Trust Public Board Meeting

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

AGENDA				Paper	Purpose	Presenter
10.00	1.	Employee of the Month Film - STHK July 2023 - S&O July 2023		Verbal	Assurance	Chair
10.20	2.	Patient Story - STHK - S&O		Verbal	Assurance	Chair
10.40	3.	Apologies for Absence		Verbal		
10.45	4.	Declaration of Interests		Verbal		
10.50	5.	Minutes of the STHK Board Meeting held on 28th June 2023 Minutes of the S&O Strategy and Operations Committee held on 7th June 2023 Minutes of the S&O Board Meeting held on 30th June 2023		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
11.00	6.	STHK Integrated Performance Report – June 2023		MWLTB (23)001	Assurance	Gareth Lawrence
		6.1	Quality Indicators			Sue Redfern
		6.2	Operational Indicators			Rob Cooper
		6.3	Financial Indicators			Gareth Lawrence
		6.4	Workforce Indicators			Anne-Marie Stretch

11.20	7.	S&O Integrated Performance Report – June 2023		MWLTB (23)002	Assurance	Gareth Lawrence
		7.1	Quality Indicators			Sue Redfern
		7.2	Operational Indicators			Lesley Neary
		7.3	Financial Indicators			Gareth Lawrence
		7.4	Workforce Indicators			Anne-Marie Stretch
STHK Committee Assurance Reports						
11.40	8.	Committee Report – Executive		MWL TB (23)003	Assurance	Ann Marr
11.50	9.	Committee Report – Finance & Performance		MWL TB (23)004	Assurance	Jeff Kozer
12.00	10.	Committee Report – Quality		MWL TB (23)005	Assurance	Gill Brown
12.10	11.	Strategic People Committee		MWLTB (23)006	Assurance	Lisa Knight

LUNCH BREAK

S&O Committee Assurance Reports					
12.40	12.	Committee Report - Executive	MWL TB (23)007	Assurance	Anne-Marie Stretch
12.50	13.	Committee Report – Finance, Performance, and Investment	MWL TB (23)008	Assurance	Jeff Kozer
13.00	14.	Committee Report – Quality and Safety	MWL TB (23)009	Assurance	Gill Brown
13.10	15.	Committee Report - Workforce	MWL TB (23)010	Assurance	Lisa Knight

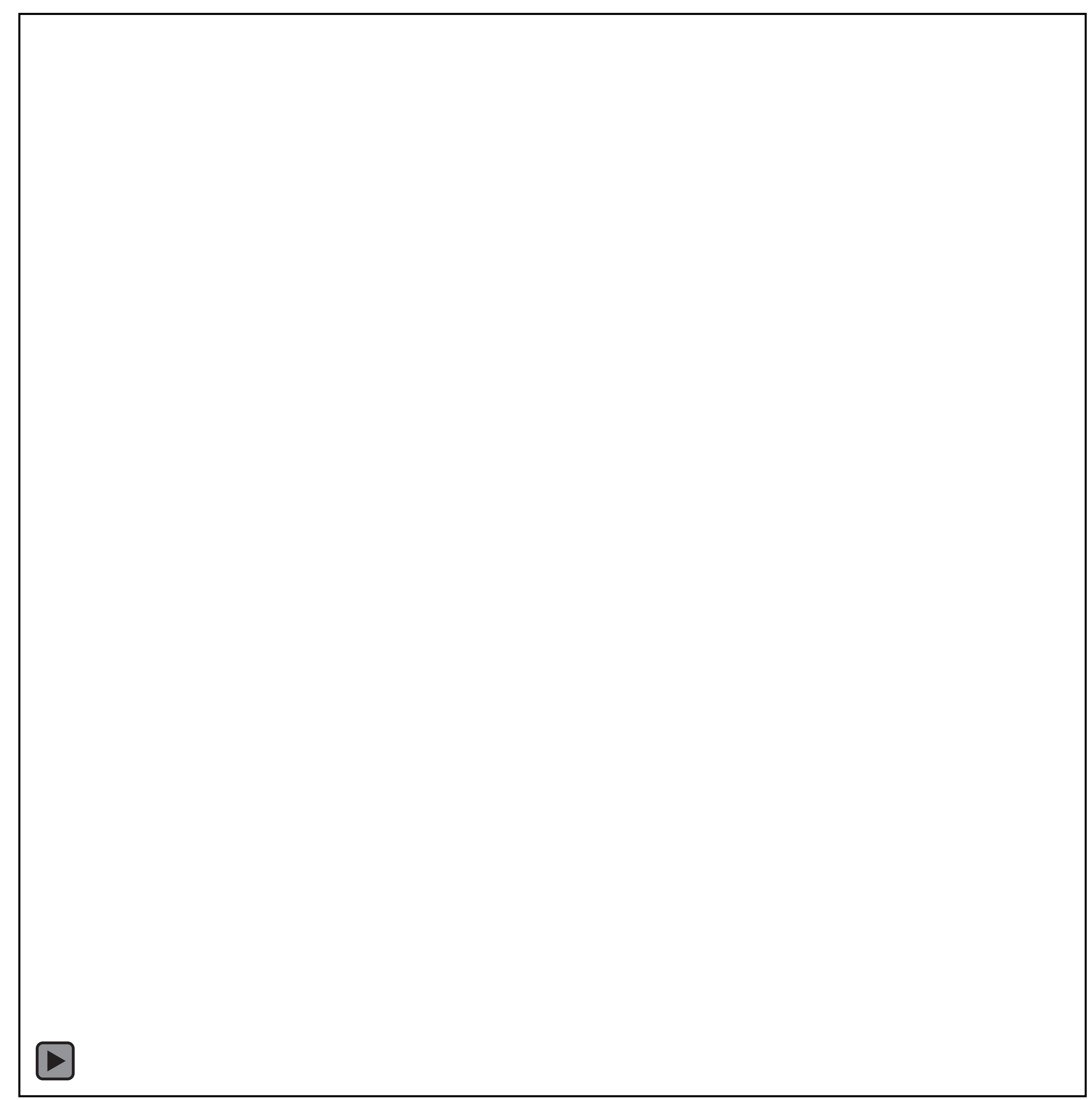
AGENDA			**Paper**	**Purpose**	**Presenter**
Other Board Reports					
13.20	16.	STHK - June Corporate Risk Register	MWL TB (23)011	Assurance	Nicola Bunce

13.30	17.	S&O - June Corporate Risk Register	MWL TB (23)012	Assurance	Nicola Bunce
13.40	18.	STHK Board Assurance Framework	MWL TB (23)013	Approval	Nicola Bunce
13.50	19.	S&O Board Assurance Framework	MWL TB (23)014	Approval	Nicola Bunce
14.00	20.	STHK Learning from Deaths Quarterly Report – Q4 2022/23	MWL TB (23)015	Assurance	Peter Williams
14.10	21	S&O Learning from Deaths Quarterly Report – Q4 2022/23	MWL TB (23)016	Assurance	Peter Williams
14.20	22.	STHK 6 monthly Workforce Strategy & HR Indicators Report	MWL TB (23)017	Assurance	Anne-Marie Stretch
14.30	23.	Information Governance & Freedom of Information Annual Report 2022/23 Part a – STHK Part b – S&O	MWL TB (23)018	Approval	Christine Walters
14.40	24.	Data Security and Protection Toolkit (DSPT) Final Submission Reports Part a – STHK Part b – S&O	MWL TB (23)019	Approval	Christine Walters
14.50	25.	S&O EPRR Annual Self-Assessment and Declaration	MWL TB (23)020	Approval	Lesley Neary
Closing Business					
15.00	26.	Effectiveness of Meeting	Verbal	Assurance	Chair
	27.	Any Other Business		Information	
	28.	Date of Next Meeting – 27th September 2023		Information	

AFTERNOON BREAK

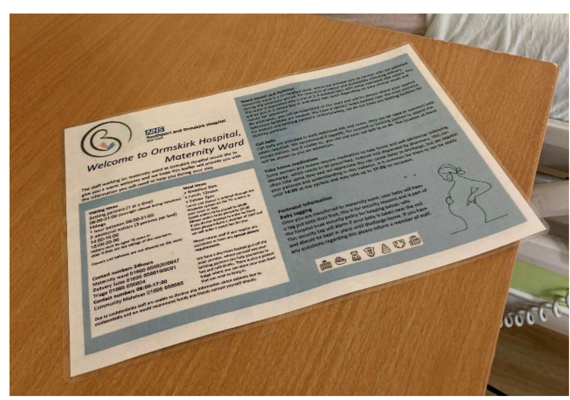
Patient Story – Ormskirk Maternity

Vivienne Hanson



Actions:-

- Introduced a bedside welcome leaflet to mat ward



- Visiting times for birth partners extended to 09:00 – 21:00 with plans to re-introduce birth partners staying over from August ’23. New recliner chairs on order.

- Patient Story to be shared within Maternity for learning and reflection.

Title of paper: My life saving experience at the Urgent Treatment Centre St Helens.

Date of meeting: 26/07/2023

Background.

St Helens Urgent Care Treatment Centre (UTC) is centrally based at the Millennium Centre since 2001. It was initially a “Walk in Centre” progressing to a “Walk in Centre and a Minor Injuries Unit” circa 2005 (when St Helens Hospital Minor Injuries Unit closed). In December 2018 the unit transitioned into an Urgent Treatment Centre (UTC). The unit assesses and treats a wide variety of clinical conditions for adults, paediatrics, and neonates via referrals from GPs, other Walk in Centres, opticians, NHS 111, in addition to self-presentations. Recently, the UTC has seen both an increase in attendances and an increase of the acuity of those patients.

The patient/family experience.

Both Stephen and his partner Adele work for Northwest Ambulance Service, (NWAS), Stephen now works in senior management and is a trained paramedic. The 2nd June started as an ordinary day with a trip to the local DIY Store with their grandson. Stephen began to experience acute cardiac symptoms; because of his paramedic training he knew that the symptoms he was experiencing may become life threatening. He believed he would not reach Whiston ED and needed to be around healthcare personnel as soon as possible. He was driven by Adele to St Helens UTC, by the time he arrived, he was very unwell. The staff immediately recognised what was happening, gave initial treatment of high dose aspirin and GTN and organised ambulance transfer to hospital. Within minutes of this Stephen had a witnessed cardiac arrest, the team were on hand to offer immediate lifesaving resuscitation using an Automated External Defibrillator (AED). These lifesaving manoeuvres were successful, NWAS attended, and Stephen was transported safely to Liverpool Heart and Chest NHS Hospital Trust by NWAS where he received specialist care and treatment.

Stephen describes being fully aware of conversations and actions of staff. His eyes were open, he knew exactly who had performed compressions on his chest and could hear the automated instructions of the defibrillator “stand clear”, “shock advised”. Within 90 minutes of being at the DIY store, he had undergone specialist treatment at the Regional cardiac centre.

Lessons learned.

It is documented that if a patient goes into cardiac arrest outside of the hospital, the survival rate is roughly 6%. Although Stephens life threatening condition was managed successfully, it has enabled the staff involved, and the team leaders, to reflect on circumstances and make recommendations, these have included:

- Staff have already/or are in the process of upskilling from Basic Life Support (BLS) to Immediate Life Support (ILS) providers for both adults and paediatrics. This has helped with confidence amongst the team when managing emergency clinical situations.

- The Resuscitation Team have conducted a clinical visit and have provided a recommendation report which included upgrade to integrated equipment to allow both defibrillation and ongoing monitoring of the deteriorating patient and a separate paediatric resuscitation trolley.
- All trained staff, regardless of grade are now involved with the completion of daily equipment checks, this has helped with ensuring that all staff are familiar with equipment.
- An activity and performance dashboard has been developed to support capacity and demand work programme to inform the future workforce model and the meet change in demand.

Next steps.

- Links have been strengthened with Mersey care NHS Trust Urgent Treatment Centres UTC) and Walk-In-Centres (WIC) to share learning and developments and enable benchmarking of future practice.
- A Standard Operating Procedure (SOP) for treating emergencies outside of the department is being developed, it will include a template for team “debrief” exercise following stressful incidents.
- All band 7 nurses will become Advanced Life Support providers to ensure there is always a member of the team with advanced skills on duty.

Stephen and his partner are extremely grateful for the care and treatment they both received, Stephen for prompt recognition and treatment, and Adele for her inclusion and compassionate care and communication throughout the traumatic experience. They have since returned to the UTC with gifts of appreciation for staff and are extremely grateful to be afforded the opportunity to share their experience of the day that changed both of their lives. They are now looking forward to retirement travels in a motorhome.

My life saving Experience at the Urgent Care Centre (UTC)

St Helens Urgent Treatment Centre (UTC)

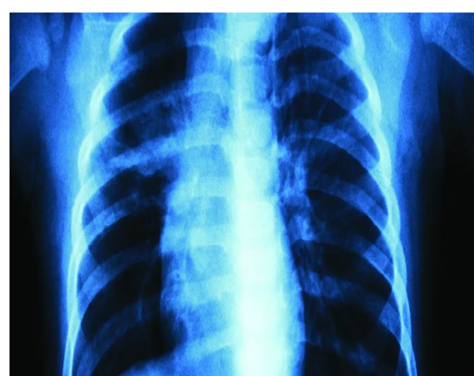
Patients can access the Urgent Treatment Centre 365 DAYS A YEAR. A team of experienced doctors and nurses can assess and treat a wide variety of illnesses and injury in adults and children that are not considered life-threatening, services include:

On-site pharmacy

X-ray

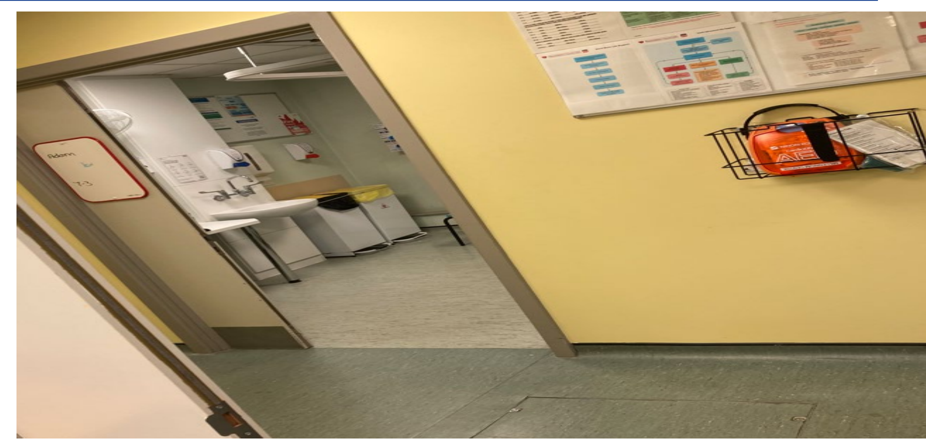
ECG

Blood tests



A little bit about us………..

What started as an ordinary day 02/06/2023……



PATSLIDE
stryker

EMERGENCY AMBULANCE
AMBULANCE

Kind & Compassionate

Respectful & Considerate

Listening & Learning

Friendly & Welcoming

Open & Honest

Lessons learned and next steps

Lessons learned

- Staff have already/or are in the process of upskilling from Basic Life Support (BLS) to Immediate Life Support (ILS) providers for both adults and paediatrics. This has helped with confidence amongst the team when managing emergency clinical situations.
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Thank you for listening to our story……..

MINUTES OF THE TRUST BOARD PUBLIC MEETING
HELD ON WEDNESDAY 28TH JUNE 2023
Boardroom, 5th Floor, Whiston Hospital

BOARD MEMBERS	
Richard Fraser (RF)	Chairman (Chair)
Anne-Marie Stretch (AMS)	Deputy Chief Executive & Director of Human Resources
Rob Cooper (RC)	Managing Director
Jeff Kozer (JK)	Non-Executive Director
Gill Brown (GB)	Non-Executive Director
Rani Thind (RT)	Associate Non-Executive Director
Nicola Bunce (NB)	Director of Corporate Services
Christine Walters (CW)	Director of Informatics
Peter Williams (PW)	Medical Director
Geoffrey Appleton (GA)	Non-Executive Director (Deputy Chair)
Ian Clayton (IC)	Non-Executive Director
Gareth Lawrence (GL)	Director of Finance & Information
Sue Redfern (SR)	Director of Nursing, Midwifery & Governance
Paul Growney (PG)	Associate Non-Executive Director
Lisa Knight (LK)	Non-Executive Director
IN ATTENDANCE	
Katie Fielding (KF)	Executive Assistant (Minutes)
Angela Ball (AB)	Halton Council Representative
APOLOGIES	
Ann Marr (AM)	Chief Executive

RF opened the meeting with welcome and introductions to the last STHK Trust Board Meeting.

1.	**Employee of the Month Film**	**RF**
	1.1. The employee of the month for June 2023 was Dilnath Gurusinghe. 1.2. PW introduced the Employee of the month video, by reading the citation. 1.3. The Board then watched the film of GL presenting the award to Dilnath and shared their congratulations.	
2.	**Apologies for Absence**	**RF**
	2.1. Apologies for absence were as noted above. RF commented that it was regrettable but fully understood that AM could not attend the last Board meeting of STHK, and the board extended their condolences to AM and her family.	
3.	**Declarations of Interest**	**RF**
	3.1. There were no new declarations of interest.	
	Minutes of the Board Meeting held on Wednesday 31st May 2023	

4.	**Minutes of the Previous Meeting** 4.1. The minutes of the Board Meeting held on 31st May 2023 were reviewed and approved as a true record. **Action Log** 4.2. Action P61 – RC confirmed there is a quality assurance process in place for the STHK elective waiting list, which routinely checked that there were no patients lost to follow up.	RF
	Performance Reports	
5.	**Integrated Performance Report – NHST (23)050** GL introduced the performance report for May and noted that this would be the penultimate IPR for STHK because the June report would continue to be presented from the pre transaction organisations. 5.1. Quality Indicators 5.1.1. SR presented the report. 5.1.2. The CQC rated the Trust as outstanding overall following its inspection in July/August 2018. SR reported that following discussions with the CQC if had been confirmed this would not change as a result of the transaction. 5.1.3. There were no Never Events reported in May 2023 5.1.4. There were no MRSA cases reported in May 2023, however SR informed the Board that unfortunately there had been two MRSA cases in June which would be formally reported to the Board in July. These were currently being investigated and would be subject to a full RCA. 5.1.5. There were 9 C. Difficile (CDI) positive cases reported in May 2023 (9 hospital onset and 0 community onset). SR added that April/ May are months when historically there had been increased cases, but she remained concerned given the reduced tolerance levels for 2023/24 and noted that an IPC summit was being planned for July. 5.1.6. There was 1 validated grade 3 hospital acquired pressure ulcer with lapse in care in March 2023. 5.1.7. Community incident reporting levels have increased to 140 in the month of April 2023 compared to 93 in the same month in 2022. 72 incidents were reported to be due to pressure skin damage. All of these were classified as no harm. 5.1.8. The HSMR April-February 2023 was 91.3. 1.1.1. GA asked if SR felt the nursing skill mix was correct given the 100% the above 100% fill rates. SR responded that the nursing workforce establishments were reviewed twice a year and adjusted in response to activity levels and acuity. In addition, there was a daily review of the skill mix by the matrons and staff were moved between wards if necessary. In relation to the HCA fill rate approximately 10% was related to supplementary care for patients requiring 1 to 1 supervision/care. 1.1.2. NB commented that the new IPR narrative did not follow the same order as the figures in the summary and suggested that a further improvement would be for this to be re-ordered. GL agreed to feed this back to the Business Information team.	GL

1.2. <u>Operational Indicators</u>

1.2.1. RC presented the report.

1.2.2. Performance against the 62 day cancer standard was below the target of 85.0% in month (April 2023) at 82.3%. The 31 day target was achieved in April 2023 with 97.2% performance in month against a target of 96%. The 2 week rule target was not achieved in April 2023 with 75.9% in month against a target of 93% and this continued to be impacted by the significant increase in referrals, compared to the same period in 2019/20, which led to capacity challenges.

1.2.3. Accident and Emergency Type 1 performance for May 2023 was 50.7% and year to date 52.0%. The all type mapped STHK Trust footprint performance for May 2023 was 72.1% and year to date 72.9%. The Trust saw average daily attendances of 333, compared to April, at 311. Total attendances for May 2023 had been 10,331.

1.2.4. The total ambulance turnaround time target was not achieved in May 2023 with 56 mins on average.

1.2.5. There were 2,422 ambulance conveyances in May compared with 2,291 in April 2023.

1.2.6. The UTC had 4,527 attendances in the month of April, compared to 4,890 in the month of March. 98% of UTC patients were seen and treated within 4 hours.

1.2.7. The average daily number of super stranded patients in May 2023 was 142 compared with 127 in April.

1.2.8. RC commented that additional bed capacity is needed in the community to accommodate patients who were ready for discharge. RC had met with the Place Directors who are working on plans to increase bed and community support capacity.

1.2.9. JK asked what is holding this up. RC explained there is a workforce issue and there are also issues with having the right type of beds commissioned to meet the patients' needs. Standardisation and consistency of provision and discharge processes across the three Places would also help.

1.2.10. GB reported that when she had visited the discharge lounge at S&O, she had asked a patient if she was looking forward to going home. The patient had said she was very nervous about going home as she would not have anyone to look after her. GB felt it must be very difficult for staff when patients don't feel they will have the support they need after discharge. RC said in the past, the Trust had worked with Red Cross who do some home check ins to make sure patients have essential items such as milk etc at home, and this had helped although he acknowledged that some patients are nervous about leaving the hospital environment if they have had a long inpatient stay.

1.2.11. LK was concerned that after the transaction MWL would be working with 5 different Places, which would make the variation in discharge processes and local services even more extreme. RC agreed but commented that STHK had faced this issue for a long time, as it served three different boroughs. There was an urgent need for standardisation between different Local Authorities. At the Place meetings, Graham Urwin was encouraging standardisation across St Helens, Knowsley and

Halton. GA added that St Helens Place had been working with Halton and Knowsley to try and standardise pathways.

1.2.12. NB noted that ED figures on the IPR summary page were incorrect and did not match the commentary. RC confirmed that the commentary included the correct performance figures.

1.2.13. IC commented on the improved performance for the Head and Neck cancer 62 day pathway but was concerned that the. Gynae and Haematology pathway performance appeared to have declined, although he acknowledged the small numbers. RC responded that the gynae cancer pathway is challenging for a number of reasons; symptoms presented could be many different things, so there is often a long diagnostic process at the beginning of the pathway.

1.2.14. The 18 week referral to treatment target (RTT) was not achieved in April 2023 with 62.4% compliance and year to date 62.4% (Target 92%). Performance in March 2023 was 62.3%. There were (1,775) 52+ week waiters. The 6 week diagnostic target was not achieved in May 2023 with 65.3% compliance. (Target 99%). Performance in April 2023 was 65.0%.

1.2.15. GB commented that not all the metrics had the targets included on the report and GL confirmed these were being added and would be in place for the new MWL Corporate Performance Report (CPR).

1.3. <u>Workforce Indicators</u>

1.3.1. AMS presented the workforce report.

1.3.2. There was a decrease in the rate of absence from 5.8% in April to 5.6% in May. The absence rate for all Nursing and Midwifery staff group decreased from 7.5% in April 2023 to 6.7% in May.

1.3.3. Appraisal compliance has dipped to 78.4% and is below target, because of the appraisal window that runs from April - September.

1.3.4. Mandatory training compliance continued to gradually improve and was 82.6% in May compared to 82.2% in April.

1.3.5. AMS reported that stress and anxiety remained the highest cause of absence reported by staff. In response all absences over 20 days were now triggering a stress risk assessment, but in many cases the causes of the stress and anxiety were related to issues outside of work.

1.3.6. Musculoskeletal issues were also a major cause of absence and staff with such problems were now automatically being referred to the trust MSK support services.

1.3.7. GA commented on recent reports that one in seven people were now in food challenge because of cost of living increases and this would include many NHS staff.

1.4. <u>Finance Indicators</u>

1.4.1. GL presented the finance report.

1.4.2. The Board approved 2023/24 financial plan was to achieve a surplus of £5.6m.

1.4.3. To achieve the 2023/24 financial plan the trust must deliver the elective recovery active target of 107%, Trust CQUIN targets and a CIP target of £28.4m (c.5%), of which £7.0m (c.1%) is to be

	delivered non-recurrently. 1.4.4. At Month 2, the Trust is reporting a YTD surplus of £0.9m, in line with the plan. 1.4.5. . At Month 2, CIP schemes delivered or at finalisation stage totalled £15.9m in year of which £7.3m would be recurrent. 1.4.6. At the end of month 2, the cash balance was £67.8m, with a planned reduction to £25.8m over the financial year. 1.4.7. Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £1.9m. No PDC funding (provided by Department of Health & Social Care) has been used. 1.4.8. GL reported that the agency spend is currently above the target of 3.7% of the pay bill, partly because of the recent industrial action taken by Nurses and Junior Doctors. All spend was being closely monitored and approved in accordance with the agreed trust financial controls. 1.4.9. JK asked about the cash loan that S&O had applied for. GL confirmed that this was still required and had been agreed as part of the financial plans and transaction agreement. 1.5. The IPR was noted.	
Committee Assurance Reports		
2.	**Committee Report – Executive NHST (23)051**	**AMS**

	2.1. AMS presented the Executive Committee Chair's Report on behalf of AM and highlighted the following items:
	• New Investments approved were workforce related.
	  • Additional pharmacy staff to respond to increases in dispensing demand.
	  • New Consultant Obstetrics and Gynaecology posts to increase resident on-call cover and capacity to reduce the gynaecology waiting list.
	  • Recruiting two Consultant Urologists, one as a joint post with S&O.
	  • Backfill funding to support the Advanced Clinical Practitioner expansion programme.
	2.2. GB asked about sexual health services and commented that she recalled the service has been hit by other reductions in previous years. GB asked if a quality impact assessment had been completed by Public Health. GL advised that the trust had insisted that a quality impact assessment be completed on the proposed reduction in scope. The contract was due for re-tender in April 2024. GA undertook to discuss this with the Director of Public Health but was aware that Public Health funding was being reduced, however this seemed to be a false economy. PW added that the sexual health service deals with a lot more than sexual health, such as teenage pregnancy and he felt that taking money out of this service is the wrong thing to do.
	2.3. RF commented on item 2.1 in the report which was the commitment to being an anti-racist organisation, which he was very pleased to see. It was important to acknowledge that there was work to be done in this area and both BAME and disabled colleagues face challenges that they shouldn't at the trust and in wider society. RT confirmed that she has been invited to be a member on the North West BAME assembly. RT also added she has worked in the organisation for a long time, and never felt out of place.	

	2.4. NB advised that the Trust has started a trial of ED staff wearing bodycams, which would hopefully act as a deterrent to unacceptable behaviour and abuse targeted at BAME staff.	
3.	**Committee Report – Finance & Performance – NHST (23)052**	**JK**
	3.1. JK presented the report and highlighted the following. 3.2. The committee had reviewed the operational and financial performance reported via the IPR. 3.3. Committee had discussed the impact of the recent industrial action on activity and income and the on-going challenges of inflation which were currently being mitigated non-recurrently. 3.4. It had been reported that Ernst Young had been commissioned to review the Cheshire and Mersey ICB financial strategy as a result of not submitting a balanced plan for 2023/24. 3.5. There had been a presentation on CIP delivery from the Surgical Care Group, who demonstrated continuing high levels of engagement throughout the care group focussing on; Maximising productivity, the minus 5% challenge through all specialities and budget holder cost controls. 3.6. The report was noted	
4.	**Committee Report – Quality – NHST (23)053**	**RT**
	4.1. RT presented the report and highlighted the following: • Challenges with bed occupancy and trying to gain access to be able to complete deep cleans. SR was pleased to report that the deep clean required following an outbreak on ward 3C had been completed since the Quality Committee meeting. • There had been an update on the work being undertaken in the Surgical Care Group to increase recording of venous thromboembolism (VTE) risk assessments and to reduce delays in routine medication prescribing, with re-audit to be presented to the Patient Safety Council. • The Diabetes standard operating procedure to optimise diabetes prior to discharge was highlighted as part of the Clinical Effectiveness Council Report. 4.2. IC commented that there were an increasing number of out of area referrals being received and demand for diabetes services would continue to rise as the population incidence increased. 4.3. GB commented that the virtual ward presentation given by PW had been very useful and suggested it would be beneficial for this to be shared with the wider board at a future development session. 4.4. PW commented that we need to think of virtual ward beds, as we would hospital beds. 4.5. The report was noted	
5.	**Committee Report – Charitable Funds – NHST (23)054**	**IC**
	5.1. PG presented the report. 5.2. An overview of the Investment Portfolio was received. 5.3. An overview of the Income/ Expenditure position was received. 5.4. A fundraising update had been received, including updates regarding various events taking place; it was reported that the children's playground appeal was progressing well. 5.5. Proposals for 'One Charity'. bringing S&O and STHK charitable funds together was considered. This creates the opportunity to rebrand and build the new charity for the new organisation. 5.6. Approval was given for the recruitment of a Head of Charity, after review and benchmarking across the North West.	

	5.7. There was a proposal for funding from the bereavement team to support patients at the end of life who have no relatives, although as this was not one-off funding the committee felt a longer-term solution was needed. The committee had suggested a business case should be submitted to the Executive Committee to support this initiative as part of the overall volunteer infrastructure RF suggested that there may be other local charities who could be approached who would have revenue funding that might support such an initiative. PG agreed to investigate this. 5.8. The report was noted.	
6.	**Committee Report – Strategic People – NHST (23)055**	**GB**
	6.1. GB presented the report on behalf of LK. 6.2. The annual workplan had been presented but this was likely to change again following the transaction. 6.3. Staff health and wellbeing occupational health service is experiencing higher DNA rates, although these had reduced compared to April. 6.4. An update was presented on the Recruitment and Retention operational plan. 6.5. The committee received the annual reports from the Guardian of Safe Working for trainees hosted in hospitals and the Guardian of Safe Working report for GP's and organisations with less than 10 trainees or those hosted in Hospices/Local authorities. 6.6. RT asked about the referral scheme for staff who introduce new members of staff. AMS explained that it's a refer a friend referral, with no monetary value, but was another way to help support recruitment. 6.7. The Board discussed the hard work to improve recruitment in recent years and the need to ensure the reputation of the organisation was not lost when the name changed. 6.8. The report was noted	
7.	**Committee Report – Audit (Including approval of the Annual Report and Accounts) – NHST (23)056**	**IC**
	7.1. IC presented the report. 7.2. The 2022/23 accounts were received in draft and the draft audit findings report and letter of representation were accepted on the understanding that work would continue to resolve the outstanding queries. The accounts were approved subject to resolution of the outstanding issues and had delegated authority to the committee chair. 7.3. The committee received the value for money report and noted that no significant weaknesses had been identified. 7.4. The annual Report was discussed and accepted with minor adjustments but would also remain draft until the accounts were finalised. 7.5. The report was noted	

Other Board Reports		
8.	**Fit & Proper Person Annual Chair's Report – NHST (23)057**	**RF**
	8.1. RF presented the annual review of board members against the Fit and Proper Persons Regulations (FPPR) and in compliance with Trust policy. e PW noted the report included designate roles. NB apologised and confirmed that this was an error, and all roles were now confirmed as substantive. The report would be amended.	

	8.2. IC queried why he had been asked to repeat the DBS check and asked if the DBS requirement has changed for everyone. AMS advised that the requirements had not changed, and she was working with the team in HR to resolve the issue. 8.3. The report was noted	
	Closing Business	
9.	**Effectiveness of Meeting**	**ALL**
	9.1. RF asked AB to comment on the effectiveness of the meeting. 9.2. AB responded that the meeting had been very interesting covering a lot of ground, but it was good to see the interaction between all board members. AB was pleased to hear those changes in shift patterns helping with nurse recruitment. A good level of detail had bene provided on each item, which she had found very informative. 9.3. RF thanked AB for her thoughtful evaluation.	
10.	**Any Other Business**	**ALL**
	10.1. AMS noted that earlier in the year, the Board approved Trust Objectives for the new organisation. Under workforce, there was an objective about HR policies being harmonised by Q3 this year. There are ongoing discussions with staff side at both hospitals, and this now would not be achieved. Therefore, AMS requested an amendment to say HR policies would be reviewed and harmonised as and when they come to an end. There will then be a discussion around what the new policy should look like. The board approved this change. 10.2. GA congratulated that St Helens Place for their recent national award. 10.3. RC noted that the Emergency Department had won a parliamentary award. 10.4. RF noted with some sadness that this is the last STHK Board meeting, and thanked the board members for their commitment, particularly over the past two years.	

Date of Next Meeting: The first Mersey and West Lancashire Teaching Hospitals NHS Trust Board meeting will take place on Wednesday 26th July 2023

Trust Board Attendance Record 2023/24

Member	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total /10	%
Richard Fraser														
Gill Brown														
Jeff Kozer														
Ian Clayton														
Paul Growney														
Lisa Knight		x												
Rani Thind														
Geoffrey Appleton														
Ann Marr		x	x											
Anne-Marie Stretch	x													
Gareth Lawrence														
Peter Williams														
Sue Redfern														
Rob Cooper		x												
Christine Walters														
Nicola Bunce														

***Draft* Minutes of the Strategy and Operations Committee (Part 1)**
Held on Microsoft Teams
Wednesday 07 June 2023
(Subject to the approval of the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Board on 26 July 2023)

Present

Name	Initials	Title
Richard Fraser	RF	Chair, STHK (Chair)
Anne-Marie Stretch	AMS	Managing Director
Geoffrey Appleton	GA	Non-Executive Director, STHK
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
Gill Brown	GB	Non-Executive Director, STHK & S&O
Nicola Bunce	NB	Director of Corporate Services
Kate Clark	KC	Medical Director
Ian Clayton	IC	Non-Executive Director, STHK & S&O
Rob Cooper	RC	Managing Director and Director of Operations and Performance, STHK
Lisa Knight	LK	Non-Executive Director, STHK
Jeff Kozer	JK	Non-Executive Director, STHK
Gareth Lawrence	GL	Director of Finance, STHK
John McLuckie	JMcL	Director of Finance
Lesley Neary	LN	Chief Operating Officer
Sue Redfern	SR	Director of Nursing, Midwifery and Governance, STHK
Jane Royds	JR	Director of HR and OD
Rani Thind	RT	Associate Non-Executive Director, STHK
Christine Walters	CW	Director of Informatics, STHK

In Attendance

Name	Initials	Title
Carol Fowler	CF	Interim Deputy Director of Nursing *(observer)*
Helen Hurst	HH	Associate Director of Nursing & Therapies, Planned Care *(Item SO099/23)*
Kevin Thomas	KT	Deputy Medical Director (*Item SO107/23)*
Maryjo Waldron	MW	Consultant Midwife (*Item SO107/23)*
Juanita Wallace	JW	Assistant to Director of Corporate Services (minute taker)

Apologies

Name	Initials	Title
Paul Growney	PG	Associated Non-Executive Director, STHK
Ann Marr	AM	Chief Executive
Richard Weeks	RW	Corporate Governance Manager
Peter Williams	PW	Medical Director, STHK

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO098/23	**Employee of the Month Film**	
	This was a new initiative for Southport and Ormskirk (S&O) Hospital NHS Trust. Staff had been asked to nominate any colleagues who they	

	felt had gone above and beyond in their normal duties. The Executive had selected the employee of the month for June from the 50-plus nominations received. The Employee of the Month for May 2023 was Charlotte Howard, Ward Manager 9a. The Board watched the film of LB presenting the award to Charlotte, including a framed certificate and voucher for £100, and shared their congratulations. **RESOLVED** The Strategy and Operations Committee **received** the Employee of the Month Film	
SO099/23	**Patient Story**	
	LB and HH presented the patient story video which focused on the experience of Lorna, a patient on G Ward, the post-operative care ward, at Ormskirk District General Hospital. Lorna had fractured her hip following a fall and underwent surgery at Southport District General Hospital. She was later transferred to G Ward for further post-operative care and therapy. HH noted that Lorna had required the use of a side room as she had developed an infection during her stay, however, as Lorna was a very sociable person she was moved back into the general ward as soon as it was possible, and this was her preference. GB noted that Lorna had required transitional care following her discharge from hospital and asked if she had been transferred to Chase Hays. HH did not think this was the case but would follow up and provide feedback to GB. GB reflected on Lorna's preference to be in the main ward area rather than a side room and commented that it was often assumed that a patient would prefer a side room, but this had highlighted the need to respond to patient preferences, wherever possible. Additionally, GB congratulated G ward on receiving a gold S&O Hospitals Clinical Assessment & Accreditation Scheme (SOCAAS) award. RF thanked LB and HH for the presentation and noted that Lorna's comment about her admiration for Trust staff echoed his thoughts. RF also congratulated G Ward on the Gold SOCAAS award. **RESOLVED** The Strategy and Operations Committee **received** the Patient Story	

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SO100/23	**Chair's Welcome and Note of Apologies**	

	RF welcomed all to the meeting included CF who was attending the meeting as an observer.
	
	RF thanked GA for chairing the last Strategy and Operations Committee meeting on 03 May 2023.
	
	RF acknowledged the following Awards and Recognition that the Trust had recently received:
	Nurses Day 2023 Hero Awards
	• Winner: Natalie Jones from the Ormskirk Treatment Centre
	• Highly Commended**:**
	  ○ Emma Houghton – Learning Disabilities Nurse
	  ○ Gill Howarth - ITU
	  ○ Leanne Gilbertson – Paediatric Ward
	  ○ Megan Stokes – Student Nurse
	
	• Heidi Ribchester was the Midwife of the year.
	• The Hospital Alcohol Liaison Team (HALT) was short-listed for the Health Service Journal (HSJ) Awards.
	• Ryan Ashcroft, Financial Services Team Manager, competed in the Leeds marathon Sunday 14 May. He achieved a fantastic 16th position (out of 10,000 entrants) in a time of two hours and 51 minutes and raised £783 for the Motor Neurone Disease (MND) Charity.
	
	Apologies for absence were **noted** as detailed above.	

SO101/23	**Declaration of interests**	
	There were no declarations of interests in relation to the agenda items.	
SO102/23	**Minutes of the previous meetings**	
	The Committee reviewed the minutes of the previous meeting held on 03 May 2022 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Strategy and Operations Committee **approved** the minutes from the meeting held 03 May 2023	
SO103/23	**Matters Arising and Action Logs**	

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	The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. The following action was updated: • SO016/23 Guardian of Safe Working report – the update about responses to booking annual leave and the cancellation of anticipated leave had been provided under Agenda Item SO066/23a on 03 May 2023 and the action was closed. **RESOLVED:** The Strategy and Operations Committee **approved** the action log	
STRATEGIC AND GOVERNANCE		
SO104/23	**Trust Objectives**	
	a) Trust Objectives 2022/23 Year End Review	
	AMS introduced the Trust Objectives 2022/23 Year End Review and NB presented the report which provided a summary of the progress made in achieving the Trust's objectives for 2022/23 which had been agreed by the Strategy and Operations Committee (SOC) at the start of the financial year. There were 26 objectives which supported the six strategic aims of the Trust, and this was the first year that S&O had set formal objectives. At the end of the financial year, a review had been undertaken and 14 objectives had been fully achieved (green), for 12 objectives progress had been made but they were not fully delivered (amber). There were no objectives where no progress had been made. GA reflected on the progress made and thanked the Executive team for their hard work. IC reflected on the scores and commented that there were one or two scores that he might disagree with but noted that this was subjective. IC commented that, in his opinion, the rag ratings for backlog maintenance (amber) and IT systems (green) should have been the other way around. NB advised that the review reflected the objectives for 2022/23 and the planned achievements for the year, rather than resolving the issues altogether. The Board was aware that it would take several years for both these issues to be fully resolved. IC commented on the audit compliance with the sepsis bundle and the reduction of incidents related to late detection (amber) as this had not been transferred across to the strategic objectives for the new organisation and raised a concern that this would not be tracked. NB confirmed that the joint 2023/24 objectives included timely assessment and treatment of patients in the emergency department, and one of the measures was the compliance with sepsis screening and guidance.	

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	Additionally, IC asked about the launch and embedding of the new Trust's values (amber). NB explained that SCOPE was a particular initiative at S&O and did not relate to the values of the post transaction organisation. AMS commented that, whilst she understood IC's concerns, these were long-term objectives (three to five years) and the review reflected the progress made over the preceding 12 months and assured that the objectives IC highlighted would still be measured going forward. AMS advised that the launch and embedding of the new Trust's values formed part of the Post Transaction Implementation Plan (PTIP) and would be a priority of the new Board. KC commented that progress had been made around the ability to recognise the symptoms of sepsis early so that a patient could be treated quickly with antibiotics and fluids, and this made a difference in the outcome for the patient. The results following a serum lactate would only be available after three days and would indicate that the patient was receiving the correct antibiotic. KC noted that a new Clinical Group would be established to review the metrics and, where necessary, update them. The Trust would continue to contribute to the sepsis bundle, and this was a Quality Account improvement objective. JK commented that whilst he understood IC's comments, he noted that the detail of the achievements during 2022/23 had been discussed at the assurance committees. Additionally, he was assured by the planned joint objectives for the new Trust. JMcL commented that Southport Hospital did not have decant facilities and that any maintenance work had been completed around live services which made some of the works very complex but noted that excellent progress had been made against the planned programme for 2022/23. JMcL confirmed that the fire compartmentation work was due to be completed by the end of June 2023. GB commented that she had reviewed the objectives for the Trust as a whole and despite the various challenges during the year, the progress made was an incredible achievement.	
	b) Approval of the 2023/24 Joint Trust Objectives	
	AMS introduced the 2023/24 Trust Objectives for the new Trust, these had been discussed but not formally launched at the Start of the Year Conference in April.	

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	NB advised that the objectives had been approved at the St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and were being presented at SOC as it was part of good governance for this to be presented to both organisations. It was noted that the Trust Objectives would be launched once the transaction was completed and were aligned with the strategic objectives and quality accounts of both trusts. **RESOLVED:** The Strategy and Operations Committee **reviewed** the 2022/23 Objectives and **approved** the 2023/24 Joint Trust Objectives	
INTEGRATED PERFORMANCE REPORT		
SO105/23	The Committee received the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local performance metrics during April 2023.	
	a) Quality and Safety Performance Report	
	LB and KC presented the report which provided an overview of performance against the quality and safety metrics and LB highlighted the following: • There had been a reduction in the number of falls and pressure ulcers reported during 2022/23 and it was noted that this was within the threshold set for the year. The Trust had reported the lowest number of falls since September 2022 with 49 falls reported in April 2023. One Category 3 pressure ulcer had been reported in April 2023 and an additional three deep tissue injuries had also been reported. • The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for April 2023 was 96.7%. The Health Care Assistants (HCA) fill rate continued to show improvement. • The Patient Friends & Family Test (FFT) - % of respondents that rated the Trust as 'Very Good or Good' (Trust overall) had increased from 90.4% in March 2023 to 91% in April 2023, and the Trust continued to perform well in comparison to peers. It was noted that 51% of the responses in April were from Accident and Emergency (A&E) and this had impacted the recommendation rate. LB advised that only 11 responses had been received from the Post Natal FFT and a safety walkabout with a focus on patient experience had taken place and patient feedback had been positive. • The percentage of complaints responded to within 40 days had reduced to 31.6% in April 2023 against the target of 80%. LB advised that the Complaints Policy had been reviewed and aligned to the STHK policy that currently allowed 60 working days to respond to formal complaints. Additionally, LB advised that there	

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	were 12 open complaints with the longest outstanding complaint at 55 days. GB reflected on the importance of having the right staff in post and that good leadership made a difference to quality. This was a common thread in the three areas that had shown improvement, namely falls, pressure ulcers and complaints. RT thanked LB for her leadership during her time as Director of Nursing of the Trust. KC provided an update on the clinical leadership for the Infection Prevention and Control (IPC) team and advised that the post of nurse consultant had now been recruited to and was due to start on 12 June 2023. Additionally, one of the international nurses had been promoted to a Band 7 role within the IPC team. KC advised that two hospital acquired Clostridium difficile (C.diff) cases had been reported in April 2023. SR asked whether any cases had been reported in May 2023. KC advised that the data was currently not available and would be included in next month's update. **RESOLVED** The Strategy and Operations Committee **received** the Quality and Safety Performance Report	
	b) Operational Performance Report	
	LN presented the report which provided a summary of operational activity and constitutional standards and highlighted the following: • The overall A&E four-hour performance for April 2023 was 78% (green) against the new national target of 76% for 4-hour waits and this compared favourably to 73.6% across the Cheshire & Merseyside (C&M) region and 74.6% nationally. • There had been a reduction in the number of patients waiting over 12 hours in ED (8.6%), however, challenges with bed occupancy remained. • The Chase Heys and 11a schemes continued to have a positive impact across the system from both a reduction in dependency levels upon discharge leading to a reduction in packages of care as well as admission avoidance from the ED. Ward 11a continued to support early discharges, improvements in dependency levels and reduction in care needs upon discharge. LN noted that an update on the benefit of these schemes, which included system savings would be presented at the next meeting. • Elective recovery performance for April 2023 was reported at 106% against a plan of 103%. There had been a slight reduction in	

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	Outpatients activity due to the Junior Doctors' industrial action as well as easter and recent school holidays. • The Trust reported zero 104+ week breaches or 78+ week breaches and was on track to deliver the planned reductions in 65+ week waiters. • All the orthodontics patients had now been transferred and a service closure report would be reviewed by the Executive Committee to identify key learning from the process. • Elective diagnostic access times continued to improve, and the Trust delivered 107% of scans against a target of 103% against the 2019/20 baseline levels as well as 125% endoscopy activity against 2019/20 levels. It was noted that the increase in activity has supported improvements in the six-week waiting times for diagnostics. • The 14-day cancer waiting times position for March was 93.8% against the 93% target and this was the highest level since before Covid. • The Cancer 62-day performance remained challenged with performance at 54.2% in March and, whilst this was an increase from February, it was still lower than the national performance (63.4%), North West (63.8%) and the C&M performance (67.4%). The following tumour sites were areas of concern: o Urology – it was important to ensure patients on the prostrate pathway were getting diagnosed timely. o Skin – there had been an increase in the number of two-week referrals. o Colorectal – this was a challenged service nationally. LN advised that although there had been improvements over the preceding months, there now needed to be more focus on transformation and meetings had been scheduled with the Directorate Manager and cancer nurses to discuss improvement plans. GB commented on the improvement made around high-risk Transient Ischaemic Attack (TIA) patients receiving treatment within 24 hours and noted that, whilst there had been an improvement in the 90% stay on the stroke ward over the preceding months, this had deteriorated during April 2023 and GB asked if this deterioration was due to capacity issues over winter and if there was anything else that could be done to improve this. LN advised this was due to capacity issues and noted that there had been a couple of instances where medical patients had been cared for on the stroke ward. LN assured that beds on the stroke ward were ring-fenced for patients being transferred back from Aintree. KC added that there had been some issues at the point of admission and provided an overview of the process, but that there had been no incidents of any significant harm to patients.	

