forward to the next meeting.	Approve
Corporate Performance Report (CPR)	• The quality metrics were discussed, noting that maternity services at Ormskirk and Whiston had had their CQC inspections in December, with the draft report expected at the end of January. • One never event had been reported since the previous meeting, for ophthalmology at St Helens relating to wrong size lens insertion. Immediate lessons learned have been identified and actions taken to prevent reoccurrence. • Further key points highlighted included the actions being taken to reduce the risk of pressure ulcers and falls (with focus on provision of appropriate supplementary care), nurse/midwife fill rates, serious incidents, nutrition and hydration, infections, complaints, friends and family test, mortality ratio and maternity indicators. • The Committee noted the disappointing number of six MRSA bacteraemia cases since April, although one case at Southport had no lapses in care identified. The Committee sought assurance that urgent action was being taken to improve compliance with aseptic non-touch technique (ANTT) training and cannula care. It was also noted that the Trust was above trajectory for a number of infections, with actions being undertaken to address this including recruitment of antimicrobial pharmacist and awareness raising.	Note

	• Further detail will be brought to the Committee relating to mortality data, following a change to processes, although no issues of concern had been identified. • Assurance was provided in relation to services in place in Maternity for perineal care and the focus on improving referrals to stop smoking services.	
Clinical Effectiveness Council report	• The Council approved the updated and harmonised Resuscitation Policy and received a number of papers, including research, development and innovation report, deep dive into increase in Medical Emergency Team (MET) calls to Bevan Court with no concerns identified, work to increase the number of solid organ donations, Medical, Emergency/Urgent Care and Therapy assurance reports, SMR/HSMR reports, Quality Improvement and Clinical Audit reports, National Confidential Enquiry into Patient Outcome and Death (NCEPOD0 update, laboratory performance report, Intensive Care National Audit & Research Centre (ICNARC) report and pharmacy governance and performance report. • The ICNARC report was noted to be mainly positive, and the successful pilot of outsourcing histopathology has led to a longer-term contract. Assurance was provided to the Committee that there were measures in place to ensure the ongoing quality of the outsourced service.	
Clinical audit programme and progress reports • StHK sites • S&O sites	• Updates were provided for both legacy organisation's clinical audit programmes, noting that the majority of audits had either been completed or were on track to complete by the year end. It was highlighted that there is good coverage of audits across the Trust, that there is a robust process in place for gaining evidence that actions have been delivered following audits and that none of the audits that were cancelled were significant or part of the national audit programme. In addition, it was noted that there is good attendance at the audit days, where learning is shared.	
Mandatory training compliance report	• Core mandatory and compulsory/essential skills training compliance to December 2023 was presented, noting that there is a project to align training across the Trust and to update the electronic staff record (ESR). Challenges with some staff groups/subjects were noted and the actions to address this. The Committee requested further assurance to be included in future reports	

	outlining the actions being taken by the lead director for areas below the compliance target. It was agreed that ANTT and nasogastric tube training would be the focus of this week's quality engagement events led by senior nurses across all sites.	
Patient Safety Council report	• The Council received a number of reports, including Surgical Care and Community and Primary Care Group updates, noting improvements in monitoring of deteriorating patients in both areas. Community services had achieved the pressure ulcer CQuIN for first two quarters. Further reports included sepsis, quarter two incident report, patient safety monthly report, Central Alerting System (CAS) update and medicines storage, noting improving compliance.	
Incidents, Never Events and serious incidents thematic review Q2 report	• The report highlighted the increase in reported incidents for delays in admitting patients to the ward and that there had been a reduction at S&O for delays in booking appointments. Details were provided for severe and above harms, including recommendations and actions, with further information to be included in future reports to provide assurance that mitigations are in place.	
Infection prevention and control Q3 report	• The report noted the position at quarter 3 and the ongoing work to strengthen clinical engagement and improve training compliance as a number of indicators were above trajectory. The increase in infections, including flu A and COVID was highlighted and the impact of current demand across the hospitals. The Trust is providing information to the ICB on the protective measures for staff that are in place, following a national increase in measles. • The Committee requested that performance with antibiotic stop dates and compliance with prescription guidance be added to the CPR.	
Patient Experience Council report	• The Council approved a number of policies and documents. The patient story highlighted gaps in care for a patient and family at the end of life. A number of reports were received including, chaplaincy & spiritual care, which highlighted the difficulties in securing Roman Catholic priests due to national shortages, with the chaplains covering where possible. Updates were received on the delivery of actions from the 2022 maternity patient surveys. Additional reports included Healthwatch St Helens, dementia and delirium, complaints and	Note

	PALS and care group patient experience summaries.	
Complaints, PALS, claims and Friends and Family Test Q3 report	• The report noted that the number of open complaints was reducing which will support work to provide more timely responses, in line with the target of 80% responded to in 60 days by end of quarter 4. The number of second stage complaints had reduced also. PALS contacts reduced slightly in quarter 3 and Friends and Family Test performance remains consistent. Assurance was provided that wards are continuing to ensure nursing staff are available to support patients during consultant reviews wherever possible. • There was a sharp increase in the number of pre-action claims, but instructed claims and inquests remain in line with previous quarters.	
Maternity Incentive Scheme	• The Committee received relevant assurance reports and papers from both Ormskirk and Whiston Maternity Services. Two detailed presentations were delivered to the Committee, each confirming compliance with the 10 safety actions for each site. • The Committee recommended Board approval and the CEO to sign and submit both compliance statements.	
Alerts:		
• Requirement to improve ANTT training compliance		
Decisions and Recommendation(s):		
The Committee recommended the Board to approve the submission of full compliance for both Ormskirk and Whiston with the Maternity Incentive Scheme.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	31 January 2024
Agenda Item	**MWL TB24/006 (8.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	22January 2024		
Committee Chair	Lisa Knight, Non-Executive Director (to be presented by Geoffrey Appleton, Non-Executive Director and Deputy Chair)		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
SPC 0124/003 - Minutes of the previous meeting	• The Committee reviewed the minutes of the meeting held on the 22 November 2023 and approved them as a correct and accurate record of proceedings.	Decision
SPC 0124/004 - Action Log and Matters Arising	• SPC 1023/008 (16/10/2023) - Staff Engagement/Culture Update. DB provided the Committee with the break down by grade for clinical and non-clinical staff within his presentation on agenda.	Assurance
SPC 0124/005 – Workforce Dashboard	• The CPR dashboard was presented focusing on the key indicators for the SPC. It was noted that Mandatory training had exceeded target 86.4% (October) against 85% target and that work is ongoing to align the two legacy organisations mandatory training requirements with Fire Training Level 1 remaining challenged. Appraisals are below target at 82.4% with legacy STHK sites above target at 87.3% and legacy S&O sites below target (73.9%). Work is underway to implement MWL appraisal documentation to the legacy S&O staff. It was noted that legacy S&O sites had not adopted the pay progression policy in contrast with legacy STHK. This will be addressed when the MWL appraisal paperwork to be adopted across for all sites. Health Care Assistants (HCA) sickness remains challenged, and the People Performance Council (PPC) have received a deep dive HCA sickness absence and have requested further analysis. It was noted that while vacancy rates have increased for Allied Health Professionals (AHP's), Registered	Assurance

	General Nurses (RGN) and Health Care Support Workers (HCSW), posts are being filled, the Trust also has an increase in demand.	
SPC 1124/006 - Big Conversation	• A presentation on the Big Conversation Update to engage with staff about the new core Values and Behaviours highlighted the following milestones had been achieved and had included 33% clinical and 67% non-clinical 67% members of staff a variety of locations and grades. • 21st September 2023 – Team Brief Live Launched Big Conversation • Tuesday 26th September 2023– Pilot Workshop • Friday 6th October 2023 – Board Event with Roy Lilley and Jon Wilks (IHSCM) • October & November 2023 – 9 x Onsite Workshops, 6x Virtual Workshops and 5x Express Workshops • December 2023 – Patient Participation Group • January 2024 – Wellbeing Champions and Symposium The SPC noted that the proposed MWL Core Values and Behaviours were being collated for Board Approval ready for launch at the Start of the Year Conference in April 2024.	Assurance
SPC 1124/007- ED&I Operational Plan and Assurance Update	• The Committee noted that the Equality, Diversity, and Inclusion (ED&I) Operational plan was being delivered to plan, that MWL had met all statutory reporting responsibilities in relation to submission of data e.g., Gender Pay, WRES and WDES. The Trust has also been re-accredited for; Disability Confident, successfully reaccredited as MWL Level 3 Leader, Veterans Aware and has joined the Apprenticeship Diversity Champion Network and over 450 staff have signed up to the anti-racist charter. It was noted that the Trust had launched eLearning Employment Law modules on discrimination law, reasonable adjustments, flexible working, and parental leave and was providing information, advice, and guidance (IAG) on reasonable adjustments, access to work & supporting disabled employees rejoining the workforce. In addition, the MWL is working with St Helens Cares to support the local population of St Helens into jobs within health and social care as	Assurance

	part of Widening Participation. The committee noted the key priorities for 2024/25.	
SPC 1124/008 Staff Story – Reasonable Adjustments Disability Passport (WDES)	• The Committee welcomed a member of staff who had recently been diagnosed the disabilities which were defined as attention deficit hyperactivity disorder (ADHD) and dyslexia. The Committee heard about the initial barrier to receiving support and the timescales and complexity of the Department of Work and Pensions (DWP) application process which included the ordering and receipt of equipment and training. It was noted that the member of staff felt valued as there is a system in place which is supporting her an individual but also as a manager and also that further training about disabilities and the Reasonable Adjustment passport and the DWP Access to Work scheme would improve employee experience along with a centralised approached to the funding of adjustments.	Assurance
SPC 1123/009 - Sexual Safety Charter	• In July 2022 NHS England established a Domestic Abuse and Sexual Violence (DASV) Programme to build on its robust safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention. The Committee received a presentation on the Sexual Safety Charter which will enhance the NHS's response to domestic abuse and sexual violence associated with NHS services and/or premises, whether experienced by patients, staff or visitors. In September 2023 by NHSE launched its first Sexual Safety Charter for patients and employees. It was noted that the Trust joined the charter on the 13h October 2023 and that the Deputy CEO/Director of HR is the Domestic Abuse and Violence Executive Lead for MWL. The Trust has an action plan in place to ensure compliance with the 10 charter principles presented to the committee by July 2024.	Assurance
SPC 1123/010 - Assurance Reports from Subgroup	• The Strategic People Committee noted the Assurance Reports from the People Performance Council, and the Employee Relations Oversight Group Annual Assurance report.	Assurance
SPC 1123/013 – Employee Relations Oversight	• The Strategic People Committee approved Employee Relations Oversight Group terms of	Decision

Group – Terms of Reference	reference and noted the increasing complexity of employment cases.	
SPC 1123/015 - Items for Escalation to Trust Board	No items to be escalated via the Assurance Report	
Alerts:		
Not applicable		
Decisions and Recommendation(s):		
• Approval of the previous minutes • Approval of the Employee Relations Oversight Group terms of reference.		

Committee Assurance Report

Title of Meeting	Trust Board	Date	31 January 2024
Agenda Item	MWL TB24/006 (8.5)		
Committee being reported	Finance, Performance & Investment Committee		
Date of Meeting	25 January 2024		
Committee Chair	Geoffrey Appleton, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Integrated Performance Report Month 9 2023/24	• Bed occupancy across MWL averaged 105.7% in December equating to 65 patients - a decrease from 108.1% in November. • Average length of stay for emergency admissions is similar across both main sites with an overall average of 8.6 days, the impact of non CTR patients being 25% at Organisation level, slightly lower than November - (26% StHK and 23% S&O). • 4-Hour performance dipped slightly in December achieving 67.7% (all types), national performance 69.4% and providers across Cheshire & Merseyside averaging 64.8%. • 18 Week performance in December for MWL was 59.3%, S&O 63.7% and StHK 57.6%. National Performance (latest month November) was 58.3% and C&M regional performance was 56.1% • Diagnostic performance in December for MWL was 79.0%, S&O 77.3% and StHK 79.7%. National Performance (latest month November) was 76.7% and C&M regional performance was 84%. • The Trust had 2,775 52-week waiters at the end of December (209 S&O and 2,566 StHK) • Cancer performance for MWL in November was 79.9% for the 14-day standard (target 93%), National performance was 75.1% and Cheshire & Mersey 79.2%. • Industrial action has impacted activity in month.	Assurance

Finance Report Month 9 2023/24	• At the end of Month 9, the Trust is reporting a surplus position of £3m which is £1m adverse to plan relating to unmitigated industrial action costs and income loss. • Trust forecast outturn for 23/24 is a surplus of £4.6m which is adverse to the planned surplus of £7.6m and includes a £3m pressure relating to unmitigated industrial action costs and income loss. The forecast position is supported by further non-recurrent support. • The underlying financial position includes significant pressures relating to pay award and inflation above funded levels, these have been mitigated non recurrently to-date in 2023/24. As at M9 c£10m of non-recurrent support has been required. • The committee noted the challenges to the underlying position as a result of delivering the in year plan due to reasons outside of the Trusts control. • Agency costs £14.7m year to date. This equates to 4.1% of total pay spend, against a target of 3.7%. PPSC continues to meet to look at the options to reduce agency in the long term. • CIP is on track to be delivered in line with target by the end of the year. • Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £11.7m, significant amount of capital to be spent in the latter part of the year. • At the end of M9, the cash balance was £4.0m, with a forecast of £2.5m at the end of the financial year. The Trust has submitted requests for cash in line with the transaction support and these have been approved.	Assurance
Month 9 2023/24 CIP Programme Update Alongside: CSS (STHK) CIP Presentation MEC (S&O) CIP Presentation	• Total targets for 23/24 (including £2.8m recurrent CIP delivered by S&O during M1-M3) are £41.6m in year and £34.6m recurrently. • Schemes identified totalling £54.8m in year and £37.0m recurrently, • Delivered/low risk schemes currently total £34.9m in year (84% of target) and £22.9m recurrently (66% of target) • Trust remains on track to deliver full CIP target by end of year. • Committee noted the update and was assured by the report and presentations.	Assurance

2024/25 Planning	• Verbal update provided by DoF on Trust progress ahead of guidance being formally published - anticipated in January 2024. • The committee noted the delays the official guidance but were reassured that the internal process are in progress.	Assurance
Elective Recovery Update	• Update provided on elective recovery. • Elective IP is currently forecasted to be below plan at MWL. • Offsetting a proportion of the underperformance in planned IP activity, significant case-mix shifts observed from IP to DC activity within General Surgery, Urology and Vascular at STHK. • A reduction in DC activity compared to 19/20 was also anticipated in the 23/24 planning round at S&O due to pathway changes. • Outpatient activity also impacted by industrial action. • Average theatre productivity at STHK is 79% compared to a target of 85% (Whiston – 84.19% St Helen's – 70.62%) • Average theatre productivity at STHK is 81% against a target of 85% (Southport – 80.3% Ormskirk – 81.7%) • Work is ongoing to increase the average number of cases per list. • RTT: S&O on track with no identified risks. STHK improvement actions outlined including exploring options for additional operating capacity and mutual aid. • MWL remains on track to deliver cancer backlog targets, with improvements outlined to recover against FDS. • Diagnostics: MWL – 79% against 95% recovery milestone. DEXA at S&O is the most significant pressure with ongoing agency support and plan for STHK to also provide mutual aid. • Endoscopy – continued focus on longest waits, cancer pathways and overdue surveillance. • Committee noted the update	Assurance
Business Case Benefits Update	• Update provided on the Benefits Realisation Programme • Progress to-date outlines 94% of tracked benefits being achieved, with 6% (12 schemes) receiving additional oversight and mitigation.	Assurance

	• Benefits Team are working on harmonisation of processes across legacy S&O investments	
Assurance Reports from Subgroups:	• CIP Council • Capital Planning Council • Procurement Steering Council • IM&T Council Update • Estates & Facilities Management Council	Assurance/ Approval

Alerts:

Finance Report Month 9 2023/24

- The financial position includes £3.0m (£1.0m M9 plus £2.0m forecast in M10) of expenditure relating Industrial Action for December and January, with the national instruction to assume no additional funding. Unless funding is provided, this presents a risk to the planned position.

- The underlying financial position further includes significant pressures relating to pay award and inflation above funded levels, these have been mitigated non recurrently to-date in 2023/24.

- The Committee noted that the Trust had not been requested to complete the forecast outturn protocol as a result of these new pressures not being included within the recent financial reset.

Decisions and Recommendation(s):

None to raise

Title of Meeting	Trust Board			Date	31 January 2024
Agenda Item	MWL TB24/007				
Report Title	Corporate Risk Register (January 2024)				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required		To Approve	X	To Note	

Purpose

To inform the Board of the risks that have currently been escalated to the MWL Corporate Risk Registers (CRR) via the Trust's risk management systems.

Executive Summary

1. Risk Management Systems

The legacy trusts both utilise DATIX to capture and report risks, however these currently remain separate systems, which embed broadly the same best practice principles.

Currently, reporting also remains aligned to the legacy organisational structures, until the new integrated clinical divisions are formally launched. Since September a single Risk Management Council (RMC) has been created and work has been undertaken to standardise reporting, as much as possible within the constraints detailed above, and to develop a single Risk Management Framework for MWL. This is now at the final stages of consultation with RMC members and is due to be presented to the Executive Committee in the coming weeks for approval.

Plans are progressing to ensure that for 2024/25 a fully integrated system for reporting and managing risks, incidents, and complaints will be implemented across MWL.

This report provides an overview of all the risks currently reported for MWL, via these legacy reporting systems.

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

- Have been identified and reported
- Have been scored in accordance with the standard risk grading matrix.
- Risks initially rated as high or extreme have been reviewed by a Director for STHK sites or the relevant CBU Governance Group for S&O sites
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

2. Risk Registers and Corporate Risk Registers

This report is based reflects a snap shot of the risk registers on 04 January 2024 and reflects all risks reported and reviewed during December 2023.

Risk Register Summary (Appendix 1)

The total number of risks on the MWL risk register was 1,065 (225 at the S&O sites and 840 at the STHK sites). In October 2023 this was 225 for the S&O sites and 795 for the STHK sites)

53 of these risks had been escalated to the CRR (12 at the S&O sites and 41 at the STHK sites). In October 2023 this was 10 for the S&O sites and 39 for the STHK sites.

11 new risks have been added to the CRR since October and eight risks have been closed or de-escalated.

Financial Implications

None as a direct result of this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to the Corporate Risk Registe report.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

January 2024 – Corporate Risk Register Quarterly Board Report

1. Risk Register Summary for the Reporting Period

This table provides a high-level overview of the "turnover" in the risk profile of the **STHK** sites compared to previous reporting periods.

RISK REGISTER STHK SITES	Current Reporting Period (January 2024)	Previous Reporting Period (December 2023)	Previous Reporting Period (November 2023)
Number of new risks reported	17	50	49
Number of risks closed or removed	8	19	40
Number of increased risk scores	6	4	14
Number of decreased risk scores	7	20	17
Number of risks overdue for review	44	41	63
Total Number of Datix risks	**840***	**842**	**806**

*840 scored risks including 4 new risks awaiting confirmation of scoring and 5 unapproved high risks

This table provides a high-level overview of the "turnover" in the risk profile of the **S&O** sites compared to previous reporting periods.

RISK REGISTER S&O SITES	Current Reporting Period (January 2024)	Previous Reporting Period (December 2023)	Previous Reporting Period (November 2023)
Number of new risks reported	8	1	1
Number of risks closed or removed	10	0	0
Number of increased risk scores			
Number of decreased risk scores			
Number of risks overdue for review	32	61	48
Number of tolerated risks	16	14	12
Total Number of Datix risks	**225**	**221**	**206**

*225 risks, including 36 waiting to be approved, including 2 unapproved high risks and 16 in the tolerated risk register

2. Risk Profiles

S&O Risk profile

Business Unit	**Very Low Risk**			**Low Risk**			**Moderate Risk**				**High/Extreme Risk**			
	1	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
Clinical Support	0	0	0	0	0	5	5	1	1	5	0	1	0	0
	0%			27.8%			66.7%				5.6%			
Corporate Governance	0	0	0	0	0	0	1	0	0	2	0	0	0	0
	0%			0%			100%				0%			
Estates and Facilities	0	0	0	0	0	1	1	0	2	1	0	0	1	0
	0%			16.7%			66.7%				16.7%			
Executive Management	0	0	0	0	0	2	0	0	0	0	0	1	0	0
	0%			66.7%			0%				33.3%			
Finance	0	0	0	0	0	2	0	0	2	0	2	0	0	0
	0%			33.3%			33.3%				33.3%			
Human Resources	0	0	0	2	0	0	1	0	0	0	0	0	0	0
	0%			66.7%			33.3%				0%			
Integrated Governance and Quality	0	0	1	0	0	1	1	0	0	2	0	0	0	0
	20%			20%			60%				0%			
Medical Director	0	0	0	1	0	6	1	4	1	0	0	2	0	0
	0%			46.7%			40.0%				13.3%			
Planned Care	0	0	2	4	0	5	2	7	4	11	1	1	2	0
	5.1%			23.1%			61.5%				10.3%			
Trust wide	0	0	0	1	0	1	0	1	0	2	0	1	1	0
	0%			28.6%			42.9%				28.6%			
Urgent Care	0	0	0	0	0	12	3	13	3	7	0	1	0	0
	0%			30.8%			66.7%				2.6%			
Women's and Children's	0	0	0	0	1	6	5	6	0	11	0	0	0	0
	0%			24.1%			75.9%				0%			
S&O Total	**0**	**0**	**3**	**8**	**1**	**41**	**20**	**32**	**13**	**41**	**3**	**7**	**4**	**0**
	3 (1.7%)			**50 (28.9%)**			**106 (61.3%)**				**14 (8.1%)**			

STHK Risk profile

Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**46**	**14**	**81**	**11**	**168**	**67**	**163**	**30**	**194**	**21**	**10**	**10**	**0**
85 = 10.12%			**260 = 30.95%**			**454 = 54.05%**				**41 = 4.88%**			

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

Surgical Care Group – 211 risks reported 25.11% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**18**	**3**	**12**	**5**	**35**	**21**	**49**	**8**	**50**	**4**	**1**	**3**	**0**
23 = 10.90%			**52 = 24.64%**			**128 = 60.66%**				**8 = 3.79%**			

Medical Care Group – 146 risks reported 17.38% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
7	**7**	**2**	**16**	**1**	**22**	**7**	**26**	**8**	**33**	**9**	**4**	**4**	**0**
16 = 10.96%			**39 = 26.71%**			**74 = 50.68%**				**17 = 11.64%**			

Clinical Support Care Group – 132 risks reported 15.71% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**7**	**0**	**14**	**0**	**19**	**7**	**27**	**7**	**35**	**7**	**2**	**2**	**0**
12 = 9.09%			**33 = 25%**			**76 = 57.58%**				**11 = 8.33%**			

Primary Care and Community Services Care Group – 46 risks reported 5.76% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
1	**0**	**0**	**5**	**1**	**14**	**2**	**6**	**3**	**14**	**0**	**0**	**0**	**0**
1 = 2.17%			**20 = 43.48%**			**25 = 54.35%**				**0**			

Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR, and Medicines Management) – 305 risks reported 36.31% of the Trust total

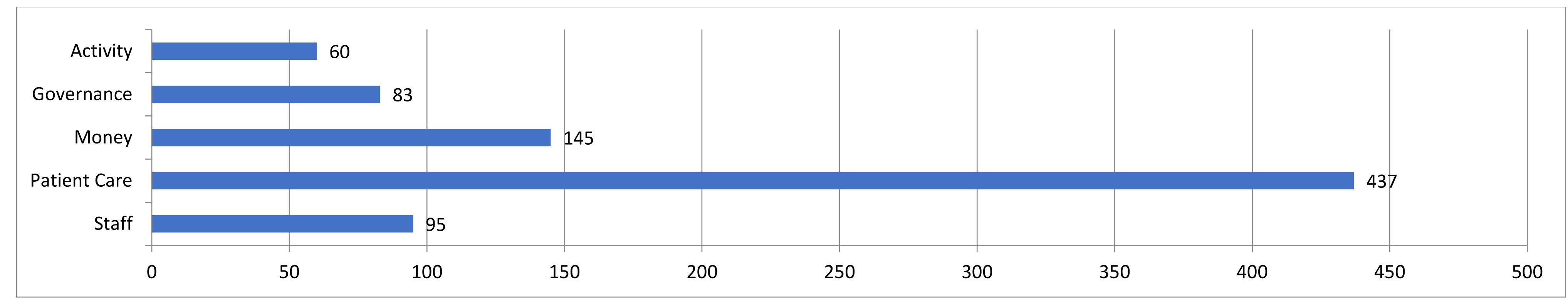
Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**14**	**9**	**34**	**4**	**78**	**30**	**55**	**4**	**62**	**1**	**3**	**1**	**0**
33 = 10.81%			**116 = 38.03%**			**151 = 49.51**				**5 = 1.64**			