	RC asked if the colorectal tumour site issues were due to surgical intervention or endoscopy capacity. LN advised that the challenges were mainly from a surgical perspective and having the right resources to meet demands and a business case was being developed to address this. RC advised that it was the opposite to the position at STHK where endoscopy capacity was the main bottleneck, and he would discuss mutual aid with LN. IC commented on the worsening trend in Outpatient Letters being sent to GPs within seven days and asked if there were any reasons for this. LN advised that there had been several delays on the administration side due to the Junior Doctors' industrial action and noted that, as there had been limited cancellations during this period, more senior doctors had been reallocated to cover these appointments which impacted on the delivery of the normal administration tasks. Additionally, this was further impacted by capacity issues within the administration team. IC commented that he had also raised this at the recent STHK board and noted that this was viewed as one of the top 30 performance indicators for the new Performance Report. RT reflected on the histopathology delays and asked if the concerns had been escalated. LN advised that she and RC would be meeting with the pathology team next week to discuss the challenges. However, LN noted that several patients that had been sent over to pathology had already been delayed and were not only waiting for histopathology results. KC advised that the Deputy Medical Director, as Cancer lead, had discussed the challenges with the clinicians who had noted that it was difficult to know if a biopsy was to exclude cancer or for other conditions. KT noted that since the Pathology Manager from STHK attended the weekly cancer meetings there had been an improvement in the requesting of urgent biopsies, however, there were still some biopsy requests that needed to be retargeted. **RESOLVED** The Strategy and Operations Committee **received** the Operational Performance Report	
	c) Financial Performance Report	
	JMcL presented the report which detailed performance against key financial performance indicators and advised that the Trust had reported a £675k deficit at Month 1 in line with the 2023/24 Plan. JMcL highlighted the following:	

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	• The Trust had assumed that the Integrated Care Board (ICB) income allocations were in line with the Plan and an assessment of Payment by Results (PbR) activity performance was currently being undertaken. • The cash balance at the end of April was £3.6m and the Trust had made an application to the ICB to bring forward the £9m of contract payments during Q1 of 2023/24 and JMcL noted that £4.5m had been received to date. • The Trust would require approval from the Strategy and Operations Committee (SOC) for £10m of Department of Health and Social Care (DHSC) revenue support which was related to the deferred income as well as £14m of Public Dividend Capital (PDC) to cover the transaction capital as outlined in the Transaction Business Case. • The Trust continued to meet the Better Payment Practice Code (BPPC) target of 95%. **RESOLVED** The Strategy and Operations Committee **received** the Financial Performance Report and approved the application for additional revenue support in line with the Transaction Agreement.	
	d) Workforce Performance Report	
	JR presented the Workforce Performance report and advised that: • Core Mandatory Training had improved from 89.6% in March 2023 to 90.1% in April, against the 90% stretch target. • There had been continued improvement in overall sickness from 5.9% in March to 5.3% in April 2023 and this was the lowest level since pre-Covid. IC commented on the vacancies and noted that there appeared to be a discrepancy between the graphs and the narrative presented. JR agreed with IC's comment and acknowledged that there was a fluctuation when reviewing the Statistical Process Control (SPC) charts and noted that a deep dive into vacancies and how to fill these was being undertaken. Additionally, there had been a focus on the recruitment of HCAs which has shown an improvement. **RESOLVED** The Strategy and Operations Committee **received** the Workforce Performance Report	
QUALITY AND SAFETY		
SO106/23	**Quality and Safety Reports**	

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	a) **Quality and Safety Committee AAA Highlight Report**	
	GB presented the AAA Highlight report and alerted the Committee to the following: • Maternity - Concerns / near misses had been raised on Datix regarding the difficulties when a second maternity theatre was required out of hours. A working group had been established to identify potential solutions and would report to the Executive Committee. • There was no agreed process for accurately recording information on transgender patients and the Trust was working with STHK and the legal team to review and update the policy on recording patient information. GB drew attention to the following advise items: • The Maternity Services Quarterly Report was presented, and it was noted that the process for elective caesarean sections taking place in the main theatre was now embedded. The number of elective theatre pathway lists had been reviewed as the seven sessions per week were not being fully utilised and it was proposed to reduce this to six sessions and a pilot was underway to assess the feasibility of this and feedback would be presented to the Executive Committee. • The Committee received a presentation from the Pharmacy team which noted that all information had been included in a variety of reports through medicines management, Drug and Therapeutics Committee (DTC) and Clinical Effectiveness Committee (CEC) AAA reports. The Pharmacy team had been pleased to be asked to present at the Committee and used the opportunity to highlight the work completed despite staffing challenges. GB noted that she had been assured that the governance systems in place were working and that information had been escalated and the Pharmacy staff had been assured by this.	
SO107/23	**Quarterly Maternity Assurance Report**	

	(MW joined the meeting)
	
	LB in collaboration with KT and MW presented the Quarterly Maternity Assurance report for the period February to April 2023 and MW highlighted the following:
	• The NHSE three-year delivery plan for Maternity and Neonatal Services was published in March 2023 and included four high-level themes:
	    • Listening to women and working and families with compassion which promotes safer care.
	    • Growing, retaining, and supporting our workforce to develop their skills and capacity to provide high-quality care.	

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	• Developing and sustaining a culture of safety, learning and support to benefit everyone. • Standards and structures that underpin safer, more personalised, and more equitable care for all women, babies, and families. MW noted that the Local Maternity and Neonatal System (LMNS) would provide support to the maternity units in C&M and an event has been arranged to discuss the priority actions across these four themes. • Work was ongoing to align and embed the Ockenden action plan and to provide evidence of this. • Maternity Incentive Scheme (MIS) – The Trust was meeting the recommendations of year 4 of the scheme and the recommendations for year five had recently been published. Work was ongoing to evidence the ten safety actions from year 4 to ensure that these were all embedded. MW noted that compliance with all five elements of the Saving Babies' Lives care bundle (safety action 6) had been included. • A mock Care Quality Commission (CQC) inspection had taken place in May 2023 and positive feedback had been received. • The unit underwent its second SOCAAS inspection and received a gold SOCAAS award. MW noted that the feedback received from the CQC mock inspection mirrored the feedback received as part of the SOCAAS inspection. • Midwifery Continuity of Carer (MCoC) remained paused; however, work was ongoing to develop a strategy and to build an enhanced carer team with a focus on the high-risk areas. • Staff Exposure to Nitrous Oxide – the Trust continued to work through the action plan as well as the Entonox national alert process and progress has been made with robust monitoring and measuring processes included in the plan. KT highlighted the following: • The Trust was currently an outlier for: o The induction of labour for the indication reduced fetal movements only and an updated guideline was in place. Additionally, the leaflets regarding the induction of labour have been redesigned in conjunction with the Maternity Voices Partnership (MVP). o Emergency caesarean section at full dilatation and KT noted that a Consultant was always present at full dilation. A review by the Lead Obstetrician had been completed and the findings were reported to the LMNS. The review was also shared locally with the team via a joint Obstetric and Anaesthetic audit meeting with discussions around further training for junior doctors in the use	

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of instruments for assisted deliveries and escalation to the Consultant.

- Progress has been made with the Tier 1 and 2 training, which would enable the Trust to be CNST and British Association of Perinatal Medicine (BAPM) compliant.
- An interim Clinical Director has been appointed for six months and an additional consultant was due to join the Trust shortly. The newly appointed consultant had a risk and governance background and would initially be the Lead for the Labour Ward.
- The Trust was taking part in several research projects that were taking place across maternity services and was working in collaboration with STHK.

MJ advised that representatives of the MVP continued to attend the monthly safety champion meetings and the safety walkabouts.

RT reflected on a safety walkabout that she had been part of, and the positive feedback received from the patients and their partners. RT commented that, whilst the report noted the stillbirths no additional narrative had been included and asked if there was additional evidence about the lessons learnt.

RT noted that the report presented at the STHK Board normally included the immediate learning around stillbirths and a more detailed report was presented at a later stage. MW advised that the Trust did complete a immediate rapid review for any stillbirth. KC confirmed that all stillbirths were reviewed using the National Perinatal Mortality Review Tool (PMRT) and noted that all stillbirths and deaths were reviewed at the weekly patient safety meetings and reported to Serious Incident Review Group (SIRG) via a rapid review report. Learning was also disseminated via the internal governance meetings. RT commented that she understood the process that was in place but felt that there should be more evidence included in the board reports and requested that additional narrative be included in future reports. NB reflected that, as these reports were in the public domain, it would be important to be mindful when including information about individual incidents and it might be more appropriate to provide this level of detail in the committee reports. Both LB and RF agreed with this.

LK commented that she had attended a quality ward round recently and had spoken to a member of the nursing team who was pregnant and had chosen to give birth at the Ormskirk unit even though this was not the closest hospital to her. LB commented that she was happy for her daughter to deliver her baby at Ormskirk and that she was proud of the maternity service as well as the leadership provided by KT, MW and the Assistant Director of Nursing and Midwifery.

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	RF thanked MW and KT for their presentation and extended his thanks to the Associate Director of Nursing and Midwifery and noted that, whilst maternity had received a great deal of scrutiny over the preceding six to 12 months, he was confident in the improvements being made and thanked the staff for all their hard work. **RESOLVED:** The Strategy and Operations Committee **noted** the Maternity Assurance Report *(KT and MW left the meeting)*	
WORKFORCE		
SO108/23	**Workforce Report**	
	a) Workforce Committee AAA Highlight Report	
	LK presented the AAA Highlight report and advised that no alerts had been raised. LK drew attention to the following advise items: • The Risk Register would be reassessed post transaction. • There had been a slight decrease in the overall completion rate for Personal Development Reviews (PDR) in April 2023, however, the completion rate for Estates and Facilities, Planned Care Clinical Business Unit (CBU) and Medicine & Emergency Care CBU was now above 80%. Assurance was provided that: • The Head of Communications had spoken about his positive experience of joining the Trust and had commented that S&O was a good place to work. • Core Mandatory Training had achieved the 90% stretch target. • Essential Skills Training had reflected a consistent improvement month on month. • Sickness absence continued to reduce and was at 5.6% against a target of 6%. There was increased monitoring and support for managers in place from HR and Health and Wellbeing. • Safe Effective Quality Occupational Health Service (SEQOHS) accreditation had been maintained following the most recent assessment.	
	b) Workforce Race Equality Standard Report (WRES)	
	JR presented the Workforce Race Equality Standard Report (WRES) and noted that this was a snapshot of data as at 31 March 2023 for the	

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	period 2022/23 as required by the Public Sector Duty for all NHS Trusts. JR highlighted the following: • an increase in Black and Minority Ethnic (BME) staff in non-clinical bands 2,3,4 and 8a as well clinical bands 2,3,5,6 and 7. • 7.41% decrease in BME staff being appointed from shortlisting and JR noted that this was attributed to the increase in the number of international nursing recruits, predominantly from the red list countries. • One BME member of staff had entered the formal disciplinary process compared to four white staff who had entered the formal disciplinary process in the same period. • 3.5% increase in BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the preceding 12 months (based on 130 respondents in 2022). • 3.2% decrease in BME staff experiencing discrimination at work from a manager, team leader or other colleagues (based on 126 respondents in 2022). JR noted that the equality objectives and action plan were being reviewed for the new organisation. RF commented that while the Trust Board membership represented and reflected the population of the area served by the organisation, it did not necessarily represent colleagues within the Trust, and this was something to be aware of going forward.	
	c) Workforce Disability Equality Standard (WDES)	
	JR presented the Workforce Disability Equality Standard (WDES) and noted that this was a snapshot of data as at 31 March 2023 for the period 2022/23 as required by the Public Sector Duty for all NHS Trusts. JR highlighted the following: • The Trust's 2021/22 Employee Staff Records (ESR) figures indicated that 4.27% of staff had noted a disability. JR noted that the NHS Staff Survey had indicated that 22.6% of 1,107 staff that had completed the survey had noted that they had a disability. JR advised that this had been discussed at Workforce Committee and would also be raised at the staff networks to try and gain a better understanding. • Disabled staff being appointed from shortlisting across all posts was 5.21% less than non-disabled staff. • No disabled staff had entered the formal capability process on the grounds of performance in 2022/23. • 1.3% decrease in disabled staff experiencing harassment, bullying or abuse from patients, relatives, or the public.	

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	• 1.0 % decrease in disabled staff experiencing harassment, bullying or abuse from managers. • 4.7% decrease in disabled staff experiencing harassment, bullying or abuse from other colleagues. • The percentage of Trust staff who believed that Trust provided equal opportunities for career progression or promotion was 41.6% for disabled staff and this was a reduction of 1.4%. RF reflected on the mismatch between the ESR system and the NHS Staff Survey and commented that staff might not be comfortable declaring their disability. JR commented that there were protections in place to support staff and that it was sad that people were still not confident to share that they had a disability. GB commented that people might not advise that they had a disability as there was a possibility that they might be discriminated against when applying for jobs. JR agreed with GB's comment and noted that a campaign where staff shared their stories formed part of the action plan. AMS commented that there had been an improvement there was still more to be done and campaigns featuring good news stories by people with disabilities and the contributions that they made to the NHS would be important. LK agreed with the comments and added that there was a wider spectrum of reasons for people not declaring a disability and sometimes it might not occur to them to declare until adjustments were required. GA commented that this was not unique to the Trust and was about culture change. This had been discussed at the Workforce Committee when the staff networks were being established. **RESOLVED:** The Strategy and Operations Committee **received** the Workforce Reports	
FINANCE, OPERATIONS, AND INVESTMENT		
SO109/23	**Finance, Performance, and Investment Committee AAA Highlight Report**	
	JK presented the AAA Highlight report and alerted the Committee to the following: • The Cancer 62-day performance was 54.2% which, whilst an improvement, was still lower than the national performance of 63.4% and C&M at 67.4%.	

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	• To mitigate the current cash position and to provide sufficient resources for the pay award that was payable in June the Trust has requested a £9m advance and it was noted that this was similar to the arrangement in 2022/23. • The Finance, Performance, and Investment (FP&I) Committee was supportive of the request to SOC to seek £10m of DHSC revenue support which was related to the deferred income as well as £14m of PDC to cover the transaction capital as outlined in the Transaction Business Case. JK advised that the latest financial plan submitted by C&M was a deficit of £51.2m with an average CIP target of 5.5% and noted that a cost control regime as a framework for the medium-term financial strategy was being drafted. JK noted that the following amendments to the items included under Assurance: • The cash balance at the end of March is £3.6m should read at the end of *April*. • The Better Payment Practice Code (BPPC) performance at month 11 is 95.8%. should read at *month 1*. The above amendments were noted, and the FP&I AAA Highlight Report would be updated, and an updated copy of the meeting pack would be uploaded to the Trust's website. **Action** The FP&I AAA Highlight Report to be updated to reflect the abovementioned amendments and an updated copy of the meeting pack to be uploaded to the Trust's website Assurance was provided that: • Elective activity achieved 106% against 103% target of 2019/20 levels. • The Trust delivered 107% scans against the target of 103% of 2019/20 levels. • The Chase Heys and Ward 11a schemes continued to have a positive impact on performance metrics and patient outcomes. • The 14-day cancer waiting times performance was 93.8% against the 93% target, and this was the highest level since pre-Covid. • The cash balance at the end of April was £3.6m. • The Better Payment Practice Code (BPPC) performance at month 1 was 95.8% against a target of 95%. **RESOLVED:**	

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	The Strategy and Operations Committee **received** the AAA Report from the Finance, Performance, and Investment Committee	
CORPORATE GOVERNANCE		
SO110/23	**Executive Committee Report**	
	AMS presented the AAA highlight report that detailed the issues considered by the Executive Committee during May 2023 and advised that several items noted in the report had already been addressed earlier in the meeting. AMS highlighted the following: • The ongoing challenges regarding the provision of the Paediatric Dietetic Service were discussed and it was noted that the meeting that KC and LN had been due to attend with representatives from Lancashire & South Cumbria IBC had been cancelled and would be rescheduled. • The Anaesthetic Resource for a second Emergency Obstetric Theatre had been discussed and a business case was being developed which included immediate actions as well as a longer-term plan to provide sufficient anaesthetic cover to be able to respond to simultaneous emergencies. • Orthodontics Service - it was noted that all patients had been transferred to alternative providers and LN would present a closure report at a future Executive Committee meeting which would include lessons learnt from the experience. • Following a window safety incident in which a patient broke a window with a chair and injured himself a concern had been raised about the type of glass used. A risk assessment had been undertaken and a report would be presented to the Executive Committee. • It was noted that progress in delivering the backlog maintenance programme was challenged by the lack of space to decant services whilst work was being completed and it had been agreed to explore alternative capacity for current services and staff that would need to be displaced to make additional room for ward accommodation. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Highlight Report from the Executive Committee	
CONCLUDING BUSINESS		
SO111/23	**Questions from Members of the Public**	
	It was noted that no questions had been received from members of the public.	
SO112/23	**Any Other Business**	

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	In response to RF's question about the effectiveness of the meeting, CF thanked RF for the opportunity to observe the meeting which had been a positive experience and had provided her with an opportunity to observe the rich conversations and debates that had taken place as well as the strength of the committee. CF reflected on the formulation of strategy and the shaping of the culture for the future, and she was looking forward to being part of the new objectives going forward. CF commented on the openness and transparency of the meeting and that a member of the public would be assured by this. CF thanked LB and wished her all the best for her new role. RF thanked CF for her feedback. RF thanked LB for her contribution during her time with the Trust and wished her the best for her new role. LB thanked everyone for their support in her first role as Director of Nursing, Midwifery and Therapies and wished the new organisation well. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.42. The next meeting would be held on **Wednesday 26 July 2023 at 09.30**	

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Strategy and Operations Committee Attendance 2023/24												
STHK Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser	A	A	✓									
Ann Marr	✓	✓	A									
Anne-Marie Stretch	A	A	✓									
Geoffrey Appleton	✓	✓	✓									
Gill Brown	✓	✓	✓									
Nicola Bunce	✓	✓	✓									
Ian Clayton	✓	✓	✓									
Rob Cooper	A	✓	✓									
Paul Growney	A	A	A									
Lisa Knight	✓	✓	✓									
Jeff Kozer	✓	✓	✓									
Gareth Lawrence	A	✓	✓									
Sue Redfern	✓	✓	✓									
Rani Thind	✓	✓	✓									
Christine Walters	✓	✓	✓									
Peter Williams	✓	✓	A									
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Lynne Barnes	✓	A	✓									
Kate Clark	✓	✓	✓									
John McLuckie	✓	✓	✓									
Lesley Neary	✓	✓	✓									
Jane Royds	✓	✓	✓									
Nina Russell	A											
Richard Weeks	✓	✓	A									
✓ = In attendance A = Apologies												

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TRUST PUBLIC BOARD ACTION LOG – 28th June 2023

No	Date of Meeting (Minute)	Action	Lead	Date Due
P62				

There are no open actions for review

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 08 June 2023

NHS
Southport and Ormskirk Hospital
NHS Trust

Status	
Red	Significantly delayed and/or of high risk
Amber	Slightly delayed and/or of low risk
Green	Progressing on schedule
Yellow	Included on Agenda
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SO056/23	05/04/2023	**Board Assurance Framework**	RT reflected on Strategic Objective 1 controls and felt that the Clinical Negligence Scheme for Trusts (CNST) and Ockenden action plan were different controls and should be listed separately. NB agreed to make this change at the next quarterly review	NB		~~01/08/2023~~ July 2023	**05/04/2023** - The controls section for maternity services (Strategic Objective 1) to be updated	Green
SO057/23	05/04/2023	**Integrated Performance Report** b) Operational Performance Report	GB commented on the investment that had been made into the Chase Heys and Ward 11a and asked if it was possible to capture what financial savings could be made as patients were being discharged home and not into intermediate care facilities. LN and JMcL would try to collate the evidence of the savings. Additionally, LN advised that there were additional beds available in Chase Heys and, that if it was possible to source the funding and a similar model was established, this could result in further savings.	LN / JMcL		~~01/05/2023~~ 01/07/2023	**05/04/2023** - LN and JMcL to collate evidence of the savings achieved with the introduction of the Chase Heys and Ward 11a model. **May update**: Additional data is required and the Trust was working with PLACE to collect this and an update would be provided in July 2023.	Green
SO085/23	03/05/2023	**Freedom to Speak Up Quarter 4 Report**	GB asked if this would be mandated in the future given the important role FTSU played in the culture of an organisation and future improvements and suggested that refresher training be considered for all staff. GA requested that JR review this	JR		Sep-23	**03/05/2023** - JR to review the possibility of mandated training for managers as well as a refresher course for all staff members	Green
SO085/23	03/05/2023	**Freedom to Speak Up Quarter 4 Report**	IC commented on the concern raised about the power of attorney and asked if the staff member had gone beyond their duties. CGE advised that this had been investigated and there were no legitimate concerns found. KC assured that all the appropriate steps had been taken, which included police involvement and the doctor had also been engaged with the process. NB suggested that the outcome of this investigation be noted in the next FTSU report for governance purposes and to protect the individual concerned.	JR		Sep-23	**03/05/2023** - An update on the outcome of the concern raised that a doctor was potentially and inappropriately acting as a Power of Attorney for their patients be included in the next quarterly FTSU report	Green

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SO086/23	03/05/2023	**Guardian of Safe Working Report**	GB reflected on the variable response to the approval of annual leave and asked if there were any trends. KC advised that this was mainly across medicine and noted that work had been done around the rota coordination. It was noted that historically there were separate rota coordinator teams for each division, however, these teams had been amalgamated and there had been an improvement in turnaround times, with the current TAT at four weeks. Additionally, it was noted that medicine was the area with the highest number of trainees	KC		Sep-23	An update on annual leave request turnaround times was to be included in the next quarterly report	**Green**
SO109/23	07/06/2023	**Finance, Performance, and Investment Committee AAA Highlight Report**	JK noted that the following amendments to the items included under Assurance: 1. The cash balance at the end of March is £3.6m should read at the end of *April* . 2. The Better Payment Practice Code (BPPC) performance at month 11 is 95.8%. should read at *month 1* . The above amendments were noted, and the FP&I AAA Highlight Report would be updated, and an updated copy of the meeting pack would be uploaded to the Trust's website	JW		Jul-23	**02/06/2023 -** The FP&I AAA Highlight Report to be updated to reflect the abovementioned amendments and an updated copy of the meeting pack to be uploaded to the Trust's website **08/06/2023 -** FP&I Highlight report to be updated to reflect the amendments and an updated copy of the meeting pack to be uploaded to the Trust's website.	**Green**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
SO016/23	01/02/2023	**Guardian of Safe Working Report**	GB commented that one of the issues raised by the trainee doctors was delayed responses to annual leave requests and the cancellation of anticipated leave at short notice. KC advised that this was a historical issue as the Clinical Business Units (CBU) and the Roster Coordinators were managed separately with different Standard Operating Procedures (SOP), however, this was now managed through a centralised team with a consistent SOP and timescales were monitored via the CBU with medical oversight. As part of the work being undertaken by the TDF trainee doctors were more aware of the process to escalate any issues. KC assured that no further issues had been reported since there had been closer scrutiny of compliance. GB requested that the effectiveness of these measures be evaluated in the next GoSW report	KC		May-23	**01/02/2023** -The effectiveness of the revised centralised annual leave booking processes would be reviewed in the next GoSW report **May update:** An update will be provided under Agenda Item SO086/23a. **02/06/2023 -** This was discussed under Agenda Item SO086/23a on 03 May. Action closed	**Completed**

S&O STRATEGY AND OPERATION COMMITTEE PART 1 ACTION LOG – 7th JUNE 2023

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SO056/23	05/04/2023	**Board Assurance Framework**	RT reflected on Strategic Objective 1 controls and felt that the Clinical Negligence Scheme for Trusts (CNST) and Ockenden action plan were different controls and should be listed separately. NB agreed to make this change at the next quarterly review	NB		~~01/08/2023~~ July 2023	**05/04/2023** - The controls section for maternity services (Strategic Objective 1) to be updated	Green
SO057/23	05/04/2023	**Integrated Performance Report** b) Operational Performance Report	GB commented on the investment that had been made into the Chase Heys and Ward 11a and asked if it was possible to capture what financial savings could be made as patients were being discharged home and not into intermediate care facilities. LN and JMcL would try to collate the evidence of the savings. Additionally, LN advised that there were additional beds available in Chase Heys and, that if it was possible to source the funding and a similar model was established, this could result in further savings.	LN / JMcL		~~01/05/2023~~ 01/07/2023	**05/04/2023** - LN and JMcL to collate evidence of the savings achieved with the introduction of the Chase Heys and Ward 11a model. **May update**: Additional data is required and the Trust was working with PLACE to collect this and an update would be provided in July 2023.	Green
SO085/23	03/05/2023	**Freedom to Speak Up Quarter 4 Report**	GB asked if this would be mandated in the future given the important role FTSU played in the culture of an organisation and future improvements and suggested that refresher training be considered for all staff. GA requested that JR review this	JR		Sep-23	**03/05/2023** - JR to review the possibility of mandated training for managers as well as a refresher course for all staff members	Green
SO085/23	03/05/2023	**Freedom to Speak Up Quarter 4 Report**	IC commented on the concern raised about the power of attorney and asked if the staff member had gone beyond their duties. CGE advised that this had been investigated and there were no legitimate concerns found. KC assured that all the appropriate steps had been taken, which included police involvement and the doctor had also been engaged with the process. NB suggested that the outcome of this investigation be noted in the next FTSU report for governance purposes and to protect the individual concerned.	JR		Sep-23	**03/05/2023** - An update on the outcome of the concern raised that a doctor was potentially and inappropriately acting as a Power of Attorney for their patients be included in the next quarterly FTSU report	Green
SO086/23	03/05/2023	**Guardian of Safe Working Report**	GB reflected on the variable response to the approval of annual leave and asked if there were any trends. KC advised that this was mainly across medicine and noted that work had been done around the rota coordination. It was noted that historically there were separate rota coordinator teams for each division, however, these teams had been amalgamated and there had been an improvement in turnaround times, with the current TAT at four weeks. Additionally, it was noted that medicine was the area with the highest number of trainees	KC		Sep-23	An update on annual leave request turnaround times was to be included in the next quarterly report	Green
SO109/23	07/06/2023	**Finance, Performance, and Investment Committee AAA Highlight Report**	JK noted that the following amendments to the items included under Assurance: 1. The cash balance at the end of March is £3.6m should read at the end of *April*. 2. The Better Payment Practice Code (BPPC) performance at month 11 is 95.8%. should read at *month 1*. The above amendments were noted, and the FP&I AAA Highlight Report would be updated, and an updated copy of the meeting pack would be uploaded to the Trust's website	JW		Jul-23	**02/06/2023** - The FP&I AAA Highlight Report to be updated to reflect the abovementioned amendments and an updated copy of the meeting pack to be uploaded to the Trust's website **08/06/2023** - FP&I Highlight report to be updated to reflect the amendments and an updated copy of the meeting pack to be uploaded to the Trust's website.	Green

Integrated Performance Report

Board Summary

Overview

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-23	99.3	100		Top 30%
Friends and Family Test: % Recommended	Jun-23	95.1%	90.0%	95.0%	Top 50%
Nurse Fill Rates	May-23	101.6%		100.6%	
C.difficile	Jun-23	4		18	Bottom 50%
E.coli	Jun-23	12		24	Top 30%
Pressure Ulcers (Avoidable level 2+)	Apr-23	2		2	
Falls With Harm	May-23	2		5	
Stillbirths (intrapartum)	Jun-23	0	0	0	
Never Events	Jun-23	0	0	0	
Complaints Responded In Agreed Timescale %	Jun-23	76.5%		72.2%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-23	68.1%	75.0%	68.5%	Bottom 40%
Cancer 62 Days	May-23	77.4%	85.0%	79.9%	Top 10%
30 Minute Ambulance Breaches	Jun-23	447	0	1,386	
A&E Standard (Mapped)	Jun-23	73.9%	95.0%	73.2%	Bottom 30%
Average NEL LoS (excl Well Babies)	Jun-23	3.6		3.3	Top 20%
Average Number of Super Stranded Patients	Jun-23	137		135	
Discharges Before Noon	Jun-23	16.8%	33.0%	17.4%	
G&A Bed Occupancy	Jun-23	96.9%		97.0%	Bottom 10%
Patients Whose Operation Was Cancelled	Jun-23	1.1%	0.8%	1.0%	
RTT 18+	May-23	18,215	0	18,215	Top 50%
RTT 52+	May-23	1,783	0	1,783	Bottom 40%
% of E-discharge Summaries Sent Within 24 Hours	Jun-23	59.4%	90.0%	59.8%	
OP Letters to GP Within 7 Days	Jun-23	22.5%		21.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-23	76.6%	85.0%	76.6%	
Mandatory Training	Jun-23	83.0%	85.0%	83.0%	
Sickness: All Staff Sickness Rate	Jun-23	5.6%	4.3%	5.7%	Top 10%
Staffing: Turnover rate	Jun-23	0.8%		0.9%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jun-23	700	12,200	2,600	
Cash Balances - Days to Cover Operating Expenses	Jun-23	26	10	26	
Reported Surplus/Deficit (000's)	Jun-23	1,294	5,588	1,294	

Board Summary - Quality

Quality

The CQC rated the Trust as outstanding overall following its inspection in July/August 2018. The caring and well-led domains were rated as outstanding, with safety, responsive and effective rated as good.
There were no Never Events in June 2023. (YTD = 0).
There were 2 MRSA cases in June 2023. (YTD = 2).
There were 4 C. Difficile (CDI) positive cases reported in June 2023 (1 hospital onset and 3 community onset). (YTD = 18).
The annual tolerance for CDI for 2023-24 is 46.
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May 2023 was 101.6%. YTD rate is 100.6%.
During the month of May 2023 there were no falls resulting in severe harm or death category. (YTD severe harm or above category falls = 1).
There were no validated grade 3 hospital acquired pressure ulcers with lapse in care in April 2023. (YTD = 0).
Community incident reporting levels have decreased to 83 in the month of May 2023 compared to 113 in the previous year of 2022. 63 incidents were reported to be due to pressure skin damage. One of these was classified as low harm.
YTD HSMR (April - March) for 2022-23 is 92.4

Integrated Performance Report

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Mar-23	99.3	100		Top 30%	
Friends and Family Test: % Recommended	Jun-23	95.1%	90.0%	95.0%	Top 50%	
Nurse Fill Rates	May-23	101.6%		100.6%		
C.difficile	Jun-23	4		18	Bottom 50%	
E.coli	Jun-23	12		24	Top 30%	
Pressure Ulcers (Avoidable level 2+)	Apr-23	2		2		
Falls With Harm	May-23	2		5		
Stillbirths (intrapartum)	Jun-23	0	0	0		
Never Events	Jun-23	0	0	0		
Complaints Responded In Agreed Timescale %	Jun-23	76.5%		72.2%		

Board Summary - Operations

Operations

Performance against the 62 day cancer standard was below the target of 85.0% in month (May 2023) at 77.4%. YTD 79.9%. The 31 day target was achieved in May 2023 with 98.0% performance in month against a target of 96%, YTD 97.6%. The 2 week rule target was not achieved in May 2023 with 84.6% in month and 80.5% YTD against a target of 93%. The deterioration in performance for 2 week rule, is related to the significant increase in referrals, compared to the same period in 2019, resulting in capacity challenges.
Accident and Emergency Type 1 performance for June 2023 was 54.8% and YTD 53.0%. The all type mapped STHK Trust footprint performance for June 2023 was 73.9% and YTD 73.2%. The Trust saw average daily attendances of 340, which is up compared to May, at 333. Total attendances for June 2023 was 10,194.
Total ambulance turnaround time was not achieved in June 2023 with 51 mins on average. There were 2,269 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,422 in May 2023.
The UTC had 4,589 attendances in the month of May, compared to 4,527 in the month of April. Overall, 94% of patients were seen and treated within 4 hours.
The average daily number of super stranded patients in June 2023 was 137 compared with 142 in May. Note this excludes Duffy and Newton IMC beds. Work is ongoing both internally and externally, with all system partners, to improve the current position with acute bed occupancy remaining high with subsequent congestion in ED as a result.
The 18 week referral to treatment target (RTT) was not achieved in May 2023 with 63.7% compliance and YTD 63.7% (Target 92%). Performance in April 2023 was 62.4%. There were (1,783) 52+ week waiters. The 6 week diagnostic target was not achieved in May 2023 with 65.3% compliance. (Target 99%). Performance in April 2023 was 65.0%.
The month of May has seen a slight increase in referrals received within the District Nursing Service however, the levels are still within average range (464 in May compared to 421 for April). The overall caseload size had decreased slightly to 1,286 in May compared to 1,293 in April. May saw a Community matron caseload of 184, compared to 142 in the month of April. Work has been undertaken with individual PCNs to look at a collaborative approach to patient care.
The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. In addition, both nursing and medical trainee industrial action has resulted in cancellation of elective activity, particularly in medical specialties. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	May-23	68.1%	75.0%	68.5%	Bottom 40%	
Cancer 62 Days	May-23	77.4%	85.0%	79.9%	Top 10%	
30 Minute Ambulance Breaches	Jun-23	447	0	1,386		
A&E Standard (Mapped)	Jun-23	73.9%	95.0%	73.2%	Bottom 30%	
Average NEL LoS (excl Well Babies)	Jun-23	3.6		3.3	Top 20%	
Average Number of Super Stranded Patients	Jun-23	137		135		
Discharges Before Noon	Jun-23	16.8%	33.0%	17.4%		
G&A Bed Occupancy	Jun-23	96.9%		97.0%	Bottom 10%	
Patients Whose Operation Was Cancelled	Jun-23	1.1%	0.8%	1.0%		
RTT 18+	May-23	18,215	0	18,215	Top 50%	
RTT 52+	May-23	1,783	0	1,783	Bottom 40%	
% of E-discharge Summaries Sent Within 24 Hours	Jun-23	59.4%	90.0%	59.8%		
OP Letters to GP Within 7 Days	Jun-23	22.5%		21.7%		

Board Summary - Workforce

Workforce

The overall sickness absence rate in June 2023 was 5.6%, a reduction of approximately 0.2% from May's rate. There has been a consecutive reduction in sickness absence rate since March 2023. This includes normal sickness and COVID19 sickness reasons. N.B This includes normal sickness and COVID19 sickness reasons.
Appraisal compliance has dipped from May to 76.6% and is below target. Mandatory training compliance continues to improve at 83.0% in June.

Integrated Performance Report

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Jun-23	76.6%	85.0%	76.6%		
Mandatory Training	Jun-23	83.0%	85.0%	83.0%		
Sickness: All Staff Sickness Rate	Jun-23	5.6%	4.3%	5.7%	Top 10%	
Staffing: Turnover rate	Jun-23	0.8%		0.9%		

Board Summary - Finance

Finance

The Trust's Board approved 2023/24 financial plan was submitted to NHSE on 4th May, at a surplus of £5.6m. In order for the Trust to deliver this plan, it will need to achieve the elective recovery active target of 107%, Trust CQUIN target and a CIP target of £28.4m (c.5%), of which £7.0m (c.1%) is to be delivered non-recurrently.

Surplus/Deficit - At Month 3, the Trust is reporting a YTD surplus of £1.3m, in line with plan. This includes pressures relating to non pay inflation above funded levels (c. £1.3m) and additional pay costs due to industrial action (£1.2m), which are being mitigated non-recurrently.

CIP - The Trust's 2023/24 CIP target is £28.4m, of which £21.4m is to be delivered recurrently and £7.0m non-recurrently. As at Month 3, schemes delivered or at finalisation stage totalled £16.2m in year and £8.0m recurrently.

Cash - At the end of M3, the cash balance was £67.7m, with a planned reduction to £25.8m over the financial year.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £2.6m. No PDC funding (provided by Department of Health & Social Care) has been used.

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Jun-23	700	12,200	2,600		
Cash Balances - Days to Cover Operating Expenses	Jun-23	26	10	26		
Reported Surplus/Deficit (000's)	Jun-23	1,294	5,588	1,294		

Integrated Performance Report

How to Interpret - Summary Table

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

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

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

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

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

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

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

Metric Category Description - Quality

Quality Metrics

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

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

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

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

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

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

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

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

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

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

Metric Category Description - Operations

Operational Metrics

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

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

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

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

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

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

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

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

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

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

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

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

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

Metric Category Description - Workforce

Workforce Metrics

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

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

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

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

Metric Category Description - Finance

Finance Metrics

Capital Spend £M
Capital Spend £M

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

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

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	2023-24 YTD	2023-24 Target	FOT	2022-23	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	83.3%	100.0%	100.0%	100.0%	88.0%	81.8%	100.0%	100.0%	100.0%	95.7%	93.1%	87.5%	100.0%	95.1%	85.0%		94.2%		
	Total > 62 days		2.0	0.0	0.0	0.0	1.5	2.0	0.0	0.0	0.0	0.5	1.0	1.0	0.0	1.0			8.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Lower GI	% Within 62 days	▲ £	76.5%	79.3%	65.2%	83.3%	42.9%	66.7%	66.7%	57.1%	44.4%	62.5%	78.9%	75.0%	72.2%	73.8%	85.0%		69.2%		
	Total > 62 days		2.0	3.0	4.0	2.0	4.0	1.0	1.0	6.0	5.0	3.0	2.0	3.0	2.5	5.5			34.0		
	Total > 104 days		0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	2.0	0.0	1.0	1.0	0.0	1.0			8.0		
Upper GI	% Within 62 days	▲ £	84.6%	100.0%	85.7%	70.0%	75.0%	80.0%	93.8%	71.4%	83.3%	100.0%	72.7%	100.0%	100.0%	100.0%	85.0%		83.5%		
	Total > 62 days		1.0	0.0	1.0	1.5	1.0	1.0	0.5	2.0	1.0	0.0	1.5	0.0	0.0	0.0			11.0		
	Total > 104 days		0.0	0.0	0.0	0.5	1.0	0.0	0.5	1.0	1.0	0.0	1.0	0.0	0.0	0.0			5.5		
Urological	% Within 62 days	▲ £	81.0%	79.2%	78.1%	85.0%	73.1%	83.3%	78.2%	87.9%	75.6%	68.4%	78.0%	80.0%	59.3%	71.0%	85.0%		78.2%		
	Total > 62 days		4.0	2.5	3.5	1.5	3.5	2.5	6.0	2.0	5.5	6.0	4.5	3.5	5.5	9.0			43.0		
	Total > 104 days		0.0	0.5	1.5	0.5	1.5	1.0	0.0	0.0	0.5	1.5	1.0	0.5	0.5	1.0			8.0		
Head & Neck	% Within 62 days	▲ £	0.0%	44.4%	0.0%	25.0%	0.0%	0.0%	0.0%	66.7%	42.9%	16.7%	100.0%	100.0%	42.9%	50.0%	85.0%		20.0%		
	Total > 62 days		3.5	2.5	1.5	1.5	1.5	4.5	3.5	0.5	2.0	2.5	0.0	0.0	2.0	2.0			26.0		
	Total > 104 days		2.0	0.5	0.0	0.5	1.0	2.0	1.5	0.5	1.0	1.5	0.0	0.0	1.0	1.0			10.5		
Sarcoma	% Within 62 days	▲ £							100.0%	0.0%	100.0%	0.0%	100.0%		0.0%	0.0%	85.0%		66.7%		
	Total > 62 days								0.0	1.0	0.0	0.5	0.0	0.0	0.5	0.5			1.5		
	Total > 104 days								0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5			0.0		
Gynaecological	% Within 62 days	▲ £	66.7%	100.0%	45.5%	25.0%	50.0%	75.0%	80.0%	0.0%	0.0%	50.0%	44.4%	0.0%	28.6%	16.7%	85.0%		53.2%		
	Total > 62 days		2.0	0.0	3.0	4.5	1.0	1.0	0.5	1.0	1.0	1.0	2.5	2.5	2.5	5.0			18.5		
	Total > 104 days		0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	0.0	0.5	0.5	1.0	0.5	1.5			4.5		
Lung	% Within 62 days	▲ £	92.3%	69.6%	30.8%	64.7%	66.7%	85.7%	70.6%	36.4%	77.8%	46.2%	50.0%	50.0%	62.5%	56.7%	85.0%		63.7%		
	Total > 62 days		0.5	3.5	4.5	3.0	1.5	1.5	2.5	3.5	1.0	3.5	4.0	3.5	3.0	6.5			30.5		RC
	Total > 104 days		0.0	0.0	1.0	0.0	0.5	0.0	0.0	1.5	1.0	1.5	0.0	0.0	0.0	0.0			5.5		
Haematological	% Within 62 days	▲ £	100.0%	75.0%	75.0%	69.2%	0.0%	80.0%	75.0%	60.0%	60.0%	71.4%	25.0%		66.7%	66.7%	85.0%		65.6%		
	Total > 62 days		0.0	1.0	2.0	2.0	1.0	0.5	1.0	2.0	2.0	1.0	3.0		2.0	2.0			15.5		
	Total > 104 days		0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0			2.0		
Skin	% Within 62 days	▲ £	93.4%	95.5%	86.9%	79.7%	92.8%	90.3%	92.3%	86.7%	90.5%	94.1%	90.8%	89.9%	90.2%	90.0%	85.0%		90.9%		
	Total > 62 days		2.5	1.5	5.5	7.5	2.5	5.5	3.0	5.0	3.5	2.0	4.0	4.5	3.0	7.5			43.5		
	Total > 104 days		1.0	1.0	2.0	0.0	0.0	0.5	1.0	1.5	2.0	0.0	2.0	1.0	0.0	1.0			11.0		
Unknown	% Within 62 days	▲ £		100.0%	100.0%	100.0%	100.0%			100.0%		0.0%	50.0%	100.0%		100.0%	85.0%		82.6%		
	Total > 62 days			0.0	0.0	0.0	0.0			0.0		1.0	1.0	0.0		0.0			2.0		
	Total > 104 days			0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0		0.0			0.0		
All Tumour Sites	% Within 62 days	▲ £	83.2%	85.4%	77.6%	76.0%	78.4%	82.6%	83.3%	76.9%	79.0%	77.8%	79.2%	82.3%	77.4%	79.9%	85.0%		80.9%		
	Total > 62 days		17.5	14.0	25.0	23.5	17.5	19.5	18.0	23.0	21.0	21.0	23.5	18.0	21.0	39.0			233.5		
	Total > 104 days		3.0	3.0	7.5	2.5	6.0	3.5	3.5	6.5	7.5	5.0	5.5	3.5	2.5	6.0			55.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%	100.0%			0.0%		100.0%	100.0%			100.0%				85.0%		81.8%		
	Total > 31 days		0.0	0.0			1.0		0.0	0.0			0.0						2.0		
	Total > 104 days		0.0	0.0			0.0		0.0	0.0			0.0						0.0		
Acute Leukaemia	% Within 31 days	▲ £			100.0%					100.0%		0.0%					85.0%		80.0%		
	Total > 31 days				0.0					0.0		0.5							0.5		
	Total > 104 days				0.0					0.0		0.0							0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				

Title Of Meeting	Trust Board	Date	26th July 2023
Agenda Item	MWLTB (23)002	FOI Exempt	
Report Title	INTEGRATED PERFORMANCE REPORT (IPR) - Southport and Ormskirk NHS Trust		
Executive Lead	EXECUTIVE MANAGEMENT TEAM (EMT)		
Lead Officer	Katharine Martin, Performance & Delivery Manager		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

To provide an update on Southport and Ormskirk NHS Trust's performance against key national and local priorities.

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 23/24 National Priorities and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator, with the exception of the Finance section, has a Statistical process Control (SPC) chart and commentary.

The Performance Summary highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendation

The Committee is asked to receive the Integrated Performance Report detailing Trust performance in June, unless otherwise stated.

Previously Considered By:

✓ Finance, Performance & Investment Committee ☐ Remuneration & Nominations Committee ☐ Charitable Funds Committee	✓ Quality & Safety Committee ✓ Workforce Committee ☐ Audit Committee

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Katharine Martin, Performance & Delivery Manager	The Executive Management Team

Trust Board - Integrated Performance Report for Southport and Ormskirk NHS Trust

Performance Summary

The Trust Integrated Performance Report covers 4 areas aligned to the Southport and Ormskirk Trust Objectives as follows;

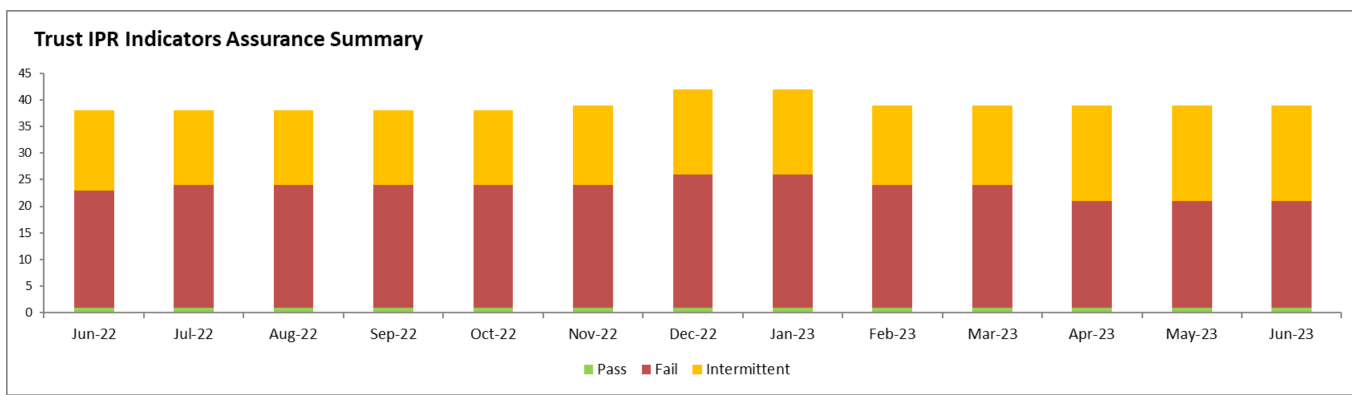
Quality - reflects those metrics aligned to Trust Objective – Care & Safety

Operations - Trust Objective – Service

Finance - Trust Objective – Financial performance and productivity.