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

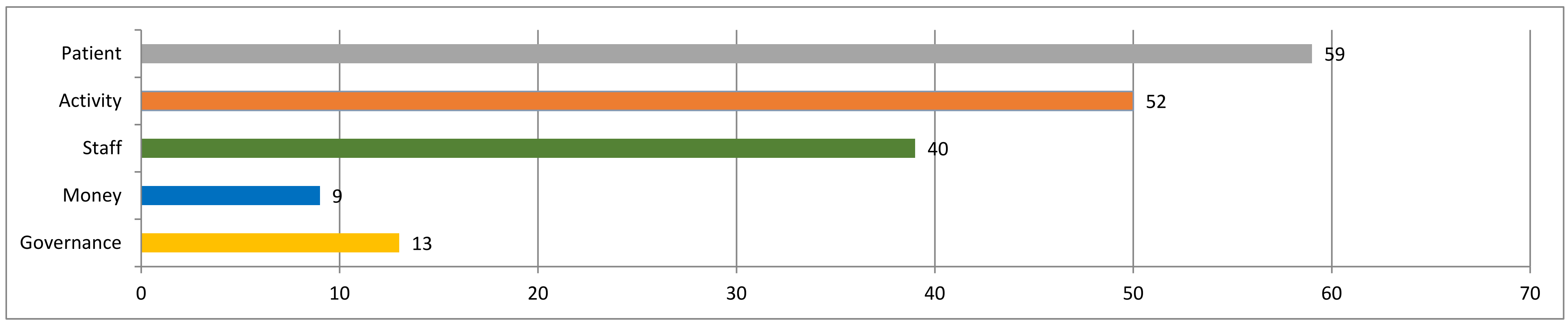
	High	Moderate	Low	Very low	**Total**
Health Informatics/ Health Records	3	20	14	4	41
Facilities (Medirest/TWFM)	0	25	13	6	44
Nursing, Governance, Quality & Risk	0	18	11	4	33
Finance	0	11	26	9	46
Medicines Management	0	26	25	3	54
Human Resource	2	51	27	7	87
Total	5	151	116	33	305

3. Categories of risk

STHK Sites



S&O Sites



4. Corporate Risk Register

No	ID	Exec Lead	CBU/Care Group/Service	LEGACY SITE	Risk	Rating (current)	Last updated
1	2432	Nicola Bunce	Estates & Facilities	S&O	Critical Infrastructure risk	20	21/12/2023
2	2168	Christine Walters	Informatics	S&O	Cyber Security - Unsupported systems	15	02/01/2024
3	2590	Lesley Neary	Planned Care	S&O	ENT Service provision	16	02/01/2024
4	2230	Rob Cooper	Executive Management	S&O	Fragile Services	16	02/11/2023
5	2601	Peter Williams	Planned Care	S&O	Inability to provide out of hours anaesthetic support for a 2nd time critical emergency at ODGH	20	11/12/2023
6	2411	Christine Walters	Informatics	S&O	Major and sustained failure of essential IT systems	15	02/01/2024

7	2572	Lesley Neary	Clinical Support Services	S&O	Malfunction and failure of the ADS (Automatic Dispensing System) Pharmacy Robot	16	04/12/2023
8	1528	Peter Williams	Medical Director	S&O	Medication error and patient harm due to absence of an Electronic Prescribing and administration of Medicines (EPMA) system	16	03/01/2024
9	2549	Lesley Neary	Trust wide - Multiple CBU's	S&O	Potential impact of regional industrial action to Southport & Ormskirk Hospitals, Mental Health (in reach) and Walk in Centres	16	08/12/2023
10	2545	Lesley Neary	Clinical Support Services	S&O	Temperature Monitoring and Control - Ward/Department drug storage areas.	20	10/01/2024
11	1603	Lesley Neary	Planned Care	S&O	Replacement of aging Autoclaves	20	27/12/2023
12	2031	Lesley Neary	Urgent Care	S&O	Risk to Patient Flow and Capacity on Southport site	16	16/11/2023
13	762	Anne-Marie Stretch	Human Resources	STHK	Potential risk of the Trust not being able to provide safe levels of staffing	16	21/12/2023
14	1152	Anne-Marie Stretch	Human Resources	STHK	Potential impact for the trust on quality of care, contract delivery and finance due to increased use of bank and agency	16	21/12/2023
15	1263	Rob Cooper	Medical Care	STHK	Corporate – Discharge & Transfer risk	15	15/11/2023
16	1772	Christine Walters	Health Informatics	STHK	Risk of malicious cyber attack	16	27/07/2023
17	1874	Rob Cooper	Clinical Support	STHK	Trust RTT incomplete position against the 92% national standard is at risk of failure	20	06/10/2023
18	1913	Rob Cooper	Clinical Support	STHK	Delay in receipt of tertiary referrals to the Patient Booking Service	15	07/12/2023
19	2082	Peter Williams	Medical Care	STHK	Medical Provision post take consultant reviews for patient whose stay in ED is delayed	20	17/11/2023
20	2083	Lesley Neary	Medical Care	STHK	Inpatient medical bed occupancy levels	15	14/12/2023
21	2223	Rob Cooper	Medical Care	STHK	ED attendances and admissions	20	04/10/2023
22	2750	Rob Cooper		STHK	Data quality and patient mismatch errors due to access to the national PDS (spine)	15	31/10/2023

23	2963	Rob Cooper	Surgical Care	STHK	Concerns regarding ability to ascertain if patients are receiving correct follow up appointments following surgery/histology due to COVID-19 disruption	20	06/11/2023
24	2985	Lesley Neary	Clinical Support	STHK	Phlebotomy staffing challenges	15	14/11/2023
25	2996	Sue Redfern	Medical Care	STHK	Nurse staffing across medical care group	20	13/12/2023
26	3043	Peter Williams	Clinical Support	STHK	Shortage of microbiology consultants	16	20/12/2023
27	3178	Lesley Neary	Clinical Support	STHK	Staffing levels in blood science	16	07/12/2023
28	3199	Sue Redfern	Medical Care	STHK	If medical patients are to 'forward wait' on a medical ward then there is a risk to patient safety, dignity and experience	16	27/12/2023
29	3251	Christine Walters	Health Informatics	STHK	Trust solution for outpatient letter printing – end of life / unsupported	20	23/11/2023
30	3349	Rob Cooper	Medical Care	STHK	Olympus managed service contract – Endoscopy	20	14/12/2023
31	3371	Sue Redfern	Medical Care	STHK	Ward areas having to accommodate an extra patient during times of heightened capacity demands	16	7/12/2023
32	3407	Rob Cooper	Medical Care	STHK	Dermatology phototherapy machines need replacing	15	29/12/2023
33	3475	Lesley Neary	Medical Care	STHK	Delays in NWAS transport for patients requiring neuro radiology thrombectomy / surgical intervention at a tertiary centre	16	01/11/2023
34	3496	Sue Redfern	Medical Care	STHK	Staffing establishment in OSM team does not meet current activity requirements overnight	15	29/12/2023
35	3513	Lesley Neary	Clinical Support	STHK	Delay in adding referrals and ERS ASI's (appointment slot issues) to careflow	15	04/12/2023
36	3514	Jayne Johnson	Clinical Support	STHK	Delay in actioning sostenuto requests (clinic cancellations and reductions)	15	07/12/2023
37	3527	Rob Cooper	Surgical Care	STHK	Delivery of care for plastic surgery patients in North Wales	20	30/11/2023
38	3532	Rob Cooper	Surgical Care	STHK	ENT equipment, Nasoendoscopy recording ability	15	04/12/2023
39	3535	Sue Redfern	Surgical Care	STHK	Potential requirement to add a 5th surgical patient into bays within surgical wards	20	28/11/2023

40	3574	Rob Cooper	Clinical Support	STHK	Careflow allocation and scheduling of outpatient appointments	15	26/10/2023
41	3598	Rob Cooper	Surgical Care	STHK	Orthopaedic Desouter drills	15	19/12/2023
42	3600	Rob Cooper	Surgical Care	STHK	Replacement of surgical diathermy machines in PDSU	15	01/11/2023
43	3622	Lesley Neary	Medical Care	STHK	Dermatology minor ops capacity	15	15/11/2023
44	3624	Sue Redfern	Surgical Care	STHK	Delay in out of hours endoscopy if there is not trained staff support	15	24/11/2023
45	3647	Rob Cooper	Medical Care	STHK	St Helens endoscopy re-design to meet JAG standards	15	13/09/2023
46	3748	Lesley Neary	Medical Care	STHK	Increased risk of not meeting dermatology 2ww target due to increased demand	15	14/12/2023
47	3770	Rob Cooper	Surgical Care	STHK	Capacity to reduce the backlog of clinic letters to meet targets	16	27/12/2023
48	3780	Guy Fagan	Medical Care	STHK	Electronic listing facility	15	14/12/2023
49	3790	Sue Redfern	Clinical Support	STHK	Risk of patient harm from ascitic drains if sufficient staff do not have after care knowledge across the Trust	15	11/12/2023
50	3795	Lesley Neary	Medical Care	STHK	Endoscopy backlog waiting lists for urgent or 2WW appointments	16	28/12/2023
51	3872	Lesley Neary	Medical Care	STHK	Quality of GP requests for cancer lesions advice and guidance	15	28/12/2023
52	3873	Rob Cooper	Clinical Support	STHK	Unauthorised access to MRI at St Helens	15	27/12/2023
53	3877	Christine Walters	Health Informatics	STHK	ODS Operational closure RVY to RBN. IT requirements in progress	20	27/12/2023

Blue text = new CRR risks added since the last quarterly board report

5. Risks closed or deescalated from the CRR since October

ID	Service	SITE	Title
2287	Medicines Management	S&O	Aseptic service automated worksheet and labelling system
2767	Maternity	STHK	Maternity staffing shortfalls
3392	Medicine	STHK	Replacement of specialist endoscopy equipment
3525	Maternity	STHK	Capacity to be able to deliver demand for 72 hour obstetric ultrasound scans
3586	Procurement	STHK	Disruption to the regular supply of good and services
3606	Neonatal	STHK	Replacement of end of life neonatal resuscitaires
3754	Clinical Support	STHK	Impact of Industrial Action by the Society of Radiographers
3783	Clinical Support	STHK	Workforce capacity to support interventional radiography

6. Changes in risk profile since the last board report

October 2023 – STHK sites

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**38**	**17**	**82**	**9**	**160**	**62**	**155**	**32**	**172**	**18**	**11**	**10**	**0**
80 = 10.1%			**251 = 31.7%**			**421 = 53.2%**				**39 = 4.9%**			

October 2023 – S&O sites

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**0**	**5**	**10**	**0**	**41**	**24**	**34**	**13**	**33**	**3**	**6**	**5**	**0**
5 = 2.9%			**51 = 29.3%**			**104 = 59.8%**				**14 = 8.1%**			

Title of Meeting	**Trust Board**		**Date**	31 January 2024
Agenda Item	**MWL TB24/008**			
Report Title	MWL Board Assurance Framework (January 2024)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

For the Board to review and agree updates to the MWL Board Assurance Framework (BAF).

Executive Summary

The MWL BAF was developed following the transaction in July 2023. This report covers the changes in quarter 3.

The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to the delivery of its statutory duties, strategic plans and long-term objectives.

In line with governance best practice the BAF is reviewed by the Board four times a year. The last review of the BAFs was in October 2023.

The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite.

Key to proposed changes:

~~Score through~~ = proposed deletions/completed
Blue Text = proposed additions
Red = overdue actions

Proposed changes to risk scores.

Risk 1 – proposed to increase to 20 because of the increased risk of patient harms resulting from operational pressures, which impact quality indicators.

Risk 2 – proposed to increase to 20 due to the underlying NHS financial position and delayed national planning guidance for 2024/25.

Financial Implications

None directly because of this report.

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board is asked to approve the changes to the Board Assurance Framework	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

BOARD ASSURANCE FRAMEWORK 2023-2024

BAF Dashboard 2023-2024 – Quarter 3 Review

BAF	Risk Description	Exec Lead	Risk Score					
			Inherent	STHK Apr	STHK Jul	MWL Oct	MWL Jan	Target
1	Systemic failures in the quality of care	Medical Director/ Director of Nursing	20	20 ↔	20 ↔	15 ↓	20 ↑	5
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Director of Finance and Information	20	16 ↔	8 ↓	15 ↑	20 ↑	10
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	16	20 ↔	16 ↓	20 ↑	20 ↔	12
4	Failure to protect the reputation of the Trust	Director of Human Resources	16	12 ↔	12 ↔	12 ↔	12 ↔	8
5	Failure to work in partnership with stakeholders	Director of Human Resources/ Managing Director	16	12 ↓	12 ↔	12 ↔	12 ↔	8
6	Failure to attract and retain staff with the skills required to deliver high quality services	Director of Human Resources	20	20 ↔	15 ↓	15 ↔	15 ↔	10
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	16	12 ↔	12 ↔	12 ↔	12 ↔	8
8	Major and sustained failure of essential IT systems	Director of Informatics	20	16 ↔	16 ↔	16 ↔	16 ↔	16

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Medical Director/Director of Nursing

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	1	5	5

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • ~~CQC routine PIR return~~ • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family scores • Quality Ward Rounds **LEVEL 2** Board Assurance • IPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework **LEVEL 3** Independent Assurance • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital	~~Development of a revised Clinical Strategy~~ Standardised approach to Quality Improvement for MWL (March 2024) Single approach to ward accreditation for MWL (March 2024)	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow. Single set of key clinical and quality policies for MWL Incident reporting framework to still include reports all incidents and learning points, in parallel to PSIRF. Escalation protocols responding to industrial action, patient acuity, winter pressures, bed occupancy and delayed discharges do not impact the quality of care for patients.	Deteriorating patient improvement project (Project scope reviewed and refreshed interim report provided to the Executive Committee in August. Project completion for STHK sites revised to March 2024) ~~IPC Summit and action plan to achieve the 2023/24 IPC tolerance trajectories (Now scheduled for November 2023)~~ Alignment of key clinical and quality policies across the new organisation (April 2024) Achieve new complaints response time of 60 days (March 2024) Agree and implement new Risk Management Framework for MWL (March 2024) Deliver action plan in response to the CQC Maternity Inspections when formal reports received (February 2024) Complete the first MWL Nurse establishment review (March 2024)

BAF 2 Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Exec Lead: Director of Finance

Inherent Risk			Current Risk			Target Risk		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	5	20	4	5	20	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. **Effect:** • Failure to meet statutory duties. • NHSE/I Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share • External intervention	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all ICBs and Spec Comm • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group	**LEVEL 1** Operational Assurance • Monthly CBU Finance and Performance Meetings • CIP Council Meetings • Agency and locum spend approvals and reporting process • Operational planning **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils • Annual Financial Plan • Audit Committee • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT) • Internal Audit Programme • CQUIN Monitoring **LEVEL 3** Independent Assurance • ICB &NHSE monthly reporting and review meetings • ~~Use of Resources reviews~~ • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit reports including VfM Assessment • Head of Internal Audit Opinion	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, taking into account current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites.	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances	Seek all possible sources of capital funding including national bids to support capacity planning and delivering the MWL Estate development plans (March 2024) Delivery of final agreed 2023/24 financial plan (March 2024) Delivery of the 3.7% reduction in bank and agency spend compared to 2022/23 levels (March 2024) Continue to track the activity and financial impact of continued Industrial Action and national guidance/direction on how the impact will be funded or activity plans revised (on-going for Junior Doctors) Continued monitoring of the impact of above plan inflation in 2023/24 (February 2024) Tracking of the costs of services over the winter period if outside planning assumptions included in the financial plan (e.g., 92% bed occupancy) (February 2024) Develop 2024/25 financial plan in line with the national planning guidance (March 2024)

BAF 3 Sustained failure to maintain operational performance/deliver contracts					Exec Lead: Chief Operating Officer

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	5	4	20	3	4	12

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand.	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	**LEVEL 1** Operational Assurance • Winter resilience plans • Care Group Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites.	Assurance that there is sufficient system response to operational pressures and delayed discharges. Progress against 2023/24 waiting list reduction and recovery targets. Tumour pathway specific recovery plans to reduce cancer waiting times and consistently achieve the national access standards.	Deliver 2023/24 combined STHK & S&O waiting list reduction and elective recovery targets (April 2024) Work with Place partners to achieve 92% bed occupancy and reduce delayed discharges (April 2024) Improve effectiveness of discharge processes to support 20% of discharges by noon, working with Place partners (As part of the 2023/24 winter plan) Implementation of Theatre Improvement Programme at Ormskirk Hospital (April 2024) Implementation of Diagnostics Improvement Plans across MWL (April 2024) Deliver the 2023/24 winter plan and winter summit action plan to maintain access to urgent and emergency care across the Trust (March 2024)

BAF 4 Failure to protect the reputation of the Trust

Exec Lead: Director of HR

Inherent Risk			Current Risk			Target Risk		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review **Impact:** • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	• Communication and Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	**LEVEL 1** Operational Assurance • Winter resilience plans • Care Group Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways • Provider representative at Place quarterly ICB performance meetings	~~Regular media activity reports, including social media, to the Executive Committee~~ Implementation of the revised Fit and Proper Persons Test Framework including the new national leadership competency framework for board members (March 2024)	Media and Public Engagement Strategy for the new organisation Creation of good working relationships with new Healthwatch/PBP areas post transaction	~~Deliver the next phase of the communication and engagement plan for MWL – focusing on Trust values (December 2023)~~ ~~Create effective working relationships and enhance the Trust's reputation with the new Places and stakeholders for MWL, including MPs~~ Communications programme to launch new trust values and 2024/25 objectives to deliver 5 star patient care (April 2024) Communications review to be completed which will inform the new MWL communications strategy (February 2024) MWL stakeholder newsletter (April 2024) Monthly media activity reports to Executive Committee (February 2024)

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Director of HR/ Managing Director

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff **Impact:** • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments	**LEVEL 1** Operational Assurance • LUHFT Partnership Board • North Mersey Ophthalmology Steering Group • Shaping Care Together Programme • Capital Assurance Group • ED&I Steering Group • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback **LEVEL 2** Board Assurance • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme **LEVEL 3** Independent Assurance • NHSE/I review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs • Membership of St Helens People Board • OSC attendance/presentations		C&M Integrated Care System performance and accountability framework ratings and reports Development of good working relationships with each Place and their Primary Care Networks Maintain or improve NHS Operating framework segment 2 (April 2024)	Work with each Place Based Partnership in the MWL catchment to improve the health of the population and reduce health inequalities (March 2024) Deliver 92% bed occupancy target for each PBP (March 2024) Re start the Shaping Care Together Programme to develop a new PCBC for the configuration of services between the Southport and Ormskirk Hospital sites (March 2024) Work with NHSE/ICB post transaction to continue to support fragile services for MWL as required (September 2024) ~~Cultural engagement and communication programme "the big conversation" to create the MWL values and culture (December 2023)~~ Outputs from the "big conversation" used to develop values and behavioural standards for launch at the start of 2024/25 (March 2024)

BAF 6 Failure to attract and retain staff with the skills required to deliver high quality services

Exec Lead: Director of HR

Inherent Risk			Current Risk			Target Risk		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	5	20	3	5	15	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion action plan	**LEVEL 1** Operational Assurance • Premium Payments Scrutiny Council • Monitoring of bank, agency and locum spend • Workforce operational plans **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Integrated Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	~~Increase frequency of the Strategic People Committee meetings in 2023/24~~ Evaluation of the impact of introducing 12 hour long day nursing shifts (StHK) (Revised to February 2024) Improve ease with which staff can move roles internally. Integration of education structure across MWL	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (March 2024) C&M Endoscopy bank pilot extended to March 2024 and piloting the hybrid employment model. Achieve 2023/24 targets for international recruitment and Nurse Associate expansion with new cohort commencing Q3 2023/24 (March 2024)	Delivery of the 2022 staff survey action plan for legacy organisations in 2023/24 and combine surveys and action plans for future (March 2024) ~~Revise reporting (Datix) system to allow more robust recording of incidents relating to ED&I and staff safety, with interim paper based recording for MWL (revised to November 2023 to align process across the legacy STHK and S&O Datix systems, with single reporting system for MWL planned for 2024).~~ Achieve the Mandatory Training and Appraisal compliance targets of 85% (March 2024) Provide the necessary support for organisational change to impellent the MWL operating model and integrated management structure (March 2024)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

Inherent Risk			Current Risk			Target Risk		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • S&O safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data **LEVEL 3** Independent Assurance • Authorising Engineer Appointments • Authorising Engineer Audits • Condition surveys • Premises Assurance Model benchmarking • Model Hospital • PLACE Audit Results and benchmarking	Maintain up to date 10-year strategic estates development plans for MWL n to support the Trusts service development and integration strategies. Create strategic site development plans for the S&O hospital sites when transaction completed (February 2024) Development of an Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Implementation of new National Standards of Cleaning for MWL - continued engagement with NHSE and proposals agreed with IPC (revised to January 2024) Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken) Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published. ~~Compliance with Fire Enforcement Notice from Mersey Fire and Rescue at S&O hospital sites~~	3-year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2024/5) Delivery of the Whiston Additional Theatres Scheme (June 2024) ~~Fire alarm and compartmentation upgrades at SDGH and fire alarm upgrades at ODGH (November 2023)~~ Complete review of Estates and FM systems, processes, and policies across all MWL sites (March 2024) Deliver the high risk backlog maintenance remediation programme for the S&O sites agreed for 2023/24 (March 2024) Deliver the MWL capital programme (capital works) for 2023/24 (March 2024)

BAF 8 Major and sustained failure of essential IT systems								Exec Lead: Director of Informatics
Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Information security dashboard • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • IM&T Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Groups • Information Governance Steering Group **LEVEL 3** Independent Assurance • Internal/External Audit Programme • CareCert, Cyber Essentials, External Penetration Test • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments	Annual Corporate Governance Structure review Technical Development of staff	Compliance with ISO27001 IT communications strategy Digital Maturity assessment Cyber Essential Certification/Accreditation – achieve by January 2026 Migration from end-of-life operating system at S&O sites MWL Digital Strategy	Review benefits of ISO27001 – if not superseded plan for implementation (March 2024) Achieve HIMMS Level 5 2018 standards and core digital capabilities and WGLL standards (March 2025) Decommission Windows 12 Servers (October 2024). Windows Server 2008 Servers are gradually being retired and will be fully replaced by March 2025. Delivery of the Frontline Digitisation Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (March 2025) Delivery of Community EPR (March 2024) Respond to cyber threat alerts and update systems as required (on going) Test major incident and data recovery plans for MWL (Revised to June 2024) Approve new MWL Digital Strategy (February 2024)

Title of Meeting	Trust Board			Date	31 January 2024
Agenda Item	MWL TB24/009				
Report Title	Aggregated Incidents, Complaints and Claims Report				
Executive Lead	Sue Redfern, Director of Nursing, Midwifery & Governance, Director of infection Prevention and Control				
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery & Governance, Director of infection Prevention and Control				
Action Required		To Approve	X	To Note	

Purpose

The aim of this paper is to provide the Board with a closure report on the management of incidents, complaints, concerns and claims during quarter 2 2023/24.

Executive Summary

Incidents

- 6,433 incidents reported in Q2 at STHK and 2,708 incidents reported at S&O
- 5,196 patient incidents at STHK and 2,165 patient incidents at S&O
- 67 patient incidents graded as moderate or above (36 at STHK and 31 at S&O)
- STHK highest number of incidents reported relate to:
    - Lack of/delayed availability of facilities 1,200 (this is due to the increase in bed waits in ED)
    - Pressure ulcers = 814 (589 non-MWL acquired and 225 Trust acquired)
- S&O highest number of incidents reported relate to:
    - Bed Management = 290 (includes sub-categories such as 12 hours breaches, delay transfer to wards & mixed sex breaches from critical care and others)
    - Access, admission, discharge, transfer = 278 (includes patients who have been lost to follow-up)

Complaints

- 101 first stage complaints were received in Q2 across MWL
- Clinical treatment was the main reason for complaints, in line with previous quarters
- Emergency Department remained the main areas to receive complaints
- 25.2% of complaints were fully upheld

Claims

- There were eight new confirmed claims and 94 new requests for records. This is the highest quarter for records requests for which combined MWL data is available.
- Orthopaedics is the only area to receive more than one confirmed claim in Q2
- The Trust was notified of 34 new inquests in Q2, with no prevention of future death reports

PALS

- There were 1,164 separate contacts with PALSs in Q2
- Communication was the single biggest cause of contact with PALS across both historic sites of MWL

The new report presents combined data (where available) for the whole of MWL.