Workforce - Trust Objectives – Supporting our workforce and Open and honest culture.

The indicator assured this month is Percentage of Patient Safety Incidents - Moderate/Major/Death(related). Finance indicators are not being reported using SPC.



Harm Free, Infection Prevention & Control, Maternity, Mortality and Patient Experience

The CQC rated the Trust as **requires improvement** overall following its inspection in July/August 2019. The caring domain was rated as **good** and well-led, safety, responsive and effective domains rated as **requires improvement**. An unannounced CQC visit to Medicine and Emergency Care in March 2021 provided overall positive feedback with 9 'should-do' recommendations.

There were no Never Events reported in June 2023 (2023/24 YTD = 0).
There were no cases of MRSA in June. (2023/24 YTD = 0).
There were four C. Difficile (CDI) positive cases reported in June (2023/24 YTD = 6).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for June 2023 was 95.3%. This is based on 98.67% for Registered Nurses and 91.69% for Un-Registered Nurses.
There were no category 3 hospital acquired pressure ulcers reported in June, but there was 1 deep tissue injury reported.
There were 77 patient falls in June, with two resulting in moderate or worse harm (2022/23 YTD = 3).
All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
The Patient Friends & Family Test - % that rate the Trust as 'Very Good or Good' (Trust overall) achieved 90.8% in June, from 90.6% in May.
The % of complaints responded to within timescales has increased to 71.4% in June against the 80% target (52.4% in May).
The Percentage of Patient Safety Incidents resulting in Moderate or above harm continues to perform lower than the target and has decreased from the spike seen in January. This has been impacted by lower incident reporting rates.

Operational Performance

As per the NHS Priorities and Operational Planning for 2023/24, the A&E target has been reduced from 95% to 76%. Overall Accident and Emergency performance for June was 77.7% (Adults ED 53.59%, Paeds ED 96.83% in June). This compares favourably with peers, with an England average of 72.38%, North-West 73.23% and Cheshire & Mersey 74.11%. 29.9% of Ambulance Handovers occurred within 15mins, consistent with the previous month (29.8%) and behind the 65% target. 77.5% of Ambulance Handovers were within 30mins, a decrease on May (79.6%), against the 95% target. 46 Ambulance Handovers breached 60mins in June, compared to 18 reported in May. S&O was third best in C&M for handover times in June.

Performance against the 14-day GP referral to Outpatients failed to achieve the 93% target in May 2023 (latest data month), but increased to 84.7%, (77.2% in April). This is above the England average of 80.7%, North-West 83.5% and Cheshire & Mersey 84.1%. (NHS Trusts, May 23 data). The 62-day cancer standard increased to 59.4% in May, against the 85% target, from 45.1% in April. This is above National performance (58.6%) in-line with North-West (59.4%) but below Cheshire & Mersey (64%). 31-day performance also increased in May, to 91.2% (85.2% in April) against the 96% target. This is above National performance (90.3%), and North-West (90.6%) but below Cheshire & Mersey (92.6%).

Operational Performance continued

The average daily number of stranded patients in June 2023 was 234 (May 224). The number of super-stranded patients increased by 2 on the previous month, to 102.
The Criteria to Reside metric increased in June, to 75. All these metrics were impacted by patient acuity, delays in care packages, availability of community beds and care home capacity.

The Trust continues to perform well on the Referral to Treatment indicator in comparison to both local and national performance, achieving 59.9% in June (61.5% May). This remains above the average for NHS Trusts in England of 58.8%, North-West 54.2% and C&M 56.8%.
There were 271 52+ week waiters at the end of June, an increase on the 199 reported in May, with 6 patients waiting longer than 65 weeks (14 at the end of May), the target is to achieve 0 by the end of April 2024. There remained no 78 or 104-week waiters. SOHT is the top performing acute trust across C&M for 52 week waits.

As per the NHS Priorities and Operational Planning for 2023/24, the Diagnostics target has been increased from 1% to 5%. Performance improved in June, achieving 15.3%, (15.7% in May). Trust performance is significantly better than the average for NHS Trusts in England (28.5%), the North-West 26.8% and Cheshire & Mersey 21.8% (April data – latest available).

The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. All patients continue to be clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust is reporting a £2m deficit at Month 3 in line with 2023/24 Plan.

The Trust has reflected income in line with fixed, variable and top up allocations associated with ICBs and Specialised Commissioning. This is subject to how variable allocations will be paid and will be adjusted following validation of activity freeze data.
Underlying pressures arising, including excess inflation, energy, and costs associated with delivery of additional activity continue to be closely monitored for the 2023/24 financial year.
The 2023/24 financial plan sets out a CIP requirement of 5.0%. The Trust is reporting full delivery of CIP at Month 3 and forecasting achievement of the £13.2m target for 2023/24.
The Trust is forecasting delivery of a breakeven plan as it transacts into Mersey & West Lancashire Teaching Hospitals NHS Trust from 1 July.

Cash - The cash balance at the end of June was £10.4m.
In June the Trust received an agreed £9m advance from Cheshire & Mersey ICB together with a £5.9m receipt from NHS England for the 22/23 non-consolidated pay award.
Both the 22/23 non-consolidated pay award and 3 months of the 23/24 pay award were all paid out in June's payroll. Note the tax, NI and pension payments associated with this will be paid out in July.
The Trust was notified on 11th July that it had been successful in its application for £10m revenue support PDC linked to the Transaction. It is anticipated that this will be drawn down in Quarter 2 23/24.

Financial Performance continued

BPPC - Performance has improved since last month on both non-NHS and NHS. The overall percentage is 94.4%.

Debt over 90 days - This has reduced since last month, down from £1,089k to £1,022k.

Capital - Total capital spend is £516k and the remaining £20.822m capital resource will be part of MWL. Internally generated resources will be managed by the MWL Capital Council from July and decisions around PDC funded schemes will be via Exec Committee.

Workforce

Personal Development Review compliance has decreased in June to 77%, against the 85% target. Performance in May was 78.4%. The Trust continues to achieve the 90% stretch target for Mandatory Training in June, achieving 90%, a small decrease on May (90.5%).

In month overall sickness continued to be below target in June, at 5.8% (5.4% in May). The rolling 12-month figure is reducing and is currently 6.4%. This is against sickness targets of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness was 5.6% in April, an increase on the 5.1% reported in May.
The overall Trust vacancy rate remained stable in June, at 8.5% against the 7.4% target, the same as the previous month. This has been impacted by an increase in the overall establishment. In-month Staff turnover remains within expected levels, at 0.9% in June, from 1% in May (target 0.83%).

Integrated Performance Report

Board Report

June 2023

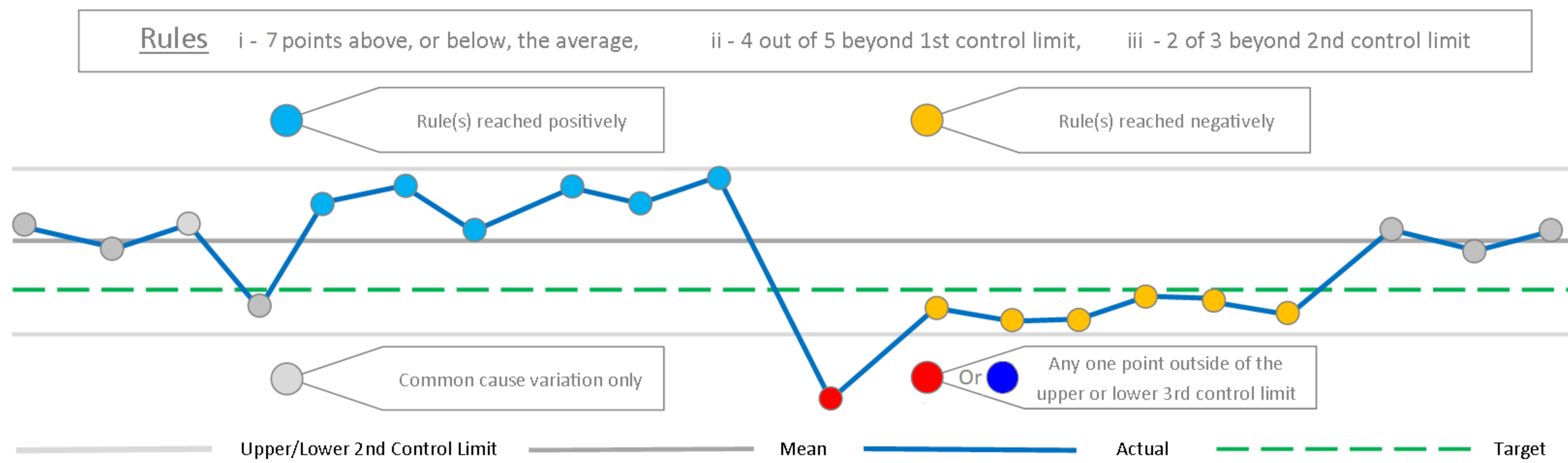
Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **http://www.improvement.nhs.uk/resources/making-data-count**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line (**dark grey**) is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.



Executive Summary

Alert Indicators

Complaints - % closed within 40 working days

Accident & Emergency - 4 Hour compliance

62 day GP referral to treatment
Stranded Patients (>6 Days LOS)
Super Stranded Patients (>20 Days LOS)

Quality

Harm Free

Hospital Acquired Pressure Ulcers

Issues
• Performance for Category 3 pressure ulcers is statistically as expected, with 1 reported in June. This was a deep tissue injury.

Management Action
• General reduction in all categories of pressure ulceration reported over the last few months, with the ongoing QIP in ED starting to have a positive impact. ED are reporting more external pressure ulcers through skin inspection and body mapping in triage. ED is working closely with TVN team & safeguarding for categorisation.
• Pressure relieving equipment ordered (inflatable trolley toppers & inflatable boots for continuous offloading of vulnerable patients) has arrived in ED in June.
• Clinical photography can be utilised if TVN team not able to cross cover for categorisation.
• Work is ongoing to align our pressure relieving equipment across all sites within MWL, including parafricta bootees for very high-risk patients identified on the risk assessment for prevention of heel damage. This will include patients in ITU/HDU, advanced frailty, bedbound and End of life (EOL) patients.
• We are currently evaluating a new foam protective dressing for patients who develop pressure damage on 7B & 9B. The new dressings are cost effective, comfortable and conformable. Liaising with procurement so that the new product can be rolled out as first line for pressure ulcer treatment.
• Nursing documentation to be updated with the Maelor risk assessment score as part of the merger. New risk assessment training will be rolled out to all wards once the new documentation is in place. It is already part of the bi-monthly training for pressure ulcer prevention.
• Work to align HAPU measurements and classifications under MWL going forward.

Patient Falls

Issues
• The Trust reported 77 falls in June, an increase of 28 on the previous month. Whilst this is not statistically significant, it is the highest number reported since January 2023.
• Two falls resulting in moderate harm were reported in June.

Management Action
• All fall related incidents are also monitored by the Trust Falls Group and escalated incidents are managed through the CBUs to the Harm Free Care Group.
• Falls documentation (care plan and post falls assessment) reviewed and updated following incident investigations and feedback.
• New enhanced care documentation now rolled out across all wards within Southport and Ormskirk Hospitals with positive feedback from staff.
• Trial without using yellow wristbands on 15a and 10b ongoing with evaluation and feedback to Trust Falls Group July 2023.
• Use of the Salus centre agreed in short term (until Sept 2024) to provide intensive programme of flojac training to increase the number of competent staff.
• Falls champion education day held June 2023, with great attendance .
• Planning for Falls Awareness Week (September 2023) commenced.
• Ward based fall simulation work commenced to identify any further falls management training needs/systemic issues.

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
	Never Events	0	0	0	Jun 23		0	0	May 23	0	0	?
	Safe Staffing	90%	95.3%	N/A	Jun 23	H	90%	95.2%	May 23	90%	95.7%	?
	Hospital Acquired Pressure Ulcers - Categories 3 & 4	1	1	1	Jun 23		1	2	May 23	12	7	?
	Patient Falls - Trust	63	77	77	Jun 23		63	49	May 23	756	175	?
	Falls - Moderate/Severe/Death	1	2	2	Jun 23		1	1	May 23	17	3	?
	Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	2.1%	1.1%	8	Jun 23		2.1%	0.7%	May 23	2.1%	0.7%	P

Never Events
Safe Staffing
Hospital Acquired Pressure Ulcers - Categories 3 & 4
Patient Falls - Trust
Falls - Moderate/Severe/Death
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)
2020/21
2021/22
2022/23

Infection Prevention and Control

C. difficile

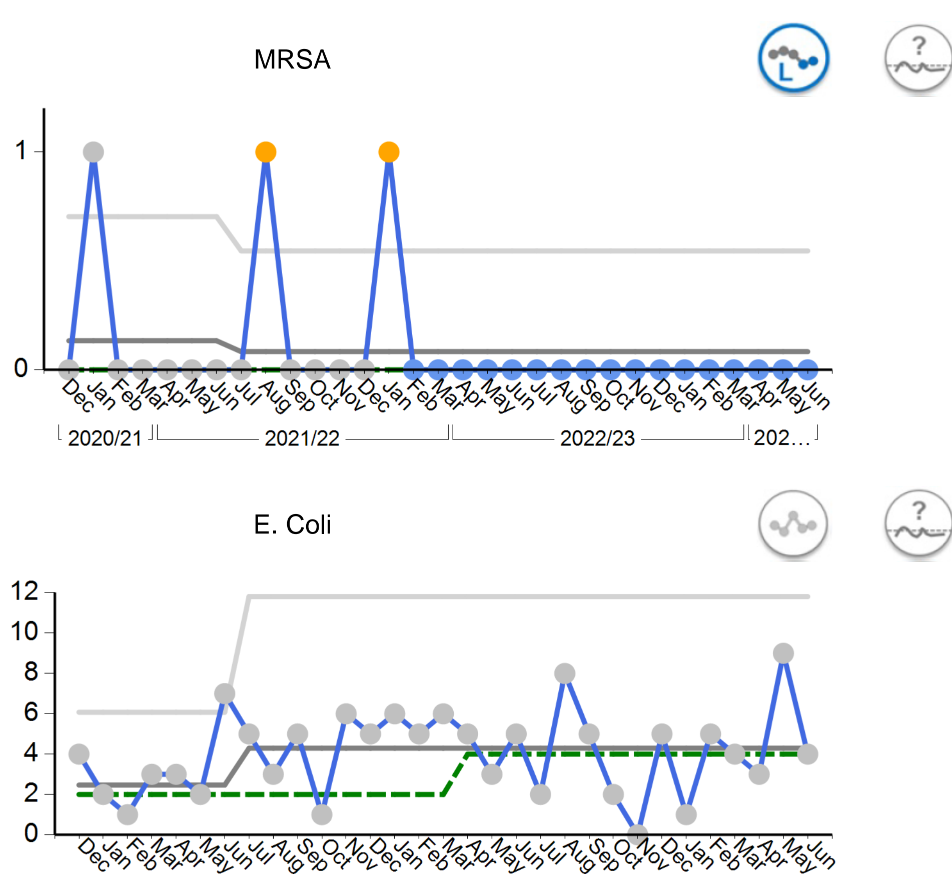
Issues
- The Trust reported 4 C.diff cases in June, all of which were Hospital Onset Hospital Acquired cases.
- The Trust target is no more than 39 cases in 23/24. There have been 6 HOHA (hospital-onset healthcare associated) cases in Q1 and the Trust is within trajectory.

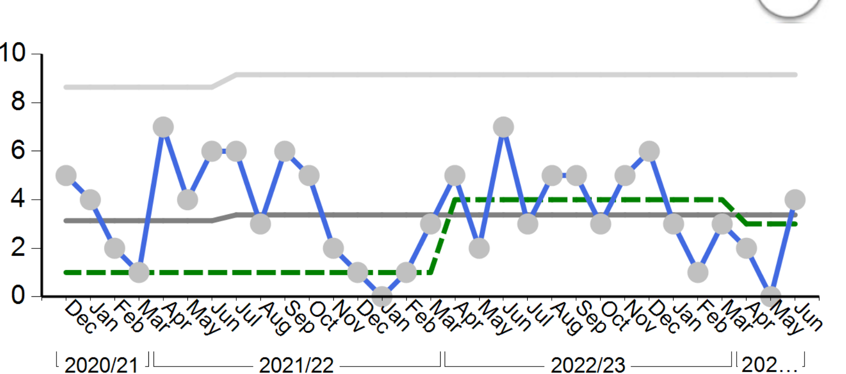
Management Action
- RCAs have been completed on five of the Q1 cases to date. Three RCAs identified no lapses in care. Two cases on Ward 14B constitute a period of increased incidence of infection. Lessons identified related to Bristol Stool Chart monitoring, ward cleanliness scores and issues with the built environment. In both cases antibiotic prescribing was not in line with formulary and there were delays in antibiotic review. A ward action plan has been developed.
- Currently, there is no decant facility and terminal cleaning requires improvement following cases of CDI and other HCAIs. HPV and UVC technologies are underused across the Trust for this reason.

E coli

- The Trust reported 4 cases in June, 3 Hospital Onset Hospital Acquired (HOHA) and 1 Community Onset Hospital Acquired (COHA).
- The Trust target is no more than 48 cases for the year. There have been 16 cases in Q1 and the Trust is on trajectory. This includes 9 HOHA cases and 7 COHA cases.
- The majority of E-Coli cases are from a urinary source and no specific lessons have been identified.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	MRSA	0	0	0	Jun 23		0	0	May 23	0	0	
	C-Diff	3	4	4	Jun 23		3	0	May 23	39	6	
	E. Coli	4	4	4	Jun 23		4	9	May 23	48	16	


MRSA
1
0
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
202…
E. Coli
12
10
8
6
4
2
0
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
202…


C-Diff
10
8
6
4
2
0
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
202…

Patient Experience

Complaints - % closed within 40 working days

See accompanying action plan.

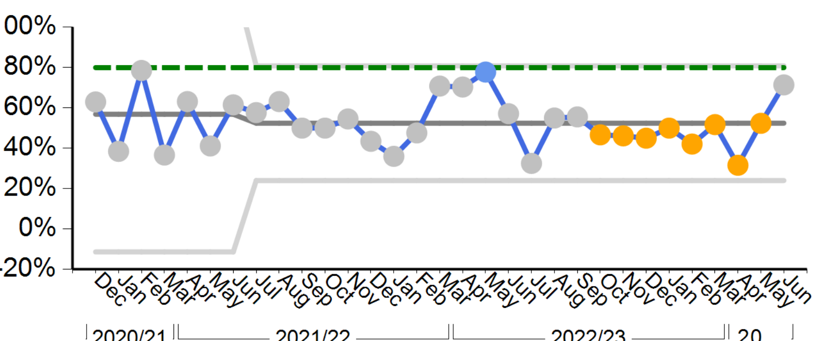
Friends and Family Test

Issues
• An issue with NHS Digital Friends and Family published data means the latest data available for comparison is February 2023.
• The Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall metric continues to fail the assurance measure but is showing positive variation for the past 6 months and has improved marginally in June to 90.8%.
• The overall indicator amalgamates Acute Inpatients, A&E and Maternity. 49.5% of responses in June were from A&E, which has impacted the overall percentage.
• The score for Acute Inpatients remains static at 95.1%. This is above the Trust internal target and the NHSE average for February of 95%.
• The top themes attached to positive ratings for Acute Inpatients are staff attitude, implementation of care and environment.
• The top themes attached to negative ratings for Acute Inpatients are staff attitude, implementation of care and environment.
• A&E achieved 86.6% (84.45% Adult's and 92.1% Children's), an improvement of 0.4% on May. This is significantly above the Trust indicator of 77.8% and February NHSE average of 80%. This indicator remains assured.
• The top themes attached to positive ratings for A&E are staff attitude, implementation of care and waiting times.
• The top themes attached to negative ratings for A&E are staff attitude, waiting times and environment.
• Outpatients – achieved 94.3%. This is above the February NHSE average of 94% and above the internal target of 92.8%. This indicator remains assured.
• Labour Ward - an increase in score from 91.7% to 94.9%. This is above the internal indicator of 94% and NHSE average of 93%.
• Postnatal Ward – a decrease in score from 95.2% to 88% (based on 25 responses). This is below the February NHSE average of 93% and internal indicator of 92%. The two negative responses provided no qualitative feedback to identify themes.

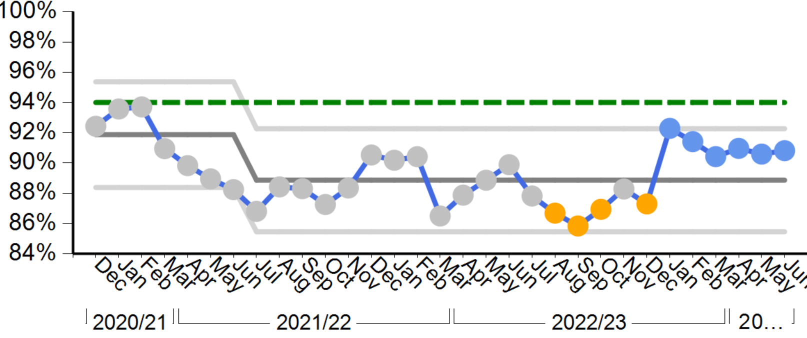
Management Action
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience and Community Engagement (PECE) group where CBU updates and actions to improve FFT are provided.
• Areas continue to review comments to identify any emerging themes or trends to inform a 'You said, we did' approach to improvement. FFT results are reviewed at ward/department level through a performance review process.
• Final report received for the 2022 National Inpatient Survey which will be reported to and monitored by the PECE group.
• The local Maternity Voices Partnership meeting continues to provide opportunities to work collaboratively and gather further feedback from this patient group.
• The co-produced 23/24 workplan has been agreed with the MVP and will focus on 4 key areas of care; - infant feeding, community antenatal care, pelvic health and birth choice.
• A Local survey is currently in place to measure key areas for improvement from the 2022 national survey results, friends and family themes and any complaint themes.
• The 2023 National Maternity Survey is currently underway, our current response rate is in line with the national average.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Complaints - % closed within 40 working days	80%	71.4%	N/A	Jun 23	L	80%	52.4%	May 23	80%	50%	F
	Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	90.8%	N/A	Jun 23	H	94%	90.6%	May 23	94%	90.8%	F

Complaints - % closed within 40 working days

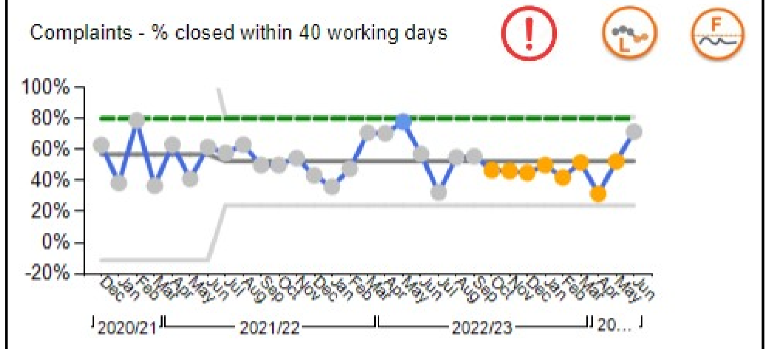


Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall

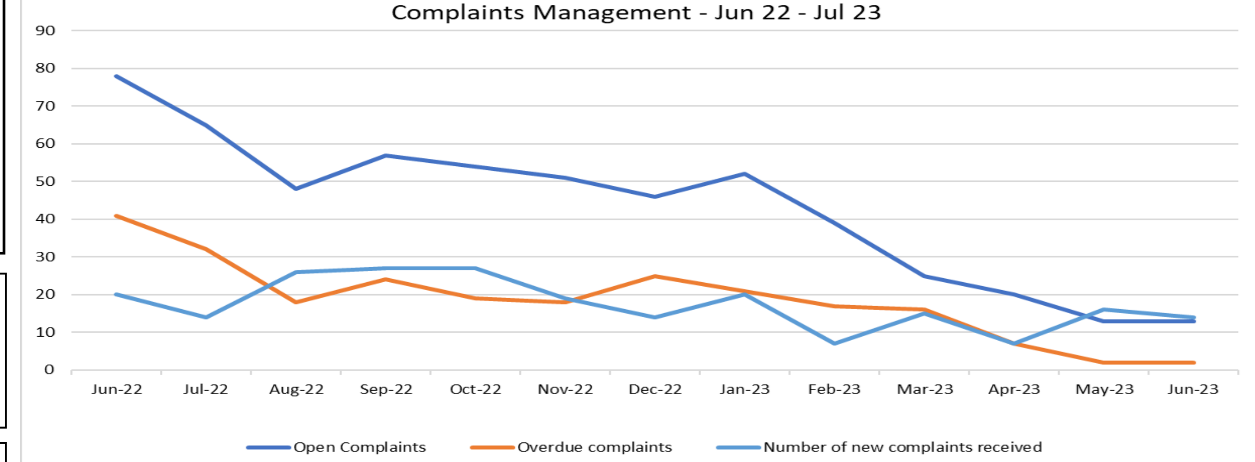


Complaints—% closed within 40 working days

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
!	Complaints - % closed within 40 working days	80%	71.4%	N/A	Jun 23		80%	52.4%	May 23	80%	50%	F



Situation: This indicator has historically struggled to achieve the 80% target. Performance in June has improved by almost 20% and is just 8.6% behind target.



Issues:

Historic backlog of overdue complaints.

Competing priorities of Clinicians to complete statements and responses.

Actions:

There is enhanced oversight and visibility of the complaints position within Medicine and Emergency Care CBU, with Lead Nurse scrutiny. As at the 6th July, they had 1 overdue complaint.

As at the 6th July, Planned Care continued to have no overdue complaints. They continue to review and progress all open complaints to ensure they are closed within timescales.

As at the 6th July, Women & Children's have 1 overdue complaint. They continue to escalate and follow up weekly to ensure the responses are collated within the timeframes, with the support from the Governance team.

The new Complaints Policy has been ratified and which allows 60 working days to respond to formal complaints with effect from 1st July 2023.

Mitigations:

The above graph demonstrates the positive progress being made.

- From Jun 22 –Jun 23, the number of open complaints has reduced by **83.3%** and the number of overdue complaints has reduced by **95.1%**.
- Re-Opened complaints averaged 2.3 per month from May—Oct 2022. From Nov 2022—Jun 2023 this has reduced to an average of 1.425per month, demonstrating improvements in the quality of responses.
- There were no complaints open greater than 100 working days.
- The number of new complaints averaged 23 per month from May—Oct 2022. From Nov 2022—Jun 2023 this has reduced to an average of 14 per month, this is due to early intervention to prevent patient concerns escalating into formal complaints.

Operations

Access

A&E

Issues
• Performance in June exceeded the national standard, achieving 77.7%. This is a 2.2% increase on the previous month and is against the same number of attendances as the previous month.
• The Trust remains in the top quartile nationally for ED performance, performing ahead of the National average (72.38%), Northwest (73.23%) and Cheshire & Mersey (74.11%) (NHS Trusts only). The Trust was the third highest performer in Cheshire & Mersey behind Liverpool Women's Hospital and Alder Hey.
• 11.9% of patients spent longer than 12 hours in the department (899 patients). This is an increase on the previous month, but statistically as expected, and is aligned with an increase in bed occupancy of 4% compared to April 2023.
• Increase in acuity of patients.
• Capacity of community services, care homes and LA to support patients.
• Additional winter escalation area still in use due to bank holidays and forthcoming industrial action.
• Bed occupancy trajectory.

Management Action
• Continuation of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment.
• Continuation of promotion of use of CDU correctly and avoid using as escalation area.
• Continuation of team building of SDEC and FAU clinical team to maximise resources and all clinical areas with appropriate staffing skill mix.
• Ensure patients are safe and receive quality of care in appropriate area to maintain privacy and dignity.
• Continue to work with system to support alternatives to hospital and reduce ready for discharge list.

Ambulance Turnaround Times

Issues
• Performance against the 15minute handover achieved 29.9% in June, against the 65% target, with 77.5% being handed over within 30 minutes. This remains consistent with the previous month.
• The number of handovers >60 minutes increased in June, with 46 reported. This was the third lowest in C&M.
• Average 15 min handover time was 24 minutes, compared to Cheshire & Mersey average of 32 minutes and North West average of 23 minutes. S&O was third best in C&M for handover times.
• Southport's average Turnaround time was 35 mins which was the same as May. The Trust again was joint 2nd (Alder Hey were first), exceeding the C&M average of 41 minutes.

Management Action
• Increased focus of handover times by senior nursing staff and Rapid Assessment Triage (RATS) continues.

Referral to Treatment

Issues
• The Trust continues to perform well in comparison to both local and national performance, achieving 59.9% in June. This remains above the average for NHS Trusts in England of 58.8%, North West 54.2% and C&M 56.8%.
• The Trust had the lowest number of 52 week waits based on Acute Trusts in Cheshire & Mersey (May data).
• There were 6 65-week waits at the end of June. The target is to achieve 0 by April 2024.
• There were 0 78-week and 104 week waits at the end of June.
• Overall ERF activity achieved 99.5% of plan. C&M latest data reported at 98.9%.
• ENT – ongoing workforce pressures.
• Gynaecology – capacity and workforce issues.

Management Action
• ENT – ongoing SLA discussions taking place with LUHFT to coordinate recruitment into vacant posts.
• Gynaecology – new Consultant commenced in post in June so improvement is anticipated.

Diagnostics

Issues
• The Diagnostic Waits indicator continues to show special cause improvement and has improved further in June to 15.3%. This is the lowest since April 2021.
• Trust performance is significantly better than the average for NHS Trusts in England (28.5%), the North-West 26.8% and Cheshire & Mersey 21.8% (April data – latest available).
• Total diagnostics activity is 96% of plan for June.
• Diagnostic scopes performance achieved 163.6% of plan.
• Diagnostic scans performance is at 92% of plan.
• Endoscopy – Supporting STHK with Mutual Aid.

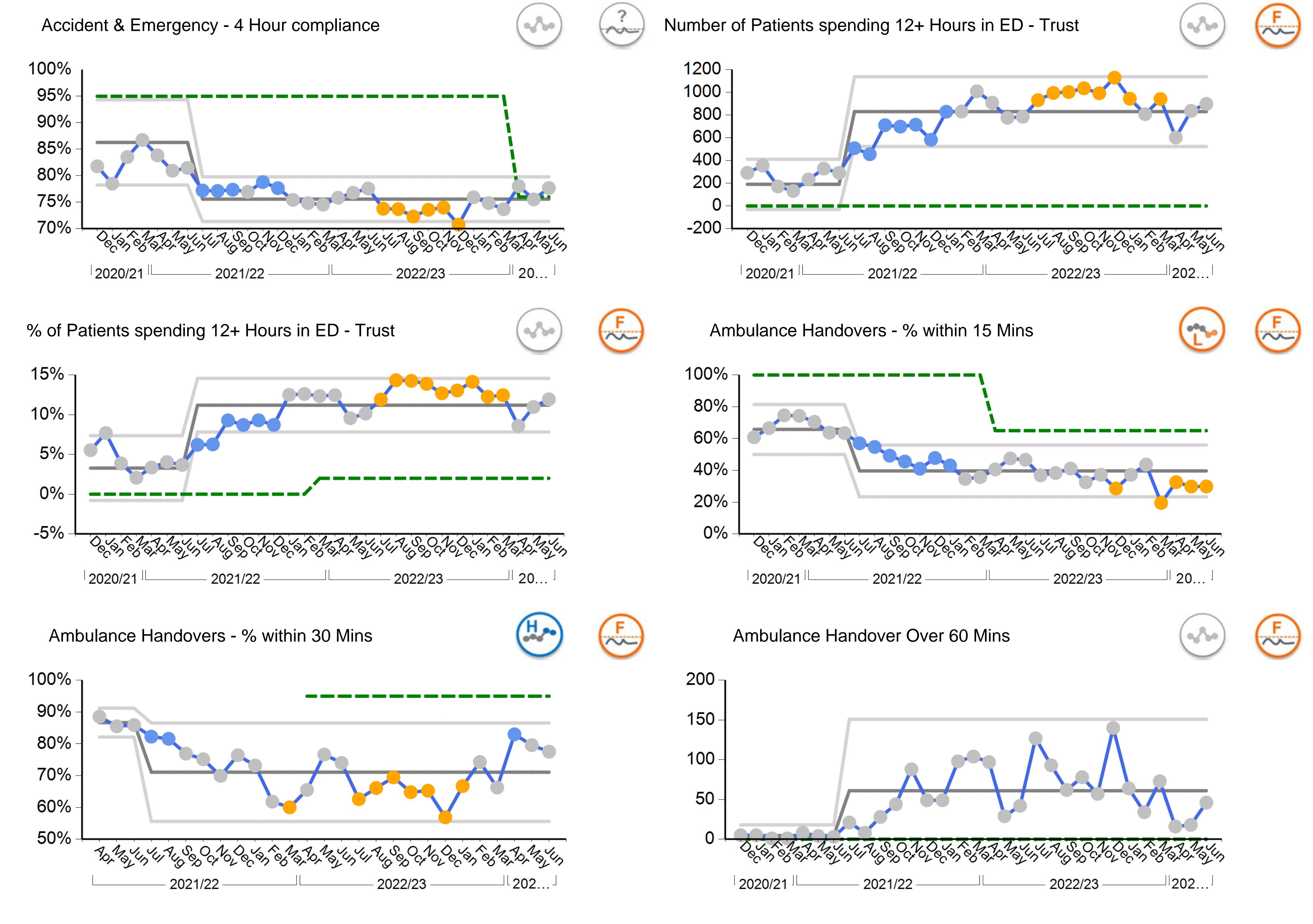
Management Action
• Endoscopy – Continuous monitoring to ensure that Mutual Aid does not impact on DM01 timescales.
• Radiology – CT: Additional activity is being covered with substantive staff where possible with additional support utilising WLI and agency staff.

Outpatient Letters within 7 days

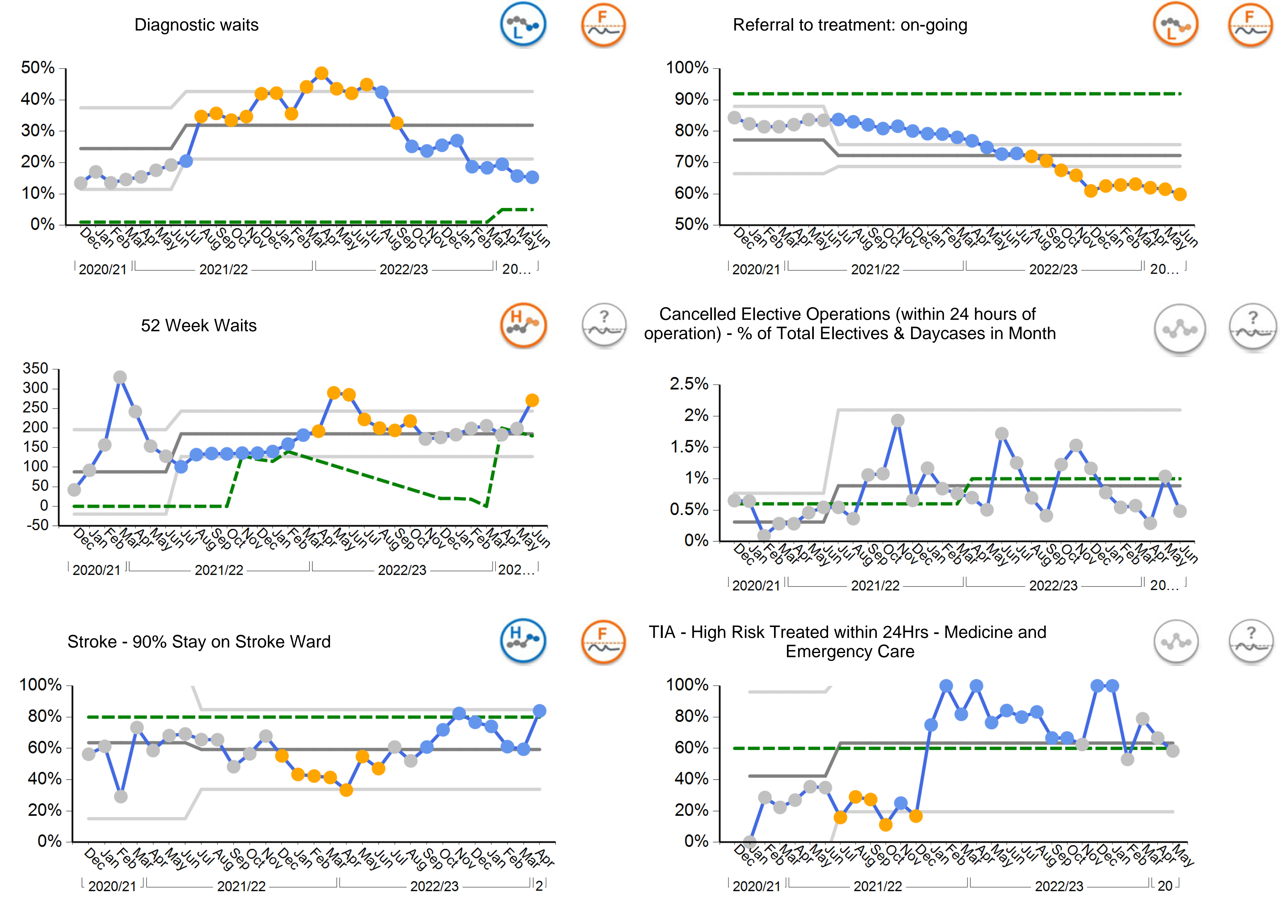
Issues
• The indicator is failing the assurance measure and is consistently failing to achieve the 85% target. Performance in June has improved to 70.7%.
• Performance has been impacted by long term sickness, annual leave and vacancies.
• Dictation delays within Paediatrics.
• Delays with Consultant sign-off.

Management Action
• Improvements in long term sickness, annual leave and vacancies.
• Delays in dictation within Paediatrics have been addressed and should reflect in future performance.
• Outstanding letters for sign off escalated to the individual consultants. Directorate Manager included in the escalation emails to pick up the delays and identify if there are a particular cohort of Consultants where the delays are encountered.

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
	Accident & Emergency - 4 Hour compliance	76%	77.7%	2367	Jun 23		76%	75.5%	May 23	76%	77%	?
	Number of Patients spending 12+ Hours in ED - Trust	0	899	N/A	Jun 23		0	838	May 23	0	2340	F
	% of Patients spending 12+ Hours in ED - Trust	2%	11.9%	N/A	Jun 23		2%	11%	May 23	2%	10.6%	F
	Ambulance Handovers - % within 15 Mins	65%	29.9%	712	Jun 23	L	65%	29.8%	May 23	65%	30.7%	F
	Ambulance Handovers - % within 30 Mins	95%	77.5%	228	Jun 23	H	95%	79.6%	May 23	95%	80%	F
	Ambulance Handover Over 60 Mins	0	46	46	Jun 23		0	18	May 23	0	80	F
	Diagnostic waits	5%	15.3%	523	Jun 23	L	5%	15.7%	May 23	5%	16.9%	F
	Referral to treatment: on-going	92%	59.9%	7943	Jun 23	L	92%	61.5%	May 23	92%	61.1%	F
	52 Week Waits	180	271	271	Jun 23	H	190	199	May 23	0	242	?
	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	0.5%	12	Jun 23		1%	1%	May 23	1%	0.6%	?
	Stroke - 90% Stay on Stroke Ward	80%	84%	4	Apr 23	H	80%	59.5%	Mar 23	80%	84%	F
	TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	58.3%	5	May 23		60%	66.7%	Apr 23	60%	63.6%	?
	Outpatient Letters to GP's within 7 Days	85%	70.7%	3197	May 23		85%	67.6%	Apr 23	85%	69.3%	F
	E-Discharges within 24hrs	85%	81.6%	233	Jun 23		85%	78.7%	May 23	85%	78.8%	F

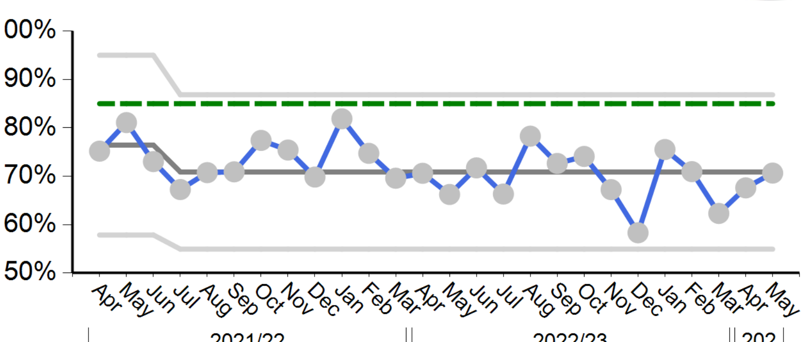


Accident & Emergency - 4 Hour compliance
Number of Patients spending 12+ Hours in ED - Trust
% of Patients spending 12+ Hours in ED - Trust
Ambulance Handovers - % within 15 Mins
Ambulance Handovers - % within 30 Mins
Ambulance Handover Over 60 Mins
2020/21
2021/22
2022/23

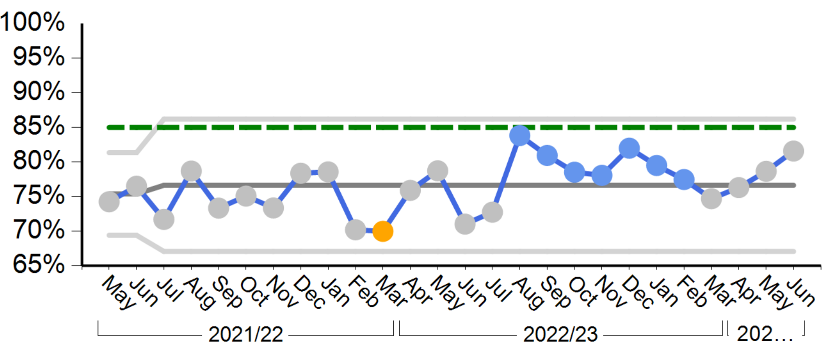


Diagnostic waits
50%
40%
30%
20%
10%
0%
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
20…
Referral to treatment: on-going
100%
90%
80%
70%
60%
50%
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
20…
52 Week Waits
350
300
250
200
150
100
50
0
-50
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
202…
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month
2.5%
2%
1.5%
1%
0.5%
0%
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
20…
Stroke - 90% Stay on Stroke Ward
100%
80%
60%
40%
20%
0%
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2020/21
2021/22
2022/23
2
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care
100%
80%
60%
40%
20%
0%
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May
2020/21
2021/22
2022/23
20

Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



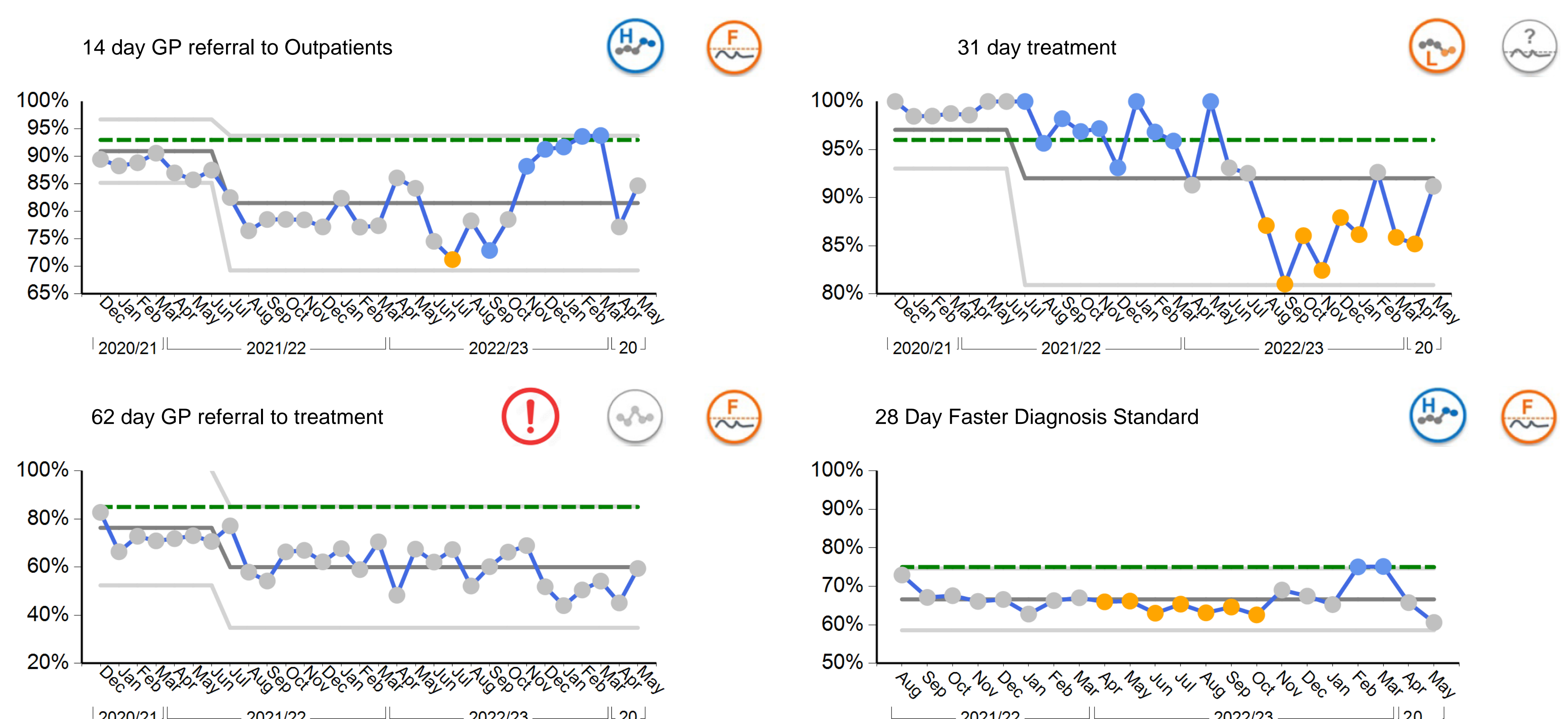
Operations

Cancer

Issues
• The 14 day GP Referral to Outpatients increased in May, to 84.7% against the 93% target (77.2% in April). This is above the England average of 80.7%, North-West 83.5% and Cheshire & Mersey 84.1%. (NHS Trusts, May 23 data).
• 31-day performance achieved 91.2% against the 96% target (85.2% in April). This is above National performance (90.3%), and North-West (90.6%) but below Cheshire & Mersey (92.6%).
• Performance against the 62 day standard improved to 59.4% in May (45.1% in April), this is above National (58.6%) in-line with North-West (59.4%) but below Cheshire & Mersey (64%).
• Histology challenges remain impacting on 7-day turnaround time, due to significant increase in demand through along with unplanned Consultant leave.
• Dermatology received the highest ever recorded number of referrals in June 2023, totalling 723.
• Radiology delays continue to have an impact on patient's pathway.

Management Action
• STHK have advised that they have offered additional WLI's to substantive staff to decrease the reporting times however as the issue is a national shortage of Histopathologists, STHK do not see the position improving in the short term. They are hopeful to recruit trainees who are due to qualify later this year.
• Intensive scrutiny on Colorectal, Skin, Urology and Gynae resulting in improvements in the backlog.
• Band 7 for FD Programme due to commence mid-July. Band 5 recruited to and employment checks have commenced with a view to potential start date of September.
• Face to face PTL meetings ongoing, with DM's leading the meeting, chaired by the Head of Elective Restoration and Cancer manager. Feedback from revamped PTL meetings is positive, these are now action focused meetings which is supporting more timely progression in patient pathways.
• Radiology Consultants recently recruited due to commence in July, August and September which should improve turnaround times for diagnostics. EDSW post commencing 31st July.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	14 day GP referral to Outpatients	93%	84.7%	199	May 23	H	93%	77.2%	Apr 23	93%	81.1%	F
	31 day treatment	96%	91.2%	6	May 23	L	96%	85.2%	Apr 23	96%	88.5%	?
!	62 day GP referral to treatment	85%	59.4%	28	May 23		85%	45.1%	Apr 23	85%	53.3%	F
	28 Day Faster Diagnosis Standard	75%	60.6%	457	May 23	H	75%	65.8%	Apr 23	75%	63%	F


14 day GP referral to Outpatients
31 day treatment
62 day GP referral to treatment
28 Day Faster Diagnosis Standard
2020/21
2021/22
2022/23
20
20…

Operations

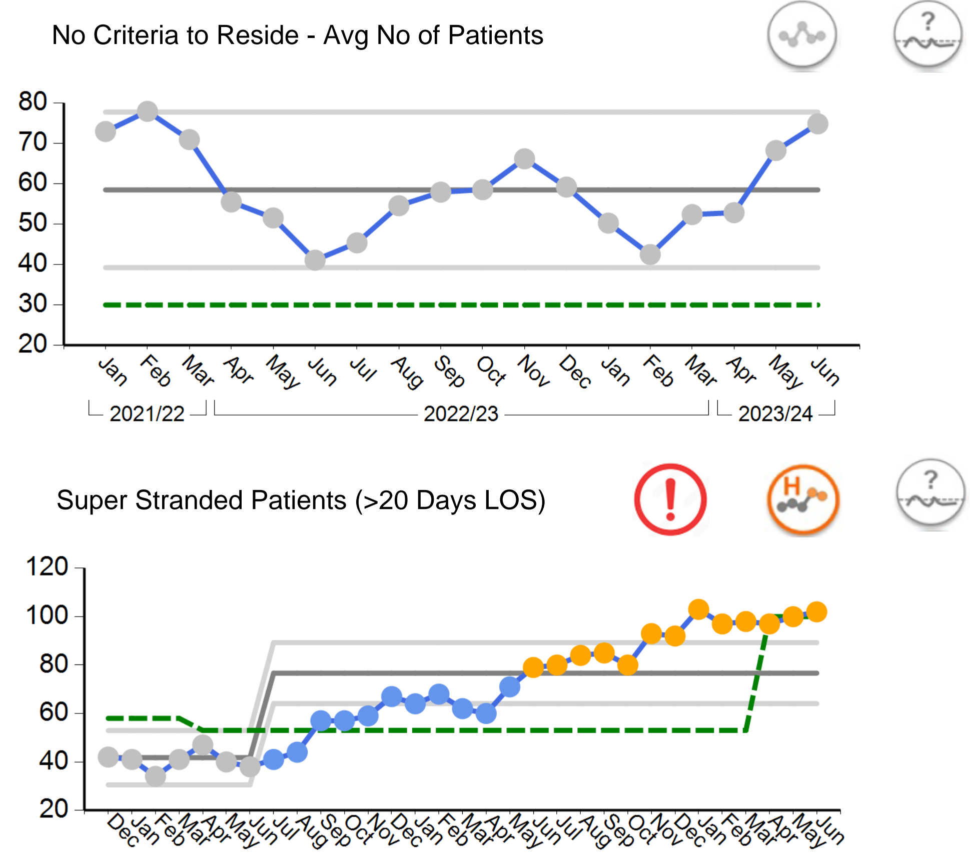
Productivity

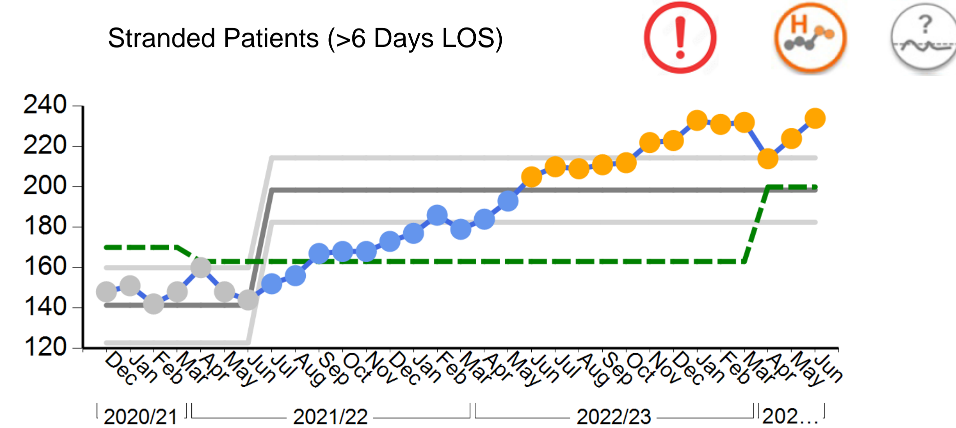
Stranded/Super-Stranded Patients/Criteria to Reside

Issues
• Both stranded patient metrics continue to fail assurance and show special cause concern, with further increases in June. Stranded patients is 34 above plan at 234, and Super Stranded patients 2 above plan.
• Increase in acuity of patients.
• RFD numbers continue to average around 60-80 per day which is the equivalent to two wards, which can be attributed to delays in for care packages and waiting for long term care home placements; community teams report high acuity and pressure to support the numbers of fast track patients at home; community beds exceeding 100% bed occupancy.

Management Action
• Continue to work with system to support alternatives to hospital and reduce ready for discharge list.
• Ongoing monthly Clinical Point prevalence's taking place across wards to ensure progress of discharge plans which has evidenced appropriate plans are in place for patients with criteria to reside and non criteria to reside.
• Focus on improvement of patients discharged at 5pm to ensure meet trajectory.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	No Criteria to Reside - Avg No of Patients	30	75	74.9	Jun 23		30	68	May 23	30	65	?
!	Stranded Patients (>6 Days LOS)	200	234	234	Jun 23	H	200	224	May 23	200	224	?
!	Super Stranded Patients (>20 Days LOS)	100	102	102	Jun 23	H	100	100	May 23	100	100	?


No Criteria to Reside - Avg No of Patients
80
70
60
50
40
30
20
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2021/22
2022/23
2023/24
Super Stranded Patients (>20 Days LOS)
120
100
80
60
40
20
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
202…


Stranded Patients (>6 Days LOS)
240
220
200
180
160
140
120
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2020/21
2021/22
2022/23
202…

Workforce

Organisational Development

Personal Development Reviews

Issues
• This indicator continues to fail the assurance measure. Performance in June has declined to 77% (78.4% in May).
• Increased compliance was noted within Planned Care and Specialist Services.

Management Action
• Managers have review schedules in place to complete PDR's in time.
• The HR team provides data on outstanding PDRs as well as those which will expire in month to managers to ensure that compliance at least remains static whilst seeking to improve compliance overall.

Mandatory Training

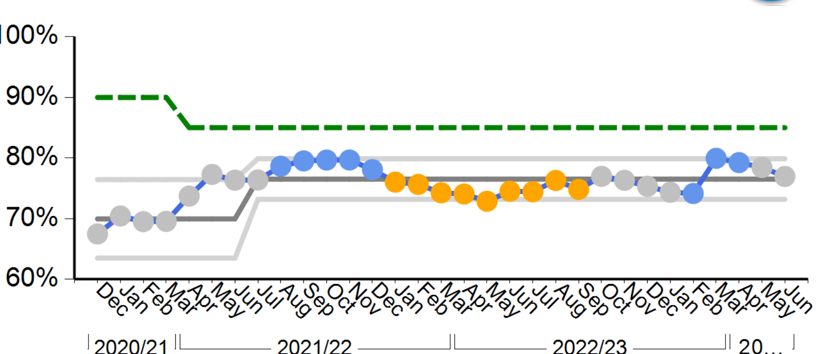
Issues

• The Mandatory Training indicator continues to show positive variation, albeit with a 0.5% decrease in June. This stretch target has now been achieved for three consecutive months.
• Areas performing below the 90% target are Conflict Resolution, Fire Safety, Infection Control Level 2, Information Governance, Moving and Handling Level 2 and Basic Resuscitation.

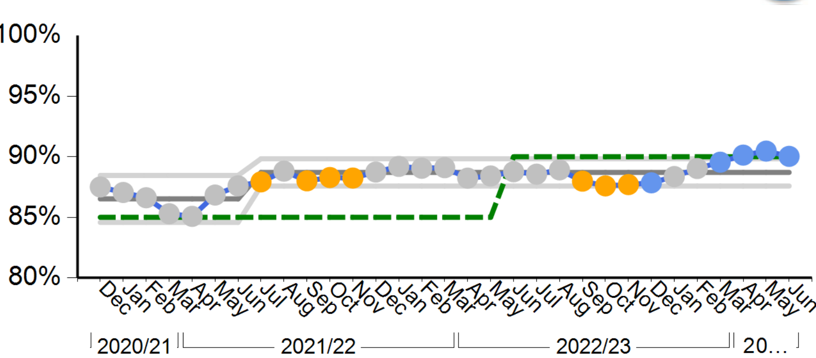
Management Action
• For Infection control, staff have access to the eLearning module, available 24/7 via ESR. There are sufficient places available on Moving and Handling for staff to remain compliant.
• Higher levels of Fire Safety training were introduced in October 2022, improvement continues, to 89.53% in month.
• For Information Governance, several actions are in place to ensure compliance, including weekly email reminders, the provision of alternative learning styles: face to face, completion of the handbook or electronically through ESR and scrutiny through the IG audit process. It is also reported through the Information Governance Steering Group.
• Both core mandatory & essential skills training are monitored monthly and governed via the Executive Team, sub-assurance and assurance committees.

		Latest					Previous			Year to Date		
Alert	**Indicator**	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
	Personal Development Review	85%	77%	N/A	Jun 23	H	85%	78.4%	May 23	85%	78.2%	F
	Mandatory Training	90%	90%	N/A	Jun 23	H	90%	90.5%	May 23	90%	90.2%	F

Personal Development Review



Mandatory Training



Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• The in-month sickness rate continues to show positive variation, with performance below target. Sickness rates in month have however increased by 0.4%, to 5.8% against the 6% target. The increase in June was also noted in June 2022.
• Increases in absence from May to June is noted for nursing, medics and most notably for HCA staff groups, with HCA rate up by 1.3% in month.
• Reasons for absence remain fairly static with gastro absences and cough / cold / flu being the main reasons followed by stress / anxiety / depression and headache / migraine having been prevalent throughout the month.
• Covid absences are massively reduced during the month with a high of 5.21% of daily absences on 2nd June to a low of 1.97% on 30th June.
• The rolling 12-month sickness rate continues to fail the assurance measure but is reducing and continues to show special cause improvement in June.

Management Action
• Targeted support has and continues to be offered such as bespoke in-house training, expanded wellbeing offers and one to one HR support.
• Short and long term absences are managed appropriately with support from the HR team.
• Return to Work Interview spot checks have commenced as a result of MIAA recommendations.
• From 1st July 2023 any new absences will be managed using the new MWL attendance management policy. All absences which were live at the point of transfer will continue to be managed with the legacy SOHT policy.

Vacancies

Issues
• The Trust Vacancy rate remains stable at 8.5% in June. The increase noted in May was due to an increase in the establishment.

Management Action
• There are currently 209 posts under offer which will have a significant positive impact on the overall Trust vacancy rate.
• Junior doctor rotation is looking very positive, with only 5 posts unfilled, and a further 3 on parental leave. The Trust have advertised all vacancies and are actively working to ensure that these are filled quickly and at present there are 27 medical posts under offer (excluding the foundation trainees).
• Ongoing work to be done to further reduce the HCA vacancies, and we are currently working with Southport college to offer interviews to those completing suitable care related courses.
• There are currently 24 AHP posts under offer, and these people will be taking up posts very shortly.

Turnover
Whilst staff turnover is still over target the Trust has seen improvements and as staffing levels improve this will be supported to continue to fall.

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
	Sickness Rate	6%	5.8%	N/A	Jun 23	L	6%	5.4%	May 23	6%	5.5%	?
	Sickness Rate (Rolling 12 Month)	6%	6.4%	N/A	Jun 23	L	6%	6.4%	May 23	6%	6.4%	F
	Sickness Rate (not related to Covid 19) - Trust	5%	5.6%	N/A	Jun 23	L	5%	5.1%	May 23	5%	5.2%	F
	Trust Vacancy Rate – All Staff	7.4%	8.5%	N/A	Jun 23	L	7.4%	8.5%	May 23	7.4%	8.5%	F
	Staff Turnover	0.83%	0.9%	N/A	Jun 23		0.8%	1%	May 23	9%	6.8%	?

Sickness Rate
10%
9%
8%
7%
6%
5%
4%
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2020/21
2021/22
2022/23
20…
Sickness Rate (Rolling 12 Month)
7.5%
7%
6.5%
6%
5.5%
5%
4.5%
2020/21
2021/22
2022/23
20…
Sickness Rate (not related to Covid 19) - Trust
7%
6.5%
6%
5.5%
5%
4.5%
4%
2020/21
2021/22
2022/23
20…
Trust Vacancy Rate – All Staff
11%
10%
9%
8%
7%
6%
202
2021/22
2022/23
202…
Staff Turnover
2%
1.5%
1%
0.5%
0%
2020/21
2021/22
2022/23
20…

Finance

Finance

The Trust is reporting a £2.0m deficit at Month 3 in line with 2023/24 Plan
The Trust has reflected income in line with fixed, variable and top up allocations associated with ICBs and Specialised Commissioning. This is subject to how variable allocations will be paid and will be adjusted following validation of activity freeze data.
Underlying pressures arising, including excess inflation, energy, and costs associated with delivery of additional activity continue to be closely monitored for the 2023/24 financial year.
The 2023/24 financial plan sets out a CIP requirement of 5.0%. The Trust is reporting full delivery of CIP at Month 3 and forecasting achievement of the £13.2m target for 2023/24.
The Trust is forecasting delivery of a breakeven plan as it transacts into Mersey & West Lancashire Teaching Hospitals NHS Trust from 1 July.

Cash - The cash balance at the end of June was £10.4m.
In June the Trust received an agreed £9m advance from Cheshire & Mersey ICB together with a £5.9m receipt from NHS England for the 22/23 non-consolidated pay award.
Both the 22/23 non-consolidated pay award and 3 months of the 23/24 pay award were all paid out in June's payroll. Note the tax, NI and pension payments associated with this will be paid out in July.
The Trust was notified on 11th July that it had been successful in its application for £10m revenue support PDC linked to the Transaction. It is anticipated that this will be drawn down in Quarter 2 23/24.

BPPC - Performance has improved since last month on both non-NHS and NHS. The overall percentage is 94.4%.

Debt over 90 days - This has reduced since last month, down from £1,089k to £1,022k.

Capital - Total capital spend is £516k and the remaining £20.822m capital resource will be part of MWL. Internally generated resources will be managed by the MWL Capital Council from July and decisions around PDC funded schemes will be via Exec Committee.

	Latest				Forecast			Year to Date	
Indicator	Plan	Actual	Period		Plan	Actual		Plan	Actual
I&E surplus or deficit/total revenue	3%	3%	Jun 23		0%	0%		3.0%	3.0%
Capital Spend	£700K	£300K	Jun 23		£21,300K	£21,300K		£800K	£500K
Cash Balance	£9,600K	£10,500K	Jun 23						

Trust Board

Paper No: MWLTB (23)003
Title of paper: STHK Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the STHK Executive Committee.
Summary: The paper provides a summary of the issues considered by the STHK Executive Committee at the meetings held during June 2023. There were five Executive Committee meetings held during this period. New investments approved were – • The Attend Anywhere virtual clinic software to increase the opportunities for video and phone outpatient appointments. • Southport and Whiston Operational Site Management model • ICU Advanced Clinical Practitioner role expansion At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration and preparation for the proposed transaction.
Trust objectives met or risks addressed: All Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 26th July 2023

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were five Executive Committee meetings held during June 2023.

At every meeting bank or agency staff requests that breach the NHSE/I cost thresholds are reviewed and the Chief Executive's authorisation recorded.

2. 1st June 2023

2.1 Acute Kidney Injury (AKI) improvement plan

The Director of Nursing, Midwifery and Governance introduced a paper detailing the actions being taken to improve the recording and monitoring of fluid balance for patients at risk of AKI. This included a proposal to add fluid balance training to mandatory training requirements for clinical staff. Committee debated whether this would be effective in improving compliance with the requirements and questioned whether the current non-compliance was linked to a lack of knowledge or skills in this area, or whether there were other causes. It was agreed that raising awareness of the importance of fluid balance monitoring was critical, but this could be achieved via many different routes.

One of the barriers identified was lack of access to portable devices for recording fluid balance and the Director of Informatics undertook to provide additional devices wherever this had been identified as an issue.

The Director of informatics also suggested that adding fluid balance as a task on Careflow could also help to increase awareness and remind staff to record the intake and outputs. This could then also be shown on the new interactive Whiz boards as a visual prompt for staff. It was agreed that these actions should be further explored with the AKI team and their impact evaluated, and then the core clinical skills training matrix would be reviewed if necessary.

2.2 CQC Inspection Preparedness

The Director of Nursing, Midwifery and Governance introduced a report on the work that had been undertaken to prepare for a future CQC inspection and raise awareness of the Trust safety culture. This work has included a review of the previous CQC inspection action plan, the introduction of a programme of mock inspections against each of the five domains. The paper also detailed the introduction of initiatives such as the safety bus to champion safety best practice.

A CQC Assurance Group had been established to oversee this programme of work and undertake regular reviews of evidence. It was anticipated that the CQC inspections of maternity units following the Ockenden Report would take place within a few months, but other key services inspections would not take place until at least 12 months following the completion of the transaction to create Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

2.3 Whiston Additional Theatres
The Director of Corporate Services provided an update on the office moves being undertaken to vacate the development space on level 4 of Whiston Hospital which would house the new theatres. Work on the scheme was due to commence in early July.

2.4 Southport and Ormskirk Hospital NHS Trust (S&O)
The Managing Director provided feedback from the S&O Executive Committee, which is reported to the Board via a separate report as part of the legacy S&O governance.

2.5 Transaction Preparation
The Committee discussed a range of operational issues, such as executive and operational on call and agreed an interim approach that would be implemented until the new operating model and management structures were in place.

3. 8th June 2023

3.1 Transaction Preparation
In line with the countdown plan the committee approved the ordering of new external signage for the hospital sites, new ID/access cards and MWL lanyards. A transaction mini business case was approved for fixed term administrative support for the policy alignment workstream. The switchboard standard greeting was also approved.

The committee reviewed the final communication and engagement plan for the pre and post transaction communications to staff, partners and stakeholders.

3.2 Trust Board Agenda - June
The Director of Corporate Services presented the draft Trust Board agendas for review in line with the annual workplan.

3.3 Cheshire and Merseyside Pathology Network
The Managing Director provided an update on the pathology network collaboration plans including the joint procurement of a new laboratory information system (LIMs) and it was noted that the business case would need to be approved by each trust board.

3.4 7 day Endoscopy Service
The Managing Director provided an update on plans to extend 7 day working for endoscopy to reduce diagnostic waiting lists, including options for staffing these additional sessions.

4. 15th June 2023

4.1 Research, development, and innovation (RD&I) – University Hospital Status
The Medical Director introduced a presentation from the Clinical Director for RD&I, detailing the process and criteria for being able to apply for university hospital status. In summary, circa 6% of the consultant workforce would need to be joint appointments with Liverpool University to make the trust eligible to apply for University Hospital status. Further

discussions were planned with the University and with the University Hospitals Association, but it appeared that this would need to be a long term ambition rather than a short term goal.

4.2 Attend Anywhere Business Case

The Director of Informatics and Managing Director jointly introduced the business case for purchase of the Attend Anywhere software to support video outpatient appointments. The system was already widely used by other Cheshire and Merseyside Trusts and had proved very successful, allowing outpatient clinics to be set up with a mixture of face to face, telephone and video appointments depending on the patient's condition and needs. Committee were supportive of the proposals on the understanding that patients should always be offered a choice of the type of appointment, so no one was disadvantaged. The business case was approved.

4.3 Southport and Whiston Operational Site Management Business Case

The Managing Director introduced the business case, which proposed investment to align and strengthen the model of on-site operational cover at the two acute sites. The additional substantive position would improve the resilience of the out of hours teams 7 days per week but would be offset against reductions in the current over time and additional hours spend. The importance of having robust and resilient site management overnight and at weekends to support the MWL operating model was recognised, and the business case was approved.

4.4 Systems of continuous improvement

The Managing Director introduced the paper which presented the planned approach to service improvement for MWL and how this aligned to the new national strategy for embedding a culture and system of continuous improvement. It was agreed that there was a need to promote the work of the service improvement team and empower staff to make and celebrate their own service improvement in teams and services. The deteriorating patient project had recently been nominated for the Quality Improvement Project of the Year at the HSJ awards, and the committee congratulated all involved.

4.5 Risk Management Council Chair's Report

The Director of Corporate Services presented the Risk Management Council (RMC) Chair's assurance report following the RMC meeting on 13th June. During May no new risks had been escalated to the corporate risk register. The council had received assurance reports from the Claims Governance Group, the CIP Council, and the Information Governance Steering Group. Several policies had been reviewed and the changes were approved by the RMC, following the usual consultation process.

4.6 Maternity Patient Experience Survey Results and Action Plan

The Director of Nursing, Midwifery and Governance introduced a paper which presented the results of the 2022 maternity patient survey. The national survey had been undertaken between April – August 2022 and 323 women who had given birth in February 2022 were invited to respond, of which 34% (109) completed the survey.

The survey results had been classified by the CQC as “worse than expected” which was extremely concerning. The survey questions were categorised into 9 areas of service provision. For 7 of these areas the trust scores were about the same as other Trusts and in two categories (care in hospital after birth and feeding your baby) the scores were worse than other Trusts.

The maternity service has been disappointed by these results and had analysed them in comparison to other local trusts and with the results of the 2021 survey and had then developed an action plan of areas for improvement.

It was noted that at the time of the survey, the Trust continued to restrict visiting because of COVID 19 and limit the number of birth partners to 1. Also, the feeding support service had remained suspended due to social distancing rules. Both had now returned to “normal”, and it was acknowledged that these continuing restrictions might explain some of the deterioration. However, the Trust’s ranking in aggregate terms, compared to others, was in the lowest quartile.

The committee reviewed the progress in delivering the action plan that had been developed by the team following full sharing and discussion of the results.

4.7 Maternity Staff Survey Deep Dive and Action Plan

The Director of Nursing, Midwifery and Governance introduced the report which provided a deep dive into the disappointing maternity staff survey results. 239 members of staff from the service had been invited to complete the survey but only 25% (59) had responded. The survey was undertaken in the autumn of 2022, and it was noted that this was following a period of high staff absences and staff turnover during the summer of 2022. The staff survey results had been discussed with staff and analysed down to team level (where numbers were large enough) and the scores had been compared with the 2021 staff survey results.

Listening events had been held with staff and the action plan developed with wide staff engagement. More regular pulse surveys for the department were planned throughout the year to monitor the impact of the agreed actions and communications plan.

It was noted that the service was now fully staffed and had recently recruited 15 student midwives who were due to complete their training this year.

Committee remained concerned that the combination of a poor patient survey and disappointing staff survey should be considered a “red flag” and both action plans would continue to be monitored closely and triangulated with other information, such as the pulse surveys and maternity friends and family test recommendation rates.

5. 22nd June 2023

5.1 Safe Staffing Report - May 2023

Committee received the report which detailed the headline fill rate figures for month 2 and a deep dive analysis for month 1. The fill rates for both registered nurses and HCAs continued to improve and in both cases was now over 100%. The report also included detail of bank and agency requests, including for supplementary care and a recruitment update. Although the current position was welcomed the committee sought further assurance on the controls in place to fill shifts and the tracking of the reasons why they had been requested. The committee also asked for further analysis of incidents that happened on wards that were fully staffed and triangulation with other quality indicators, such as compliance with mandatory training and completion of appraisals.

The average time to recruit had been reduced to 43 days in April, which was recognised as a significant improvement.

5.2 Tobacco Treatment Service

The Tobacco Dependence Policy that had been developed to deliver the NHS Long term Plan objective to offer tobacco dependence treatment to all inpatients. Ring fenced funding for 2023/24 had been received from the ICS, which would be used to fund a project manager and 4 tobacco treatment advisors. In future years the funding would be added to trust baseline allocations. This service would operate across MWL following the transaction. The plans were approved.

5.3 Mandatory Training and Appraisal Compliance

The Deputy CEO/Director of HR Managing Director presented the performance recorded for May 2023. Mandatory training compliance had increased marginally to 83%, but appraisal compliance had reduced to 78% because of the 2023/24 appraisal window which meant staff appraised at the start of the 2022/23 window were now due their next appraisal.

5.4 IT Strategy - five year investment plans

The Director of Informatics presented the 2023/24 five year forward IT investment plans for STHK and S&O (which would be combined for MWL), which is refreshed each year. The committee accepted the plan as a working guidance but due to the uncertainty about capital allocations in future years only the capital for 2023/24 could be approved as part of the Trust capital programme. Revenue funding to continue the digital nurse roles to support the implementation of new clinical systems was also made recurrent.

5.5 Draft Clinical Strategy

The Medical Director presented the latest draft of the MWL Clinical Strategy for review and comment. The intention was to present to the Trust Strategy Board meetings, ahead of communication and engagement with staff and stakeholders over the next three months, which would then enable the final strategy to be approved by the MWL Board in September.

5.6 2022/23 Audit

The Director of Finance and Information provided a briefing in relation to the audit progress at both STHK and S&O and the ongoing discussions with the auditors.

6. 29th June 2023

6.1 Transaction

Committee discussed post transaction executive on-call arrangements, with the separate on-call rota remaining in place until the new divisional management structures were implemented. It was also reported that the financial ledgers for the two trusts had been combined and would operate as a single ledger from 1st July. It was agreed that the new MWL Chief Pharmacist post should be advertised.

6.2 ICU Advanced Clinical Practitioner (ACP) Role Business Case

The Managing Director introduced the business case which was seeking funding support to create two ICU ACP training posts. The proposal explained how the ACPs supported the junior doctor rota and provided continuity and resilience for the ICU staffing. These posts also provided a clinical career progression route for nursing and AHP staff. The training costs for the trainees was supported by Health Education England (now NHS England) and the funding requirement was to backfill posts in the current establishment. The case supported the Trust's workforce strategy and was approved.

6.3 Review of Junior Doctor bank shift rates

The Deputy CEO/Director of HR introduced a proposal to uplift the junior doctor bank shift rates offered on the collaborative bank, to remain attractive when compared to other local trusts. The cost benefit analysis demonstrated that more competitive rates would increase the % of shifts filled and reduce the need for escalated rates and resorting to agency. These benefits would be tracked with the service improvement team and reported back in six months.

6.4 Partnership Update

The Director of Integration presented an update from key partners, including the ICB forward view and governance structure and a summary of the actions agreed following the discharge summit.

The mid-mersey place collaboration of St Helens, Halton and Knowsley had agreed to focus on three priorities; admission avoidance, neurodiversity, and the creation of a skills academy to attract young people into NHS careers.

6.5 Equality Delivery System (EDS) 2022

The Director of Nursing, Midwifery and Governance introduced a report detailing the plans for STHK to adopt the EDS 2022 standards. It was noted that S&O had adopted these standards in 2022 so in the future there would be a need to align the services selected. For

year 1 of the STHK EDS early cancer diagnosis, sexual health and end of life care were the proposed services to demonstrate inclusive leadership. The proposal was supported.

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: MWLTB (23)004
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 20th July

Summary
Meeting attended by:

J Kozer – NED & Chair
I Clayton – NED
G Appleton – NED
A M Stretch – Deputy Chief Executive/Director of HR
R Cooper – Managing Director STHK
S Redfern – Director of Nursing & Governance
G Lawrence – Director of Finance & Information
N Bunce – Director of Corporate Services
L Neary – Chief Operating Officer
C Walters – Director of Informatics

J McCabe– Divisional Medical Director – Surgery
A Bassi – Divisional Medical Director – Medicine
C Oakley – Deputy Director of Finance & Information
A Large – Deputy Director of Finance
R Weeks - Corporate Governance Manager
J Foo – Assistant Director of Operations – Urgent Care
L Evans – Head of Nursing & Quality – Urgent Care
K McLachlan – Head of Pathology
S Pitt – Finance Business Partner CSS/Community

Agenda Items

For Assurance

A) Integrated Performance Report STHK

- 62 day performance was below the 85% target in May, at 77.4%.
- Target 31 day performance was met in May, at 98.0% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in May, at 84.6% delivery against a target of 93.0% linked to a significant increase in referrals.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 54.8% in June. All type mapped STHK Trust footprint performance was 73.9% in June.
- The ambulance turnaround time target was not achieved in June, at 51 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- In June, overall sickness had decreased by 0.2% to 5.6%.

Integrated Performance Report S&O

- 62 day performance was below the 85% target in May, at 59.4%, above the national average (58.6%), in-line with the North-West (59.4%) but below Cheshire & Mersey (64%).
- Target 31 day performance improved in May, at 91.2% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in May, at 84.7% delivery against a target of 93.0% linked to a significant increase in referrals.
- Trust exceeded the A&E target of 76% in June, achieving 77.7%, which is a 2.2% increase on the previous month. The Trust was the best performing non-specialist Trust in Cheshire & Mersey in April against the 4-hour A&E standard.
- Trust continued to have 0 78 and 104-week waiters and are on plan for delivering against the 65+ week target by March 2024. SOHT is top performing acute trust across C&M for 52 week waits based on May position.

B) Finance Report Month 3 STHK

- At Month 3, the Trust is reporting a year to date surplus of £1.3m which was in line with plan.
- Capital expenditure for June (including PFI lifecycle maintenance) totals £2.6m.
- At the end of Month 3, the Trust has a cash balance of £67.7m.
- Agency expenditure of £3.7m is included in the position. This exceeds the 3.7% target that has been set nationally. Work is ongoing within Care groups on reducing the agency bill.
- The financial position does not include any impact for PbR changes. The Trust awaits central guidance on how activity will be dealt with as a result of the impact industrial action.
- The financial position includes the expenditure impact of the industrial action (£1.2m) which is currently being mitigated by items including overperformance of interest recievable.
- The Trust continues to see high levels of inflation on products which are currently being non recurrently mitigated (£1.3m).

Finance Report Month 3 S&O

- At Month 3, the Trust is reporting a year to date deficit of £2m which was in line with plan.
- Capital expenditure for June totals £0.5m.
- At the end of Month 3, the Trust has a cash balance of £10.4m including a £9m ICB advance.
- Agency expenditure of £1.8m exceeds the 3.7% target that has been set nationally. Work is ongoing within Divisions on reducing the agency bill.
- The financial position does not include any impact for PbR changes. The Trust awaits central guidance on how activity will be dealt with as a result of the impact industrial action.
- The financial position includes the expenditure impact of the industrial action which is currently being mitigated by items including overperformance of interest recievable.
- The Trust continues to see high levels of inflation on products which are currently being non recurrently mitigated. (£0.7m)

C) Underlying financial position

- STHK and S&O submitted combined 23/24 plans of £5.6m surplus for 23/24
- As a system C&M submitted a deficit plan of (£-51m). MWL is the only DGH with a surplus plan.

- By the end of quarter 2, all systems are required to prepare a medium-term financial plan, demonstrating how recurrent financial sustainability will be delivered.
- Development of a consistent view of the underlying 2023/24 position across ICS
- MWL underlying financial position of (£22.8m) deficit made up of (£15m) non recurrent transaction support, (£7m) non recurrent CIP, (£4m) non recurrent COVID income, (£2.5m) smaller adjustments linked to plan.
- ICS guidance stated only COVID income is non recurrent, System top-up (circa £53m) assumed recurrent with a "System over-lay" to follow. Committee discussed the potential for this to change the position materially and the risk this poses to the Trust position.
- No in year emerging risks included as mandated by the ICB however the committee discussed that these were real and relevant in understanding the underlying position.
- Return provided to ICB, with assumptions clearly articulated, including emerging risks.

D) CIP Programme Update STHK

- The Trust continues to work towards the CIP target of £28.4m of which £21.4m to be delivered recurrently and £7m to be delivered non recurrently.
- Over £32m of ideas have been currently generated, the Trust has finalised £16.2m of schemes.

CIP Programme Update S&O

- The Trust continues to work towards the CIP target of £13.2 recurrently.
- Over £13.2m of ideas have been currently generated, the Trust has finalised £5.2m of schemes.

CIP Programme Update CSS STHK

- The CSS Care group working on innovations to transform services including CDC services, outpatient transformation, pathology collaboration, international recruitment.
- Cost control processes outlined and ownership across care group highlighted.

E) Urgent care update STHK

- Q1 23/24 1.8% decrease in ED attendances against 22/23, 0.3% decrease against 19/20
- 5% reduction in walk in attendances, 7% increase in conveyance by ambulance.
- Increase in attendances from South Liverpool following change in pathways at LUHFT.
- Action taken to improve performance include embedding good practice from other EDs, estates changes within the department, trial of MDT hub to improve demand management and increase direct access.

For Information

- **Capital Council Update** – Update noted by the committee
- **CIP Council Update** – Update noted by the committee
- **S&O Procurement Group Update** – Update to be noted by the committee
- **IM&T Steering Group AAA Highlight Report** - Update to be noted by the committee

• **Estates & Facilities AAA Update -** Update to be noted by the committee **Risks noted/items to be raised at Board** N/A
Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: J Kozer, Non-Executive Director
Date of meeting: 20th July 2023

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Trust Board

Paper No: MWLTB (23)005
Reporting from: Quality Committee
Date of Committee Meeting: 18th July 2023
Reporting to: Trust Board
Present: Gill Brown, Non-Executive Director (Chair) Rani Thind, Non-Executive Director Geoffrey Appleton, Non-Executive Director Anne-Marie Stretch, Deputy Chief Executive and Director of Human Resources Sue Redfern, Director of Nursing, Midwifery and Governance Peter Williams, Medical Director Rob Cooper, Managing Director Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance Lesley Neary, Chief Operating Officer **In attendance:** Anne Monteith, Assistant Director of Safeguarding Anne Rosbotham-Williams, Deputy Director of Governance Brendan Prescott, Deputy Director Quality, Risk and Assurance Carol Fowler, Deputy Director of Nursing Midwifery & Therapies Debbie Stanway, Head of Nursing and Quality, Medical Care Group Fionnuala Browne, Consultant Nurse Infection Prevention Control Karen Barker, Associate Head of Nursing and Quality, Surgical Care Group Lynn Ashurst, Associate Head of Nursing and Quality, Quality and Risk Lynn Evans, Head of Nursing and Quality, Urgent and Emergency Care Group Rajesh Karimbath, Assistant Director of Patient Safety Richard Weeks, Corporate Governance Manager Sharon Seton, Assistant Director of Safeguarding Sue Orchard, Head of Midwifery Teresa Keyes, Deputy Director of Nursing and Quality Tom Briggs, Head of Complaints and Legal Services Tracy Greenwood, Head of Nursing and Quality, Community and Primary Care Services Care Group **In attendance to present specific reports or feedback:** Jo Simpson, Assistant Director of Quality
Matters Discussed The action logs from former StHK and S&O Quality Committee/Quality and Safety Committee were discussed with three actions closed and two due in September. This included an update on progress in delivering improvements within theatres and across surgery via Project Shakespeare, noting that these were ongoing and would be shared with new starters.

Integrated Performance Report (IPR) StHK
The IPR was discussed with the following points highlighted in particular:
- CQC outstanding rating was transferred to the new organisation on 1st July 2023
- Comprehensive action plan developed following two incidents of MRSA bacteraemia
- Continued high levels of bed occupancy
- Positive impact of the reconfigured Emergency Department with improvements in some indicators, including reduction in patients being held in ambulances, unplanned reattendances and patients leaving without being seen
- Verbal update regarding operational performance metrics

Integrated Performance Report (IPR) S&O
- Reduced number of complaints and improved response times
- Provision of one-to-one care for women in labour for eight consecutive months
- Achievement of above 76% target for patients being seen within four hours in ED
- Continued high levels of bed occupancy
- Verbal update regarding operational performance metrics

Patient Safety Council report StHK
A number of papers were received, with the following highlighted at the meeting:
- Effective management of controlled drugs noted for quarter 4 2022-23
- Majority of nursing care indicators met the target in quarter one, with action plans required for three areas below target; the Committee requested further details on the actions being taken to improve fluid balance recording
- 20% reduction in pressure ulcers per 1000 bed days in 2022-23 compared to previous year

Patient Safety Update June S&O
- Improvement work continues in relation to pressure ulcers and falls, with education undertaken in ED and work to ensure appropriate equipment is available
- Ongoing work to prepare for the introduction of Patient Safety Incident Response Framework (PSIRF) in September
- Delivery of human factors training and risk management training

Safeguarding Activity Quarter 1 StHK
- Assurance rating remains amber, with improvement noted relating to training, however issues remain with initial health assessments for looked after children, with work being undertaken to address both internal and external barriers
- Noted a positive increase in domestic abuse risk assessments
- Ongoing increase in DoLS applications, up to 501 compared to 299 in the same period last year
- Challenges in managing the process for patients detained under the Mental Health Act and in securing appropriate placement for child and adolescent mental health service patients
- Review of recent domestic homicide case to identify if any changes to processes are required

Safeguarding Assurance Report Quarter 1 S&O
- A number of national reports and their recommendations have been reviewed with no outstanding actions identified for the team

- One action required following a Sefton domestic homicide review has been completed
- Positive impact of service level agreement with Mersey Care for patients detained under the Mental Health Act
- Sustained level of DoLS applications
- Ongoing engagement and input in external meetings, including review of process for multi-agency safeguarding hub (MASH) enquiries

Infection Control Report Quarter 1 2023-24 StHK
The following key points were highlighted at the meeting:
- Thresholds for this year have been set with a 20% reduction, which will be challenging
- Reduction in COVID patients seen, however 27.9% nosocomial infections noted in the quarter
- Action plan in place following the MRSA bacteraemia cases
- Infection control summit planned for September as part of patient safety week
- Noted 11 outbreaks this quarter
- Improvement seen in training compliance with ANTT at 97%
- Majority of infection control Board Assurance Framework requirements are compliant with four areas requiring further work, including ventilation at one site, implementation of the national standards of healthcare cleanliness and Board-level reporting of face fit testing compliance

Infection Control Report Quarter 1 2023-24 S&O
The following key points were highlighted:
- No MRSA bacteraemia since 2021 with screening compliance at 89% and improved performance relating to time taken to isolate patients, up from 58% to 79% in June
- Lessons learned from review of C.Diff cases, including improvements needed in Bristol Stool Chart monitoring
- Reduced numbers of COVID positive patients seen
- Twice yearly audits of all clinical areas, with increased frequency where below average findings are reported
- 6 amber areas noted on the infection control Board Assurance Framework, including ventilation, national standards of healthcare cleanliness and contact time for cleaning products - the Committee requested further detail relating to the gaps in assurance and mitigating actions and discussed the issues arising from lack of a decanting ward

Maternity Service Update - StHK
- All 10 indicators for the maternity incentive scheme were achieved and the team are now looking at the requirements for next year which are due in February for the Trust as a whole
- Learning identified through the perinatal mortality reviews has been shared, although it was noted that there were no actions identified that would have altered the outcome
- Compliant with Saving Babies Lives Care Bundle2 and currently reviewing the next iteration
- Noted the recent work to triangulate claims, incidents and complaints to identify any themes or improvement actions, which confirmed that the culture of learning had developed across the Trust
- Internal survey of women's experiences currently being undertaken to identify negative feedback that will need to be addressed and noted that the bleep holder

conducts a daily walkabout to address any issues of concern. Key improvements include the introduction of central referral line for bookings, single point of contact for triage and advice line for early pregnancy advice

- Sickness absence has reduced
- 1 divert reported in June in line with regional escalation process with no harm reported

The Committee queried the red flag relating to delays of 30+ minutes from presentation to triage and noted that there were four incidents during the time of the divert. It was also confirmed that an action from the final Ockenden Report, that is the requirement to develop a formal risk assessment for clinicians which includes an escalation protocol in the event of competing workloads between Obstetrics and Gynaecology would be completed the next day when the procedural document was approved.

Patient Experience Council Report - StHK

The following points were highlighted from the report:

- Robust process for managing internal patient and staff surveys with action plans followed up
- No complaints received by Urgent and Emergency Care were fully upheld in quarter 1
- Actions being identified to strengthen communication and overall experience of those awaiting the outcome of an investigation
- Positive feedback received from a bariatric patient in relation to staff consistently displaying the Trust's values and providing information in ED
- Daily walkabouts by matron and ward manager on AMU have led to reductions in PALS concerns
- Ongoing delivery of deaf awareness courses and reminders regarding process for accessing interpreters in and out of hours

Patient Experience and Community Engagement Council – S&O

The following key points were highlighted:

- Urgent Care Clinical Business Unit (CBU) reported the improvements to the ED bereavement room to provide a better environment for relatives and two areas received gold accreditations, Short Stay Unit (9a) and ward 11b
- Planned Care CBU reported silver accreditation for theatres and third gold for Intensive Care Unit
- Specialist Services reported that in Women's and Children's all areas achieved gold accreditation except maternity ward which achieved silver and noted that safety walkabouts continue with support from Maternity Voices Partnership and Healthwatch
- Patient representatives requested an update on patient benefits arising from the merger and noted that they have been invited to the MWL Patient Participation Group where the draft Clinical Strategy will be shared for comments in July

Complaints, Concerns, Claims and Friends and Family Test Quarter 1 - StHK

- 72.9% compliance with response times agreed with complainant for first stage complaints, with actions taken to reduce this to 60 working days from July 2023, including guides for staff writing statements and quality checking to reduce delays in the process
- Currently 99 open complaints at all stages, with clinical treatment as the biggest reason for complaints and more complaints closed in the quarter than opened
- No investigations opened by the Parliamentary and Health Service Ombudsman (PHSO)

- PALS contacts remain at similar levels to previous quarters, but higher than 2019-20 base year
- 11 new and 30 pre-action claims were received, with 11 previous pre-action claims converting to instructed claims. Examples of actions taken following claims and complaints were provided
- 15 inquest notifications were received, which is a decrease from previous quarters, with 16 closed and no Prevention of Future Deaths orders received
- FFT activity remained consistent with previous quarters, noting slightly improved recommendation rates in all areas

The Committee queried if further work could be done by PALS escalating concerns to senior staff to prevent them converting to formal complaints and it was confirmed that PALS do escalate to the relevant head of department where this is appropriate.