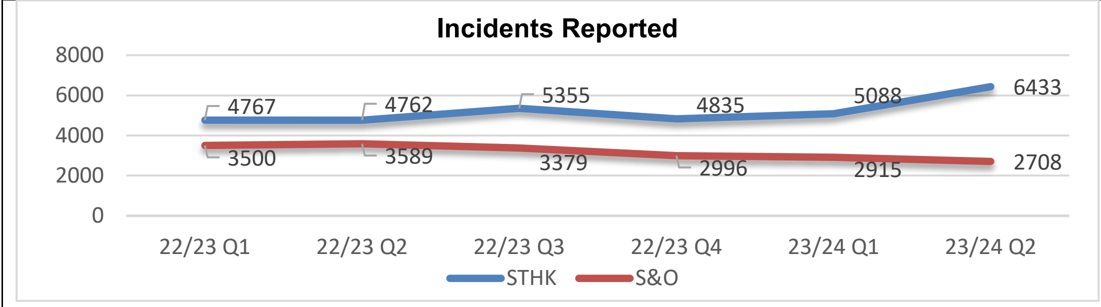
Financial Implications

None as a direct consequence of this paper.	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Aggregated Incidents, Complaints and Claims Report.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

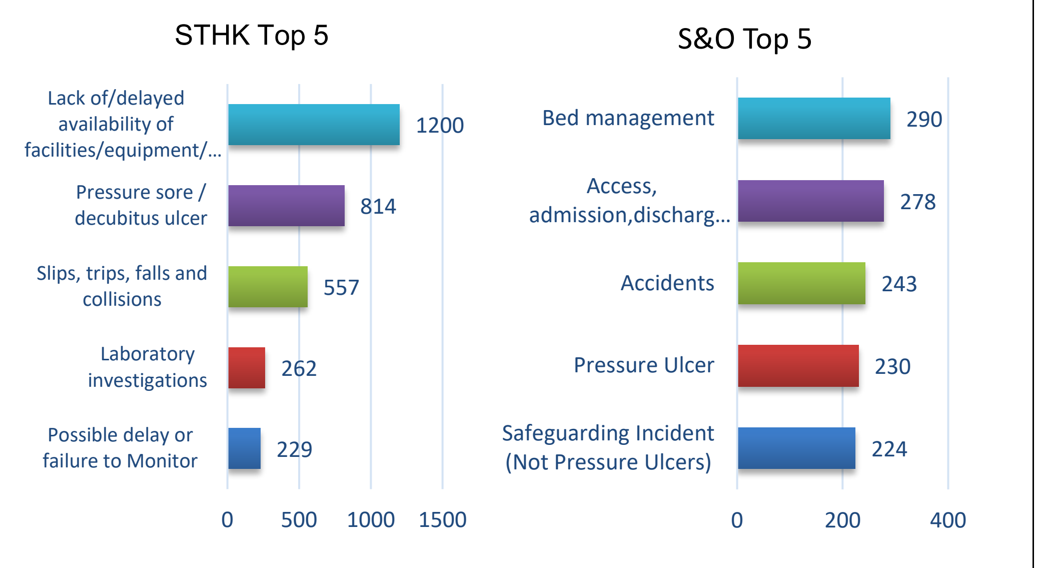
This paper includes reported incidents, complaints, PALS contacts, claims and inquests during quarter 2 2023-24, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS and claims, with two different Datix systems currently in use from legacy organisations.

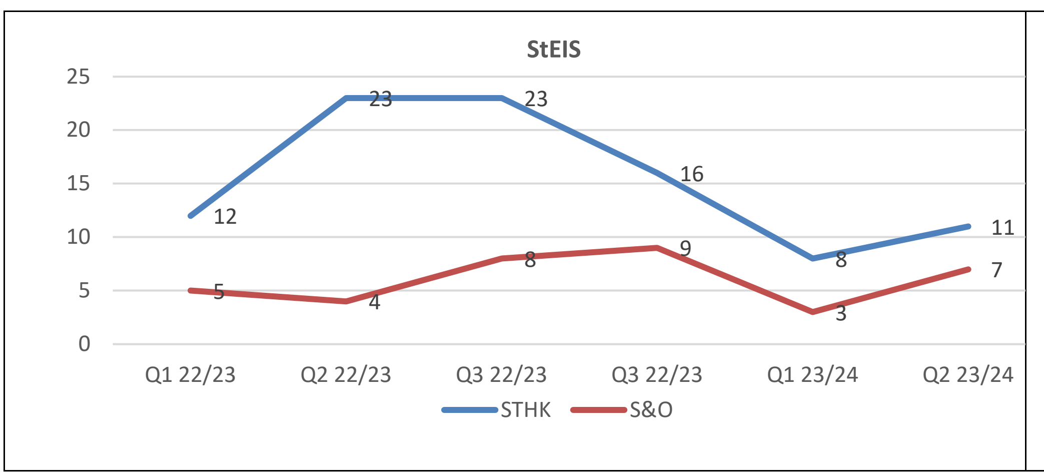
2. Incidents



STHK	S&O	
5196	2165	**Incidents affecting patients**
503	218	**Incidents affecting staff**
698	303	**Incidents affecting the Trust or other organisation**
36	22	**Incidents affecting visitors, contractors or members of the public**

- STHK sites recorded a notable rise in total incidents during Q2. This is a result of a lack of availability of beds in ED (Top category)
- Pressure ulcers remain one of the highest reported categories on STHK Datix with 814 incidents. 589 were not MWL acquired and 225 were Trust acquired
- Bed management incidents remain the highest reported incidents at S&O (includes sub-categories such as 12 hours breaches, delay transfer to wards & mixed sex breaches from Critical Care and others)
- StEIS reportable incidents at STHK have significantly dropped in comparison to the last financial year. StEIS framework was closed at the end of Q2 and Patient Safety Incident Response Framework (PSIRF) was launched on 1st October 2023. Both STHK and S&O now report to PSIRF as a combined service.





STHK	Q1	Q2	Q3	Q4	Q1	Q2
Moderate	19	16	16	15	25	22
Severe	8	10	11	10	5	9
Death	2	3	8	5	3	5
Total	29	29	35	30	33	36
S&O	Q1	Q2	Q3	Q4	Q1	Q2
Moderate	18	23	14	23	19	23
Severe	0	3	6	4	2	8
Death	1	0	3	0	1	0
Total	19	26	23	27	22	31

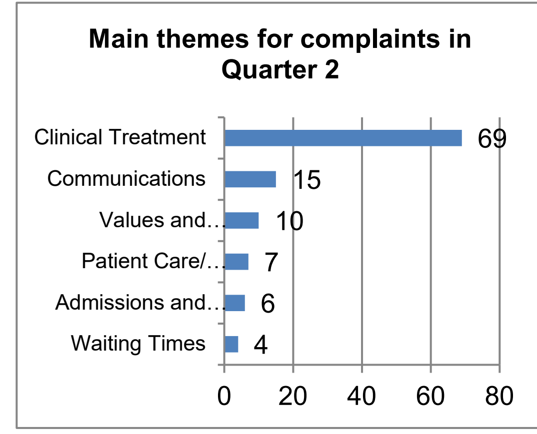
2.1. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q2. Duty of candour is completed for all patient safety incidents graded as moderate or above harm.

3. Complaints

Indicator	2019-20	2020-21	2021-22	2022-23	2023-24 Q1	2023-24 Q2
Total number of new complaints (S & O figures in brackets)	325	251	266 (274)	213 (247)	54 (39)	101*
Response to first stage complaints within agreed timescale – target 90%	93.4%	94%	80% (59%)	75.67%(51%)	72.9% (55%)	75%*
Second stage complaints	36	23	32	38	12	16*

*Combined figures for MWL



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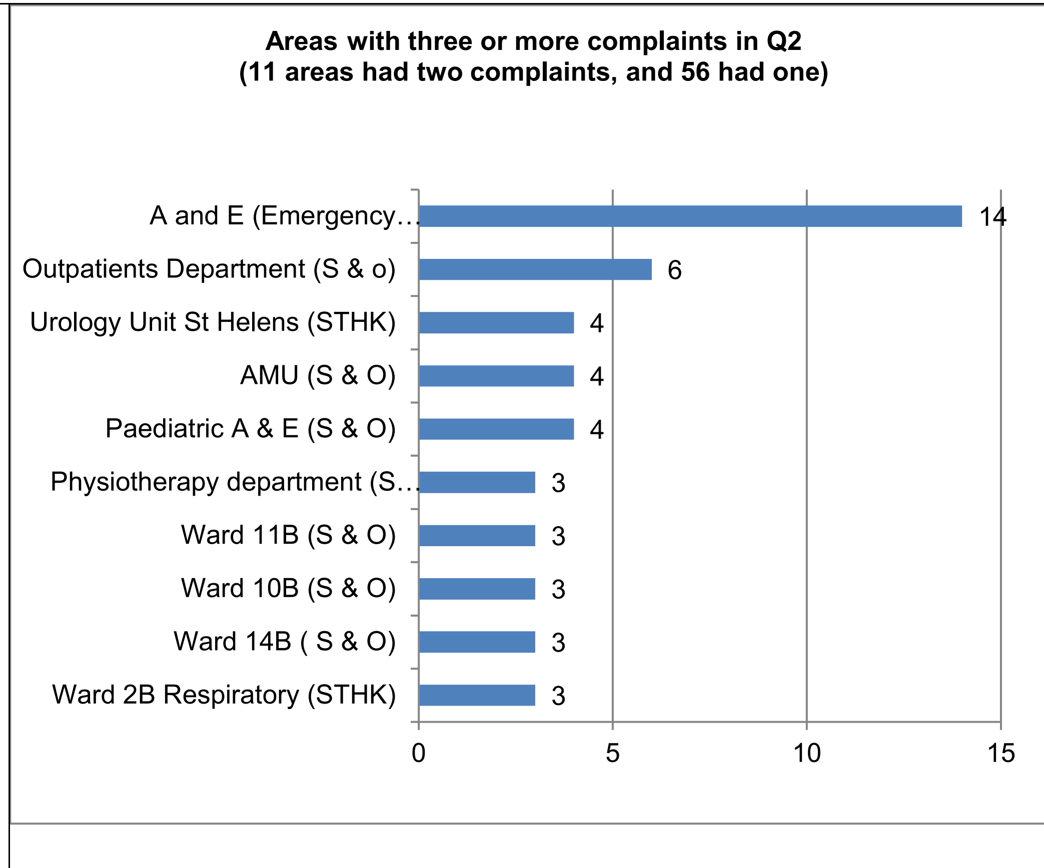
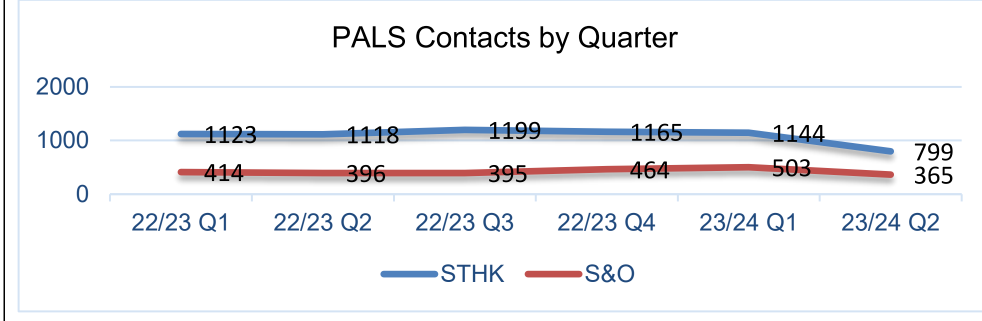
Complaint Outcome Decision	23/24 Q2
Not Upheld Locally	27 (27.3%)
Partially Upheld Locally	47 (47.5%)
Upheld Locally	25 (25.2%)
Total	99

PALS converting to complaints
It is not possible to identify complaints that were previously PALS contacts in the S&O data due to the way it is captured. In respect of the 53 complaints received by the STHK in Q2, 41 had some previous involvement with PALS; 22 of those complaints had one linked PALS enquiry and 19 of the complaints had two or more linked enquiries. Also 22 of those complaints had an incident recorded in Datix linked to the file. The data collected does not currently identify the extent to which the nature and contents of the various issues/concerns/incidents and complaints are directly linked. However it does appear to indicate that efforts were made to resolve the majority of complaints across STHK on an informal basis first.