Complaints, Concerns, Claims and Friends and Family Test Quarter 1 – S&O
The following points were highlighted from the report:

- 39 complaints received in the quarter, with 14 currently open, noting a 10.6% reduction last year in the number of complaints received compared to 2021-22
- Reduction in reopened complaints and no enquiries from the PHSO
- 20% decrease in PALS activity last year compared to the previous year, noting also the positive impact of the PALS officer temporarily assigned to ED
- FFT noted all areas above target for response rates with inpatients, outpatients and delivery suite above target for recommendation rates
- 16 pre-action claims and 2 NHS Resolution instructed claims received
- 4 inquest notifications, with 4 closed and no Prevention of Future Deaths orders

Clinical Effectiveness Council report - StHK
The following points were highlighted:

- Presentation from Resuscitation Service noted the sustained lower rate per 1000 admissions than the national average for cardiac arrests, set against improved compliance with recording observations at the correct interval and the work on the deteriorating patient project
- Presentation from Urology highlighting the work relating to staff training
- Improved governance for Non-Medical Prescribers with the establishment of an overarching steering group
- Further information to be obtained regarding CRAB data for areas with upward trend towards the observed/expected outcome range
- Quality Improvement/Clinical Audit action and activity reports presented
- Research, Development and Innovation Department Annual Report 2022-23 received and the Council commended their achievements

Clinical Effectiveness Council report – S&O
The following points were highlighted:

- Ongoing actions to address high temperatures in clinical areas affecting medication storage
- Work to improve trajectory for paediatric immediate life support (ILS) training
- Successful recruitment of radiology staff to increase capacity for ultrasound scanning
- Noted challenges with pharmacy staffing levels
- Smokefree pregnancy pathway introduced
- Reduced instances of lost to follow up patients in gynaecology

Nursing and Midwifery Strategy update - StHK

The presentation outlined progress in delivering year one actions, noting the positive work that had been undertaken. It was also noted that the strategy aligns well with S&O's strategy and that the delivery plans will be brought together.

Research, Development and Innovation Department Annual Report 2022-23
The Quality Committee commended the work of the RDI department and the successes outlined in the annual report, including winning the COVID 19 Research and Innovation award along with Liverpool School of Tropical Medicine and achieving the highest number of responses to the Patient Research Experience Survey, with very many positive responses. The work to increase commercial studies and to reinvest the income from this into further research was also noted.

Assurance provided:

- Improvement work in ED leading to some targets being achieved across both sites
- Positive audit results for antimicrobial prescribing reported (StHK)
- All 10 indicators for the maternity incentive scheme were achieved with 10% refund on clinical negligence scheme for trusts (CNST) contributions (StHK)
- Improvements in complaints management noted at S&O with overall reduction in complaints, reopened complaints and response times
- Sustained lower rate than the national average per 1000 admissions for cardiac arrests (StHK)
- Many achievements of the Research, Development and Innovation Department, including an increased number of commercial projects successfully delivered (StHK)

Decisions taken:

- Research, Development and Innovation Department Annual Report 2022-23 approved

Risks identified and action taken:

- Ongoing discussions relating to provision of decant ward at Southport
- Review of second stage complaints to identify areas for improvement

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

Committee Chair: Gill Brown, Non-Executive Director

Date of meeting: 26th July 2023

Trust Board

Paper No: MWLTB (23)006
Reporting from: Strategic People Committee
Date of Committee Meeting: Monday:17th July 2023
Reporting to: Trust Board
Core members: Lisa Knight (LK) Non-Executive Director (Chair) Sue Redfern (SR) Director of Nursing, Midwifery &Governance Claire Scrafton (CS) Deputy Director of HR & Governance Malise Szpakowska (MS) Deputy Director of HR Rob Cooper (RC) Managing Director Gareth Lawrence (GL) Director of Finance Nicola Bunce (NB) Director of Corporate Services **In attendance:** Nicola Tinsley - Minutes (NT) Senior HR Administrator/PA Laura Codling (LC) Head of Workforce Development and Resourcing Patricia Birkett (PB) Senior HR Business Partner Richard Weeks (RW) Corporate Governance Manager **Apologies:** Ian Clayton (IC) Non-Executive Director Anne-Marie Stretch (AM) Deputy CEO/Director of HR Jane Royds (JR) Director of Culture & Engagement
Agenda Items: • Feedback from Trust Board meeting – June 2023 • Workforce Dashboard – Legacy STHK • Workforce Dashboard – Legacy S&O • The Long Term Plan • Chair/AAA reports from legacy STHK People Council and S&O Workforce Committee
Assurance Provided: The committee received the legacy reports from STHK and S&O for June performance. Combined reporting for MWL will commence from month 4.

Workforce Dashboard
Workforce Dashboards for the legacy STHK and S&O organisations were presented.

Legacy STHK

Assurance was provided that the following areas were showing improvements month on month:

- **Trust Vacancy rates –** rates have reduced from 7.68% to now 6.84% and there is a sustained level recruitment activity this will help continue to close the gap.
- **Turnover –** remains stable. There has been a continued uptake on the staff transfer scheme. Exit interview indicate that 92% of the leavers would work for the Trust again and 85% would recommend the Trust to family or friends. Work life balance is the main reason for leaving. Further analysis will be undertaken to understand further actions required to improve retention going forward.
- **Time To Hire –** has risen slightly this month after previously reporting the reduction. A new onboarding pilot is being launched along with the automation for new starter forms and time to hire is being monitored weekly. It was noted that 88 managers have completed a lunch and learn training session with a further 31 to attend in the future.
- **Occupational Health Clearance Metrics –** remain positive.
- **Sickness –** The figure of 5.57% for sickness remains static. AHP workforce has the biggest reduction. The biggest reason for sickness is Stress, Anxiety & Depression 37% of sickness absence. Musculoskeletal numbers are rising 9.5%. It was noted that the HWWB and Core HR teams have created new letters to target these issues to get support to these staff members straight away by giving staff the knowledge of how they can get help before the issue worsens.

It was noted that DNA rates for HWWB appointments remain challenging. Assurance was provided that action is being taken to understand how the appointments are booked to ensure that staff in work can be released from their shifts to attend. Work is also taking place to understand if the current target is realistic.

Legacy SOHT
Assurance was provided that the following areas were showing improvements month on month. Key points noted were:

- **PDR compliance performance** was 77%, but there had been increases in compliance in both the specialist services and medical care CBUs.
- The **Mandatory training** the 90% stretch target had been achieved for the 3rd month. Weekly reminders are sent out to anyone not compliant.
- **Sickness absence** was 5.8% in June against the 6% target, with the 12 months the average at 6.39%. Gastro, cough cold & flu are the highest reasons for absence with covid still being reported at 1.97% daily absence rate.
- The **vacancy rate** is static in June / July at 8.5%. The AHP vacancy rate is 13.2% against the target of 9%. Time to hire has increased due to technical

issues with TRAC but improvements expected in July. Time to hire is currently 50 days.

Additional - was provided with regards to IPC training. A new nurse consultant been appointed, and it will be a priority for MWL for the policies and training to be aligned.

People Council

It was noted that the legacy STHK People Council had met on the 12th July and had received any outstanding, papers, minutes, risk registers and policies to be approved from both STHK and S&O legacy organisations. There were also reports providing updates on the ED&I 2023/24 action plan, Health Work and Wellbeing KPI and deep dive into DNA rates, and a Safety and Security update from the H&S team. This included assurance that risks were being managed.

The NHS Long Term Plan

The committee received a presentation on the NHS Long Term Plan. The key these discussed were around training, retention, and reform which aimed to ensure the following:

Train

- Increased training and education placements across all staff groups
- Increase in advanced, enhanced and consultant practitioners.
- Creation of new apprenticeships
- Developing Healthcare Support Worker (HCSW) Careers
- Increased expectation to utilise apprenticeships.
- Reducing time to hire for HCSW's

Retain

- We are compassionate and inclusive.
- We are safe and healthy.
- We are recognised and rewarded.
- We are always learning.
- We are a team.
- We have a voice that counts.
- We work flexibly.

Reform

- Shift Skills and Capacity into Community
- Educating and Training the Workforce differently
- Digital and Technological Innovations
- Enablers supporting education and training expansion and reform.
- Optimising multidisciplinary teams
- Bringing People into the Workforce more efficiently
- Step change needed in education and training planning.

The next steps for NHSE, NHS Trusts and ICBs will be to understand how the plan is to be delivered and what the implementation will need to look like locally especially relating to; Education & Training Budgets, Recruitment & Retention, Reviewing the detail behind the NHS Long Term Plan, Collaboration on Workforce Planning and Collaboration with our ICB colleagues.

The committee welcomed the NHS Long term plan and were interested to see how this translates to ICB's and for MWL and noted that agreement with professional bodies/royal colleges as to how the new training pathways will be funded and

supported on the job by the expansion of apprenticeship will be key. The committee were encouraged by the focus on different pathways into NHS careers and the intention to collaborate on workforce plans, however noted their disappointment that social care was not included in the plan.
Decisions Taken: There were no decisions taken.
Risks identified and action taken: There were no new risks identified.
Matters for escalation: None
Recommendation(s): The Trust Board are requested to note the report.
Committee Chair: Lisa Knight, Non-Executive Director
Date of Meeting: 26th July 2023

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	S&O Executive Committee
MEETINGS HELD:	June 2023
LEAD:	Anne-Marie Stretch, Managing Director

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

No Alert items to escalate.

ADVISE

Policy Update (05 June and 27 June)
An update was provided on the management of Trust Policies and to provide assurance on the work undertaken to ensure all policies are up to date and compliant with the corporate template, prior to the creation of single policies for MWL. The period covered May – June 2023

Anaesthetic Resource for 2nd Emergency Obstetric Theatre (12 June 2023)
The Chief Operating Officer presented a draft update paper in relation to the requirement of having 2nd obstetric emergency theatre available out of hours to respond to simultaneous emergencies. The paper set out the current mitigations to reduce the level of risk associated with the requirements for staffing a 2nd obstetrics emergency theatre out of hours and the next steps for developing the solution further including medium and long-term measure identified.

Managed and Collaborative Bank Services Contract (NHSP) (12 June 2023)
Due to the expiry of the contract with NHSP on the 31st July 2023 the Executive Committee approved the recommendation to award a 1-year contract with the option to extend for a further year to NHS Professionals to provide a managed bank service. A review of the longer-term options for MWL will be undertaken.

Urgent and Emergency Care (MEC) Patient Survey – CQC Early Release Publication (27 June 2023)
The Committee noted that 268 S&O patients responded to the survey and the response rate for S&O was 22.96%. The Trust's results were about the same as other Trusts for 33 questions but the responses to 4 questions were worse than peers relating to privacy when discussing a condition with the receptionist, emergency department wait times, pain control, and help to manage condition or symptoms whilst waiting. The results will be reviewed by the Patient Experience & Community Engagement Group (PECEG) and in conjunction with MEC CBU will develop an improvement action plan.

Window Safety (27 June 2023)
A paper was tabled at Executive Committee in May 2023 that outlined the issue raised from an incident that occurred in which a patient smashed a window and was injured by a shard of glass. An approach was recommended to draw up a list of all wards and clinical areas which would be deemed to have high-risk windows/glass doors. This list was reviewed by Patient Safety Group (PSG) on 12 June who recommended priorities for strengthening based on the clinical patient profile and environmental factors (the data excluded the glass fire doors as they meet current fire standards regulations). The window film has been sourced that will bring the windows up to the required glazing standards and has a life span of 10 years. The Executive Committee approved the funding for the application of the window film to the areas identified.

Use of Entonox in Maternity (27 June 2023)

A paper was presented that provided assurance regarding the levels of Entonox exposure to staff in the Maternity Delivery Suite. An assessment of ventilation following the introduction of an agreed Standing Operating Procedure (SOP) showed that the results were within the current workplace exposure limit (as detailed within Health & Safety Executive (HSE) guidance document Workplace Exposure Limits EH40/2005). This demonstrated a safe environment for staff exposed to Entonox in delivery suite rooms.

Bleeps and Ascoms (27 June 2023)

The Director of Informatics presented an update on the current position in relation to the Ascom solution's stability and reliability and plans/timescales for replacing the solution. The Director of Informatics noted following a number of incidents logged with IT in particular relating to Ascom wireless handsets, immediate actions were taken to rectify issues and following work done in late 2022, the total number of incidents reported that related to ASCOMs significantly reduced and 8 incidents were reported during March – May 2023. The Ascom Radio Frequency Pagers will be replaced by the end of September with a new system known as Multitone. The purpose of this system will be to replace the Ascom Radio Frequency pagers and provide a dedicated system for critical crash calls. The Executive Committee were asked to support and approve the recommendation that mobile phones are more appropriate devices than the Ascom Wireless handsets for some staff groups or be used in conjunction in the short-term, whilst a new communications strategy is developed for MWL.

Replacement of Managed Print Systems and Hardware for Southport & Ormskirk (27 June 2023)

The existing contract in place at S&O will reach the end of its term in August 2023. The Executive Committee approved Option 2 (recommended) to agree a 5-year contract with the current supplier.

Roll Out of Manual EPMA to the Spinal Injuries Unit (27 June 2023)

The roll out of the Manual EPMA in the Spinal Injuries (in April 2023) unit went well overall and the system is being used well by the staff. Further rollout of the solution to other areas has been delayed due to data quality issues in relation to unverified NHS numbers. Working is ongoing with the supplier and informatics teams from both S&O and StHK to try to find a non-manual solution.

CDC and TIF (12 June and 27 June 2023)

The Executive Committee received an update on the request made to NHS England for additional capital funding to recognise the increased costs for the CDC based upon the tender responses. The paper set out the reasons for the additional capital costs of the CDC, activity expectations associated with the funds.. Unfortunately, the bid for additional funds had not been successful and alternative mitigations were proposed, including re-tendering the building work and working with contractors to better manage the costs.

Transaction Progress (every meeting)

The Executive Committee received weekly updates on the progress of the Transaction with STHK. On 22nd June ministerial approval was confirmed and the orders were made by parliament on 26th June. TUPE letters were sent to S&O staff on 28 June 2023 that confirmed the new organisation would be established on 01 July 2023.

IA Update (every meeting)

The Executive Committee received updates for assurance. Operational planning was overseen by Gold Command. At the Executive Committee on 12 June 2023, the Committee was advised that due to the Junior Doctor's IA, Liverpool University had cancelled their Quality Assurance Visit on 15 June and the visit would be rearranged.

ASSURE	
System Meetings (every meeting) Executive Directors provided feedback from external meetings and events with system partners where they had represented the Trust. Core Mandatory and Essential Skills Training (12 June 2023) The report reflected on the Core Mandatory and Essential Skills training compliance at 31 May 2023. Core Mandatory reported 90.47% (up 0.33% in-month and 0.47% above target) and Essential Skills reported 83.49% (up 0.098% in-month and 1.51% behind the 85% target Nursing and Midwifery Monthly Staffing Report (27 June 2023) The paper provided the Executive Committee with an update regarding the nursing, midwifery and HCA staffing fill rates, costs, and vacancies (based on the reporting period May 2023). The paper also included a financial spend update and monitoring measures in place against costs in delivering a Safe Nurse Staffing position in-month and provided an update on nurse vacancies and recruitment actions going forward. Assurance was given that the overall Trust position is good. Risk and Compliance AAA Report (27 June 2023) The Risk and Compliance AAA Report from the meeting held in June 2023 was received. Employee of the Month (27 June 2023) The Employee of the Month for June 2023 was selected. Data Security and Protection Toolkit (DSPT) (27 June 2023) DSPT is an annual submission that was approved at the Integrated Governance Steering Group (IGSG) meeting on 27 June 2023. Following an Audit, MIAA have concluded 'Significant Assurance'. Carpark Lighting (27 June 2023) The work near the Spinal Unit is complete but work continues improving the lighting in the main staff carpark behind the CMO at SDGH. MIAA Safety Culture Review – Final Report 2022/23 (June 2023) The final MIAA report concludes 'Substantial Assurance'. An action plan will respond to the recommendations in the report.	
New Risk identified at the meeting	N/A
Review of the Risk Register N/A	

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	S&O Finance, Performance, and Investment Committee
MEETING DATE:	26 June 2023
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Cancer 62-day performance remains a challenge – performance in April 23 declined to 45.1%, a reduction on the previous month (54.2%) and lower than national (60.9%), North-West (61.9%) and Cheshire & Mersey (63.6%). Tumour specific paper was presented on risks and mitigations.

ADVISE

- The Trust has received the £9m temporary cash support from the ICB, and the request to seek £10m of revenue support Public Dividend Capital (PDC) was approved by the Committee.
- April 2023 saw a decline in cancer two week wait performance to 77.2% against the 93% target. This decline mirrors the national picture, with an England average of 77.6%, North-West 79.6% and Cheshire & Mersey 76%.
- Overall, Trust Accident & Emergency (A&E) 4-hour performance for May 2023 was 75.5% this compares to 74% across Cheshire and Mersey and nationally. Compares with 76% new national target. Trust was in the top quartile nationally and best behind Alder Hey.

ASSURE

- The Trust is reporting a £1.3 deficit at month 2, which is broadly in line with the plan.
- The fire compartmentation remediation work at Southport is now complete and the team met with Merseyside Fire Brigade on 26 June to present the evidence. As a result, the notice relating to compartmentation at Southport will cease on 30 June.
- May 2023 saw 84% stroke patients achieve over 90% of their stay on a stroke ward. This is the first time since pre covid this metric has been achieved.
- May 2023 best month on record for elective and day case activity. The Trust achieved 113% vs 103% 2019/20 level and 108% of first outpatient appointments.
- A risk had been identified about the grade of window glass, all windows had been assessed and a paper presented to the Executive Committee proposing adding a safety film to the high risk windows, until the glass can be replaced.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	S&O QUALITY & SAFETY COMMITTEE (QSC)
MEETING DATE:	26th June 2023
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Updates on Previous Alerts:

- Risk around estates standards and inability to decant wards to complete refurbishments – potential options being reviewed by the Executive Team.
- Maternity: Concerns / near misses have been raised on Datix regarding the difficulties when a second maternity theatre is required out of hours. Paper submitted to EMC outlining immediate mitigation and future actions with business case expected in August.
- No agreed process for accurately recording information of transgender patients – iInterim solution identified following risk assessment supported by legal.

New Alerts:

- Nil to alert

ADVISE

Presentation received from Maternity Voice Partnership outlining the work undertaken to enable women's voices to be heard and the actions taken as a result. Work was highly commended and well received.

Operational Performance

- Elective activity achieved 107% of plan
- Zero 78-week waiters at the end of March 2023
- Attendances for May were 6% below plan.
- 4-hour standard performance was 75.5% below national standard
- The Trust remains above C&M and above national performance

Integrated Performance Report

- Complaints performance continues to improve
- Increase in percentage of 3rd/4th degree tears (four patients), planned review of cases and standards to identify any learning
- FFT responses rate services as good or very good, noting that assurance measure is not being met.
- HAPU recording to align with STHK in next report
- Above trajectory for E.Coli infections – PIRs in progress to identify learning

Patient Safety Report

- Overview of themes from incident reporting – access, admission, discharge and transfer continue to be highest reported themes.
- 'Lost to follow up' cases will be reported within the 'access' category of incident reporting.
- Two StEis incidents remain open.
- Increased compliance with all components of falls bundle
- No new CQC enquiries for May 2023

Patient Safety Group AAA

- Concerns raised regarding the lack of progress of the program to improve administration of IV fluids. Further engagement with education teams needed

- Progress provided on other schedules of work.

IPC Assurance Group AAA
- Delay in ability to provide haemodialysis on HDU due to estates issues – awaiting timescale for resolution.
- Estates issues and inability to decant wards remains a risk.
- IPC team now fully recruited to and staff in post.

Clinical Effectiveness Committee AAA
- Joint project to reduce 'Wrong Blood IN Tube' incidents across S&O and STHK following increased number of incidents.

Patient Experience & Community Engagement Group AAA
- Identified issues with lack of access to facilities for ablution and prayer on ODGH site. Options explored for facilities.

ASSURE

Annual Integrated Governance Report 2022/23
- Three never events
- Robust process to ensure serious incidents are StEIS reported and investigated within the recommended timescales.
- Learning identified from incidents with significant assurance from MIAA following a Safety Culture review.
- 100% compliance with duty of candour
- Positive outcomes from the Scrutiny and Assurance Group to monitor actions arising from incidents, complaints, risk, claims and CQC concerns.
- Human factors Introduction training continues with positive impact.
- 100% compliance with communication of Patient Safety Alerts
- Risk Management Training rolled out across the Trust with improvements seen in quality of reported risks and their management.
- No regulation 28 orders issued in 2022/23
- Integrated Governance Team won 'non-clinical team of the year' in Trust awards.

Safeguarding Annual Report 2022/23
- Overview of the responsibilities of the Trust with respect to Adult and Childrens safeguarding
- Key achievements noted:
  - recruitment to posts and expansion of the team to provide greater support for domestic violence, and patients with learning disabilities and autism;
  - closer working and integration with system partners,
  - use of digital solutions to support staff with DOLS compliance
  - implementation of MAYBO training
- Case studies provided demonstrating the impact of the team were highly commended by the Chair and NEDs

Clinical Audit Annual report 2022/23
- All annual objectives achieved.
- Working with integrated governance and service improvement teams to undertake clinical audit to demonstrate effectiveness of actions taken to improve clinical services and hosted first joint QI and clinical audit awards.

Patient Experience Annual Report 2022/23
- Highlighted progress made in addressing feedback received to improve the experience through the environment and processes with 'You said we did' examples.

Complaints and PALS Annual Report 2022/23

- Demonstrated improvements in response times and significant reduction in number of open complaints.
- Outlined progress made to improve process, address complaints early to reduce likelihood of progressing to formal complaint.
- Reduction in the number of complaints received from CQC and MPs.
- Significant increase in numbers of compliments received.
- Zero complaints fully upheld by PHSO.

Cancer Annual Report 2022/23

- Overview of cancer services quality and performance, noting:
  - reduction in backlog and implementation of 'faster diagnosis' pathways
  - no evidence of moderate or severe harm through harm review process
  - strengthening of workforce
  - improvements in quality of processes to improve patient experience
  - Improved data submission processes

Annual Resuscitation Report 2022/23

- Highlighting wider role of the resuscitation team in supporting both education and training as well as direct clinical input into deteriorating patients and mortality review process.
- Improving compliance with training requirements aligned to trajectory

Board Assurance Framework SO1 – Q1 Review 2023/24

- Updates accepted

- Chair noted the progress made in quality and content of reports and that information contained within the annual reports had been seen by the Committee over the 2022/23 period providing assurance of the underlying governance process
- Chair and NEDs thanked the hard work of everyone involved in improving Quality and Safety and contributing to the committee.
- Actions reviewed and closed

New Risk identified at the meeting	None
Review of the Risk Register: Not applicable	

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	S&O Workforce Committee
MEETING DATE:	27th June 2023
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Nil

ADVISE

- Risk Register – Risks will be re-assessed post transaction.
- Board Assurance Framework - Strategic Objectives 4 and 5 were updated for the month of June 2023 and noted by the Committee.
- PDRs – Slight decrease in May 2023 at 78.4%. The Corporate area is seeing the biggest drop in month and support is in place to address.
- Sickness – Slight increase in month from 5.3% to 5.4% and continues to sit below a target of 6%.
- Trust vacancies – Increased slightly in May from 7.3% to 8.5% which was expected with recruitment plans in place to address. Also working in partnership with Southport College to recruit Healthcare Support Workers.
- 26 Medical posts currently under offer.
- Time to Hire – Increased in May at 46 days which is predominantly due to overseas recruitment which has taken slightly longer. This area remains green on the dashboard.
- Medical and Bank Workforce Race Equality Standard – This new standard has recently been introduced nationally and the report was provided for information purposes only to show what data had been submitted to the national portal.
- Quality Revisit from University of Liverpool to be rescheduled due to original date planned for 15th June 2023 falling during the recent Junior Doctors industrial action. Further date awaited.

ASSURE

- Presentation received from the new Senior Research Nurse on her experience of joining the Trust which has been very positive, she thoroughly enjoyed the induction session and said that S&O was a lovely place to work.
- Core Mandatory Training – Increased in month to 90.5% which is above the 90% stretch target.

New Risks identified at the meeting: Nil

Review of the Risk Register: Yes

Trust Board

Paper No: MWLTB (23)011

Title of paper: STHK Corporate Risk Register Report – July

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

Summary:

This is a legacy STHK report reflecting the CRR for June 2023. A combined CRR for MWL will be presented at the end of the next quarter to maintain the quarterly reporting cycle.

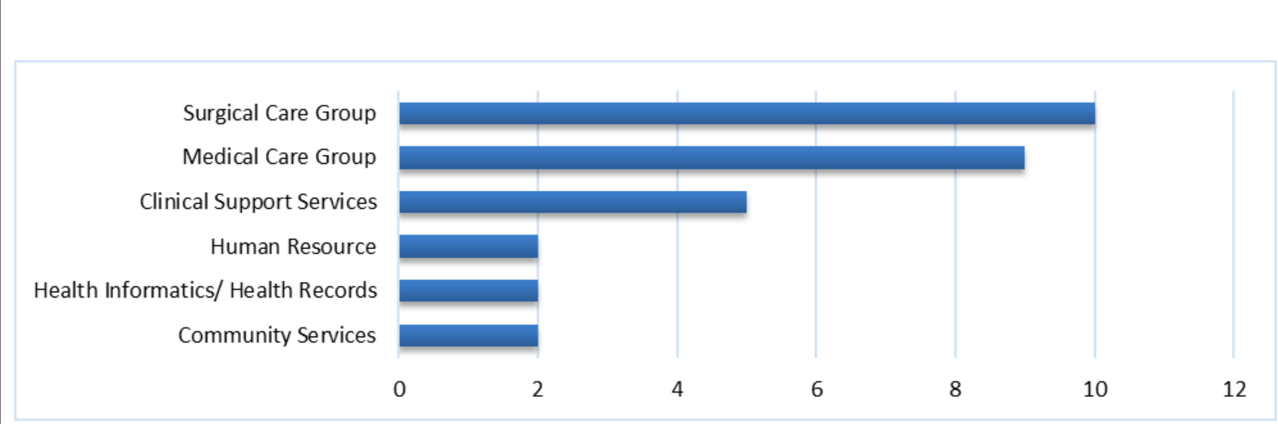
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

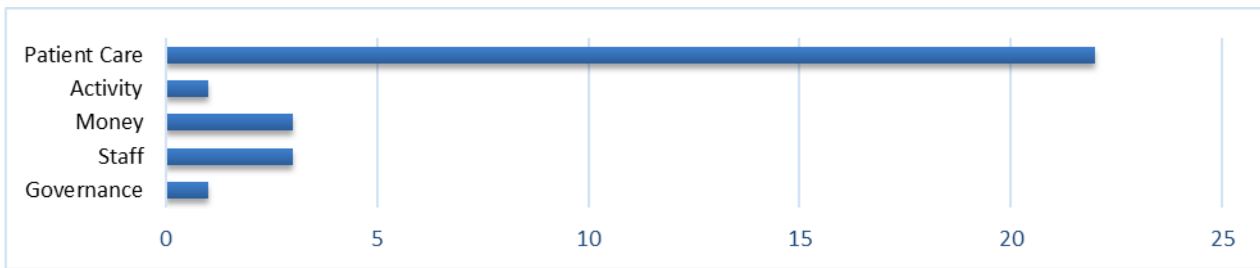
This report (appendix 1) is based on Datix information and covers the risks reported and reviewed during June 2023. The report shows –

- The total number of risks on the risk register was 796 compared to 820 in April
- 56.7% (451/796) of the Trust's reviewed risks are rated as Moderate or High, compared to 55.1% (452/820) in April.
- There are 30 high/extreme risks that have been escalated to the CRR (appendix 2) compared to 30 in April. No risks have been removed or added to the CRR during the last quarter.

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



The risk categories of the CRR risks are -



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

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

Financial implications: None directly from this report.

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

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 26th July 2023

Appendix 1

CORPORATE RISK REGISTER REPORT – JULY 2023

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 03/07/2023	Previous Reporting Period 01/06/2023	Previous Reporting Period 02/05/2023
Number of new risks reported	20	25	17
Number of risks closed or removed	29	40	17
Number of increased risk scores	4	5	4
Number of decreased risk scores	11	3	4
Number of risks overdue for review	72	65	75
Total Number of Datix risks	**796***	**805**	**820**

*781 risks have been approved and scored. 15 risks have been reported but not yet scored or approved in DATIX as it is a live system. The remainder of this report is based on the 781 scored risks

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

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**36**	**16**	**82**	**9**	**162**	**66**	**160**	**29**	**166**	**13**	**8**	**9**	**0**
77 = 9.67%			**253 = 31.78%**			**421 – 52.89%**				**30 = 3.80%**			

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

2.1 Surgical Care Group – 201 risks reported 25.00% 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	**11**	**3**	**11**	**3**	**34**	**22**	**45**	**12**	**42**	**6**	**1**	**3**	**0**
1615 = 7.96%			**48 = 23.88%**			**121 = 60.20%**				**10 = 4.98%**			

2.2 Medical Care Group – 136 risks reported 16.96% 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	**5**	**2**	**10**	**1**	**23**	**7**	**26**	**9**	**35**	**2**	**3**	**4**	**0**
14 = 10.29%			**34 = 25.00%**			**77 = 56.62%**				**9 = 6.62%**			

2.3 Clinical Support Care Group – 120 risks reported 15.08% 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	**5**	**0**	**13**	**0**	**21**	**7**	**24**	**5**	**32**	**2**	**1**	**1**	**0**
10 = 8.33%			**34 = 28.33%**			**68 = 56.67%**				**4 = 3.33%**			

2.4 Primary Care and Community Services Care Group – 51 risks reported 6.28% 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**	**6**	**1**	**14**	**2**	**8**	**2**	**14**	**2**	**0**	**0**	**0**
1 = 1.96%			**21 = 41.18%**			**26 = 50.98%**				**2 = 3.92%**			

2.5 Corporate – 288 risks reported 36.18% 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	**15**	**11**	**42**	**4**	**70**	**28**	**57**	**1**	**43**	**1**	**3**	**1**	**0**
36 = 12.51%			**116 = 40.28%**			**129 = 44.79%**				**5 = 1.74%**			

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	Unapproved high score	**Total**
Facilities (Medirest/TWFM)	0	12	13	6	0	**31**
Nursing, Governance, Quality & Risk	0	15	13	4	1	**33**
Health Informatics/ Health Records	3	17	12	5	0	**37**
Finance	0	10	24	9	0	**44**
Medicines Management	0	25	26	3	0	**54**
Human Resource	2	50	28	9	0	**89**
Total	**5**	**129**	**116**	**36**	**1**	**288**

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

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

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

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies, **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	26/05/2023	4 x 2 = 8	✓	Strategic People Committee
2	Money	1152	**If** there is an increase in bank and agency, **then** there is a risk to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	30/06/2023	4 x 3 = 8	✓	Finance & Performance Committee
3	Patient Care	1263	**If** the Trust cannot achieve the required numbers of patient discharges and transfers, **then** there is a risk to operational performance	3 x 3 = 9	3 x 5 = 15	18/07/2022 Rob Cooper	29/06/2023	3 x 2 = 6	✓	Executive Committee
4	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	21/06/2023	4 x 3 = 12	✓	Executive Committee
5	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance, **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	27/04/2023	4 x 2 = 8	✓	Finance & Performance Committee
6	Patient Care	2082	**If** there is no robust established daily process for review of all medical patients who remain in the ED/EAU due to the lack of an available bed on the ward, **then** this can result in patient safety and experience issues	4 x = 12	3 x 5 =15	27/05/2022 Peter Williams	15/05/2023	3 x 2 = 6	✓	Quality Committee
7	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	19/06/2023	2 x 2 = 4	✓	Quality Committee
8	Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels, **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 3 = 12	4 x 5 = 20	09/12/2021 Rob Cooper	30/06/2023	2 x 4 = 8	✓	Executive Committee
9	Patient Care	2545	**If** the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, **then** there is a risk that compliance with this standard may not be maintained	4 x 4 = 16	4 x 4 = 16	21/07/2021 Sue Redfern	13/06/2023	4 x 2 = 8	✓	Quality Committee
10	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient for diagnostic imaging results	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	13/06/2023	5 x 2 = 10	✓	Quality Committee
11	Patient Care	2767	**If** inpatient maternity staffing shortfalls persist **then** there could be a negative impact on patient safety. It will also have an impact on patient experience. Inpatient maternity staffing shortfall	3 x 3 = 9	3 x 5 = 15	23/03/2022 Sue Redfern	30/06/2023	2 x 3 = 6	✓	Quality Committee
12	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to	5 x 4 = 20	5 x 4 = 20	21/10/2020	05/06/2023	5 x1= 5	✓	Quality Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
			delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.			Rob Cooper				
13	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	31/03/2023	3 x 2 = 6	✓	Executive Committee
14	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas, **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	27/10/2020 Sue Redfern	05/06/2023	3 x 2 = 6	✓	Executive Committee
15	Staff	3178	**If** there are not sufficient staff in post in blood sciences, **then** there is a risk to service delivery	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	06/06/2023	4 x 2 = 8	✓	Strategic People Committee
16	Patient Care	3199	**If** medical patients are to 'forward wait' on a medical ward **then** there is a risk to patient safety, dignity, and experience	4 x 4 = 16	4 x 4 = 16	02/11/2021 Sue Redfern	23/05/2023	4 x 1 = 4	✓	Executive Committee
17	Patient Care	3251	**If** the current end of life solution for outpatient letter printing fails before a replacement system is implemented, **then** there is a risk that letters will be delayed or could impact other EPR functionality	4 X 5 = 20	4 X 5 = 20	21/10/2021 Christine Walters	21/06/2023	1 x 1 = 2	✓	Executive Committee
18	Patient Care	3349	**If** the stock of Olympus scopes is not maintained, **then** there is a risk to business continuity for the endoscopy service	4 x 5 = 20	4 x 5 = 20	29/04/2022 Rob Cooper	05/06/2023	4 x 2 = 8	✓	Executive Committee
19	Patient Care	3371	**If** medical wards are to accommodate an additional patient due to insufficient medical beds, **then** there is a risk to patient safety, dignity and patient experience.	4 x 4 =16	4 x 4= 16	29/04/2022 Sue Redfern	23/05/2023	2 x 2 = 4	✓	Executive Committee
20	Money	3392	If capital funding is not approved to purchase specialist replacement endoscope equipment, then Patients may need to undergo 2 separate procedures	3 x 3 = 9	3 x 5 = 15	03/02/2023 Rob Cooper	25/04/2023	3 x 2 = 6	✓	Executive Committee
21	Patient Care	3475	**If** there is a delay in NWAS transferring patients who have had a stroke for neuro radiology intervention(thrombectomy), **then** this can make a significant difference to patient outcomes.	4 x 5 = 20	4 x 4 = 16	09/08/2022 Rob Cooper	29/06/2023	4 x 1 = 4	✓	Executive Committee
22	Patient Care	3496	**If** there are insufficient staff to provide effective Operational Site Management overnight, **then** there could be an impact on patient safety	3 x 3 = 9	3 x 5 = 15	27/10/2022 Sue Redfern	01/06/2023	3 x 1 = 3	✓	Executive Committee
23	Patient Care	3527	**If** there is not sufficient plastic surgery capacity commissioned **then** non urgent patients in North Wales may face extended waits to be seen, and there will be a reduction in follow up appointments for cancer patients	4 x 5 = 20	4 x 5 = 20	21/09/2022 Rob Cooper	05/06/2023	4 x 1 = 4	✓	Executive Committee
24	Patient Care	3532	**If** the ENT service does not have the appropriate equipment, **then** it will not be compliant with BAHNO recommendations for nasoendoscopy	3 x 5 = 15	3 x 5 = 15	30/11/2022 Rob Cooper	30/06/2023	3 x 2 = 6	✓	Executive Committee
25	Patient Care	3535	**If** operational pressures mean that a 5th surgical patient needs to be accommodated in the bays on surgical wards, **then** there is a requirement for additional staffing to provide the required level of care	5 x 4 = 20	5 x 4 = 20	15/11/2022 Sue Redfern	17/03/2023	5 x 2 = 10	✓	Executive Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
26	Patient Care	3574	**If** Careflow does not allocate patients correctly **then** there is a risk that outpatient appointments will not be scheduled	3 x 5 = 15	3 x 5 = 15	09/11/2022 Rob Cooper	06/06/2023	3 x 3 = 9	✓	Executive Committee
27	Money	3598	If specialist orthopaedic drills are not replaced before the current equipment becomes obsolete, then theatre productivity will decrease	3 x 5 = 15	3 x 5 = 15	23/02/2023 Rob Cooper	17/04/2023	3 x 2 = 6	✓	Executive Committee
28	Patient Care	3600	If there are not the required number of surgical diathermy machines, then patient procedures could be cancelled	3 x 5 = 15	3 x 5 = 15	09/02/2023 Rob Cooper	01/05/2023	3 x 1 = 3	✓	Executive Committee
29	Staff	3624	If there are not suitable trained staff available out of hours to support clinicians, then endoscopy therapeutic interventions could be delayed.	3 x 5 = 15	3 x 5 = 15	19/01/2023 Sue Redfern	05/04/2023	3 x 1 = 3	✓	Executive Committee
30	Patient Care	3647	If the design of the endoscopy suite at St Helens is not adapted to meet national guidance for single sex recovery facilities, then there is a risk of not maintaining JAG accreditation.	3 x 5 = 15	3 x 5 = 15	09/03/2023 Rob Cooper	28/06/2023	3 x 2 = 6	✓	Executive Committee

No risks have been de-escalated from the CRR or closed since April 2023

Appendix 3

Trust Risk Profile – April 2023

Comparison of the Trust risk profile in the last Board Report

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

Trust Risk Profile – July 2022

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

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
29	**35**	**18**	**91**	**9**	**157**	**72**	**172**	**35**	**155**	**8**	**12**	**10**	**1**
82 = 10.20%			**257 = 31.97%**			**434 = 53.98%**				**31 = 3.86%**			

ENDS

Title of Meeting	MWL TRUST BOARD	Date	26th July 2023
Agenda Item	MWLTB (23)012	FOI Exempt	YES
Report Title	CORPORATE RISK REGISTER		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Mr M Stephen, Asst Director of Integrated Governance		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

To provide an update on open risks in the Southport and Ormskirk, Corporate Risk Register.

Executive Summary

Continued training and support have been provided to the local governance teams and reviews of the current risk register have been underway. Advancements have been made to review these risks with their respective owners and the CBUs/BUs have provided updates against individual risks.

The report has been updated **05/07/2023** and approved in Risk and Compliance Group **11/07/2023** to show further improvements to risk management across the organisation.

All risks have been updated within their 30-day review and actions plans are in place.

(11 risks in the Corporate Risk Register in total)

Note:

As of the 1st of July 2023, the Trust became 'Merseyside and West Lancashire Teaching Hospitals'. There will be a change of ownership of the Corporate Register Risks, and these will be discussed in the Risk and Compliance Group.

Corporate Risk Register

ID	ADO/Exec Lead	CBU	Title	Risk Lead	Rating	Date of Last Review	Action plan?
2432	John McLuckie	Finance	Critical Infrastructure risk	Chris Davies	**20**	04/07/2023	7 actions in date
2545	Kate Clark	Medical Director	Temperature Monitoring and Control - Ward/Department drug storage areas	Atique Rehman	**20**	05/07/2023	2 actions in date
2287	Kate Clark	Pharmacy	Malfunction and failure of the ADS (Automatic Dispensing System) Pharmacy Robot	Atique Rehman	**16**	05/07/2023	1 action in date
2572	Kate Clark	Pharmacy	If the aseptic service does not have an automated worksheet & labelling system there is a risk of labelling errors	Atique Rehman	**16**	05/07//2023	No actions in place – awaiting review
2059	Kate Clark	Specialist Services	Difficulty Recruiting to Authorised Establishment of Radiologists	Nicky Taggart	**16**	05/07/2023	1 action in date

2230	Lesley Neary	Executive	Fragile Services	Kate Clark (To be reviewed)	**16**	05/07/2023	Actions have been completed – awaiting further update.
1528	Kate Clark	Specialist Services	Medication error and patient harm due to absence of an Electronic Prescribing and administration of Medicines (EPMA) system	Atique Rehman	**16**	05/07/2023	2 actions in date.
2031	Lesley Neary	Executive	Risk to Patient Flow and Capacity on the Southport Site	Nicky Ambrose-Miney	**16**	05/07/2023	1 action in date.
2549	Lesley Neary	Executive	Potential impact of regional industrial action to Southport & Ormskirk Hospitals Mental Health (in reach) and Walk in Centres	Sharon Gibson-Clarke	**16**	05/07/2023	Actions have been completed – awaiting further update.
2168	John McLuckie	Finance	Cyber Security - Unsupported systems	James Calvert	**15**	05/07/2023	10 actions in date
2411	John McLuckie	Finance	Major and sustained failure of essential IT systems	James Calvert	**15**	05/07/2023	1 action in date

Closed Corporate Risks

2471 | Sustained increased demand for Paediatric Accident and Emergency **Services (Downgraded March 23)**
2220 | Covid 19 - Constitutional access standards **(Downgraded March 23)**

Requiring downgrade

N/a

New risks for discussion and inclusion for CRR (Corporate Risk Register)

N/a

Corporate Risk Register Heat Map

Clinical Support Services	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)					
Unlikely (2)					
Possible (3)					2168, 2411,
Likely (4)				1528, 2031, 2059, 2230, 2287, 2549, 2572,	2432,
Almost Certain (5)				2545,	

Recommendations
The board is asked to receive and note the current open risks and their individual management.

Previously Considered By:	
☐ Strategy and Operations Committee	☐ Executive Committee
☐ Finance, Performance & Investment Committee	✓ Quality & Safety Committee
☐ Remuneration & Nominations Committee	☐ Workforce Committee
☐ Charitable Funds Committee	☐ Audit Committee

Strategic Objectives
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
✓ **SO3** Efficiently and productively provide care within agreed financial limits
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
M Stephen, Assistant Director of Integrated Governance	

Trust Board

Paper No: MWL TB (23)013
Title of paper: Review of the STHK Board Assurance Framework (BAF) – July 2023
Purpose: For the board to review and approve changes to the BAF.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review of the STHK BAF was in April 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. This will be the last version of the STHK BAF presented to Board for the legacy issues pre July 2023, and at the next quarterly review the Board will receive the new Mersey and West Lancashire Teaching Hospitals NHS Trust BAF. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** No recommended changes to risk score's this quarter.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE, CQC, ICB, Trust Board
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 26th July 2023

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2023/24 Objectives and Long Term Strategic Aims

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Original Risk Score	Key Controls	Sources of Assurance	Current Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with ICP/ICB • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • ~~COVID~~ IPC Board Assurance Framework	5 x 4 = 20	Development of a revised Clinical Strategy (Post Transaction Clinical Strategy now being developed)	Routinely achieve 30% of discharges by midday 7 days a week ~~Demonstrate a reduction in similar incidents because of sharing lessons learnt from incidents, never events, claims, inquests, and mortality reviews (review included in Quality Account to be approved in May 2023)~~ Alignment of key clinical and quality policies across the new organisation (September 2023)	Deteriorating patient improvement project – Project resources in place for 12 months, with quarterly updates to CEC – final evaluation report March 2024) Birth Rate Plus review of maternity staffing (report not yet finalised – now rescheduled for August 2023) ~~Undertake a deep dive in to falls and the impact of the falls action plan (Jan to June 2023 review in progress with 6 monthly made to Quality Committee)~~ IPC Summit and action plan to achieve the 2023/24 IPC tolerance trajectories	5 x 1 = 5	PW/ SR

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

Risk 3 – Sustained failure to maintain operational performance/deliver contracts	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit reps • ICB CEO Meetings	4 x 4 = 16	Implementation of routine capacity and demand modelling	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow COVID-19 and restoration escalation plan to release capacity and trigger mutual aid in place and operational. Assurance that there is sufficient system response to operational pressures and delayed discharges – additional community beds managed by the Trust are operational ~~Phase 2 – Discharge Lounge improvement work to optimise capacity (audit of effectiveness taking place and will be reported to Executive Committee – May 2023)~~	Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) ~~Assess the impact on activity of the opening of the new Royal Liverpool Hospital (formal evaluation report to Executive Committee – July 2023)~~ Work with Place partners to achieve 92% bed occupancy and reduce delayed discharges (March 2024)	4 x 3 = 12	RC

Risk 4 – Failure to protect the reputation of the Trust	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaint response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Strategic People Committee • Quality Committee • Audit Committee • Charitable funds committee • IPR • Staff Survey • COVID pandemic reflections staff feedback • Complaints reports • Friends and Family Ratings • National Quarterly Pulse Surveys • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution • ED&I Steering Group Other; • Health Watch • CQC • NHSE/I Segmentation Rating	4 x 3 = 12	Regular media activity reports, including social media, to the Executive Committee	Media and Public Engagement strategy for the new organisation (August 2023) Creation of good working relationships with new Healthwatch/PBP areas post transaction	~~Work in partnership with S&O to provide consistent messaging and communications channels for staff and stakeholders about the ALTC and Transaction (extended due to transaction delays – June 2023)~~ Deliver phase 1 of the Communications and engagement plans for MWL (September 2023) Create effective working relationships and enhance the trusts reputation with the new Places and stakeholders for MWL, including MPs	4 x 2 = 8	AMS

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

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention operational plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management Strategy	To Board; • Strategic People Committee • People Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce operational plans • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • National Quarterly Pulse Surveys • WRES, WDES, EDS2022, and Gender, Race and Disability Pay Gap, reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Group Other • HR benchmarking • Nurse & Midwifery staffing benchmarking	5 x 3 = 15	Increase frequency of the Strategic People Committee meetings in 2023/24 Evaluation of the impact of introducing 12 hour long day nursing shifts (October 2023)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. Capacity to deliver the recovery and restoration plans via the CDC (September 2023) Establish diagnostic collaborative bank (Revised to March 2024 due to proposed extension of scope) Achieve 2023/24 targets for international recruitment and Nurse Associate expansion (March 2024)	Delivery of the 2022 staff survey action plan for legacy organisations in 2023/24 and combine surveys and action plans from March 2024 ~~Completion of the TUPE transfer of S&O staff (consultation completed, transfer will take place on the date of the transaction)~~ Revise reporting (Datix) system to allow more robust recording of incidents relating to ED&I and Staff safety, with interim paper based recording for MWL from July (Datix replacement now scheduled for September 2023) Achieve the Mandatory Training and Appraisal compliance targets of 85% (March 2024)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Original Risk Score (IxP)	Key Controls	Sources of Assurance	Current Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards ~~and social distancing (COVID-19)~~ • Compliance with NHS Estates HTMs • Green Plan	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns/Data • PLACE Audit Results and benchmarking • Premises Assurance Model benchmarking • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Maintain 10 year strategic estates development plan to support the Trusts service development and integration strategies. Create strategic site development plans for the S&O hospital sites when transaction completed.	Implementation of new National Standards of Cleaning for MWL - continued engagement with NHSE and proposals agreed with IPC (December 2023) 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	3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2023/24) Delivery of the Whiston Additional Theatres Scheme (2023/24)	4 x 2 = 8	NB

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

Title of Meeting	TRUST BOARD	Date	26th July 2023
Agenda Item	MWLTB (23)014	FOI Exempt	NO
Report Title	S&O BOARD ASSURANCE FRAMEWORK – QUARTERLY REVIEW		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Richard Weeks, Corporate Governance Manager		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ☐ To Receive	

Purpose

To review and agree the Board Assurance Framework (BAF) updates.

Executive Summary

The BAF allows the Directors to understand how the controls put in place by the Trust to provide assurance on the reduction of risk in relation to the delivery of its strategic objectives. The BAF report is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls.

Since the last review, the BAF has been reviewed by the lead Directors for each strategic risk and the individual risks have been presented to the relevant committees. Progress has been made on mitigation for all BAF risks. It is recommended that the score of SO3 is now reduced to a score of 16 (from 20) reflecting the increased financial certainty and investment.

Key to changes:
~~Scored through text~~ = deletions
Blue text = additions/updates
Red Text = overdue actions

Recommendations

The Strategy and Operations Committee is asked to approve the proposed changes to the BAF.

Previously Considered By:

☐ Strategy and Operations Committee	✓ Executive Committee
✓ Finance, Performance & Investment Committee	✓ Quality & Safety Committee
☐ Remuneration & Nominations Committee	✓ Workforce Committee
☐ Charitable Funds Committee	☐ Audit Committee

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Richard Weeks, Corporate Governance Manager	Nicola Bunce, Director of Corporate Services

Risk Description: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety

Strategic Objective 1: Improve clinical outcomes and patient safety to ensure we deliver high quality services	**Assurance Committee:** Quality & Safety Committee **Executive Lead:** Director of Nursing / Medical Director

RISK ID	**1**	**Risk Description**	**If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety**

Inherent Risk			**Risk as at June 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	5	**20**	3	5	**15**	2	5	**10**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Trust Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing five priority areas: • Falls • Pressure Ulcers • AKI: hydration & nutrition • Communication with families • Ockenden Compliance 4. Risk Management Strategy and escalation framework. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Application of clinical pathways and guidelines. 8. Programmes in place for clinical standards and professional practice. 9. Work plans for medical staff. 10. Clinical revalidation. 11. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle • 7-day staffing matron in place for oversight and management • Weekly staffing review and sign off • Roster sign off meeting • Monthly nurse/midwifery staffing reports to Executive Committee 12. Training programme (mandatory and non-mandatory). 13. Regular resuscitation updates to Executive Committee 14. CQC actions from 2019 inspection complete. Continued oversight through Quality priorities, dashboards and SOCAAS. 15. Supervision and education of clinical staff across all professions. 16. Application of Patient Safety and other safety alerts. ~~17. Patient Safety Specialists appointed.~~	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. Nursing, midwife, AHP and support staff recruitment and retention programme needs continued focus including HCAs	**LEVEL 1** (Operational Management) 1. Alert, Advise, Assure reports from Groups. • Harm free care panel • Serious Incident Review Group • Health and Safety Group • Risk and Compliance Group 2. Performance, Improvement, Delivery and Assurance (PIDA) with suite of measures. 3. Patient feedback (FFT/Patient Surveys) 4. Clinical audit reports 5. Mortality and SJR Process. 6. Review of documentation and quality indicators through use of tendable. 7. Health and Safety Inspection Programme 8. IPC Assurance Framework 9. Health and safety/fire risk assessment/audit programme. 10. Medical Examiner's office/officers now set up and in practice. 11. Quality Improvement Programme Board **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SOCAAS ward accreditation programme 8. VitalPac deterioration measures 9. Freedom to speak up guardian 10. IPC BAF 11. Winter Staffing Assurance Framework Assessment	1. CQC 'Must and should do' actions not addressed in full. 2. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests, and audit. 3. Guardian of safe working post vacant	1. Clinical workforce strategy to be completed by Nov 22. **June 2023 Update** – progressing in collaboration with StHK. 2. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. **June 2023 Update** – progression in collaboration with StHK. 3. Nursing, midwifery & AHP recruitment and retention strategy (Dec 2022). **January 2023 Update** – Nursing & Midwifery strategy complete and launched in Q3. AHP strategy in draft, further work needed. Successful recruitment noted in nurse staffing reports. Actions in place to support HCA recruitment and retention (May 2023) **March 2023 Update** – AHP strategy to be incorporated with the StHK AHP team. 4. Repeat MIAA audit of lessons learnt (Q1 2023/24) 5. Implementation of PSIRF and roll out of new Incident management framework (IMF) (~~April~~ July 2023) 6. ~~GOSW -Exception reporting reviewed by HR, Director of Medical Education and Medical Director. No internal applicants & STHK unable to support. Further expression of interest request to go external (Oct 2022)~~ ~~**March 2023 Update** – Interview to be arranged~~ **June 2023 Update – Appointee in post action closed**

		18. Cycles of business for governance meetings 19. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. 20. Patient safety specialist roles 21. Medical examiners roles and fully established programme to review all deaths 22. Full roll-out/reporting of Tendable app measures 23. Nursing, midwife, AHP and support staff recruitment and retention programme in place. 24. Regular risk management training taking place across the Trust and available to book onto for all Trust staff. Patient safety managers also holding risk management training within the CBU's and specialities. 25. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the SOC 26. Incident reporting and investigation process 27. Ockenden 2 action plan 28. Compliance with 10 safety standards for maternity and neonates 29. Reporting of nosocomial infections and outbreaks 30. Corporate Objectives		**LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits 4. CQC Insight Report, Outlier Alerts and engagement meetings 5. Healthwatch 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. Place monthly quality and performance meetings. LMNS in attendance for maternity updates. 11. Internal/External Audit 12. Quality Account 13. Risk management deep dives and self-checks by the Integrated Governance team 14. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the board.		
	The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge					

AMBITION: To improve clinical outcomes and patient safety to ensure we deliver high quality services					
	AVERSE	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	**The Trust is willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.**	Tending always towards exposure to only modest levels of risk to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Risk Description: If the Trust cannot achieve its key performance targets it may lead of loss of services

Strategic Objective 2a: Deliver services that meet NHS constitutional and regulatory standards	**Assurance Committee:** Finance, Performance, and Investment Committee **Executive Lead:** Chief Operating Officer

RISK ID	**2**	**Risk Description**	**If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts.**

Inherent Risk			**Risk as at June 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	4	**16**	4	4	**16**	2	4	**8**

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts. **CAUSE** • COVID-19 backlog causing delays in elective and diagnostic recovery, cancer pathways and patient discharge. • Continued rise in UEC demand and challenges with patient discharge due to insufficient/inconsistent alternative provisions across the system. • Industrial action resulting in a reduction in elective activity, response times in ED and timely & efficient discharges. • Reduction in the supply of suitably skilled and experienced staff	~~COVID-19 and~~ Elective Recovery • ~~In line with national guidance Living with Covid, oversight and decision making has been assigned as part of BAU process to ETM. Systems and processes remain valid and can be stood back up dependent upon prevalence.~~ • Part of C&M Acute Provider Collaborative monitoring elective ~~COVID-19~~ recovery and supporting mutual aid discussions. • Single accountability framework for reviewing CBU areas for development/strengths. • ~~2022/23 RTT restoration plan being monitored on a monthly basis and reported to Exec Committee & FP&I.~~ • Elective restoration update reported at FPI • ~~Non RTT trackers in place with planned programme of work~~ • Directorate Manager role that is solely responsible for access - providing greater strength~~en~~ in governance and compliance. • Access policy for validation of all patients on waiting lists. • Clinical prioritisation of all patients. • Weekly extraordinary PTL meeting chaired by COO to reduce long waiters • CBU plans developed for every round of industrial action with assessment on activity and staffing levels to deliver safe	1. The expected outcomes and opportunities of partnership with STHK are still being explored across some services. 2. Delivery of SLA's 3. Need to identify other appropriate stakeholders for clinical services partnerships. ~~4. Shaping Care Together programme is yet to secure capital and define preferred option.~~	**LEVEL 1** (Operational Management) 1. Quarterly Performance, Improvement, Delivery and Assurance (PIDA) Boards – CBU assurance 2. Monthly CBU FPI's in place from April 2022 – CBU assurance. 3. Number of improvement boards in place reporting in via PIDA ○ Theatre Utilisation Board ○ Urgent and Emergency Care Improvement Board ○ Endoscopy Improvement Board ○ Cancer Improvement Board 4. Review of CBU Risk Registers at Risk and Compliance Group. 5. CBU review at Clinical Effectiveness Committee. 6. CBU Governance Meetings in place. 7. Local IPRs in place to monitor performance which are presented at monthly CBU FP&I and quarterly Performance, Improvement, Delivery and Assurance (PIDA). 8. Extraordinary PTL for long waiters (including cancer) in place ~~from Aug 22 chaired by COO~~ 9. Revised PTL process in place for cancer tumour sites **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 10. CEO's reports to Board 11. Integrated Performance Report (IPR) to SOC, FP&I, Q&S and Workforce Committee (monthly)	1. Constitutional standards are not routinely being met	1. Elective recovery plans in place. ~~**March 23 Update:** SOHT remains best acute trust for 52+ weeks and 78 weeks with 0 x 104 week breaches. Elective performance impacted by emergency demand and industrial action but remains in line with C&M position. Draft activity plans for 2023/24 have been submitted to NHSE, elective target 103% 2019/20 levels.~~ **June 23 Update:** SOHT remains best acute trust for 52+ weeks with 0 x 78 week waiters and 0 x 104 week breaches. Elective performance at M1 reported at 106% vs 103% plan. 2. Develop cancer improvement plan to address performance across all cancer metrics in line with plan for 2023/24~~22/23~~. ~~**March 23 Update:** SOHT continue to improve cancer performance and positively below the 62 day backlog trajectory. Tumour specific improvement plans in place, presented at Weekly Cancer Performance meeting. Draft cancer plans for 2023/24 have been submitted to NHSE in line with new targets.~~ **June 23 Update:** SOHT continue to improve cancer performance and positively below the 62 day backlog trajectory. 2 week wait performance is performing well against the national standard. Challenges with 62 day performance across 3 x tumour sites but tumour specific improvement plans have been further developed,

	across several services. • Ineffective use of resources to support improvements in productivity and improve clinical outcomes. • Failure in operational leadership **CONSEQUENCE** • Failure to deliver safe, high quality patient care • Reduced patient experience • Poor clinical outcomes • Over-reliance on temporary workforce due to current and projected workforce gaps leading to increasing costs and potential impact upon quality of patient care and experience. • Failure in delivery of national performance targets/plans which could lead to intervention by regulator(s)/ and/or commissioner(s) • Reputational damage and loss of public confidence. • Financial penalties and loss of services. • Loss of market share. • Reliance on other acute providers to support the delivery of clinical services • Loss of ERF funds.	care. Gold command calls established and chaired by COO/MD to oversee planning and delivery in relation to industrial action. • Dedicated Directorate Manager role, responsible for cancer & dedicated matron for cancer in place. • Process and training for capacity & demand developed which has supported planning for 2023/24. • ~~DRAFT~~ Activity plans for 2023/24 submitted to NHSE with trajectory set to achieve 103% of 2019/20 levels. UEC and Discharges • Tier 1 Trust therefore no mandate for support. • System Control Centre calls daily to report against operational pressures. • ED RCA process for breaches • System wide capacity and flow meeting held twice weekly to review system discharge delivery. • 4 x daily bed capacity meetings to support daily planning. • Development of winter plan 2023/24 being led by Urgent Care Board • Out of Hospital capacity at Chase Heys continuing. • ~~Agreed in-hospital winter plan 2022/23~~ • ~~Agreed out of hospital (system) winter plan for 2022/23~~ • ~~Additional funding to support +14 beds at Chase Heys £840k for Sept 22-Mar 23~~ • System escalation system (OPEL) in place to trigger support from partners Workforce • ~~Shaping care together programme.~~ • Comprehensive trust service assessment completed to establish levels of fragility and core drivers Use of Resources • Use of Resources Programme established to support well led approach for clinical and corporate services. • Quality impact assessments (QIAs) for all service changes that are considered.		to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments ○ Financial position 12. Monthly reports on elective restoration, UEC performance (including Covid) to FP&I. 13. Monthly reports on cancer improvement to QSC 14. Quarterly Joint Performance Meeting (NHSE, STHK and S&O) . **LEVEL 3** (Independent/Semi-Independent) 15. NHSI Single Oversight framework and monitoring arrangements 16. CCG monthly quality and performance meetings. 17. NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting 18. Getting it right first time (GIRFT) programme. 19. Cancer Alliance oversee delivery and performance regarding cancer metrics. 20. NHS England / NHS Improvement 21. CQC 22. Internal Audit 23. External Audit 24. NHSE confirmed full ERF funding for 2022/23, recognising the challenges faced by providers		presented at Weekly Cancer Performance meeting. Revised weekly cancer PTL meeting in place. 3. Discharge planning: Improve the effectiveness of discharge processes to support 30% discharges before noon. ~~**March 23 Update:** Focus remains on discharge. RFD meeting 4 x per week & LLOS 1 x per week. COO/MD attendance. Focus on golden discharges for early flow. Escalation in high levels of escalation for support from system partners.~~ **June 23 Update:** Focus remains on discharge. RFD meeting 3 x per week & LLOS 2 x per week. COO/MD attendance at times of high escalation. Focus on golden discharges for early flow. Attendance at ICB discharge event, S&O flagged as best performing trust across C&M for NC2R. System wide action plans being developed, led by PLACE directors. 4. Theatre Improvement ~~**March 23 Update:** Trust identified 3 x team for train the trainer theatre improvement programme. Trust observed by ICS theatre improvement team with positive feedback. Theatre improvement group remains in place. Draft plans for 2023/24 have been submitted to NHSE in line with 80% utilisation target for 2023/24.~~ **June 23 Update:** Continue to take part in the train the trainer theatre improvement programme. Trust continues to be flagged by ICS theatre improvement team with positive feedback. Theatre improvement group remains in place. Plans for 2023/24 have been submitted to NHSE in line with 80% utilisation target for 2023/24. M1 achieved 77.1% vs 72% at M1 2022/23. 5. Radiology Improvement Plan ~~**March 23 Update:** Draft review received and improvement plan is being developed. Despite challenges, good progress reported 1 month in for CDC.~~ **June 23 Update:** Despite some challenges with workforce and estate, good progress reported in M1 for diagnostics and CDC. Currently 84% patients seen < 6 weeks vs 90% target by March 23.

	• Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. Operational leadership • Weekly Senior Operational Leadership (SOLT) Meetings • Monthly Senior Operational group (SOG) meetings with development plan in place • Essential skills and mandatory skills training programme				

The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To give every person the best care every time and deliver our operational performance standard

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Risk Description: There is a risk around condition of estates and backlog maintenance issues

Strategic Objective 2b: Deliver services that meet NHS Constitutional and regulatory standards

Assurance Committee: Finance Performance and Investment Committee
Executive Lead: Director of Finance

RISK ID	2432	Risk Description	If the condition of the Trust estate is not improved then there is a risk to the delivery of high quality safe and effective services and to the experience of patients, visitors, and staff

Inherent Risk			Risk as at March 2023			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	4	5	20	1	5	5

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk that essential hospital infrastructure could fail or not be fit for purpose to meet recognised H&S requirements or NHS HBN standards **CAUSE** Lack of capital investment to reduce CIR (Critical Infrastructure risk) backlog **Fire safety risk to life** as a result of lack of early warning (fire alarm) and ability to prevent spread of fire (compartmentation) **Failure of primary electrical systems (Southport)** which could result in loss of mains electricity to the site and loss of backup supply in the event of a power interruption **Failure of secondary electrical systems (Southport)** which result of loss on power through internal distribution network. Inability to effectively isolate areas **Inadequate ventilation (both sites)** resulting from insufficient air changes to meet HTM (Health Technical Memorandum) and infection control standards **Failure of nurse call system (both sites)** due to aging and obsolete parts causing rise to patient safety concerns and inability to care for patients safely **Failure of BMS (Building management System) (both sites)** resulting in inability to control critical	• Estate asset List & information in place on asset management software (Invida system) • 6 Facet & Condition Surveys undertaken • Engineering Safety Systems Group has been established • Annual Capital Programme • Additional project management and construction capacity secured • Trust Green Plan • E&F Governance & performance management report • E&F Policies & SOP's	1. Some assets awaiting surveys to be undertaken 2. Need for the development of an Estates Strategy that responds to the Shaping Care Together preferred service configuration option 3. Implementation of national standards of cleaning and new hospital food standards	**LEVEL 1** (Operational Management) 1. Planned Preventative Maintenance (PPM) Programme 2. Health & Safety Group 3. Water Safety Group 4. Estates Operational Statutory Compliance Group which monitors compliance with PPM's 5. Engineering safety Group 6. E&F Governance Group 7. Daily review of DATIX incidents to ensure timely response to mechanical & building related issues. 8. Weekly review of overdue reactive tasks relating to mechanical & building related issues. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 9. Capital plan 2022/23 – identifies internal & external funding to address backlog maintenance projects listed adjacent 10. ERIC 21/22 Submission identifies how much backlog has reduced 11. Fire safety action plans for both sites which are monitored at the H&S Group. Progress meetings held with Merseyside Fire Service who continue to be satisfied with progress made to date. Extension to current notice extended to allow for full completion and commissioning of fire alarm system. 12. Progress monitored at Capital Investment Group	1. Current PPM Programme does not meet SFG20 - Standard maintenance specification for building engineering 2. Fire enforcement notice from and Mersey fire and Rescue Service.	1. ~~Current CAFM system does not have capabilities required for sufficient asset management or the ability to API link to SFG20 standards – Currently in Mobilisation phase site drawings are being uploaded and asset collection commenced in June.~~ ~~**March 23 Update:** Invida went live for reactive tasks on 1st March 2023, API link and use of SFG20 in progress due to go live April 2023. Action Completed~~ 2. Fire Safety Notices - Trust has received £3.2m to tackle fire safety issues in 2022/23 which includes completion of fire alarm upgrade & fire compartmentation at SDGH and upgrade of fire alarm at ODGH. Merseyside Fire and Rescue continue to be satisfied with the actions and progress taken to date. **June 2023 Update -** The compartmentation work should be completed by the end of June enabling that fire notice to be closed. The fire alarm work is progressing well and should be completed in the next couple of months. Once that is complete that will have addressed the remaining fire notice relating to SDGH. 3. 2022/23 Backlog Maintenance Schemes - A further £2.6m has been awarded which will be targeted against access control/CCTV at ODGH, electrical safety issues at SDGH & additional fire compartmentation works at ODGH to be completed in 2022/23. 4. Internally funded schemes to be completed in 2022/23 are SDGH

	systems that are linked to it such as heating, cooling, fire alarm systems **<u>Failure CCTV and Access control systems (both sites)</u>** resulting in lack of adequate security for both patients and staff **Failure lifts (both sites)** Impacting on the ability to transfer patients safely **<u>Failure Mechanical/plumbing (water, oxygen, gas etc) (both sites</u>)** due to ageing systems causing rise to patient safety concerns and inability to care for patients safely **<u>Failure of autoclaves (Southport)</u>** resulting in inability to deliver sterile services to the Trust, impacting on patient safety **<u>SDGH (Southport District General Hospital)</u>** Energy Centre plant and equipment. **CONSEQUENCE** If our infrastructure fails or has issues there are several consequences which could potentially happen as a result, such as: • injury to patients, staff, visitors and contractors • Fines for non-compliant systems and support • Risk of fire • Death • Loss of trust assets • Public perception			**LEVEL 3** (Independent/Semi-Independent) 13. AE (Authorising Engineer) Appointments 14. AE (Authorising Engineer) Audits undertaken 15. Condition surveys		water tank replacement, laundry decommissioning works, nurse call replacement for wards 7a,9a,9b,10a, 10b & ENT, lighting improvements to both sites and resurfacing of Ruff Lane car park entrance 5. ~~Completed schemes to date include theatre fire safety storage works, replacement generator cables SDGH, Estates welfare workshop, & replacement energy centre chimneys, laundry decommissioning works, nurse call upgrade and lighting improvement works on both sites.~~ 6. Backlog maintenance funding – **March 23 Update:** £26m secured to further eradicate backlog, plan for £10m signed off by Executive Committee which includes completion of fire compartmentation works at ODGH, replacement of CCTV & access control at SDGH, Primary electrical infrastructure works at SDGH and resurfacing and road repairs across both sites. 7. Work is ongoing to establish the resources which will fill the gaps in Estates maintenance, cleaning, and hospital food standards.

AMBITION: To provide sustainable					
Category	**AVERSE**	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels to secure successful outcomes and meaningful reward/return.

Risk Description: There is a risk that major and sustained failure of essential IT systems

Strategic Objective 2c: Major and sustained failure of essential IT systems	**Assurance Committee:** Finance Performance and Investment Committee **Executive Lead:** Director of Finance

RISK ID	**2411**	**Risk Description**	**There is a risk of major and sustained failure of essential IT systems**

Inherent Risk			**Risk as at June 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
5	4	**20**	5	4	**20**	4	2	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK There is a risk of a major and sustained failure of essential IT infrastructure **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 • Inadequate investment in systems and infrastructure **CONSEQUENCE** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	• IM& T Committee Oversight & IT Management Governance • Procurement Frameworks • Trust Digital Strategy • Performance framework and KPI's • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Major Incident Reviews • Disaster Recovery Policy • Disaster Recovery Plan and restore procedures • Backup System in place and operational • Engagement with C&M Cyber Security Group • Cyber Associates Network Membership • Business Continuity Plans • Care Cert Response Process • Project Management framework • Change Advisory Board • Digital Design Authority • Information asset owner / administrator register • Cyber Security Provision provided by Mid-Mersey Digital Alliance (MMDA) • Monthly Patching Strategy in place • Microsoft Defender Anti-Virus in place and actively monitoring for malware, viruses, and threats • All servers and PCs linked to Microsoft ATP\Defender • Regular Cyber Security Comms	1. Technical Development of Trust Staff	**LEVEL 1** (Operational Management) 1. IM&T Committee 2. Digital design Authority 3. IT On Call (including Network specific cover provided by MMDA) 4. Risk and Compliance Group 5. Information Governance Steering Group 6. Executive Management Committee 7. Information Asset Owner Framework 8. Benefits Realisation Framework monitoring 9. Cyber Security Action Plan 10. Monthly Cyber Security Assurance Group with MMDA **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 11. Board and Committee Reports 12. Quarterly Digital Strategy Reviews 13. Monthly Cyber Security Reporting **LEVEL 3** (Independent/Semi-Independent) 14. Internal Audit reports 15. Annual Penetration Test and Report 16. Data Security Protection Toolkit Submission 17. Microsoft Unified Support Contract 18. Microsoft Server 2008 Extended Support 19. 24/7 Support Contracts in place for core systems such as EPR, Kainos, VMWare, Dell, etc. 20. Quarterly NHS Digital simulated phishing attack reports	1. Migration from end-of-life operating system ongoing and due to complete in 2022 2. Cyber Essential Certification / Accreditation - achieve by January 2026	1. Network Remediation Rollout underway (Ongoing with completion now scheduled for Q4 22/23) **June 23 Update**: July 2023 for completion, slight delay due to having to cancel planned work to avoid service disruptions on Industrial Action days. Approximately 95% complete 2. ~~Cisco Identity Services Engine Implementation (Now Scheduled for Q4 2022/23).~~ 3. ~~PC Network Segregation (to be complete Q3 2022/23~~ 4. ~~The AD for digital at S & O has now left the organisation and professional support is now being provided by the team from STHK while a proposal for the long-term arrangement is being developed.~~ 5. Full review of IT service and contracts, asset owners and system versions in-order to fully understand the risks across the IT service is underway. 14 risks identified to date – Ongoing **June 23 Update:** Contract review complete and appropriate plans in place to address risks as part of the formalisation of the StHK and S&O collaborative partnership 6. Digital Maturity/EPR replacement funding - £2.22m due to be received Jan/Feb 2022. Work is underway on the OBC for the remaining £19.4m. **June 23 Update:** OBC work ongoing, completion date end July 23 7. Migration from end-of-life operating system ongoing and due to complete in 2023 **June 23 Update:** Good progress has been made migrating away from end of life operating systems. A new programme of work has also commenced to start

		• Backup System with backup schedule in place • Care Cert Response Process in Place • Role Based Access Control in place across domain and all clinical systems • Failover technology in place across Trust VMWare estate • Server Network Segregation in place • Imprivata Single Sign On in place • Patch My PC in place for 3rd party application patching • Intrusion Prevention System in place				migrating away from operating systems that go end of life August 2023.

AMBITION: To provide sustainable

Category	AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Risk Description: Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Strategic Objective 3: Efficiently and productively provide care within agreed financial limits

Assurance Committee: Finance, Performance and Investment Committee
Executive Lead: Director of Finance

RISK ID	3	Risk Description	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Inherent Risk			Risk as at June 2023			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	2	4	8

Risks to objective

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

CAUSE:
- Failure to achieve the Trusts statutory breakeven duty
- Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders
- Failure to develop and deliver strategic financial plans
- Failure to control costs or deliver CIP
- Failure to stabilise Fragile Services
- Failure to secure sufficient capital support to address significant backlog, and transformational requirements
- Failure to ensure alignment of essential co-dependant clinical services
- Failure to implement transformational change at sufficient pace
- Failure to respond to commissioner requirements
- Failure to respond to emerging market conditions

Controls

- Operational Plan and HCP/ICS financial modelling
- Annual Business Planning
- Annual budget setting
- CIP plans and assurances Processes
- Monthly financial reporting
- Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital)
- Contract monitoring and reporting
- Activity planning and profiling
- IPR
- NHSEI annual provider Licence Declarations
- Signed Contracts with all Commissioners
- Signed SLAs with all partners
- Premium/agency payments approval and monitoring processes
- Internal audit programme
- Compliance with contract T&Cs
- Standards of business conduct
- SFIs/SOs
- Declaration of interests
- Benchmarking and reference cost group
- Increased collaboration across C&M to deliver transformational CIP contribution
- Capacity and Demand process and training
- E-rostering fully utilised across all clinical departments

Gaps in Controls

- Currently no financial recovery plan that delivers break-even/ addresses drivers of the underlying financial position
- Lack of medium & long-term financial plan, taking in to account current position and savings from any reconfiguration
- Ability to mitigate inflationary pressures – specifically relating to Energy prices into 2023/24, other non-pay, plus 2023/24 pay award
- Lack of strategic capital plan

Sources of Assurances

LEVEL 1
(Operational Management)

- Monthly CBU FP&I meetings now established
- ~~Use of Resources Programme Board~~
- CIP Council meetings
- Monthly budget holder meetings
- Premium Rate Pay Control Panel across CBUs
- ~~Capacity and Demand~~ Operational planning

LEVEL 2
(Reports and Metrics monitored at assurance committees and/or Board)

- Finance, Performance & Investment Committee
- Audit Committee
- Annual Financial Plan
- Monthly Finance Reporting
- IPR
- Annual Accounts
- SLR/PLICs update reports
- ~~UoR Reports~~
- Internal Audit Programme
- National costing returns
- ~~Shaping care together programme~~

LEVEL 3
(Independent/Semi-Independent)

- ICB/NHSE~~ngland/Improvement~~ monthly reporting
- CQC Reports
- ~~CCG~~ Contract Review Meetings
- Head of Internal Audit Opinion
- External Audit reports inc VfM Assessment

Gaps in Assurance

- Ability to monitor trajectory against financial recovery plan until developed
- ~~Demand and Capacity modelling to inform Operational Planning~~
- Trust PMO capacity to support delivery of CIP, UoR Action Plan, capital business cases, and service transformation

Mitigating Actions/Progress

- Collaboration agreement in place with StHK with proposed transaction delayed from April 2023 – now anticipated July 2023. Close working with STHK to ensure pre-transaction alignment of processes, and delivery of PTIP
- Development of Medium & Long-Term Financial Model & strategic capital plan – note absence of national medium & long term financial framework including payment mechanisms and economic modelling assumptions required in order to provide robust Medium & Long-Term plan
  ~~**March 23 Update:** 2023/24 Plan development aligned with STHK and Transaction Business Case – working with ICB to ensure revenue support and capital investment as assumed in the Business Case to achieve financial sustainability in the medium to long term~~
  June 23 Update £26m backlog capital secured in 2022/23, with transformation capital profiled from 2023/24 onwards. 2023/24 Plan approved, with revenue support to breakeven as per the Transaction Business Case
- Development and implementation of monthly financial reporting suite and forecasting model to drive ownership and accountability for performance – in place from April 2022 – **June 2023 Update** now rolled out as part of 2023/24 planning and monthly reporting. Action Completed
- Seek all possible sources of capital and revenue funding through national bids to support capacity and transformation, including opportunities re co-location of services – ongoing
- Working with STHK and ICB to ensure consistency of assumptions relating to income and excess inflation
- Working with ICB to ensure cash management arrangements are supported pending transaction

• Failure to respond to new models of care (FYFV / NHS LTP) **EFFECTS:** • Failure to meet statutory duties • External Cash Support Requirements • NHS Single Oversight Framework Segmentation Status increase **IMPACT:** • Unable to deliver viable services • Loss of market share • Regulatory intervention					

The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To provide care efficiently and productively, within agreed financial limits

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Strategic Objective 4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

RISK ID	**4**	**Risk Description**	**If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience**

Inherent Risk			**Risk as at June 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial	• Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan • Our Resourcing Plan (Strategy supported by clinical workforce plan). • Inclusive recruitment and selection processes in place • Overseas Recruitment Campaign for Nurses • Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. • Job plans for medical staff. • Warm Welcome staff induction in place • Quality PDR process and career development discussion • Flexible working options in place including team rostering • Ward/departments non-medical staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. • People Activity Group (PAG) with oversight of business cases for additional staffing • Leadership development programmes & 360 feedback available to all staff	1. Low number of applicants from BAME backgrounds successful at interview 2. Poor PDR compliance rate 3. Limited options for flexible working 4. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management 5. No easy ability for staff to move internally without full application process 6. Education structure requires integration	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (WIG) oversees work against the four operational priorities: ○ Agile working ○ Workforce systems ○ Clinical workforce plan ○ Change management 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. PDR completion; 3. Sickness rates. 4. Absence Data 5. Turnover Data 6. Vacancy Rate 7. Time to Hire monitoring and reporting. 8. Apprenticeship Levy/Programmes 9. Staff Survey & Quarterly Staff FFT/Survey 10. GMC Medical Staff survey – annual	1. Sickness absence not maintained below target 2. Low compliance rates for PDR completion 3. A number of medical vacancies have been vacant for a long time	1. Clinical workforce plan to be developed. A work stream has been established as part of Workforce Improvement group (led by the Deputy Medical Director) to develop a framework for workforce planning and link to Fragile Services and Shaping Care Together. Implementation of establishment control is required before a robust workforce plan can be developed, the implementation of establishment control is progressing at pace and most of the preparation work is now complete. ~~**March 2023 Update:** Medical Workforce Plan awaiting final comments from Medical Director prior to publication, this will then progress to Workforce Committee and progress will be regularly reported~~ **June 2023 Update:** progressing in collaboration with STHK as part of the joint Clinical Workforce Plan 2. Engagement planned with staff network colleagues to review Recruitment and Selection process to identify improvements & develop further inclusive approaches. **June 2023 Update:** Current improvements - support for disabled applicants on adverts and at interview, guaranteed interview scheme, EDI charter marks - Navajo, Disability Confident & Fair Employment Charter. Plan to commence a combined QI Project with STHK's Inclusive Recruitment Steering Group, new appointees and staff network colleagues in Q3 to build 'lived' experience into recruitment process.to reduce barriers to inclusive recruitment. 3. Review of current rostering practice across each area and guidance and support is being offered to improve as phase 2 of the benefits realisation. 4 departments identified as pilots for team/self-rostering is now underway

	penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	• Apprenticeship programmes available to all staff from Level 2-7 qualifications • Effective approach to supporting attendance to reduce sickness absence levels. • Updated Resourcing Plan required and no clinical workforce plan in place • Lead Employer progression • Internal transfer principles to be explored • Core mandatory & essential skills training programmes in place • Clinical Education Review undertaken • Bespoke and tailored support provided to newly recruited international colleagues. • Essential skills training action plan in place to drive compliance and reviewed monthly. • Early identification of junior doctor rota gaps and proactive block booking to address. • Alignment of job planning rounds to business planning cycle • E-rostering system fully utilised across all clinical departments at the Trust		11. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		~~**January 2023 Update:** further guidance being prepared to support with the introduction of self rostering.~~ **June 2023 Update:** Continuing work to align processes with STHK to ensure consistency and equity. 4. ~~Each CBU to have an improvement trajectory for planned reduction in sickness absence and progress to be monitored through monthly PIDA.~~ **June 2023 Update** – sickness is reducing month on month and at a 2-year low. Work will continue to prevent absence and support staff back to work. 5. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust ~~**March 2023 Update:** post re-advertised with no interest, looking at a different specialty for post~~ **June 2023 Update:** meeting arranged with Edge Hill in July to explore the possibility of further posts across the Trust 6. ~~Internal transfer principles to be explored. There is no easy ability for staff to move without a full application process. T&F group established mid-October 2021 to assess need for transfer SOP with potential qualifying criteria to be determined.~~ ~~**March 2023 Update**: with senior nursing team for launch locally.~~ **April 2023 Update –** action completed, and all requests are considered as they are submitted 7. Clinical Education Risk 2424 – Failure to meet the outcomes of the HEE Quality Framework & supporting governance structure & processes **June 2023 update:** Clinical Education review on hold in view of StHK/SOHT future collaboration. Clinical Education risk rating reduced from High 12 to High 8 (Dec 2022) following improvements implemented by the Clinical Education Teams that meet the outcomes of the HEE Quality Framework Standards. Risk monitored via HR Governance. 8. PDR action plan in place to drive improved compliance ~~over the summer 2022 period (typical trend for reduced compliance)~~ and progress monitored monthly. ~~**March 23 update** – performance remained static in month despite significant attention from Exec, senior managers and HR~~

The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To be the employer of choice in Merseyside and Lancashire				
AVERSE	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels to secure successful outcomes and meaningful reward/return.

Risk Description: If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Strategic Objective 5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

RISK ID	**5**	**Risk Description**	**If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted**

Inherent Risk			**Risk as at June 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours: leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s);	• Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan • Trust SCOPE Values • Trust values and behaviours embedded in the employee life cycle • Our Equality, Diversity, and Inclusion Plan in place to deliver Trust's mission and objectives • Equality, diversity, and inclusion networks in place • Just and learning principles embedded at the Trust, particularly in processes for raising/investigating concerns and lessons learned • Freedom to speak up guardian • Joint negotiating committee (JNC) • Staff Stories presented to Workforce Committee • Access to NHS Leadership Academy Programmes & 360 feedback, and internal leadership and management development programmes available • Mandatory and role specific training programme in place • Quality PDR discussions to promote positive behaviours • Apprenticeship programmes leadership & management offer Levels 3-7 • Board role modelling and visibility through: a. Executive Back to the Floor sessions. b. Non-Executive Board to Ward visits c. Staff Voice Partnership quarterly activities including Exec Pop Ups and Team Talks. • Embedding Values and Behaviours in Induction and PDR processes. • 'Foundations of leadership programme	1. Limited alignment of values to key stages in employee life cycle 2. Low participation in staff networks 3. Team development interventions are on hold currently due to expensive and resource intensive 4. No talent management/succession planning frameworks in place 5. Low visibility of leadership team reported in recent Staff Survey 6. Pause of Board Development sessions due to COVID-19. 7. No Board Development programme in place for the year	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group oversees the Transformational Leadership programme outlined in Our People Plan 3. Valuing Our People Inclusion Group oversees the culture and staff engagement programmes outlined in Our People Plan. 4. EDI Special Interest Group 5. Quality and Safety Committee 6. Clinical Effectiveness Committee 7. Finance, Performance, and Investment Committee. 8. Risk and Compliance Group. 9. Clinical Effectiveness committee. 10. Remunerations and Nominations Committee. 11. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 12. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training. ○ PDR completion. ○ Sickness rates. 2. Turnover. 3. Vacancies. 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey	1. Staff Survey Engagement score remains below national average. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address poor engagement with equality, diversity, and inclusion networks.	1. EDI Board development programme agreed to promote and embed inclusive leadership practices at a senior level. ~~**March 2023 update:** Programme paused in view of StHK/SOHT future collaboration so that activities can be aligned. EDI Training Programme in place for all staff until Q2 2023.~~ **June 2023 update:** Programme paused in view of StHK/SOHT future collaboration. EDS 2022 Domain 3 Inclusive Leadership (Board & Senior Leaders) under consideration of how to improve this year's outcomes. S&O staff accessing STHK's EDI training programme. 2. Talent management/succession planning framework, participation in the Workforce Improvement Group. **June 2023 update:** Awaiting launch of NHS Leadership Academy Scope for Growth TM Model – to work in conjunction with StHK L&OD colleagues to implement. Further measures in progress: Nursing Career Pathway developed. Operations Career Pathway & Framework in Development. MSW Career Framework in progress with HEE / place-based Colleagues. Core Leadership Development Offer in place: - https://bit.ly/3YQVNkR 3. People Plan programmes monitored by the Valuing Our People Inclusion Group (VOPIG). ~~**March 2023 update:** Staff Voice Partnership phase 3 in progress Jan to June 2023 to increase Board visibility – work in progress to align to StHK model(s). EDI action plan in place to promote EDI agenda.~~ **June 2023 update:** Staff Voice Partnership paused at the end of June 2023 to align with STHK's listening plan. Key People Plan deliverables continue to be discussed at VOPIG. 4. The Trust is reviewing its corporate induction messages to embed the Trust's SCOPE

reputational damage; loss of public confidence.	• PDR Improvement Plan monitored though PIDA and the valuing our people inclusion. • A reciprocal arrangement in place through the Mediation Network accessed by the Trust on a case-by-case basis where appropriate. • The Trust has 7 trained Schwartz Round facilitators as well as access to a further 3 as part of Sefton Place partnership. • EDI strategic objectives for 2022-24 established • Just and Learning principles established and aligned to employee relations and incident management processes		7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education Northwest 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		Values to engender compassionate & inclusive behaviours for new starters. ~~**March 2023 update:** A second revision to the Trust's Warm Welcome has been undertaken with a clear focus on the SCOPE values & the inclusive agenda. Launch of a new online induction programme delayed due to collaboration with StHK. Induction will be reviewed as the new organisation & values/behaviours framework forms.~~ **June 2023 update:** Values based corporate induction in place and delivered monthly. **Complete**
The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Cheshire & Merseyside

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire			**Assurance Committee:** Trust Board **Executive Lead:** Director of Transformation (CEO)
RISK ID	**6**	**Risk Description**	**If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population.**

Inherent Risk			**Risk as at June 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	5	**20**	3	5	**15**	2	5	**10**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population. **CAUSE** • Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire • Lack of system-wide workforce planning to address reduction in supply of suitably skilled and experienced staff. • Emerging Cheshire & Mersey Integrated Care Board (ICB) wide acute provider partnership approach • Complex health economy • Lack of clarity about additional investment to address sustainability challenges • Lack of public and staff engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** • Clinical unsustainability due to current and projected workforce gaps. • Failure to deliver safe, high quality patient care and	• Whole system engagement to address the required whole system change • SCT Programme Plan including key milestones to enable public consultation • Robust system governance structure in place to support the Shaping Care Together (SCT) programme a. Programme Board b. Operational delivery groups c. Clinical Leaders Group • Strategic partnership (ALTC) established with StHK • Comprehensive trust service assessment completed to establish levels of fragility and core drivers • Member of Sefton Integrated Care Partnership (ICP) • Member of the Cheshire & Merseyside Acute Provider Collaborative • Patient and Public Engagement strategy for SCT programme • Comprehensive due diligence completed, and documentation library created • Quality and equality impact assessments completed and reviewed in advance of any changes to Trust service provision • System Equality Impact Assessment process established	1. Clear alignment between Shaping Care Together programme, System Management Board & Sefton Partnership 2. Sefton Borough is still developing plans for the Place. These have been delayed whilst the ICB plans develop further 3. Lack of established Patient & Public Reference Group 4. Expected outcomes and opportunities of partnership with StHK are still being explored for some service areas. 5. Identification of other key stakeholders for clinical services partnerships where StHK is not appropriate and needs to link into Place and Provider Collaborative discussions which are still at early stages. 6. Shaping Care Together programme is yet to secure capital and define preferred option 7. Clinical workforce strategy not fully developed. 8. Risks relating to current estates and	**LEVEL 1** (Operational Management) 10. CBU FP&I (Monthly, Performance, Improvement, Delivery and Assurance (PIDA) Boards (Quarterly), with suite of measures 11. Ongoing review and management of 'fragile services' 12. Collaboration Senior Team Meetings (StHK & S&O Trust) reviewing immediate priorities and opportunities. 13. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board 14. Patient and public engagement strategy monitored at Programme Board 15. Equality Impact Assessment outcomes monitored at SCT programme board. 16. Ophthalmology Improvement Group – partnership meeting to develop and monitor system improvement plan 17. North Mersey Stroke Board – partnership board to develop and implement case for change, engagement & operational plans 18. Therapies Assurance Group – partnership meeting to monitor the improvement delivery 19. Trust attending Cheshire and Merseyside Acute Provider clinical pathway collaboration meetings 20. Finance and Capital Assurance Group **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Fragile Services reports to SOC and Board 2. Integrated Performance Report (IPR) to SOC and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: o Mortality o Incident data o CQUINS o Operational performance data	Development of good working relationships with the new Primary Care Networks/Place Boards ICB 23/24 Operational plan – final due 30 Mar 2023 HCP developing Joint Forward Plan – final due June 2023	1. SCT Programme to develop Models of Care and define preferred option. ~~**March 23 Update:** Further engagement planned in Spring 2023; discussions ongoing regarding future state of the programme~~ **June 2023 Update** – Meetings have continued with planning to re-energise the programme once the transaction has been completed, so the two issues are not conflated 2. Continue to develop collaboration opportunities with StHK ~~**March 23 Update:** Post Implementation strategic plans in development~~ **June 2023 Update** – post transaction transition and integration plan has been agreed 3. ~~Ophthalmology clinical working group established to support clinical workforce recruitment challenges.~~ ~~**March 23 Update:** STHK & S&O integration planning continues. Ophthalmology bid for North Mersey Hub funding to support service development.~~ 4. Continue to support Sefton Partnership Board with the development of priorities. High-level draft has now been produced by Sefton Partnership Delivery Group and expected to finalised by Autumn 2022 **March 23 Update:** HCP developing Joint Forward Plan which will support place plans 5. North Mersey Ophthalmology Steering group in place supported by ~~local CCGs~~ ICB ~~**March 23 Update:** Group in place, data pack in production and will support development of North Mersey Hub bid.~~ **June 2023 Update:** £6.7m capital bid submitted June 2023 for Southport (off site) HVLC hub with Ormskirk refurbishment to

	experience in the most appropriate environment • Financial unsustainability due to increased costs • Poor estate utilisation due to inability to fully reconfigure services • Failure to provide acute core services to our population • Potential impact on neighbouring organisations if core acute services can no longer be delivered by the Trust • Reliance on other acute providers to support the delivery of clinical services • Reputational damage	• Cheshire and Merseyside Integrated Care System governance structure • North Mersey Stroke Pathway implemented.	infrastructure continues to be defined within the SCT Programme (this includes the wider system) 9. Places are still defining their commissioning and transformation priorities for 22/23	○ Complaints and compliments 3. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group 4. Sustainability and collaboration update to Strategy and Operations Committee 5. Quarterly Joint Performance Meeting (NHSE, StHK and S&O) 6. LUHFT & S&O Partnership Board **LEVEL 3** (Independent/Semi-Independent) 1. Participation in the C&M ICS leadership and programme boards 2. Active member of Sefton Partnership Attend the monthly Sefton Partnership Board 3. Active Member of the Cheshire & Merseyside Acute Provider Collaborative & supporting transformation/improvement work stream 4. Active member of the Cheshire and Merseyside Independent Sector working group 5. Collaborative working with Place to develop commissioning and transformation priorities for 22/23 – ~~draft priorities agreed and expected to be finalised Autumn 2022~~ 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. Internal Audit 10. External Audit		support opening referrals and new pathways to include cataracts, glaucoma, and AMD. 6. Continue to develop Liverpool University Hospitals FT relationship with a particular focus on the SLAs already in place. ~~**March 23 Update:** Partnership Board being scheduled for April 2023, collaboration continues.~~ **June 2023 Update:** Partnership board have not met this year due to senior leadership changes in LUFT. Areas of concern being picked up via both COO's. Expected to be re-established Q2 2023/24.
	.					
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To provide sustainable services for the patients we serve					
Category	**AVERSE**	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

TRUST BOARD

Paper No: MWLTB (23)015

Title of paper: STHK Learning from Deaths Quarterly Report July 2023

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.

Summary:

Number of reviews carried out Q3 2022/23

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
*October**	31 **(20)**	10	1	0	0	0
November	30	17	7	6	0	0
December	37 **(1)**	19	10	6	1	0

Number of reviews carried out Q4 2022/23

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
January	37 **(1)**	20	11	5	0	0
February	19 **(8)**	6	3	2	0	0
March	47 **(28)**	12	2	5	0	0

* *delayed reporting subject to an alternative process to assist in retrospective catch up*

Corporate objectives met or risks addressed: 5 Star patient care: Care, Safety, Communication

Financial implications: None arising from this report

Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners
Recommendation(s): To approve the report, policy and good practice guide
Presenting officer: Dr Peter Williams – Medical Director
Date of meeting: 26th July 2023

1 EXECUTIVE SUMMARY

"Learning from deaths of people in our care can help us improve the quality of the care we provide to patients and their families and identify where we could do more" NHSI 2017.