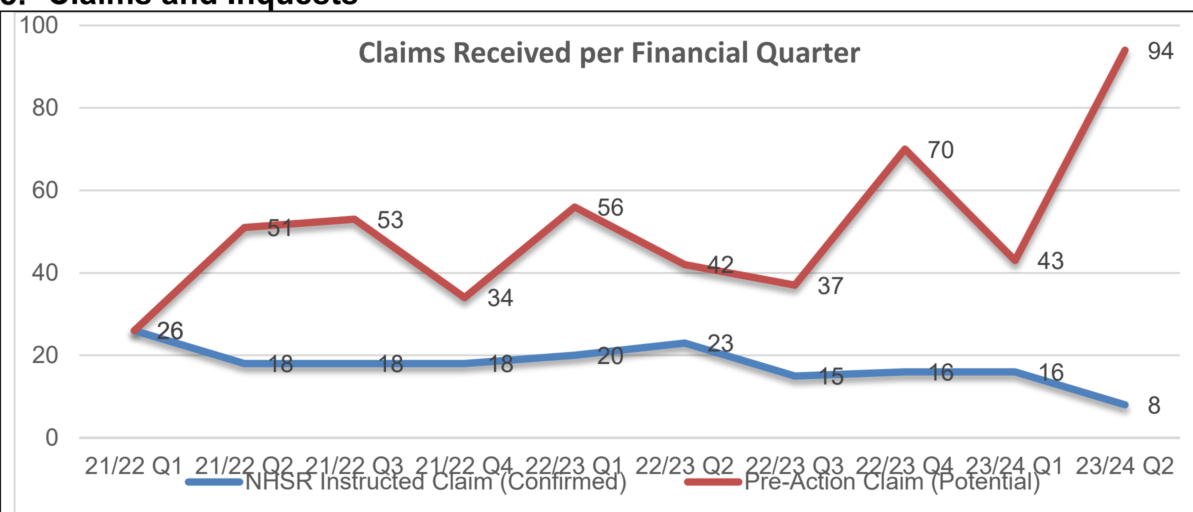


4. PALS

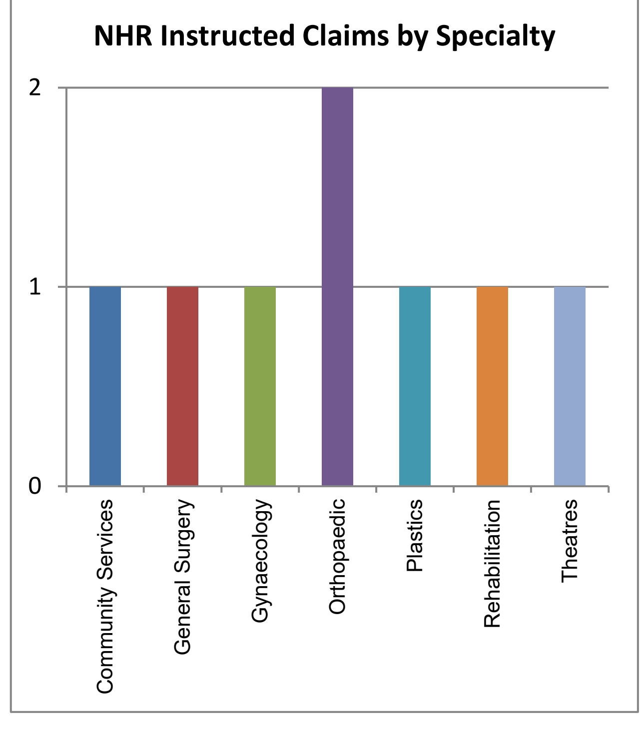


STHK		S&O	
Communications	233	Communication	1st
Appointments	122	Clinical Care	2nd
Admissions and Discharges (excl. delayed discharge re care package)	91	Values / Behaviours and Attitude	3rd
Clinical Treatment	83	Length of waiting time for appointments	4th
Patient Care/ Nursing Care	37	Patient Property	5th

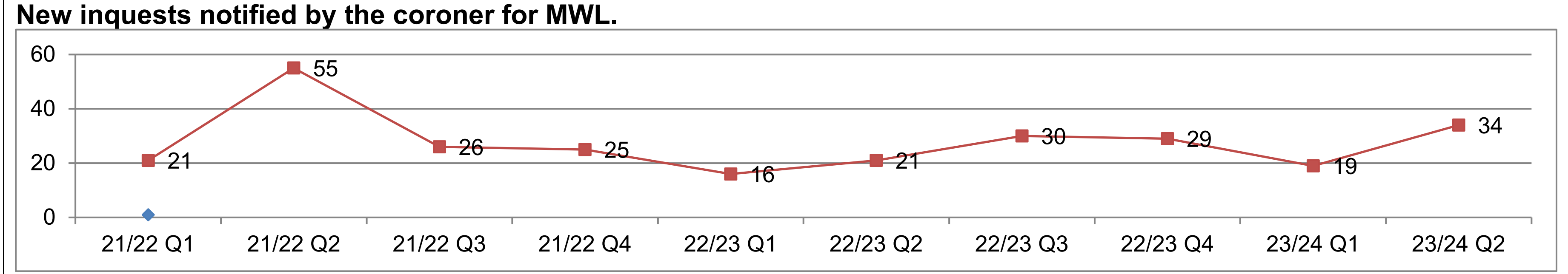
5. Claims and Inquests



Orthopaedics across MWL had the highest number of confirmed claims in Quarter 2. Nowhere else had more than 1 claim. All confirmed claims in Q2 related to former STHK services



New inquests notified by the coroner for MWL.



MWL receives around 10 new inquest notifications a month. There have been no Prevention of Future Death reports for MWL in over 2 years. The coroner did not require any additional reassurance to the information previously provided by the Trust during Quarter 2.

6. Lessons Learned

6.1. Dissemination of learning from Incidents

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

2023/11407 – Renal Radiology Discrepancy - Completed actions

- Radiology clinical director met with Radiologist concerned to discuss the findings of the case and to reflect and learn.
- This report was shared at REALM – the Radiology Governance lead attended to answer any questions surrounding this report.
- Outsourced a sample of radiology reports to review by external Radiologists with a key focus on CT scans. A report will then be created with any discrepancies from these.

2023/14589 – External pacing wire burns - Completed actions

- The CD of Cardiology has shared the immediate learning with the relevant teams
- The CD of Cardiology ensured that ED/ICU are included on the investigation panel and has spoken with the clinicians involved to provide any education and support as required

2023/9709 - Lung nodule progression – Radiology discrepancy - Completed actions

- The importance of the BTS guidelines was reiterated within Radiology and Trust wide to ensure that regular follow-up imaging is achieved when necessary.
- An audit was completed to determine current compliance in Radiology with following the BTS guidelines with regards to the management of pulmonary nodules.
- Sharee the case at the regular radiology discrepancy meeting (REALM).

2023/9723 - Failure to recognise a deteriorating patient - Completed actions
- Reviewed current process for patients who have undergone gynaecological surgery requiring follow up ward reviews by senior medical team.
- Developed a pathway for treating patients with low sodium.
- Training provided for all nursing and medical staff on trust policy of Deteriorating Patient.
- Standards for expected length of stay for all surgical patients to be developed and shared with all staff.

6.2. Learning from Complaints and PALS
A summary of key learning from complaints is provided to the Quality Committee and to the Patient Experience Council, with examples below:
- Ensuring clear communication to patients and relatives around the transfer process.
- Better information regarding access to the main hospital out of hours, particularly for patients who are in labour.
- More training to staff regarding Fast Track/CHC funding to improve the discharge process.
- Improved knowledge of dental abscess/lymphadenitis in children and how to access specialist advice and support.

6.3. Learning from Claims
A summary of key learning from claims is presented to the Quality Committee and to the Patient Safety Council, with examples below:
- Establishing a standard process of booking endoscopic surveillance, with clear roles and responsibilities defined.
- Ensuring no child with a diagnosis of potential or confirmed torsion is discharged home from ED without a physical review and examination by a senior urologist (ST4 or above).This involved a Trust policy on the diagnosis and management of paediatric testicular torsion and associated training.
- Trust nasogastric procedure updated to include chest X-ray hot-reporting, training requirements and competency assessment and chest X-ray reporting competency guidance.

END

Title of Meeting	Trust Board	Date	31 January 2024
Agenda Item	**MWL TB24/010 (12.1)**		
Report Title	Learning from Deaths Quarterly Report (Whiston and St Helens)		
Executive Lead	Dr Peter Williams, Medical Director		
Presenting Officer	Dr Peter Williams, Medical Director		

Action Required		To Approve	X	To Note

Purpose

To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths and key learning has been disseminated throughout the Trust.

Executive Summary

Number of reviews carried out Q4 2022/23

Of the 99 cases reviewed from Q4 (95%) there were no amber and no red outcomes identifying areas of concern

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
January	38	21	12	5	0	0
February	19 **(2)**	8	4	6	0	0
March	47 **(3)**	21	9	11	0	0

Number of reviews carried out Q1 2023/24

Of the 89 cases reviewed from Q2 (90%) there were 3 cases with Amber outcomes and no red. The Amber cases will be reviewed at Mortality Surveillance Group and learning passed back to clinical teams.

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
April	34 **(4)**	11	4	8	1	0
May	34 **(3)**	15	4	3	0	0
June	30 **(2)**	11	4	4	2	0

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable	
Recommendations	
The Board is asked to note the Learning from Deaths Quarterly Report (Whiston and St Helens)	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

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 4 2022/23

In this quarter there were 104 SJR requests
5 of which are incomplete (4.8%)
0 were graded as Red
0 were graded as Amber
50 were graded as Green (48%)
25 were graded as Green with Learning (24%)
22 were graded as Green with Positive Feedback (21%)

Source of SJR Request	Cardiac Arrest Death	Concern Death	Diagnosis Group Death	Internal request	Learning Disabilities Death	Medical Examiner Referral	Post operative death	Severe Mental Illness Death	Total
Jan 2023	3	1	13	0	2	8	7	4	38
Feb 2023	1	2	5	0	0	2	6	5	21
Mar 2023	4	2	10	1	3	5	10	15	50

In Quarter 1 2023/24

In this quarter there were 98 SJR requests
9 of which are incomplete (9%)
0 were graded as Red
3 were graded as Amber (3%) ((all are being managed via the Patient Safety Team))
37 were graded as Green (37%)
12 were graded as Green with Learning (12%)
15 were graded as Green with Positive Feedback (15%)

Source of SJR Request	Cardiac Arrest Death	Concern Death	Diagnosis Group Death	Learning Disabilities Death	Medical Examiner Referral	Post operative death	Severe Mental Illness Death	Total
Apr 2023	6	1	8	2	2	11	4	34
May 2023	5	0	5	1	6	5	12	34
Jun 2023	5	1	3	3	3	4	11	30

Shared learning

Neurological assessment in the confused patient	**Assessment of Pain**
Patients presenting with acute confusion should have a neurological assessment carried out and documented in their medical notes at the time of their initial assessment. This will result in earlier identification of those with a focal neurological deficit and prompt earlier stroke team involvement where appropriate. It also provides a baseline assessment that can be used for comparison later in the hospital admission.	Patients who are confused cannot reliably indicate whether they are in pain. The Abbey Pain Scale is a tool that is validated for use in patients who cannot verbalise their level of pain. It is available via the trust intranet, and should be used as an alternative to the standard 1-10 scoring system used in other patient groups. Click Here for the Abbey Pain Score Tool

Previous learning can be found in the “Learning into Action” section of the Trust Intranet

Sharing and embedding learning

This learning is shared & evidenced in meeting minutes as per matrix in appendix 2.

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.

Appendix 1

Total Deaths in Scope[1]

Check	Review
Check against NWB downloaded LD List[2] **'Learning Disability Death'**	LeDeR Death Review
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	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'**	National EMBRACE system (also perinatal)
Check against current year 'Alert List'[5] **'Alert Death'**[5]	SJR
Check against coding **'Patients with a diagnosis of Autism'**[8]	SJR
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
8. Patients who have a diagnosis of Autism

Appendix 2

Forum/Communication Channel	Chair	Support
Quality Committee	Rani Thind	Joanne Newton
Finance & Performance	Jeff Kozer	Laura Hart
Clinical Effectiveness Council	Peter Williams	Helen Burton
Patient Safety Council	Rajesh Karimbath	Jill Prescott
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Kate Walton	Jane Bennett
MCG Integrated Governance & Quality Meetings	Ash Bassi/Debbie Stanway	Joy Woosey
MCG Directorate Meetings	Debbie Stanway	Joy Woosey
SCG Governance Meetings	Karen Barker	Gina Friar
SCG Directorate Meetings	Phil Nee	Julie Rigby
CSS Directorate Meetings	Caroline Dawn	Sam Barr
ED Teaching	Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Brenda Longworth	
Grand Rounds	Brenda Longworth	

Title of Meeting	**Trust Board**			**Date**	31 January 2024
Agenda Item	**MWL TB24/010 (12.2)**				
Report Title	Learning from Deaths Quarterly Report (Southport and Ormskirk)				
Executive Lead	Dr Peter Williams, Medical Director				
Presenting Officer	Dr Peter Williams, Medical Director				
Action Required		**To Approve**	X	**To Note**	

Purpose

To Inform the board of themes from Learning from Deaths.

Executive Summary

- No deaths in Quarter 2 were reported as avoidable following conclusion of reviews.
- Diagnoses of concern with a higher than expected Hospital Standardised Mortality Ratio (HSMR) include Lower Respiratory Tract Infection (LRTI) and Acute Kidney Injury (AKI).
- A review of the rise in HSMR for LRTI demonstrates that this relates to six patient deaths, none of which were deemed to be unexpected on clinical review.
- A review into the rise in HSMR in the AKI Group is ongoing and will report back to the Mortality Operational Group (MOG).