In Quarter 3 2022/23

Although October was subject to delayed reporting, November and December were fully allocated to reviewers, and there is only one outstanding review from November and December.

To date the combined quarter has 98 cases reported, 46 are green, 18 green with learning, 12 green with positive feedback and 1 amber case.

In Quarter 4 2022/23

All cases have been allocated, although the March cases have only been allocated in the last couple of weeks, which is reflected in the number of cases still awaiting review.

To date the combined quarter has 103 cases reported, 38 are green, 16 green with learning, 12 green with positive feedback and 0 amber cases.

1.1. Shared learning

Adopting a "comfort first" approach	**Management of the delirious patient**
There have been some excellent examples of end-of-life care in recent months, particularly in frail older patients who may benefit from a "comfort first" approach. In frail patients with a limited life expectancy, carefully consider the burdens of treatment as well as the benefits. Communication with the patient and their family is vitally important to establish patient wishes.	Delirium can be challenging to manage, particularly in the patient with an underlying dementia diagnosis. The delirium bundle can be found on the trust intranet. Further advice can be sought by contacting Marie Honey, Nurse Consultant for Older People, psychiatry liaison team or referring to the Department of Medicine for Older People for specialist advice.

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

1.2 Sharing and embedding learning

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

2 IMPACT OF LEARNING FROM DEATHS PROCESS

The Deteriorating Patient Team originated through Mortality Reviews of multiple MET calls, poor parent team decision making & planning and specialist teams working in silo for the same patients. They first started working together in Dec 2020.

HSJ Awards for Patient Safety
The team was delighted to have been shortlisted for HSJ Patient Safety Awards 2023, with the panel to be held later this month and the awards ceremony held in September 2023.

Category: Quality Improvement Initiative of the Year
Project Title: Deteriorating Patient Improvement Programme
Organisation Name: Mersey and West Lancashire Teaching Hospitals NHS Trust

3 CONCLUSION AND RECOMMENDATIONS

The Board is asked to note the contents of this report and receive assurance that:

- Learning from Deaths is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised. (Appendix 2)
- Where concerns have been identified these have received further peer review and escalated as appropriate.
- The new SJR process has now been distributed to all reviewers, initial assurance has been provided that concerns are detected and reported. We will continue to monitor its reliability and provide the appropriate assurance once we have 12 months of data (April 2024).

Appendix 1

Total Deaths in Scope[1]

Check	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'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List'[5] **'Alert Death'[5]**	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
Random Sample, include all low risk deaths[6] **'Sample Deaths'**	SJR
Cardiac Arrests that result in death[7] **'Cardiac Arrest Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths; include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.
6. Random sample to ensure monthly we cover at n30 or 25% whichever is the greater
7. Cardiac Arrests calls that result in death

Appendix 2

Forum/Communication Channel	Chair	Support
Quality Committee	Rani Thind	Joanne Newton
Finance & Performance	Jeff Kozer	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	Elspeth Worthington	Jane Bennett
MCG Integrated Governance & Quality Meetings	Ash Bassi/Debbie Stanway	Joy Woosey
MCG Directorate Meetings	Debbie Stanway	Joy Woosey
SCG Governance Meetings	Tracy Greenwood/Wendy Harris	Gina Friar
SCG Directorate Meetings	Phil Nee	Julie Rigby
CSS Directorate Meetings	Caroline Dawn / Stephen Beckett	Sam Barr
ED Teaching	Ragit Varia/Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Brenda Longworth	
Grand Rounds	Brenda Longworth	

Title of Meeting	Trust Board	Date	26th July 2023
Agenda Item	MWLTB (23)016	FOI Exempt	NO
Report Title	S&O LEARNING FROM DEATHS (LFD) QUARTER 4 REPORT (2022/23)		
Executive Lead	Dr Kate Clark Executive Medical Director		
Lead Officer	Dr Chris Goddard Associate Medical Director (AMD) for Patient Safety		
Action Required	☐ To Approve ✓ To Assure	✓ To Note ☐ To Receive	

Purpose

To Inform the Board of the learning and improvement driven by the analysis of mortality in the reporting period.

Executive Summary

- Headline figures remain stable, but elevated disease specific SMR for renal failure presentations to be evaluated.
- No avoidable deaths identified.
- 16 SJRs in Q4 – overall positive results.
- Learning presented around End of Life care, sepsis, networked care, failed discharge, the deteriorating patient, radiology discrepancies and transfers of care.
- The purpose of this learning is to influence individual clinical decision making, operational and strategic decisions for the improvement of patient care.

Recommendations

The Board is asked to note the Q4 Learning From Deaths Report for assurance.

Previously Considered By:

☐ Strategy and Operations Committee	☐ Executive Committee
☐ Finance, Performance & Investment Committee	✓ Quality & Safety Committee
☐ Remuneration & Nominations Committee	☐ Workforce Committee
☐ Charitable Funds Committee	☐ Audit Committee

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ☐ **SO3** Efficiently and productively provide care within agreed financial limits
- ☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Dr Chris Goddard, AMD for Patient Safety	

Learning From Deaths

Quarter 4 2022-23

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Centre

Contributors

Medical Examiners Office

- Dr Annie Leigh
- Dr Ciara Cruise
- Dr John Kirby
- Dr Michael Vangikar
- Dr Paddy McDonald
- Dr Sudakar Kandasamy
- Dr Preethi Narla
- Dr Mairi Reid
- Dr Sarah Parkinson
- Dr Jayne Wilkinson
- Mandy Power
- Deborah Marshall
- Andrea Foster

SJR Reviewers

- Emma Roney
- Janette Mills

Integrated Governance

- Pete Gale

Claims and Inquests

- Sam Seagraves

Audit / M&M / Governance

- Audit and Effectiveness Department
  - General Surgery
  - Orthopaedics
  - Urology
- Emergency Medicine PSM
- Anaesthetic Governance Meeting

Informatics

- Mike Lightfoot

Compiled By

- Dr Chris Goddard

Shared At

Corporate

- Clinical Effectiveness Committee
- Membership of Medical Leadership Team

Medical

- Departmental Governance / Audit / M&M

Nursing

- Ward Manager & Senior Nurse Meeting

AHP

- AHP Governance Meeting

Doctors in Training

- Foundation Training Programme

Southport and Ormskirk Hospital
NHS Trust

Key national and local mortality indicators

	2021/22	2022/23											Target
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Rolling 12 Month HSMR	75.5	76.0	76.2	75.9	75.1	75.5	76.0	79.1	79.2	78.1			100.0
Monthly HSMR	74.3	79.4	75.0	60.4	70.1	94.0	83.7	92.2	66.7	74.2			100.0
SHMI	102.6	102.4	101.0	101.9	100.9	100.1	100.4	101.9	102.2				100.0
Local HSMR Bronchitis	46.4	54.3	54.5	55.5	65.4	60.7	68.7	71.5	72.1	72.2			100.0
Local HSMR LRTI	54.4	54.7	55.0	59.8	66.8	76.7	51.1	57.2	72.7	73.8			100.0
Local HSMR Pneumonia	81.0	82.1	82.8	82.1	79.5	78.5	75.9	83.0	87.0	90.9			100.0
Local HSMR Septicemia	76.9	76.7	77.3	75.9	77.0	77.6	78.7	77.2	75.7	73.1			100.0
Local HSMR Stroke	79.4	80.9	83.9	84.1	82.8	82.7	84.9	82.8	86.1	83.5			100.0
Local HSMR UTI	53.6	50.0	43.7	39.9	30.3	25.6	23.9	29.3	30.1	30.8			100.0
Local HSMR Acute Renal Failure	79.0	83.0	84.4	81.2	86.7	87.5	91.1	103.8	99.5	107.7			100.0
Local HSMR FNOF	75.8	85.8	84.7	81.0	71.3	58.3	62.6	61.9	50.6	46.2			100.0
Mortality Screens - %	97.33%	97.47%	98.44%	100.00%	96.72%	97.44%	97.65%	97.37%	95.92%	98.70%	98.06%	93.55%	90.00%
SJRs		5.0		1.0		8.0	2.0	3.0		2.0		3.0	0.0
2nd Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
In Hospital Deaths	75.0	79.0	64.0	55.0	62.0	78.0	85.0	76.0	49.0	76.0	104.0	62.0	77.0
In Hospital Deaths Crude Rate	28.7	31.6	20.4	22.5	25.1	34.0	31.1	23.9	24.8	32.6	33.7	29.1	31.0
LD Deaths	0.0	0.0	0.0	0.0	5.0	1.0	1.0	1.0	2.0	0.0	2.0	4.0	1.0
Sickness Absence Medics	4.25%	3.01%	2.47%	3.24%	4.41%	3.34%	3.75%	3.86%	3.44%	4.06%	3.56%	3.66%	1.00%

Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

- Rolling headline figures remain settled.
- As previously reported, the SMR for patients presenting to hospital with a primary diagnosis of renal failure is rising. This has now triggered for a condition review which is ongoing and will be reported to MOG.
- LD deaths continue to be elevated above the historical norms. As yet, no care-related contributors have been found. It is believed that this may represent improved identification and recognition of LD. The situation will be monitored.

Avoidable deaths Quarter 4 2022-23

Concluded investigations in Quarter 4 have not identified any avoidable deaths or deaths which are felt to be more likely than not to be due to problems in healthcare.

SJR Quarter 4 2022-23

16 SJRs were completed in Q4

Avoidability of death rating as follows:
Definitely not avoidable: **16**

Reason for SJR:
Cardiac arrest reviews: **13**
Medical Examiner Referrals: **1**
Learning Disability Reviews: **2**

Problems in Healthcare Identified:
Yes: **1** (lack of proforma completion)
No **15**

Overall Care Rating:
Excellent: **8**
Good: **4**
Adequate: **3**
Poor: **1**

Quarter 3 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Incident Investigation, Claims and Inquests, Departmental Patient Safety/Audit/Mortality & Morbidity Meetings

End of Life Care

Communication is key when delivering end of life care; this is an area which is frequently discussed both in terms of good practice, and as an area that can be improved.

Instances were reported in Q4 were relatives felt unprepared for what they were going to see, leading to distress. Whilst distress is not always avoidable, it is good practice to describe how patients may appear, especially in the event of a change in condition, if it is an initial visit or if patients are in critical care.

CPR is a medical treatment and cannot be demanded if it will not be effective or is not in a patients best interests.

In complex cases the use of specialist resources such as the Learning Disability Specialist Nurse or the Specialist Palliative Care Team can aid good care and treatment

Quarter 3 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Incident Investigation, Claims and Inquests, Departmental Patient Safety / Audit Meetings

Sepsis

Good initial sepsis care, particularly IV antibiotics within 60 minutes of diagnosis has been demonstrated.

Deterioration subsequent to this is not uncommon and sepsis contributes to a large number of hospital deaths. Reviews should be regular after initial treatment to identify this.

Treatment escalation should be defined in advance so this can be actioned when and if required. The Treatment Escalation Proforma is designed to facilitate this.

Frequently sepsis occurs in patients with overwhelming co-morbidity. Relatives sometimes report feeling that the bigger picture has been lost and that treatment can appear overly aggressive without benefit to the patient. Involving patients and relatives in care will help identify these situations.

Quarter 3 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Incident Investigation Claims and Inquests, Departmental Patient Safety/Audit Meetings

Regional Networks of Care

Decisions to transfer patients for urgent specialist intervention can be complex. This has been highlighted in some cases of patients presenting with suspected ST elevation myocardial infarction. One patient deteriorated and died whilst awaiting ambulance transfer for PPCI. Early discussion with LHCH is advocated.

If concerns are identified regarding access then these should be incident reported for investigation and on-going quality improvement.

Failed Discharge / Frailty

Failed discharge (readmission shortly after going home) is the most frequent issue reported this quarter. This is most commonly in the frail, elderly population.

This is often associated with the acquisition of infection including Covid-19 and Flu in de-conditioned patients.

Quarter 3 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Incident Investigation Claims and Inquests, Departmental Patient Safety/Audit Meetings

Admission to hospital will not improve functional capacity – this often worsens deconditioning.

Identification of frailty, recurrent hospital admissions and the impact that has on life expectancy is important and should open up conversations about what matters most to patients and escalation decisions.

Radiology Discrepancies

There is a process for reporting discrepancies to be investigated. If it is believed that a radiology test has been reported incorrectly, this should be reported on Datix.

The test will be reviewed and duty of candour followed as necessary by radiology following this review.

Quarter 3 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Incident Investigation Claims and Inquests, Departmental Patient Safety/Audit Meetings

Deteriorating Patient

In the event of unanticipated deterioration of a patient it is crucial to make an accurate diagnosis to allow prompt treatment. Early CT scanning and involvement of other specialties is often associated with making this diagnosis promptly.

Acute confusion is often a sign of significant illness in previously orientated patients. In vitalpac this should be recorded as ‘alert/confused’ not ‘alert’ as this can be misleading.

Relative hypotension (a blood pressure which is ‘normal’ but ‘low for the patient’) can be a sign of developing significant illness and should be identified and managed.

Quarter 3 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Incident Investigation Claims and Inquests, Departmental Patient Safety/Audit Meetings

Shared Care / Transfers of Care

Transfers of patients across boundaries of clinical responsibility are times of increased risk.

- A patient moved from orthopaedics to a covid ward due to a positive surveillance swab without a handover of care led to delayed initiation of treatment.
- A patient had their Thyroxine stopped and was discharged with an instruction for repeat TFTs in the community. They re-presented to hospital some time later with myxoedema and died.
- Transferring patients requiring high flow oxygen is hazardous. Sometimes the act of moving can be enough to decompensate to the point of cardiac arrest. This must be planned for and communicated to the receiving clinical area.

TRUST BOARD

Paper No: MWLTB 23 (017)
Subject: STHK Deep dive People Indicators Report for the period Jan 2023-June 2023
Purpose: This paper provides Trust Board with details of achievement of the delivery of the Trusts Workforce Strategy over the period January 2023 to June 2023. In addition to the monthly Trust board workforce updates, the paper provides a comprehensive update on the management and delivery of workforce matters and provides assurance on areas of progress
Summary: The Trust is committed to developing the organisational culture and supporting our workforce in line with our Trust objectives and in particular the commitments the Trust has made in terms of the NHS People Plan. This paper provides a comprehensive update on workforce activity and summarises achievements and progress to date aligned with the four pillars of the NHS People Plan.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: None at this time
Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues
Recommendation(s): The Trust Board is requested to note the content of the paper and receive assurance that actions are in place to ensure continued delivery of the Trusts Workforce Strategy
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Trust Board: Wednesday 26th July 2023

This report provides an updated position for People Indicators for the period 1st January 2023 to 30th June 2023.
The data and narrative reflect the commitments made in the Trust's People Strategy 2020 - 2025 and provides the Trust's Board with assurance on priority areas in line with the **four key pillars** from the National NHS People Plan Priorities as well as the Trust's Corporate Objectives. The four pillars are:

with quality health and wellbeing support for everyone;

with a particular focus on the discrimination that some people face;

capturing innovation, much of it led by our NHS people;

how we recruit, train and keep our people, and welcome back colleagues who want to return;

Summary – Strengths and Opportunities This Period

- **Re-accreditation of SEQOHS in March 2023 in** Occupational Health for the next 5 years, reflecting the high level of standards and the comprehensiveness of services provided by the Health Work and Wellbeing Department

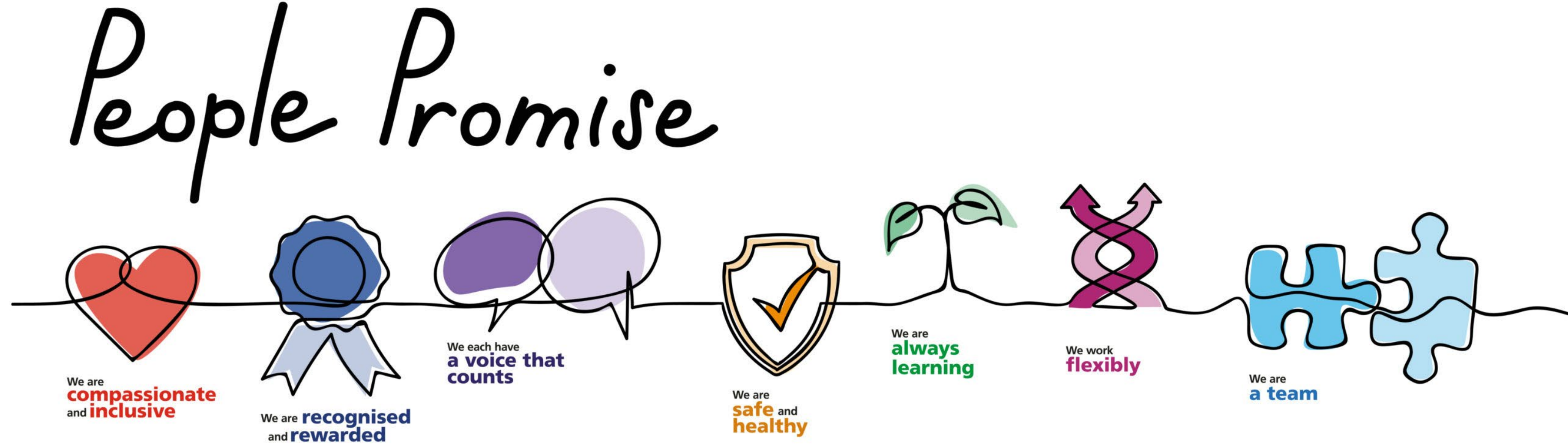
- The Trust has been shortlisted for a **HPMA Excellence in People Awards** for the Reasonable Adjustment Policy and Passport.

- Achieved the target of **85% appraisal compliance** in this reporting period
- We continue to focus on **improving our people practices**, closing more cases quicker – in the last six months 71 cases were closed compared to 58 cases in the six months to December 2022 and 40 in the six months before that. We have recently trained 25 new mediators, supporting our just and learning approach.
- Turnover has **decreased** this period, in January 2023 turnover was 15.07% and in June 2023 it is 14.04%.
- HWWB DNA performance **has improved by 2.0%** compared to the last reporting period (20%), now at 18% against a target of 9%, Targeted programmes are in progress to help continue to improve non attendance performance, with one key area identified around pre-employment assessments and the HCA and temporary workforce.
- **Flu vaccination campaign 2022/23** achieved an overall uptake of 74.40%
- STHK Health Care Academy has had huge success in streamlining both recruiting and onboarding process - reducing turnover of those within the first year of service.
- Wellbeing Hub activities have produced positive results, 99% of staff attending sessions have said they would recommend a event or session to a colleague.

Summary – Areas for improvement

- **Sickness absence**. Stress and anxiety remains a high reason for sickness absence, in common with many other Trusts regionally and nationally.
- A deep dive has been undertaken into sickness absence categorised as anxiety, stress and depression, to ensure we are supporting every member of staff suffering from anxiety, stress and/or depression. This data analysis has shown that home issues are the main reason for this absence as opposed to work issues/combination of home and work issues. Every member of staff in this category is having regular welfare meetings and have been referred to HWWB. To support staff, bespoke and tailored support to teams and individuals is offered across the organisation and trends are analysed in order to provide targeted support.
- Although **HWWB DNA rates** are slowly improving, more work needs to be done to move closer to the target of 9%. We are looking at those areas where the staff member has been unable to attend due to operational requirements and supporting the department to understand better the importance of staff access to HWWB services
- **Staff Vaccination Campaigns** – although the seasonal Influenza campaign for 2022/23 achieved an overall uptake of 74.40%, planning is beginning now to achieve an increased uptake in the new campaign for 2023/24. Never the less this compares favourably with the national uptake for flu vaccination of 49.9%.

Pillar 1 – Looking after our people – We are Safe and Healthy



This pillar focusses on the action we will take to keep our people safe, health and well. The relevant People Indicators for this pillar are:

- Occupational Health
- The Wellbeing Hub & Network Activity
- Sickness Absence Management & Support
- COVID-19 & Influenza

Pillar 1 – Looking after our people – We are Safe and Healthy

Areas of focus

- **The Wellbeing Hub** have delivered 168 sessions and events with an average attendance of 15 per session, when staff are asked ''how likely would you recommend a event or session to a colleague'' 99% of staff would recommend.
- Staff have accessed 1:1 support through our Mental Health Nurse/Counsellor and Psychologist with 531 appointments and 41% average improvement in wellbeing post assessment. This is measured and monitored through the wellbeing dashboard using clinical evidence based practice assessment outcome scores
- Planning is well underway for the **COVID-19 risk assessment** process removal at pre-employment, which will be replaced with a business as usual risk assessment process (July 2023)
- **Reducing DNA's in HWWB** continues to be an ongoing area of focus. DNA performance has improved by 2.0% compared to the last reporting period (20%), now at 18%. However this remains above target (9%). Targeted programmes are in progress for example with HCA's and the temporary workforce to help continue to improve non attendance performance,.
- **The Improving attendance programme** has seen a reduction in the overall sickness absence rate from 6.48% in January 2023 to 5.57% in June 2023. A month on month comparison between 2022 and 2023 rate show consistent reduction in absence rates ranging from 0.28 to 3.08%
- Staff members who are absent due to sickness are being supported with welfare meeting and HR/HWWB guidance. There is targeted support for those who are absent due to Anxiety/Stress/Depression and Other musculoskeletal problems as these are part of the top reasons for absence.

PILLAR 1 IN ACTION…

Supporting our people through health, wellbeing and fitness to work assessment continues to drive **sustained levels of activity and demand**. The HWWB service delivered 889 pre-employment clearances, 792 management referrals, and 5,247 appointments during this period which is >1.2% vs last reporting period for the Trust.

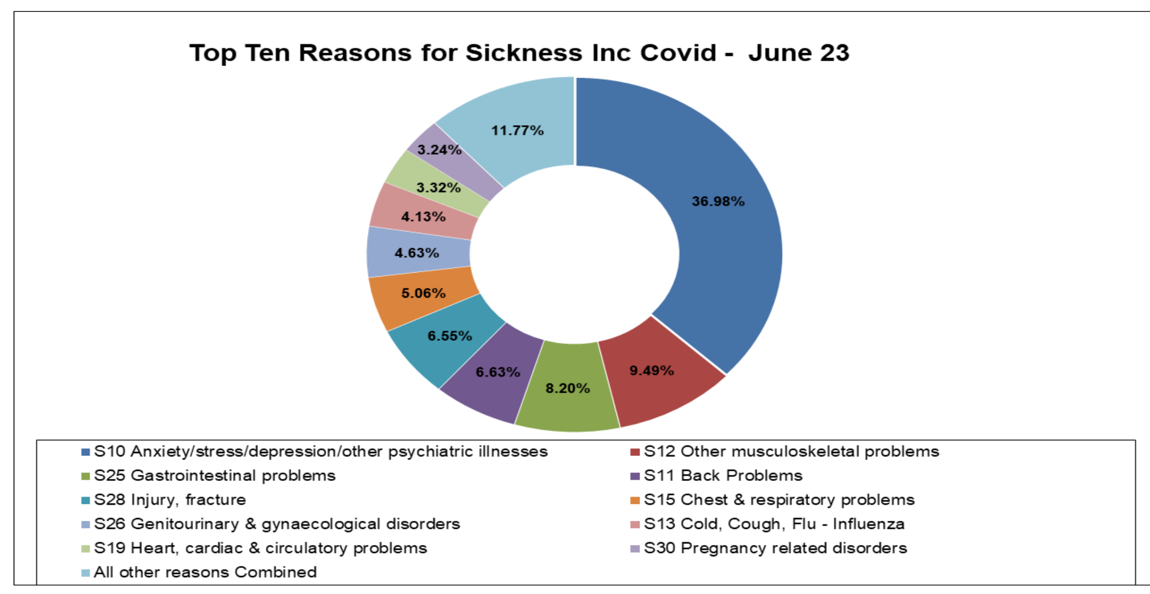
Progress To date

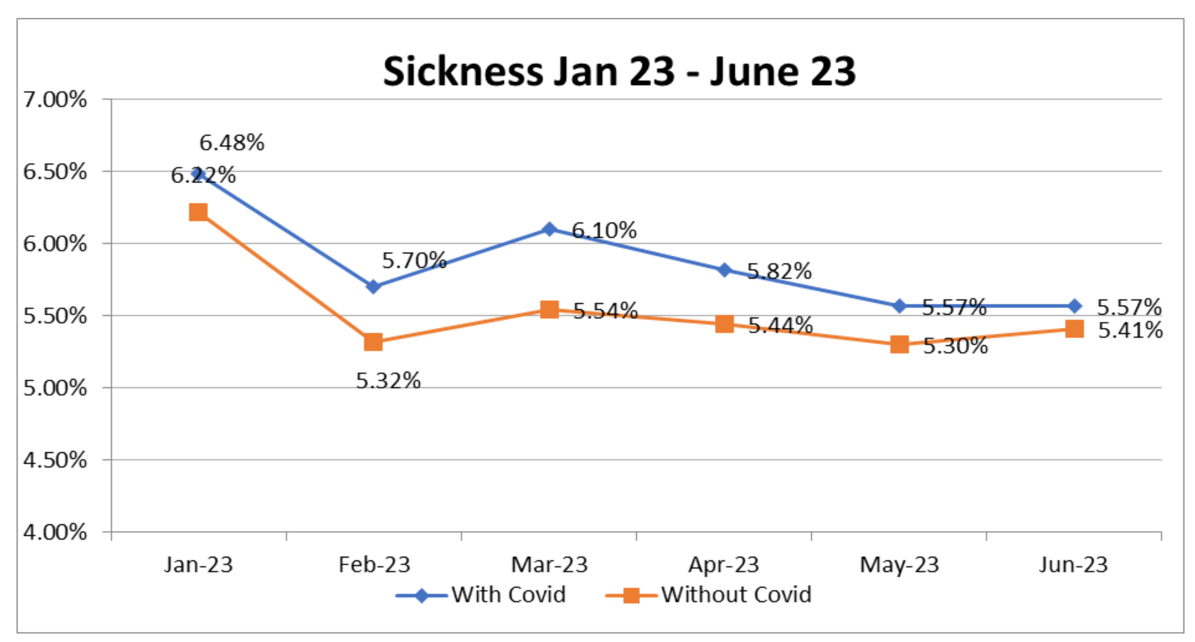
- **A Wellbeing Reporting Dashboard** has been developed to showcase the benefits of all staff health and wellbeing initiatives
- Staff networks supported by staff wellbeing champions continue to actively support the wellbeing of the workforce. For example the recruitment team have attended staff networks to understand barriers to recruiting and are formulating an action plan to address key areas.
- **COVID-19** The self-isolation Hub service for staff has officially ended as of the 31st March 2023, having supported over 10,000 referrals across 2 years.
- The Healthcare Worker COVID-19 Autumn booster campaign 2022/23 achieved an overall uptake of 42.66%, with no formal target set by the national directive.
- **MIAA Audit of the Attendance Management Policy and processes –** received the final report in March 2023 with Substantial Assurance, there was a good system of internal control designed to meet the system objectives, and controls were generally being applied consistently.

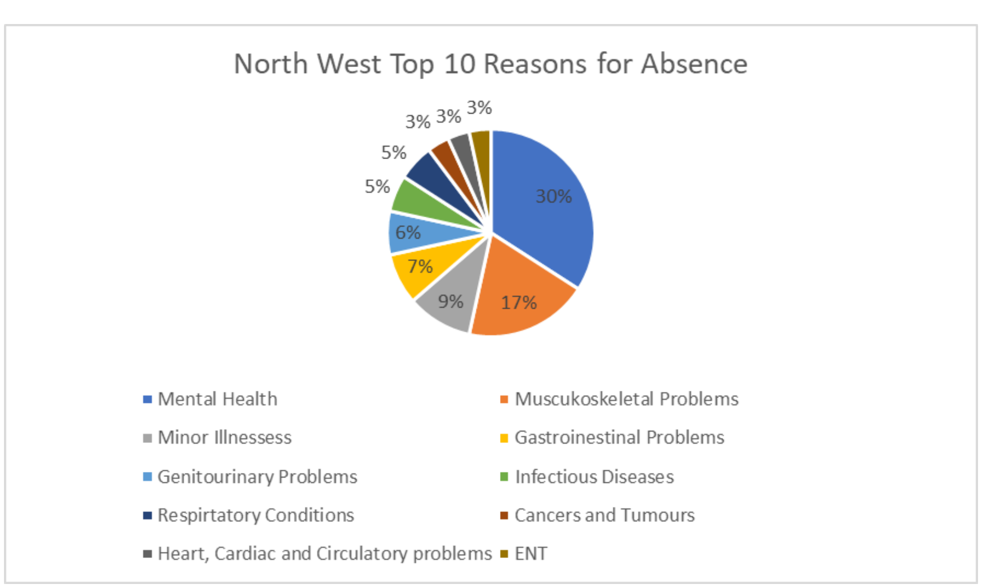
Areas of risk and mitigation

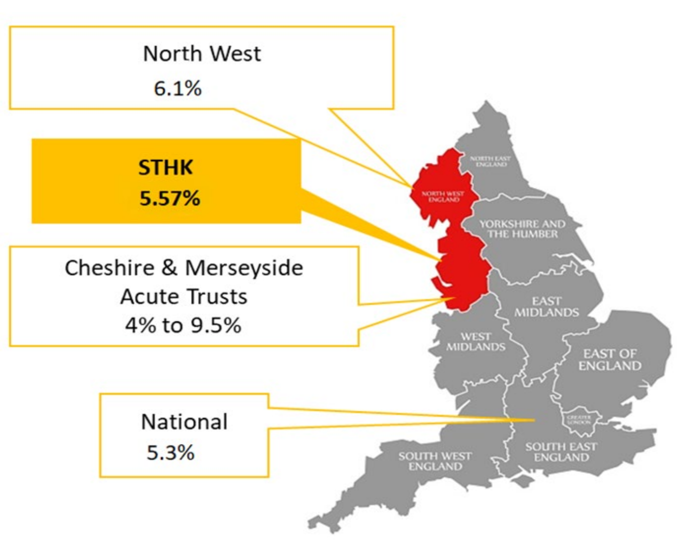
- The MIAA Audit identified two key risks which will be monitored:
  1. Appropriate completion and sign off of sickness absence documentation by managers and employees
  2. Reconciliation of ESR data with the information on the return to work forms.
- Mitigation includes undertaking internal audits to identify any areas requiring additional support, monitoring the paperwork as part of the Attendance Management Process and addressing these in the Attendance Management Training with managers

Pillar 1 – Looking after our people – Metrics and Activity



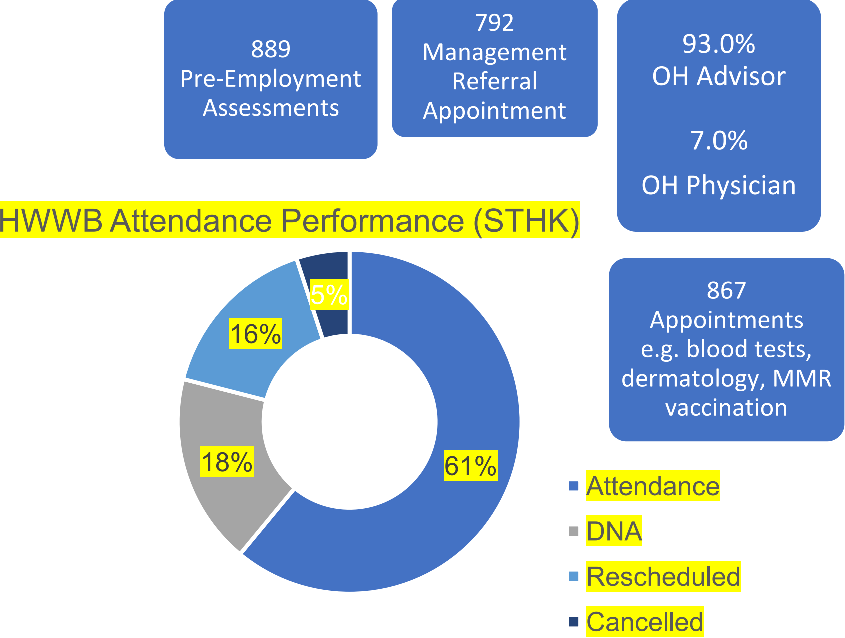






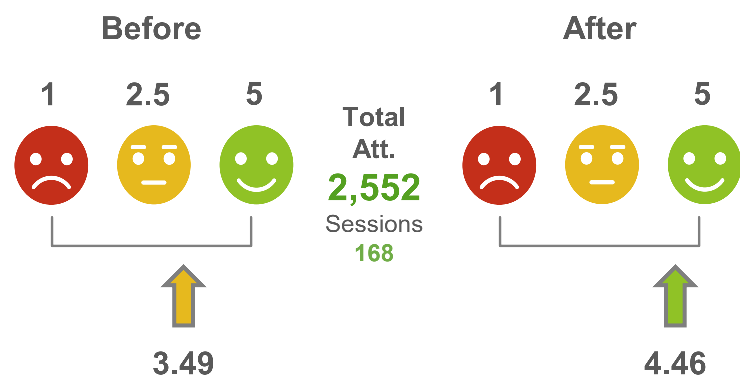
Comparator Sickness
As at April 23* (*Data taken from HEE e-product portal)
STHK benchmarking lower than Trusts within the North West

Pillar 1 – Looking after our people – Metrics and Activity



Wellbeing Hub Session or Event

How are you feeling before and after todays attendance



Wellbeing Dashboard – Key Improvements

April 2022 to March 2023

Sickness Performance:

- Long-Term Sickness Reduced 2021 vs 2022 by **<4.38%**
- Pregnancy Related Disorders Reduced by **<57%** from peak to latest reportable figure

Staff Survey:

- People Promise; ''We are Safe & Healthy'' **Best** in the Northwest & C&M
- Impact of staff Burnout **>5.88%** better than our National Comparators
- Organisation supporting staff health & Wellbeing improved by an average **>4.0%**

Psychological:

- Staff Health & Wellbeing improved by an average of **>40%**
- Staff accessing session/event attendance average **14.5,** 2021/22 vs 2022/23 **>114%**

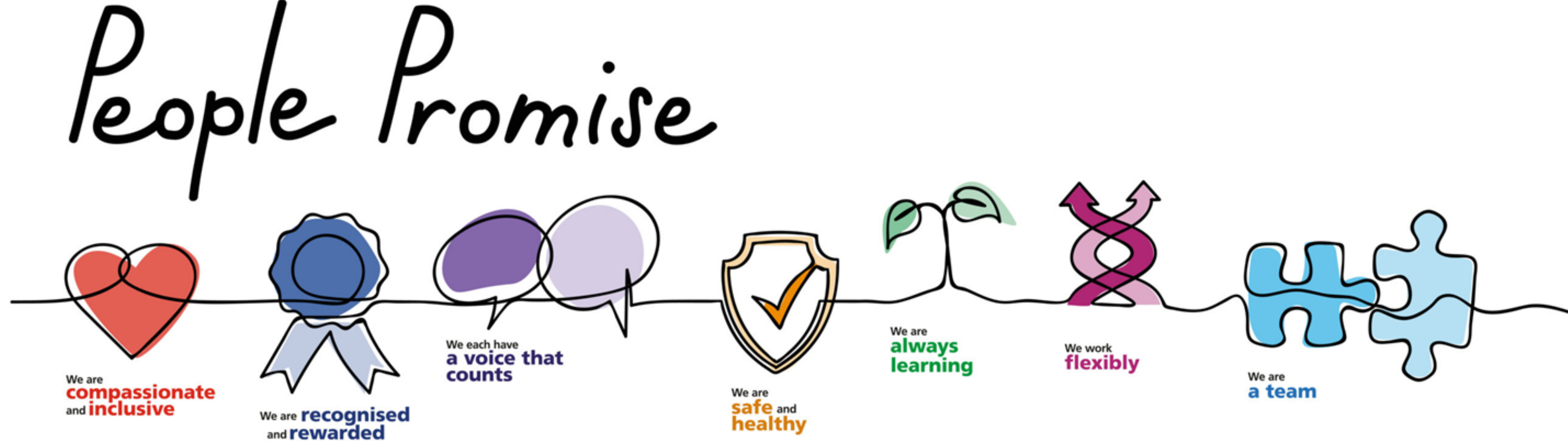
Influenza Vaccination Campaign:

- Trust 2022/2023 HCW uptake **>22%** greater than National average
- Achieved CQUIN Target 2022/23 (70-90%) **74%**

MSK conditions:

- Achieved **<62%** pain reduction and **>22%** increase in mobility post treatment on average

Pillar 2 – Belonging in the NHS



Belonging in the NHS highlights our delivery of actions to create an organisation whose culture makes our people feel they belong. The relevant People Indicators for this pillar are:

- Trust Workforce Profile
- Data on Employee Relations Cases
- WRES and WDES update
- Staff Survey

Pillar 2 – Belonging in the NHS

Areas of Focus

EDI Statutory and Regulatory Returns for 2023 have been completed:

- **Equality Delivery System 2023 Assessment: (EDS2)** assesses the Trust against patient, workforce and leadership criteria. The Trust continues to make improvements in a number of areas:

Goal	Outcom	2019	2021	2023
Better health outcomes	1.1	Achieving	Achieving	Achieving
	1.2	Achieving	Achieving	Achieving
	1.3	Achieving	Achieving	Achieving
	1.4	Achieving	Achieving	Achieving
	1.5	Achieving	Achieving	Excelling
Improved patient access and experience	2.1	Achieving	Achieving	Achieving
	2.2	Achieving	Achieving	Achieving
	2.3	Achieving	Achieving	Achieving
	2.4	Achieving	Achieving	Excelling
A representative and supported workforce	3.1	Achieving	Achieving	Achieving
	3.2	Excelling	Excelling	Excelling
	3.3	Developing	Achieving	Achieving
	3.4	Achieving	Achieving	Developing
	3.5	Achieving	Achieving	Achieving
	3.6	Excelling	Excelling	Excelling
Inclusive leadership	4.1	Achieving	Achieving	Developing
	4.2	Achieving	Achieving	Developing
	4.3	Achieving	Achieving	Achieving

WRES and WDES – production of an action plan against benchmarking data when available, in line with WRES and WDES timelines.

Workforce Race Equality Standard (WRES) indicators:

- 13% Trust staff are BAME, including 45% of Clinical Medical & Dental staff
- The Trust continues to have a underrepresentation of BAME staff on Non-Clinical Bands 8c and above; and Clinical Non-Medical Bands 8d and above
- White applicants are more likely to be successful in recruitment
- BAME staff, particularly Black staff report higher levels of dissatisfaction than White staff; and higher levels of harassment and discrimination

Workforce Disability Equality Standard (WDES) indicators:

- The number and proportion of known disabled staff has increased, although there are no known disabled staff on Bands 8b and above.
- Disabled staff are reporting significantly higher levels of dissatisfaction in the staff survey compared to non-disabled staff.

PILLAR 2 IN ACTION…

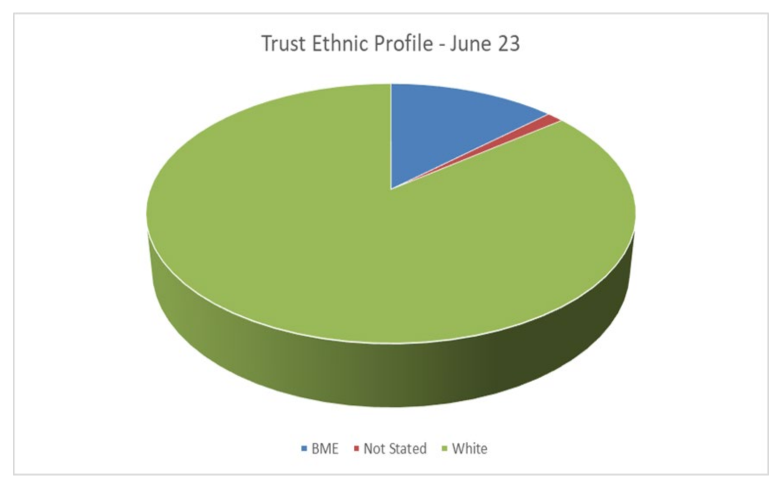
The Trust has been shortlisted for a HPMA Excellence in People Awards for the **Reasonable Adjustment Policy and Passport.**

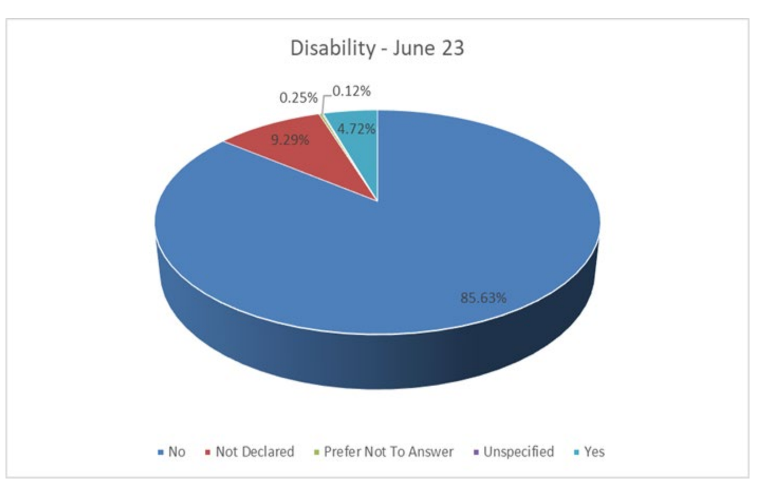
Progress to date

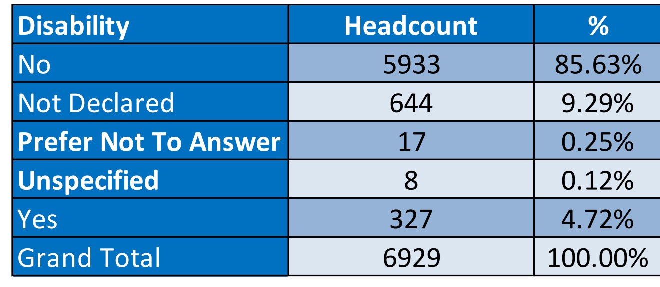
- Staff survey had a 40% response rate. Action plans are implemented for the relevant areas and being driven by each Care Group/ Directorate, with overview of progress by the Staff Survey Operational Group. L&OD team are providing targeted support to Theatres and Maternity.
- Achieved the 85% target for staff appraisals by the end of the window closing. As the appraisal window reopens from April to September, we are now at 78% compliance. The medic appraisal compliance as at June 2023 is 95.4%
- Celebrating EDI: The Trust launched a EDI events calendar covering 2023-2024 identifying key dates and events to mark, including gold and silver events which have been selected on a priority basis in collaboration with the staff equality networks. The most recent gold event was Pride Month (June 2023) and the next upcoming event is planned to be Black History Month (October 2023).
- Key activities have included the first EDI Festival which included a week of activities; LGBT History Month, Deaf Awareness Week and Carers Week.

Areas of risk and mitigation

- **Staff ED&I Competency** was raised as a risk last period as surveys and feedback indicated a need for additional ED&I competence training and development. A gap analysis took place to and in response to that we have now launched nine new in-person training courses for line managers, key recruiters and decision makers. The aim to increase the knowledge and capacity of leaders/managers. Training topics includes disability reasonable adjustments; equality impact assessments; and unconscious bias.

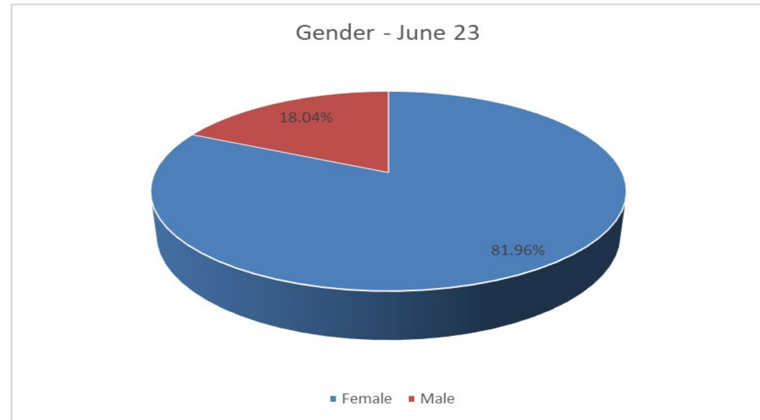




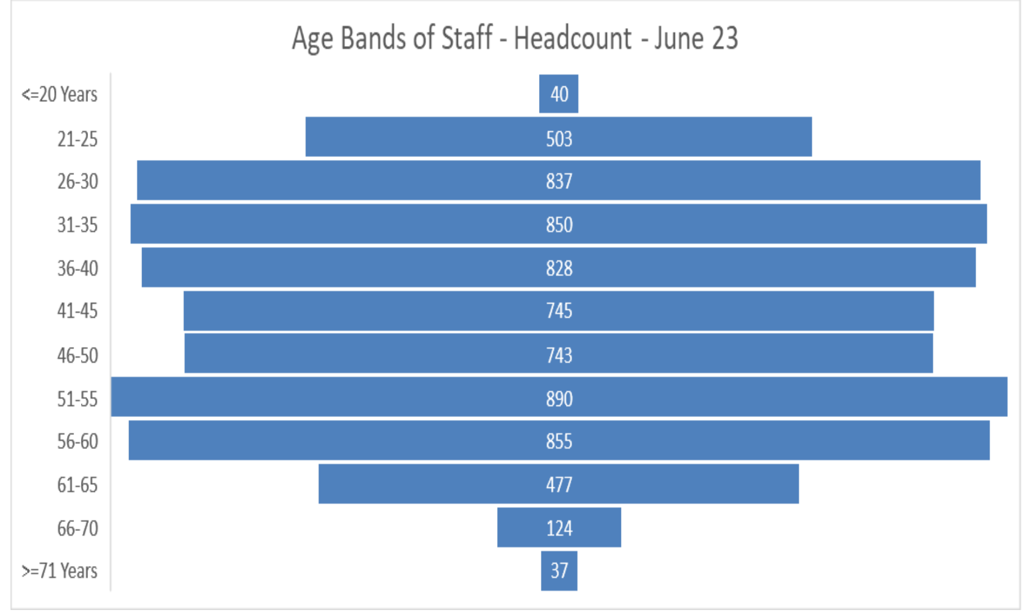


Disability	Headcount	%
No	5933	85.63%
Not Declared	644	9.29%
Prefer Not To Answer	17	0.25%
Unspecified	8	0.12%
Yes	327	4.72%
Grand Total	6929	100.00%

Supporting Disabled Staff: Work continues to increase the disability disclosure rate and ensure staff and managers are aware of the support available, and the reasonable adjustment passport. Online banners are encouraging staff to disclose in ESR; the disability information on the webpages has been developed; and training is continuing for line managers.