Financial Implications

Not applicable

Quality and/or Equality Impact

Learning from deaths seeks to promote continuous learning in order to foster a culture that leads to ongoing improvement of care, pathways and services.

Recommendations

The Board is asked to note the Learning from Deaths Quarterly Report (Southport and Ormskirk)

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Learning from Deaths Report Quarter 2 (Southport and Ormskirk Sites)

1. Introduction

The learning from deaths report for Southport and Ormskirk Hospitals is compiled from a variety of sources which are reviewed considered at the Mortality Operational Group (MOG). The purpose of the group is to identify any avoidable deaths which have occurred in hospital and identify any themes for learning and improvement.

2. Review of Deaths Q2

Following review of the deaths in hospital for patients in Quarter 2 of 2023/24, no deaths were found to be avoidable or related to problems in healthcare. 3 Structured Judgement Reviews (SJR) were completed in Q2. Of these:

Avoidable Deaths: 0

Reason for SJR: Cardiac arrest reviews: 3

Problems in Healthcare Identified? Yes: 0 No: 3

Overall Care Rating: Good: 3

3. Thematic Review of HSMR Diagnostic Groups

Review of the Hospital Standardised Mortality Rate reviewed higher than expected mortality in the Lower Respiratory Tract Infection (LRTI) and Acute Kidney Injury (AKI) groups.

The rise in HSMR patients with LRTI has been clinically reviewed. This relates to 6 patient deaths. None were found to be avoidable.

The rise in HSMR in AKI is currently under review and a Quality Improvement Project (QIP) is underway to improve the inpatient management of AKI in critical illness (eg. Sepsis)

4. Quarter 2 Learning Points

<u>Medication Safety</u>

Medication is often withheld for good clinical reasons, such as anticoagulants in severe renal failure. It is important that the rationale for this is documented, so that if the situation changes these medications can be restarted. Critical Medications should not be withheld and should be given by an alternative route unless an active medical decision has been made to discontinue. In patients where swallowing is expected to be permanently impaired, capacity assessments and decisions in the patient's best interest should be made, in conjunction with relatives and loved ones.

End of life Care

National audits of care at the end of life have shown that in Southport, the discussion about end of life care is led by a senior clinician 33% of the time. These decisions should always be senior led, but for reasons of urgency, discussions may be delegated. In all cases there must be adequate access to senior colleagues in the event of any persisting concerns or unresolved issues.

Do not attempt Cardiopulmonary Resuscitation (DNA-CPR)

Audit of DNACPR forms shows an general improvement in documentation of involvement of the patients relatives / NOK. One recurrent issue is the use of 'learning disability' as the reason for DNACPR. Care must be taken with documentation of the rationale for DNA-CPR; "Learning Disability" or "Dementia" are themselves never a reason to complete a DNA-CPR form. A DNACPR decision is made in circumstances where the end of a patient's life is predictable and unavoidable. Anticipating what may happen in predictable circumstances is good medicine and will be supported. Senior colleagues are available for advice.

Communication has been sent to all medical staff reminding them of the learning points outlined above.

Appendix 1

Mortality Operational Group Membership

Mike Lightfoot - Business Information

Jess Hassan - SJR Analysis

Emma Roney - Resuscitation Services

Clare Finnegan - Supportive and Specialist Palliative Care

Sam Seagrave - Claims and Inquests

Helen Vangikar - Clinical Risk and Investigations

Emma Houghton - Learning Disability including LeDeR

Janette Mills - Mortality and Morbidity Meetings

Chris Goddard - Medical Examiners Office

Nicola Orr (Planned Care) Laura Gwynne (MEC) Linda Conolly (Womens and Childrens) - CBU Patient Safety Meetings

Medical Examiners

Dr Annie Leigh

Dr Ciara Cruise

Dr John Kirby

Dr Michael Vangikar

Dr Paddy McDonald

Dr Sudakar Kandasamy

Dr Preethi Narla

Dr Sarah Parkinson

Dr Jayne Wilkinson

Mandy Power

Andrea Foster

ENDS

Title of Meeting	**Trust Board**		**Date**	31 January 2024
Agenda Item	**MWL TB24/011**			
Report Title	Freedom to Speak Up Annual Self-Assessment 2024			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required	X	**To Approve**		**To Note**

Purpose

Trust Boards are required to have an oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive self-assessment in the required template provided by National Guardians Office (NGO), conducted at least every two years. The self-assessment completed for 2024 forms part of Trust Boards assurance process of its review of Freedom to Speak Up process as a merged organisation.

Executive Summary

The Trust's 'Freedom to Speak Up' and 'Raise a Concern' vision is to promote an open and transparent culture across the organisation to ensure that all members of staff feel safe, supported, and confident to speak out and is to the Trust's objective of delivering 5 Star patient care.

Trust Boards are required to have an oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive self-assessment. conducted at least every two years. The STHK Trust Board undertook Self-Assessment in 2023 as part of its assurance process and the Strategy and Operations Committee for S&O under the ALTC, understood self-assessment in older version of assessment document. Areas requiring improvement identified by individual trusts in their respective assessment have now been resolved. This includes open recruitment for dedicated Guardian role and enabling access to Freedom to Speak Up training for all staff and managers.

Self-assessment has been completed by the Trust Board as part of merged organisation, on the subscribed new template from NGO for 2024. As part of the assessment, the findings of the assessment are as expected and meeting all requirements, and aspects for further improvement have been identified to achieve enrichment in the Trust's freedom to speak up systems.

Financial Implications

Nil

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to review the self-assessment for 2024, note associated actions and approve.

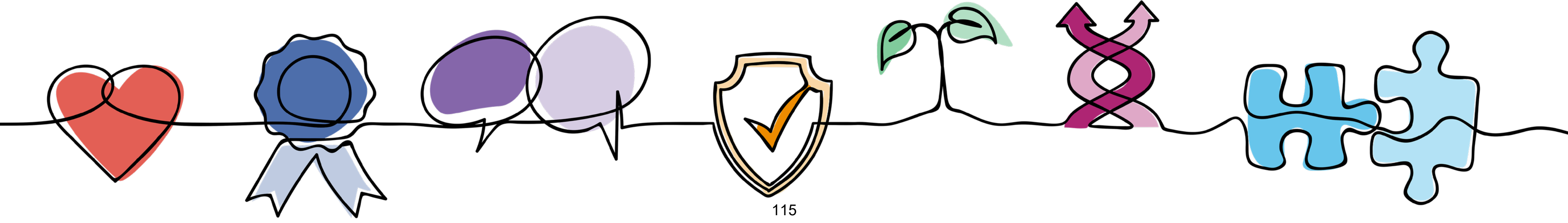
Strategic Objectives

	SO1 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication

	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Freedom to Speak up.

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide.

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up.

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5
I am assured that our guardian(s) was recruited through fair and open competition	4
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5

Enter summarised commentary to support your score.

- Trust newly formed following merger, work underway to bring pre-existing FTSU structures and processes together. The two former Trust's had completed a self-assessment in 2023 and completion of this Reflection and Planning Tool will enable the new organisation to develop an organisational FTSU forward plan.
- CEO, Chairman and Medical Director are FTSU Guardians, along with Director of Human Resources and Executive Lead for FTSU - Director of Nursing who are knowledgeable and offers direction, advice, support, and challenge in relation to the FTSU culture, structure, systems, and process.
- Organisation has 6 FTSU Guardians, three of whom are members of the Trust Board. Two of the other dedicated Guardians have been recruited through open advert and fair competition.
- Review of speaking up arrangement is carried out regularly and triangulated with other performance measures impacting speaking up.
- A review of FTSU guardians' structure has been undertaken post-merger and a further Guardian has been appointed. Two of the FTSU Guardian are employed part time to solely deliver the FTSU function and the others, complete their guardian role, in addition to their main job role. This offers staff a mixture of Guardians to approach.
- The Executive Leads meets regularly with all Guardians.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
All future FTSU Guardians to be appointed through a fair and open process in line with national guidance.

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	4
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	5

Enter summarised evidence to support your score.

- Non-Executive lead is the Trust Chair, who is also a FTSU Guardian.
- 3 Trust Board members are nominated established FTSU Guardians, with knowledge and awareness of FTSU process and NGO guidance.
- Board level engagement and promotion of speaking up agenda with visibility, promotion, role modelling and communication using appropriate forums, including Trust Team Brief Live events and Trust Social media channels.
- Regular review of speaking up process and challenge to improve arrangements through reflective evaluation at Guardians meetings.
- Organisation has 6 FTSU Guardians, three of whom are members of the Trust Board. Two of the other Guardians have been recruited through open advert and fair competition.

- A review of FTSU guardians' structure has been undertaken post-merger and a further Guardian has been appointed. Two of the FTSU Guardian are employed part time to solely deliver the FTSU function and the others, complete their guardian role, in addition to their main job role. This offers staff a mixture of Guardians to approach.
- In collaboration with Trust Guardians, will be providing oversight into any investigation that relate to the board.
- Support to Guardians as required in setting speaking up process and systems.
- Facilitative function of Board members being FTSU Guardian in enabling system changes and assurance.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

All future FTSU Guardians to be appointed through a fair and open process in line with national guidance.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture.

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	5
We regularly and clearly articulate our vision for speaking up	5
We can evidence how we demonstrate that we welcome speaking up	5
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	4
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	5
We regular discuss speaking-up matters in detail	5

- Members of the Board encourage staff to speak up and this has been raised several times on Trust Brief Live and is also part of the Trust Objectives, relating to developing the organisational culture and workforce.

- High visibility of the Executive Team and Senior Leaders through the Staff Voice Partnership, Staff Network and clinical role encourages staff to speak up.
- Staff networks are in place which supports staff, with protected characteristics to have a safe space to discuss concerns and raise issues.
- Trust participates in the October Freedom to Speak up Month and undertook several activities across the month in 2023.
- Feedback to the Guardians, from staff who have spoken up, is positive.
- Guardians are aware of the NHS England FTSU Support Scheme and how to refer staff, who have reported detriment, to the scheme.
- FTSU Quarterly Reports taken through the Valuing Our People group and then through to Quality Committee for assurance, oversight, and scrutiny to the Trust Board.
- Regular communication with all staff members through forums to inform of the support and mechanism for Freedom to Speak Up
- Periodic communication regarding Freedom to Speak Up using Team Brief Live, Newsletters, Global Emails, Team Talk events and engagement events.
- FTSU Guardians seek feedback, as per national guidance, from all staff who speak up through them.
- Staff who speak up to the guardians are supported through the process and are asked to report any perceived detriment.
- Process in place to identifying detriment experienced because of speaking up.
- Quarterly and ad-hoc meeting in place to discuss Speaking up arrangements.
- Highly visible Executive members and senior leadership teams, role modelling of speaking up culture.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

Formalise and refine approach to monitor detriment for staff who have spoken up via the FTSU Guardian

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	5
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	5
We support our guardian(s) to make effective links with our staff networks	5
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	5

• Experience with supporting and leading speaking up process, with knowledge and commitment for speaking up process • Speaking up culture is integral to culture improvement plans and organisational development plans. A Just and Leaning Culture embedded within the organisation. • Trust has a consistent open and honest reporting culture, with high incident reporting indicative of a just and learning culture. Trust objective is supportive of developing an open management style that encourages staff to speak up, in an environment which values, recognises and supports the workforce. • FTSU Guardians have links with the staff networks within the Trust. • We have reviewed the FTSU indicators within the staff survey to review our culture and plan activities. Staff survey feedback is extremely positive. • We have undertaken a short FTSU effectiveness and awareness evaluation to measure awareness of FTSU processes, with positive findings. • We utilise and encourage FTSU Champions to share soft intelligence regarding the FTSU culture at regular meetings as well as formal FTSUP concerns. Actions are captured and progress reported at next meeting.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Statements about how much time the guardian(s) has to carry out their role	**Score 1–5 or yes/no**
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	5
We have reviewed the ringfenced time our Guardian has in light of any significant events	5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	5
Enter summarised evidence to support your score.	

• 6 Guardians in place across the Trust, two of whom are ring fenced posts as FTSU Guardians. This provides a variety of roles and leadership levels for staff to approach and allows for cross site cover. • There has been a review undertaken post-merger of FTSU resulting in one additional post, being appointed to and the expansion of the network of FTSU champions across the Trust. • FTSU Specialist Administrator post provide administrative support to Guardians. • Trust Executive Team has reviewed FTSU guardian capacity and supported business case to expand capacity by creation of additional part time dedicated FTSU Guardian role and expansion of network of FTSU champions. • FTSU champions roles reviewed, development programme is in place and ongoing recruitment in progress at all sites. • Guardians are supported by a growing network of FTSU Champions.
Review the establishment for FTSU at least annually going forward and adjust if required.
Continue to recruit and support FTSU Champions across all sites of the Trust.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so.

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	4
We can evidence that our staff know how to find the speaking-up policy	5

- Harmonisation of FTSU policy in new format, post-merger in progress.
- There is a dedicated intranet page for staff to review and read which includes a links to additional information, policy and ways for staff to raise concerns.
- Staff are asked as part of quality walkarounds regarding FTSU and information is shared if staff indicate they are unaware of the processes.
- Pop up stalls, engagement events and awareness sessions are held on a regular basis to support raising staff awareness.
- Evaluation audits on FTSU awareness were undertaken in 2023 and these have informed further work.
- FTSU Guardians has a presence on the staff Facebook page, raising awareness of speaking up.
- There has been an increase in the numbers of staff speaking up in 2023/24 when compared to the year 2022/23.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Continuous review and revision of FTSU policy as required.

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	4

Enter summarised evidence to support your score.

- There is a dedicated intranet page for staff/leaders to review and read, which includes a links to additional information and ways for staff to raise concerns.
- There are posters placed around the trust to identify FTSU Guardians and guardians have been highlighted in the Trust Newsletter.
- Executive and Guardian led briefs on Speaking Up provided through Team Brief Live events.
- Regular meetings with Freedom to Speak Up Guardians to discuss themes and communication requirement.
- There are screen savers on Trust computers describing FTSU support available for staff.
- Electronic notice boards in place, in high visibility public areas with information about speaking up.
- The Trust participated in October, Freedom to Speak up Month and held several activities and pop ups to raise awareness.
- FTSU Guardians has a presence on the staff Facebook page, raising awareness of speaking up.
- Reports to Trust committees include what changes have been made because of speaking up, where appropriate and whilst protecting staff confidentiality
- Positive changes and ‘You Said We Did’ summaries shared at engagement events highlighting positive stories and changes as a result of speaking up.
- Guardians have planned pop up stands once a quarter to raise awareness of speaking up and talk to staff.
- Formal and informal collection of feedback on effectiveness of communication.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Continue to develop and implement plan of engagement events and speaking up profile-raising events

Principle 4: When someone speaks up, thank them, listen and follow up.

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	5
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	4

- FTSU information is included in both the corporate and clinical inductions.
- All Guardians and FTSU Champions have completed appropriate National Guardian's Office and Health Education England training.
- National Guardian's Office and Health Education England training made available on Moodle platform and ESR for all staff to access.
- Information regarding training shared through engagement events and communications from Guardians.
- FTSU Guardians attend induction for student nurses, junior doctors, international nurses and complete ad hoc sessions for other staff on request.
- All staff who speak up receive a thank you from one of the guardians.
- National staff survey and Pulse survey in place to measure effectiveness of speaking up process and findings reviewed.
- Sample survey of induction programme and contents delivered includes measuring impact of speaking up training.
- Positive feedback on awareness sessions delivered by Guardians.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Continue to promote and deliver training to staff members raising awareness and supporting staff.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	5
All managers and senior leaders have received training on Freedom to Speak Up	4
We have enabled managers to respond to speaking-up matters in a timely way	4
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	4

- Individual managers are offered support by guardians when receiving and reviewing concerns raised via guardian.
- When raising concerns, guardians ask for a response from managers and leaders within a timeframe which varies depending on the concern being raised. This approach acknowledges that some areas of concern may take longer to review and offers a flexible and dynamic approach.
- National Guardian's Office and Health Education England training for managers 'Listen Up' made available on Moodle platform and ESR for staff to access.
- All management and leadership development programme incorporates the systems, process and benefits associated with FTSU as part of a compassionate leadership.
- All managers and senior leaders have access to learning modules and has been promoted.
- Information shared with managers through engagement events and communication on their role in supporting and responding to speaking up.
- Reflective improvement and feedback from staff and managers on learning from speaking up and adapting their environments to ensure a safe speaking-up culture.
- Guardians have close working relationship with HR and OD team to develop a supportive and learning culture and develop staff members.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Consider delivering relevant Speaking Up Training for all managers through available forums.

Incorporate speaking up as integral part of inhouse course for leaders and managers regarding building and supporting a Speak Up Culture.

Principle 5: Use speaking up as an opportunity to learn and improve.

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	5
We use triangulated data to inform our overall cultural and safety improvement programmes	4

- Guardians are supported via one-to-one meeting with the Executive lead for FTSU and meet as a collective to discuss emerging or actual areas of concern/themes.
- Guardians follow through on cases raised through them to completion to ensure that any lessons identified are taken forward.
- Regular meetings with all Guardians in place to raise and address any areas of concerns and develop actions to resolve.
- We have highly visible Executive team and Board member involvement as Freedom to Speak Up Guardian.
- We use triangulation of data obtained through various process to inform and develop overall cultural and safety improvement programmes.
- Guardians attend quality and patient safety groups/committees.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	4
We use this information to add to our Freedom to Speak Up improvement plan	3
We share the good practice we have generated both internally and externally to enable others to learn	4

- FTSU Guardians are members of the Northwest FTSU Guardians Network and share and learn from other FTSU Guardians
- Annual assessment has been undertaken by both former Trust and presented to the Trust Boards
- Gap analysis against reports published by the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Revise FTSU Strategy and Improvement Plan for the next two to three years, incorporating gap analysis as identified in reviews and evaluation.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements.

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	4

- Two of the 6 guardians have been appointed through an open recruitment process.
- FTSU Guardians, who have a dedicated role, follow the national prescribed job description.
- A number of the guardians are registered with the NGO and have completed the training required.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
All guardians recruited to be undertaken training from NGO. Existing guardians will undertake annual refresher training or appropriate development programmes as required by NGO standards or individual requirement.

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5

- All guardians have had a PDR and have objectives in place.
- Guardians have regular 1:1 with the Executive lead for FTSU and meet as a collective
- Peer support through Trust Guardians regular network meetings.
- Support from Trust Board members and Trust Executive team to Guardians in advisory and facilitative support.
- Guardians have access to wider range of emotional support mechanism within the Trust.
- Guardians are members of the Northwest FTSU Network and can gain emotional support via this group or via the NGO.
- Multiple Guardians in place to provide mutual support and cross cover in absence.
- Multiple processes in place for staff members to contact Guardians and raise concerns including Confidential Hotline and Anonymous Work in Confidence system.
- Guardians can provide cross site cover when there is annual leave/absence.
- The organisation submits data to the NGO on a quarterly basis.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
We are assured that confidentiality is maintained effectively	5
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	5
We are confident that if people speak up within the teams or directorates, we are responsible for, they will have a consistently positive experience	5

- Case handling procedures are documented in policies.

- Information shared with managers through engagement events and communication on their role in supporting and responding to speaking up.
- When raising concerns, guardians ask for a response from managers and leaders within a timeframe which varies depending on the concern being raised. This approach acknowledges that some areas of concern may take longer to review and offers a flexible and dynamic approach.
- There is a dedicated intranet page for staff to review and read which includes a links to additional information and ways for staff to raise concerns.
- Regular updates given through Team Brief, Newsletter and other engagement events on the role managers and other key stakeholders in handling speaking-up cases.
- Speak Up and Listen up modules available on education portal for all staff to access
- Staff can raise concerns openly, confidential via a guardian or anonymously through the "work in confidence system".
- Guardians maintain confidential files for all cases open to them and are only accessible by the FTSU Team.
- Soft intelligence suggest that most people asked, feel able to speak up in their teams, however this is not reflected in staff survey results across all sites.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Incorporate speaking up as integral part of inhouse course for leaders and managers regarding building and supporting a Speak Up Culture.

Principle 7: Identify and tackle barriers to speaking up.

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	5
We know who isn't speaking up and why	4

We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	4

- Barriers to speaking up have been identified through networking and engagement. Identified barriers mitigated by creation of new dedicated Guardian role and expansion of Champion network.
- FTSU strategy to be revised and revised, based on organisational need.
- Engagement of Guardians in staff network, EDI forums and international recruitment support process to develop understanding of barriers from speaking up.
- Champions are given training on recruitment and work to the NGO guidelines issued in 2023.
- Champions are supported via monthly meetings and one to one meeting, with a guardian, as required.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Analysis of Staff Survey data, once received to identify individual areas where staff feel unable to speak up and provide some targeted support.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	4
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	5
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	5

- We carry regular engagement events on understanding speaking up looks and feels like, along with detriment.
- FTSU Guardians discuss determinant with staff who raise concerns through them, and staff are asked to report if they feel they are experiencing detriment.

- Where possible, Guardians follow up on staff who have raised concerns to monitor whether workers feel they have suffered detriment after they have spoken up
- Guardians are aware of the FTSU support scheme run by NHSE England and can refer staff to the scheme as required.
- Non-executive Director for Freedom to Speak Up is regularly attends Guardians meeting and scrutinises instances of detriment.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

FTSU Policy to define how detriment will be monitored and reviewed as part of the FTSU process.

Principle 8: Continually improve our speaking up culture.

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	4
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	4
Our improvement plan is up to date and on track	4

- Legacy Trusts had a FTSU Strategy, a strategy for the newly merged organisation in Q4 23/24..
- Strategy is aligned and fits with organisational objective and overall cultural improvement.
- Trust continuously evaluates the Speaking Up process and effectiveness, using a range of qualitative and quantitative measures like Annual Staff Survey, Pulse Surveys, feedbacks from staff, review of concerns by Guardians and regular Guardians meetings.

• Continual evaluation of speaking up process and improvements made
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Develop a formal and dynamic improvement plan reflective of continuous evaluation.

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	4
• Each former trust has completed an annual self-assessment. • Staff survey results are reviewed in relation to FTSU and triangulated with other relevant information applicable to speaking up. • Continuous evaluation of speaking up arrangements by Trust Board members, Executive Team, and Guardians • High staff satisfaction results in staff surveys	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
Implement a recognised quality improvement approach in evaluation of speaking up arrangements.	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	5
We have we evaluated the content of our guardian report against the suggestions in the guide	5

Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	4

Enter summarised evidence to support your score.

- Both legacy Trust Boards received regular reports relating to FTSU and as a merged organisation reports will be produced quarterly
- A variety of qualitative and quantitative information is used to evaluate Freedom to speak up arrangements, including staff surveys results, direct feedback.
- Assurance of positive impact of speaking up, with learning and improvement from senior leaders shared at appropriate forms.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Stage 2: Summarise your high-level development actions for the next 6 – 24 months.

Development areas to address in the next 6–12 months	Target date	Action owner
1. Formalise and refine approach to monitor detriment for staff who have spoken up via the FTSU Guardian.	31 March 2024	RK/CGE/ FTSU Exec Lead
2. Continue to develop and implement plan of engagement events and speaking up profile-raising events.	31 March 2024	RK/CGE/ FTSU Exec Lead
3. FTSU Policy to define how detriment will be monitored and reviewed as part of the FTSU process.	31 March 2024	RK/CGE (FTSUG)
4. Develop a formal and dynamic improvement plan reflective of continuous evaluation	31 March 2024	RK/CGE (FTSUG)
5. Implement a recognised quality improvement approach in evaluation of speaking up arrangements.	31 March 2024	RK/CGE (FTSUG)
6. Revise FTSU Strategy and Improvement Plan for the next two to three years, incorporating gap analysis as identified in reviews and evaluation.	30 April 2024	CGE/RK/SN
7. Formally incorporate speaking up as integral part of in-house course for leaders and managers regarding building and supporting a Speak Up Culture.	30 June 2024	FTSU Guardians/ Organisational development team
8. Analysis of new Staff Survey data, once received to identify individual areas where staff feel unable to speak up and provide targeted support.	30 June 2023	FTSU Guardians/ Organisational development team

Development areas to address in the next 12–24 months	Target date	Action owner
1. All future FTSU Guardians to be appointed through a fair and open process in line with national guidance.	Ongoing	RK/CGE/ FTSU Exec Lead

2. Continue to recruit and support FTSU Champions across all sites of the Trust.	Ongoing	RK/CGE
3. Deliver relevant Speaking Up Training for all managers through available forums.	Ongoing	RK/CGE
4. Continue to promote and deliver training to staff members raising awareness and supporting staff.	Ongoing	RK/CGE
5. All guardians recruited to be undertaken training from NGO. Existing guardians will undertake annual refresher training or appropriate development programmes as required by NGO standards or individual requirement.	Ongoing	RK/CGE
6. Review the establishment for FTSU at least annually going forward and adjust if required.	30 December 2024	RK/CGE (FTSUG)
7. Continuous review and revision of FTSU policy as required.	30 December 2024	RK/CGE (FTSUG)

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. Continue to recruit and support FTSU Champions across all sites of the Trust.	Ongoing	RK/CGE/SN