Gender	Headcount	%	FTE
Female	5679	81.96%	4892.81
Male	1250	18.04%	1182.73
Grand Total	6929	100.00%	6075.55



Pillar 2 – Belonging in the NHS – Employee Relations Metrics

Improving People Practices

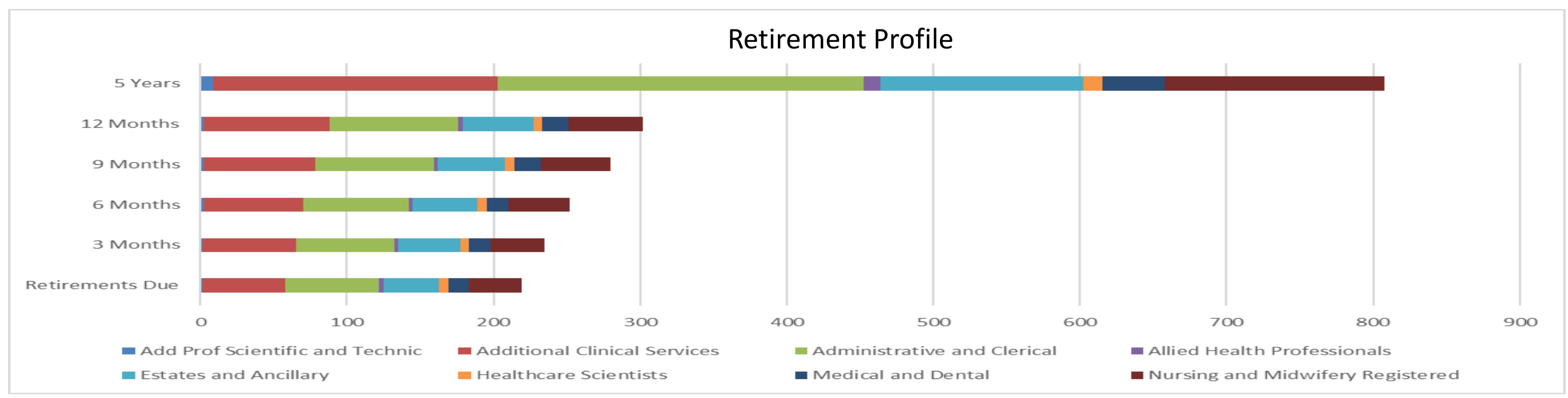
- During this period, 71 cases were closed compared to 58 cases in the previous period making full utilisation of the fast track process
- The Operational HR team deliver bite-sized training to managers, utilising recurring meetings already scheduled e.g., the Nursing Professional Standards meetings.
- We have recently trained 25 new mediators who are completing the final requirements to become qualified. This will support our just and learning approach.

Current Cases - June 2023

Case Category	Medical Care Group	Surgical Care Group	Clinical and Support Services	Corp, CSSG, Medirest ROE	Medical	Total
Disciplinary	3	0	0	0	0	3
Employment Tribunals	1	0	0	0	1	2
Fast Tracks	0	0	1	0	0	1
Grievances	1	1	1	4	0	7
Investigations	7	2	0	2	2	13
Respect and Dignity at Work	4	0	0	0	1	5
Overall Total	16	3	2	6	4	31

Closed Cases	July - December 2022	January – June 2023
County Court Cases	0	0
Disciplinary	6	7
Employment Tribunals	0	3
Fast Tracks	9	17
Grievances	19	25
Investigations	16	16
Respect and Dignity at Work	8	3
Total	58	71

Pillar 2 – Belonging in the NHS – Retirement Workforce Profile



Staff Group	Retirement Profile	3 Months	6 Months	9 Months	12 Months	5 Years
Add Prof Scientific and Technic	1	1	2	2	2	9
Additional Clinical Services	57	64	68	76	86	194
Administrative and Clerical	64	67	72	81	88	249
Allied Health Professionals	3	3	3	3	3	12
Estates and Ancillary	38	42	44	46	48	138
Healthcare Scientists	6	6	6	6	6	13
Medical and Dental	14	15	15	18	18	43
Nursing and Midwifery Registered	36	37	42	48	51	150
Grand Total	**219**	**235**	**252**	**280**	**302**	**808**

Pillar 2 – Belonging in the NHS

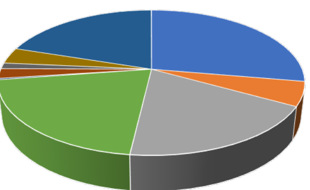
Top 8 most popular apprenticeships (live and completed) since the programme started in 2017

Most popular apprenticeships	Jun-23
Nursing Associate L5	53
Senior Healthcare Support Worker L3	28
Senior Leader L7	28
Business Administration L3	27
Healthcare Science Practitioner L6	25
Registered Nurse L6	18
Team Leader / Supervisor L3	11
Payroll Administration L3	10

Growing apprenticeships: the Trust continues to offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles. In this reporting period four new apprenticeships started that had not been used before. The Trust continues to:

- Increase the range of apprenticeships available to our staff, working with staff and providers to identify and promote new courses.
- New apprenticeships are always in development nationally by employers and training providers.
- Increasing use of apprenticeships to support Advanced Clinical Practice places.
- Working with recruitment and corporate teams to introduce apprenticeships as an entry to the Trust, particularly in HCA and nursing roles, linking the nursing career progression to the apprenticeship offer
- Successful engagement activities during National Apprenticeship Week in February 2023

Levy Spend Jan-June 2023



Levy spend data January to June 2023:

Levy Paid	£701,745
Levy Spent (not including Transfer)	£312,779
Transferred	£20,486
Expired	£272,993

Levy Activity

- Apprenticeship activity at June 2023 shows a continuing increase in the number of live apprenticeships across the Trust – there are currently 169 apprentices with 192 completed and 33 in the application process.
- The groups with the highest level of apprenticeship activity this period are Clinical Support Services , Surgical Care Group, Medical Care Group and HR Directorate

Pillar 3 – New ways of working and delivering care – making the most of the skills we have

New ways of working include innovation, change and our ability to make effective use of our people's skills. The relevant People Indicators for this pillar, focus on:

- Effective use of our workforce skills, learning and experiences, enabling us to work differently in the future
- Innovation and horizon scanning - planning for the future in our service areas
- Developing the skills and knowledge of our people for the future
- Ensuring our people practice safely

Pillar 3 – New ways of working and delivering care

Areas of Focus

- **Band 2-5 Workforce Modernisation** – supporting corporate nursing to undertake a clinical model review of the band 2-5 nursing workforce, including Health Care Assistants (HCA), Trainee Nursing Associates (TNA), Nursing Associates (NA) and Registered Nurses (RN).
- **Widening Participation** – the STHK Health Care Academy continues to support delivery of training for new HCAs to the Trust. This includes the St Helens Place Skills Academy Health & Social Care Project on Entry to Health and Social Care Careers. Events continue to be organised with Health and Social Care colleagues from across St Helens, Knowsley and Halton supported by the Clinical Education department.
- **Anaesthetic Associates (AA's) -** Two AA's commenced their training in March 2023 and the Trust is now preparing a bid for a further two for next years cohort of AA trainees
- Submission and monitoring of the Operational Workforce Plan to the IBC covering workforce growth predictions for 2023/24
- **Roster Improvement** – Supporting nursing to have improved ways of rostering.
- Maximising full use of Safecare software.
- Work underway to recruit to roles agreed as part of the successful Clinical Diagnostics Centre (CDC) business case which includes endoscopy, cardio-respiratory, radiology and pathology pathways
- Work continues to develop and implement Collaborative Staff Banks, building on the success of the NW Doctors in Training Bank.

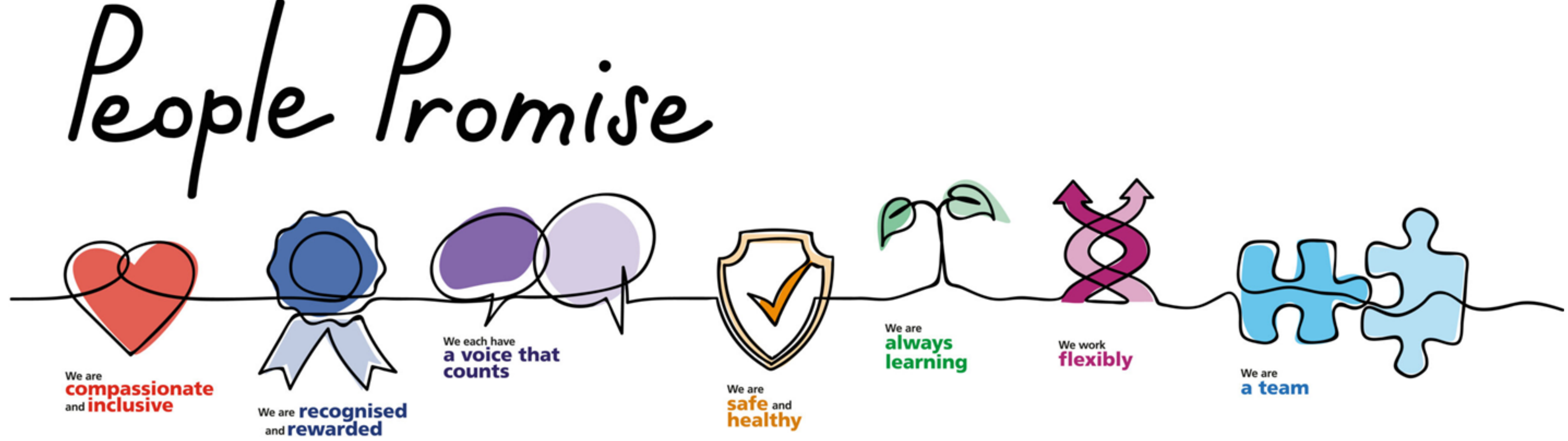
Progress to date

- **ACPs –** we have been successful in bidding for a further 14 trainee ACP places with Health Education England. These roles are in ICU, ED, AMU, Paediatrics and Obs & Gynae. Recruitment to the roles is underway for individuals to start their training in September 2023.
- **STHK Health Care Academy** continues to be a success in streamlining the recruiting and onboarding process - reducing turnover of those within the first year of service. Feedback remains very positive showing a marked increase in knowledge and skills prior to commencing on their first clinical shifts
- 35% reduction in the number of HCAs leaving the Trust in 2022/23 compared to 2021/22 and three times as many members of staff utilising the internal transfer scheme
- **National Care Certificate** compliance and completions continues to rise across all ward areas. This has been as a consequence of ward based visits from clinical education to support new starters and colleagues in completing healthcare modules whilst in practice.
- The redesign of the preceptorship course and recruitment of 6 WTE **Preceptorship Champions** was completed in January 23. Initial feedback of the role is positive:
    - The team received the Cavell Star Award in May 23 based on the excellent feedback. Cavell Star Awards are given for the delivery of exceptional care to colleagues, patients and patients families.
    - In March 23 the Trust received the Quality Standards Accreditation Award for the preceptorship course.
    - Commencement of the Pre- Preceptorship course for third year nurse students started in May 23
- **e learning materials** are under review to increase flexibility of access and minimise time commitment for all staff groups and new subjects are under development such as safeguarding

Risk and Mitigation

- **Safecare Training -** Supporting with a relaunch of Safecare the rostering team have offered system training. An e-learning package for Acuity training is being developed. Policy is being reviewed to support any changes to process for nursing rostering. Appropriate coding of additional shift and bank reasons completed for accurate monitoring and reporting.
- **National Care Certificate Completion Rates** – a large number of staff continue to miss the 12 week deadline for completing the care certificate following deployment. This is mainly due to the completion rates for Trust mandatory training as per policy. The new Clinical Education Support Tutor has started in post. Their role is to support HCSWs whilst in practice, liaise with and support ward managers with HCSWs who are non-compliant and support the completion of the National Care certificate within the set 12 week timeframe.

Pillar 4 – Growing for the future, recruiting, retaining and attracting people



The relevant People Indicators for this pillar focus on:

- Staff retention – including turnover, workforce stability and leavers
- Staff movement – including the Internal Transfer Scheme and planning for potential retirements
- Temporary workforce – including recruitment of bank staff
- Recruitment Activity – including international recruitment

Pillar 4 – Growing for the future, recruiting, retaining and attracting people

Areas of Focus

- Average of 41.98 days for time to hire for all staff groups - this has reduced gradually since January 23 due to a weekly focus on KPIs and areas being escalated to review.
- Design and delivery of **TRAC training** to support managers to get the most from the system– to enable timelier processes and improved candidate experience.
- **Recruiting new to care HCAs** – focussing on monthly recruitment events, staff transfer Scheme and HCA Academy.
- **Band 5 Recruitment** – reduced to 70.91fte from 124fte in January 2023. Local recruitment campaigns have continued and we have recruited 66 Nurses and 14 Midwives since the start of the year. There are 35 newly qualified nurses due to commence in the Trust in September 2023. Attendance at local university career fairs will continue into the summer months and targeted engagement with student nurses on placement with the Trust in the last 12 weeks of their final year will be undertaken.
- **Temporary workforce -** an additional 162 workers were on-boarded to the bank in the last 6 months including 83 HCAs. Due to the significant reduction in nursing vacancies, there is no longer the requirement for the RN support pool which will contribute to the NHSEI target of a 3.7% reduction in use of agency staff within the year.

Progress to date

- **International Recruitment** – target of 50 international nurses set for this year. 9 arrived on 29th May with 21 in the pipeline. We are working with NHSP to recruit further numbers for the rest of the year. In addition, 2 Radiographers and 3 Midwives have been recruited and on-boarded to the Trust since January.
- **Band 5 retention –** 46fte nurses left in this reporting period compared to 70fte in the last period. 10.6fte out of 46fte had less than 12 months service. To address this going forward the Team are contacting all RNs in their notice period and have met with several newly qualified staff to access support via Heads of Nursing and the Preceptorship team.
- Retention overall is increasing, demonstrating he benefit following recruitment of 7 WTE preceptorship Champions and our redesigned preceptorship course which commenced January 2023.
- **Staff transfer scheme** – 4 RNs and 8 HCAs have transferred since January 2023. There are 14 staff on the waiting list pending moves, including 4 RNs and 5 HCAs. Promotion of the staff transfer scheme via team brief live and to staff in their notice period to try to retain them where possible is on-going.
- **Supporting and educating our managers on recruitment processes –** 49 managers have been trained since January (86 in total) with sessions scheduled for the rest of the year. Uptake and attendance is monitored via our recruitment system. All new managers are signposted to undertake this training via the L&D manager induction session. Such sessions have helped decrease our time to hire and 100% of managers would recommend to their peers.
- **HCA Vacancy gap –** has increased from end of year at 65.99fte to 90.71fte. Budgeted establishment has increased by 13fte. There is a strong pipeline of HCAs with 33 in offer stage and 160 invited to interview.
- The STHK **Health Care Academy** has resulted in a 65% reduction in the number of HCAs leaving within six months of starting.

Risk and Mitigation

- The Trust continues to use bank and agency to fill **temporary workforce**. Nursing vacancies have reduced significantly and this is reflected in the reduced numbers of support pool RNs per shift (reduced from 5 to 2) required. However, there continues to be a significant requirement for supplementary care HCAs and for that reason support pool HCAs. Rolling recruitment for HCAs is underway and the impact of the HCA academy is decreasing leavers.
- **50 international nurses are to be recruited for 2023/24** – rotations for last year's international nurses have been brought forward to accommodate support and placements for this year's nurses.

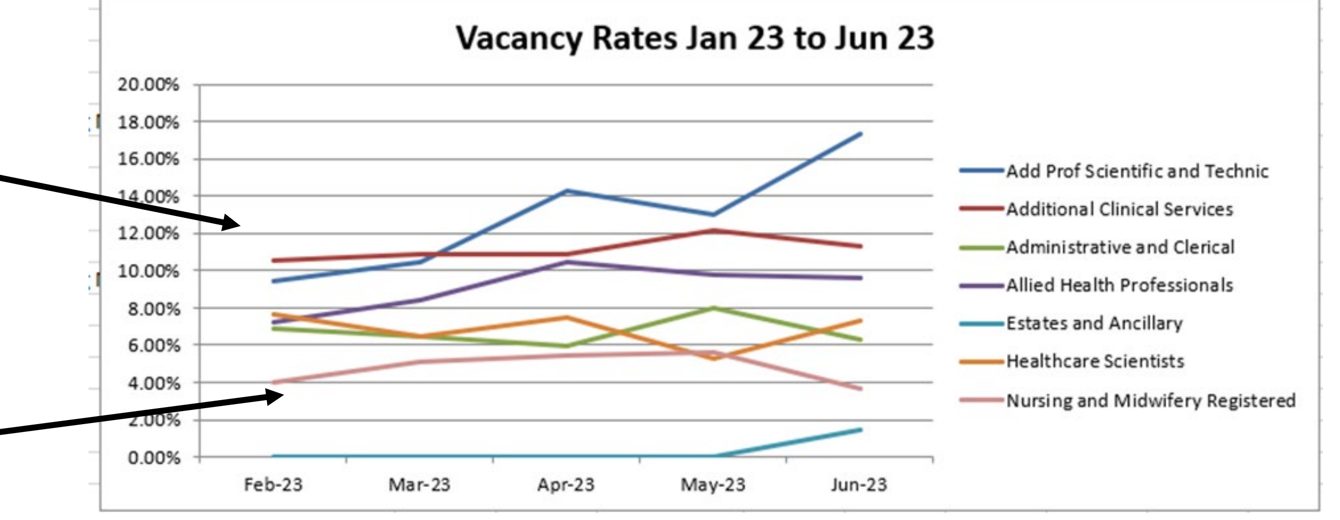
January – June 2023

Focus on Time to Hire: average of 41.98 days for January to June 2023.
Benchmark: In Q4, STHK ranked 20 out of 182 trusts for time to shortlist and 65th out of 182 for pre-employment checks to be complete. For the last quarter, the Trust benchmarked 46/177 Trusts for time to shortlist and 51/177 for checks to be completed.
Candidate experience of recruitment process: 4.88 out of 5
Manager experience of recruitment process: 4.58 out of 5

Increase in overall Trust vacancy rate from 5.97% to 6.84% - due to budget establishment increase of 45fte

Turnover has decreased by 1% since January 2023 (15.07% in January compared to 14.04% in June 2023)

Band 5 RN Vacancies have reduced significantly from 11.61% in January to 2.71% in June 2023.
Overall nursing vacancy rate has decreased from 7.87% to 4.3% from January to June.



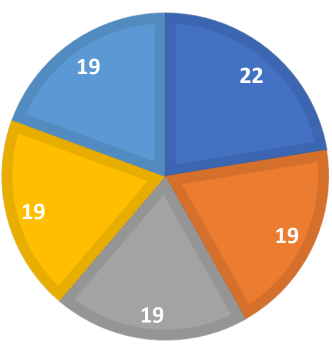
Pillar 4 – Growing for the future – "Leaving Well"

- A task & finish group has been created that has finalised a **new leaver e-form** that will help to collate further information on reasons why staff are leaving the organisation and help to retain them whilst in their notice period. The e-form is in production with expected completion timeframes to be confirmed this month.
- **Exit questionnaires** – Of 326 leavers sent the questionnaire, 56 responded to the exit questionnaire- (17% response rate). **76% would consider working for the Trust again and 75% would recommend the Trust as a place to work.** Those who did not receive one were due to sensitive cases e.g. palliative condition or they had not provided the Trust with a personal email address. This information is shared with the HRBP Team who share an overview at Finance and Performance Quarterly Care Group Meetings and these results inform specific retention strategies e.g. staff transfer scheme, flexible working initiatives, development of career pathways, increasing awareness of apprenticeships. Where specific issues are flagged relating to certain departments, this is picked up via our Recruitment and Retention Manager, the relevant Dept / Ward Manager and designated HRBP.

305 statements selected overall 98/390 – Top 5 statements

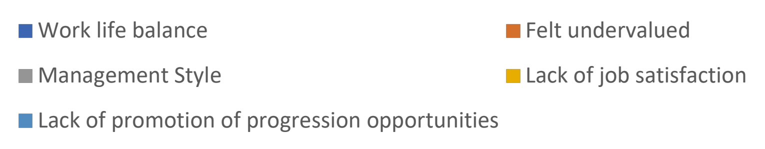
TOP 5 STATEMENTS ABOUT THE TRUST

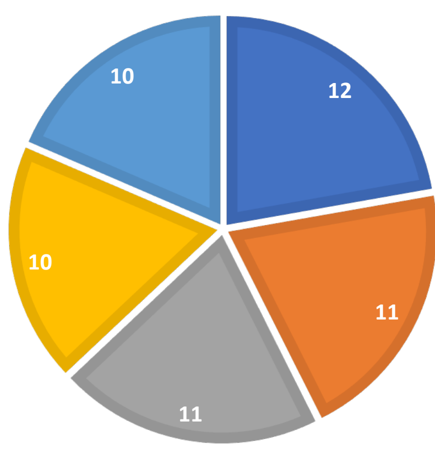
- Team Brief was regularly communicated to the team
- I have always been involved in decisions that affect me in my area of work
- The Trust has encouraged me to learn and develop
- I have regularly discussed my objectives and performance with my line manager
- My duties were clearly defined



124 statements selected overall 54/124 – Top 5 Statements

TOP 5 STATEMENTS: REASONS FOR LEAVING





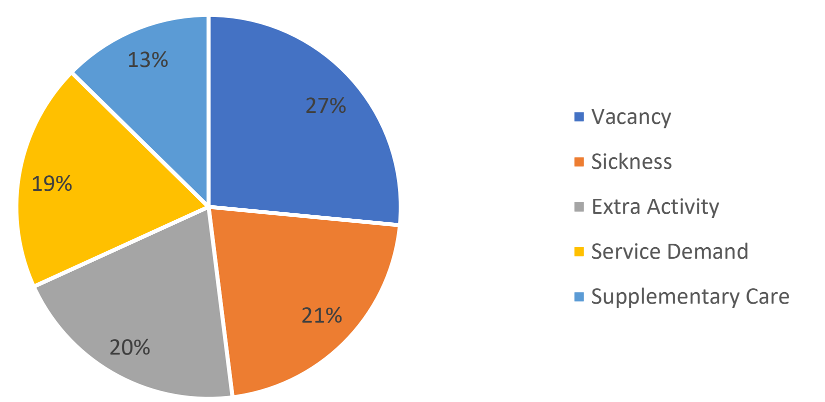
Pillar 4 – Growing for the future, recruiting, retaining and attracting people

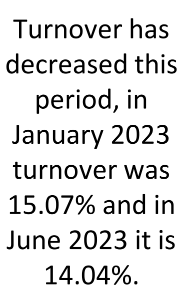
Temporary Workforce Shift Data – January to June 2023

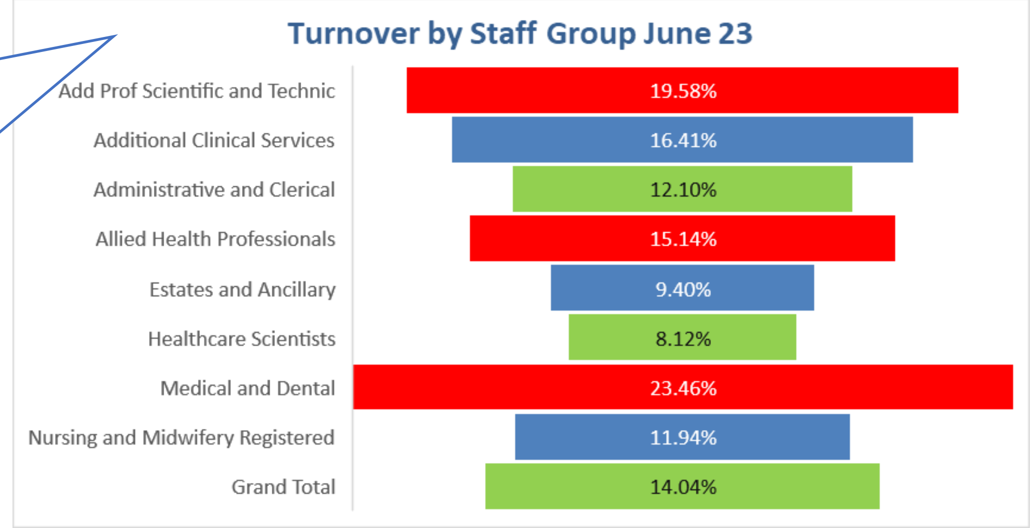
	Shifts requested	Shifts filled	Shift fill rate %	Bank fill	Agency fill	Unfilled
Jan-23	13875	9993	72%	7216	2777	3882
Feb-23	12561	9394	75%	6987	2407	3167
Mar-23	15209	10688	70%	7693	2995	4521
Apr-23	12498	9050	72%	6504	2546	3448
May-23	13250	9970	75%	7185	2785	3280
Jun-23	14077	10387	74%	7545	2842	3690

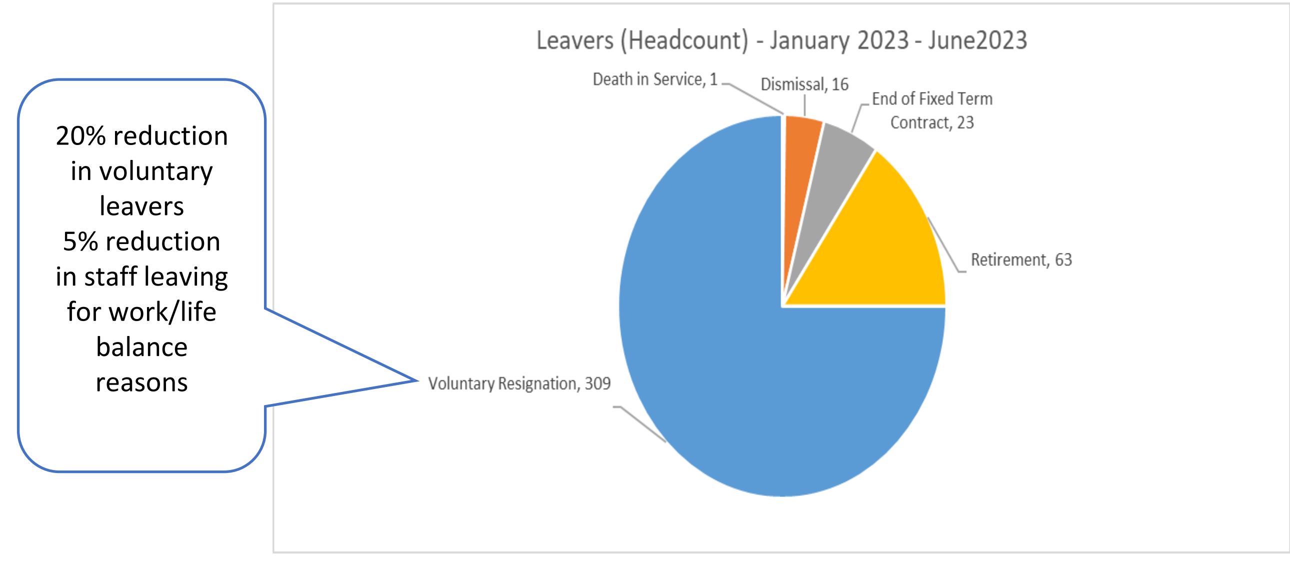
81470 shifts were requested during the period with 73% of these being filled. Of those shifts filled the split between bank and agency was 72.5% (bank) and 27.5% (agency).

The request reasons for bank and agency during the period were as follows:









TRUST BOARD

Paper No: MWLTB (23)018a
Title of paper: Information Governance Annual Report (including Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Teaching Hospitals Trust had an effective Information Governance Agenda and Framework in place
Summary: This Report is designed to inform and give assurance to the Board of progress made against the Information Governance (IG) work programme for 2022-23. IG is a framework that not only provides a consistent way for staff to deal with the many different information handling requirements but brings together all of the requirements, standards and best practice that apply to the handling of information, specifically information that contains personal confidential information, now referred to as personal data. IG has four fundamental aims: • To support the provision of high-quality care by promoting the effective and appropriate use of information in a secure manner • To encourage staff to work closely together, preventing duplication of effort and enabling more efficient use of resources • To develop an information management structure to provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards • To enable organisations to understand their own performance and manage improvement in a systematic and effective way St Helens and Knowsley Hospitals NHS Trust (STHK) had a duty to ensure that it complied with its legal and regulatory obligations, for IG this is data protection legislation, more specifically the UK GDPR and Data Protection Act 2018. STHK was committed to conducting frequent reviews and improvements of its services; this included Information Governance (IG). This report details the progress that was made against the Information Governance work programme for 2022-23 and provides a 'year ahead' programme of work on areas that are necessary to achieve IG compliancy and to further embed IG within the new Trust 'Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL)'.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: *None directly from this report.*
Stakeholders: *Staff, Patients, Executive Committee, Trust Board and Commissioners.*

Recommendation(s): • The Trust Board to be assured that robust arrangements were in place to effectively manage the Information Governance Agenda within STHK and these arrangements will be further embedded within MWL. • The Trust Board to approve the contents of this report.
Presenting officer Christine Walters, Director of Informatics/SIRO
Date of meeting: 26th July, 2023

Introduction

The NHS Information Governance Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. This Framework allowed STHK to ensure that all personal, sensitive and confidential data was handled legally, securely, efficiently and effectively. Information Governance (IG) is an ongoing process which covers many different areas including records management, data quality, legislative compliance, risk management and information security.

STHK had a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), the Freedom of Information Act 2000 (FOIA 2000), and to meet Information Governance (IG) / Information Security / NHS specifications and requirements mainly relating to the National Data Guardians Data Security Standards and other related legislation, guidance and contractual responsibilities to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

STHK had its own IG strategy which set out the approach it took in developing and implementing a robust Information Governance Framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further supported the IG work including the Records Management Policy and Procedure, Confidentiality Code of Conduct Policy, Data Security & Protection Breaches / Incident Reporting Policy and Procedure, Freedom of Information Policy, Data Protection Impact Procedure, Data Quality Policy. All of which were made available to staff via the STHK intranet.

STHK completed and submitted the Data Security and Protection Toolkit (DSPT) on an annual basis. The DSPT enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. To provide assurance that STHK's DSPT was of a good standard it was audited by Mersey Internal Audit Agency. For 2022-23 STHK received the rating of Substantial Assurance.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2022-23.

This section will provide assurance, from the SIRO, that STHK:

- Had a sufficient framework in place to ensure compliance with all elements of the Information Governance Agenda
- Had an active and effective Information Governance Steering Group forum, meeting regularly
- Managed and investigated any Information Governance / Confidentiality incidents and issues

Roles and Responsibilities

The Role of the SIRO

Christine Walters, Director of Informatics, was STHK's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

A SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to a Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the organisation's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within a Trust and advise the Board on the effectiveness of information risk management across a Trust.

The SIRO has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The focus of the DSPT is on setting standards and providing tools to achieve them. The SIRO authorises the DSPT Self-Assessment annual submissions once the relevant assurances have been provided by the Information Governance and IT Security teams. The data security standards provide assurance across ten areas.

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection

10 Accountable Suppliers

Christine Walters will be the SIRO for MWL.

The Role of the Caldicott Guardian

Mr Alex Benson was STHK's registered Caldicott Guardian. Mr Benson was tasked with ensuring that the personal information about those who use its services was used legally, ethically and appropriately, and that confidentiality was maintained. Mr Benson provided leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader information governance agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that all NHS organisations achieve the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance to the Trust Board that the Caldicott Guardian function within STHK operated at a satisfactory level and that it was appropriately supported within the existing Information Governance structure.

STHK's Caldicott Guardian was supported by STHK's Director of Informatics in her role as Senior Information Risk Owner (SIRO) and STHK's Head of Information Governance & Data Protection Officer and her team.

Alex Benson will be the Caldicott Guardian for MWL and will be supported by MWL's Director of Informatics as SIRO and MWL's Head of Information Governance / Data Protection Officer and her team.

Data Protection Officer

Camilla Bhondoo was STHK's Data Protection Officer. New to Data Protection legislation under the UK General Data Protection Regulation 2018 (UK GDPR) are Data Protection Officers (DPO's).

DPO's are at the heart of this legal framework for many organisations, facilitating compliance with the provisions of the UK GDPR. It is therefore mandatory for certain Data Controllers and Processors to designate a DPO (Article 37, UK GDPR).

This will be the case for all public authorities and bodies (irrespective of what data they process). STHK was therefore required to appoint a DPO.

The named DPO must be:
- Independent
- An expert in data protection
- Adequately resourced
- Report to the highest management level

As per Article 39 of the UK GDPR the DPO tasks are to:

- inform and advise you and your employees about your obligations to comply with the UK GDPR and other data protection laws
- monitor compliance with the GDPR and other data protection laws, and with your data protection polices, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits
- advise on, and to monitor, Data Protection Impact Assessments
- cooperate with the supervisory authority and
- be the first point of contact for supervisory authorities and for individuals whose data is processed (employees, customers etc).

Camilla Bhondoo will be the Data Protection for MWL and will report into the Director of Informatics/SIRO.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) was a standing committee which was accountable to STHK's Risk Management Council and ultimately STHK's Board. The Group, which had been operational since January 2008, oversaw the implementation of the IG Agenda throughout the organisation.

Its main purpose was to support and drive the broader Information Governance Agenda and provide the STHK's Board with the assurance that effective Information Governance best practice mechanisms were in place within STHK.

The IGSG was chaired by STHK's Caldicott Guardian Mr Alex Benson, with STHK's SIRO as Deputy Chair. Core membership included STHK's Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG saw the Group address the following topics in addition to achieving DSPT compliance –

- Implement an IG Workplan for 2022-23 that detailed the IG tasks that were required for the year, not only listing DSPT requirements but areas that are required as part of the data legislation (not included in the DSPT). The aim was to provide assurance to the Group (including the SIRO, Caldicott Guardian and DPO) that all areas of data protection law were being addressed and therefore STHK were complying with this law.

- Continue to embed the Data Security and Protection Breaches / Incident Reporting Policy and Procedure, which saw high scoring data breaches being effectively managed and escalated by completion of an IG Incident Investigation proforma. The proforma not only captured findings, lessons learned but enabled an action place to be put in place and monitored. This year the IG team saw a rise in the proformas being completed to not only capture high scoring data breaches but those that scored low but deemed complex in nature and required further action. Completed and approved proformas provide evidence should it be required to the ICO if a data breach is escalated to that level.

- Establishing key Information Asset Owners (each Exec) and Information Asset Managers and Administrators (delegated responsibility from the Exec to a senior member/s of their team) to support the Information Asset Register workstream and IG agenda for their area to understand what key Information assets each area may have and what securities are in place around them. Where a system is in use i.e. ESR this linked into the IT System Register.

- Establishing an IT System Register, in particular focusing on the critical IT Systems with assigned Information Asset Owners. Ensuring that governance arrangements were in place for these systems and gaining more detail in one place from IT colleagues such as last back up, next upgrade etc.

- Review of key policies and procedures, such as; IG Training Needs Analysis, IT Asset Management Policy, Print Policy, Back Up Policy and Network Security Policy.

- Following on from the introduction of the Data Protection Impact Assessment (DPIA) Procedure in 2021/22 which documented STHK's approach to securely implementing new projects / systems / initiatives that require personal data to be processed, the IG team continued to embed this process throughout STHK which has been demonstrated by the number of DPIAs (39) and Due Diligence Questionnaires (40) which provides Supplier Assurance completed in the past year. A reminder that these are mandatory under the UK GDPR, particularly where high risk processing of personal data is involved.

- Manage the outcome of a phishing exercise carried out by the IT Security Team, which saw 49 members of staff who had been previously 'phished' click a link once again and 29 staff provide credentials again. In addition there were 152 members of 'new' staff who clicked the link and 50 that provided credentials. The IG Team were responsible for notifying these members of staff that they had been 'phished' and they were required to complete their IG Mandatory training, for those who had been previously phished they were required to attend bespoke phishing training, which was designed and delivered by the IG Team. Results were monitored by the Group.

- Reinstate walk around confidentiality audits around all hospital sites (that were previously put on hold due to Covid). The audits were designed to give STHK's Board assurance that STHK, and its staff, were acting in accordance with Information Governance principles when on-site. This included ensuring identification badges are worn, clear desk policies are adhered to, secure areas are kept locked when unoccupied, and so on. The Group were presented with a number of actions that will continue to be monitored.

- Continued to build on a closer working relationship with IT security team.

- Trailing the IT Helpdesk Sostenuto to see whether FOIs could be managed more effectively through a system.

MWL will establish an Information Governance Steering Group as a standing forum which will report to MWL's Risk Management Council.

Reportable Incidents

STHK had a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2022/23 there was one incident. This incident required no further action from the ICO and STHK were informed to manage it locally.

A breakdown of the reported incident to the ICO is below:

April 2023	Between 27/03/2023 and 28/04/2023 forwarding to a small number of STHK mailboxes had been enabled on five shared NHS mailboxes, and the criteria to 'keep a local copy' was not selected against each mailbox, which it should have been. Forwarding is blocked on outbound NHS mail to external domains and the emails were not sent to the STHK mailboxes, nor were copies kept in the NHS mailboxes, so in effect the emails were lost. These email addresses were used by GPs to send referrals to the STHK District Nursing team. All GPs were contacted and informed of the change to the email addresses as a result of moving from the RIO Community solution to the EMIS Community solution, in advance of the change, automatic forwarding and an out-of-office was also applied. It was discovered that one referral was made by a GP which was not forwarded to the new address. The referrals can cover the need for intervention in the patient's home that covers wound care, palliative/End of Life care, medication administration and a variety of other clinical needs. This concerned 1 patient and as this one was found almost immediately this did not affect the patient's care. Subsequent 'deep diving' has shown that all other emails have been forwarded on. All GPs have been reminded of the change of email address, however there will now be regular checks on this inbox to ensure no further emails are missed.

There have been no fines issued by the ICO to STHK in 2022-23.

Areas to Note

In October 2021, STHK received an 'Infringement Order' from the ICO. Although no financial penalty was applied this was classed as a warning. The ICO were alerted to a number of similar data breaches concerning Subject Access Requests (SARs) that had not been appropriately processed; personal data has been released when it should not have been and personal data belonging to others has been released when it should not have been.

Findings demonstrated that although a three check step process had been implemented before any personal data was released to an individual, Information Governance (IG) rules were not applied (i.e. knowing what can and should not have been released, particularly around confidential matters). In addition, although this was not reported as part of the data breaches it was found that these SARs were not processed within the set calendar month and communication was poor at keeping the individuals up to date with their request.

The processing of SARs requires Information Governance (IG) / Data Protection knowledge. The SAR team did not have relevant IG knowledge and experience, furthermore the team sat separate to STHK's IG team.

STHK recognised the importance of the Infringement Order and the need to review the SAR process. This was raised on the Corporate Risk Register. It was therefore proposed by the SIRO that STHK's IG team took on overall responsibility of all SARs, aligning with how other organisations process SARs. This would then ensure all SARs would be processed in the same way, following the required legislation, guidance and rules.

The Executive team agreed that the SAR team should therefore move under the management of the IG team. The team will be moving across imminently under MWL.

Reporting & Monitoring

Progress against STHK's DSPT and compliance with relevant legislation was monitored by the Head of Risk Assurance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports were presented to the IG Steering Group and subsequently to the Risk Management Council, then ultimately to the STHK's Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met required action plans to be prepared, which were then monitored to ensure improvement and compliance.

Progress reports will also be part of MWL's IG Steering Group agenda.

The Year Ahead

The next 12 months will see MWL continue to build upon the former Information Governance strategy of STHK and Southport and Ormskirk, and will ensure it remains compliant with the DSPT, data protection legislation and its own IG framework. Maintaining compliance will occur through planning and day to day activities, which will need to be balanced against the needs of the organisation.

It is important that any outstanding IG actions from STHK are fully completed and not lost (this will be monitored by MWL's IG Steering Group) and all processes are monitored, revisited and updated where necessary. This ensures that they remain relevant and work in line with other MWL policies.

In 2022-23 an Information Governance Workplan was introduced, which was monitored by the IGSG and highlighted the progress in each area required to ensure STHK's adherence to not only the DSPT but Data Protection law as a whole. It was presented at the IGSG in June to show the final status of each area for 2022-23 – all complete. The IG Workplan details what work the hospital will need to carry out during the course of this year to ensure it remains on track with its compliancy. A new IG Workplan for 2023-24 for MWL is now in place.

This year the following areas will be of primary focus:

- **Complete any outstanding STHK IG actions** – There are actions that existed when STHK was a Trust as part of the IG Steering Group work and also of the DSPT audit. These will be monitored under MWL's IG Steering Group.

- **To create and implement an Information Governance Workplan for the new Trust** – The IG Workplan details what work the new Trust will need to carry out during the course of this next year to ensure it remains on track with its compliancy. This will keep the new Trust in line with the DSPT. To include the review and merging of IG policies and procedures to be brought to the subsequent IGSGs for approval. The IG Team will ensure there is a continuous review of the IG workplan throughout the year and provide assurance via the IGSG.

- **Continue to engage with IAOs (Information Asset Owners) and IAMs (Information Asset Managers) ensuring they understand and comply with their responsibilities across the new Trust** – specific IAO training has been developed and after a review ensuring it is suitable for the new Trust, the IG Team will continue to arrange training sessions to all MWL IAOs to ensure they understand their IG responsibilities and how an IAO provides support to the SIRO and the IG Team. IAOs are the Executive Team who delegate responsibility to a nominated Information Asset Manager (IAM) for each individual Asset. Dependent on the size of the division there may be multiple IAMs. There is a need to understand they are responsible for the information in their area, specifically personal data and to ensure its protected at all times – this is highlighted through completed Information Asset Registers (IARs) see next bullet point This aligns with a requirement in the DSPT.

- **Continue to implement Information Asset Registers (IARs) across the new Trust** – The IAR was revamped last year under STHK and was developed incorporating ICO and data protection legislation requirements. There is a need to understand where in the new Trust the personal data is located that is being processed and to ensure this data can be processed legally, is being held as securely as possible and to identify any risks. The completion of IARs will continue and any high risks will be highlighted to the SIRO. Required by the DSPT.

- **Continued use of the Data Breach Investigation Report** – This was implemented last year at STHK and saw the IG Team completing a full report on data breaches and near miss data breaches working with the teams involved to understand where processes could be improved. It is important that a full report continues to be carried out with lessons learned and an action plan. In liaison with the IAO/IAM, the reports will provide the SIRO and Caldicott Guardian (and any relevant parties) with assurance that a breach has been fully investigated. The data breach and incident reporting proforma, which was approved by IGSG in April 2021, is currently in use to demonstrate incident management across the new Trust, it was recently implemented at Southport and Ormskirk. A review of the Data Breach process has occurred in advance of being one Trust and the team continue to complete a report when required.

- **Review of Mandatory IG Training** – The training package that was delivered varied slightly across STHK and Southport and Ormskirk. There is a need for a full review of the Mandatory IG Training to ensure the new Trust will benefit from a fresh package.

In addition, there will be a review of the suite of training packages the IG Team delivers to ensure the same message is being delivered i.e. to volunteers, estates and facilities teams.

- **Continue to work with the IT Security Team** – the DSPT will continue to want IT evidence and it is important that the IG Team work closely with the IT Security Team to ensure actions that are produced due to the audit are completed, continue to collate evidence for the new version on the DSPT. Required to ensure completion of the DSPT.

Conclusion

STHK continued to build and improve on the Information Governance foundations which were previously embedded. This has been demonstrated by the completion of the Data Security and Protection Toolkit and the robust processes it had in place in terms of reporting data breaches, the completion of DPIAs, data sharing agreements, data processor agreements, delivering training and awareness, providing advice and guidance on a range of data protection queries.

This year as MWL, we will build on what STHK had implemented and as part of becoming one organisation, we will align our processes so we can continue to see new innovative systems and initiatives / processes being put in place that will involve the use of the personal data not only for use at MWL but wider across the Cheshire and Mersey Health Care Partnership and the North West. This is welcomed and required for cross organisational and collaborative working. It is therefore important that MWL's IG Steering Group continue to monitor the progress of MWL's Information Governance Agenda, to ensure the IG team receive full support, so that compliance can be maintained, processes are embedded and improved upon and proactive involvement occurs as a new organisation.

TRUST BOARD

Paper No: MWLTB (23)018b – Appendix

Title of paper: Freedom of Information Act Annual Report 2022/23

Purpose: To provide the Trust Board assurance that St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) strived to comply with the Freedom of Information Act.

Summary: This report is designed to give the Trust Board assurances that STHK was compliant with the Freedom of Information Act. This report summarises the key points of FOI compliance for 2022-23

For the 2022-23 financial year STHK received 730 requests, at the time of writing this report, 98% of the requests received were completed, of those completed requests, 60% were completed within the 20 working daytime frame.

	2021/22	2022/23
Requests received	623	730
Requests completed	100%	98%
20 working day compliance	64%	60%

The number of requests received compared to the previous year has increased by 107 requests, this increase has seen compliance dip by 4%.

Corporate objectives met or risks addressed: Systems, Communications

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.

Recommendation(s): The Trust Board to note and approve the content of this report

Presenting officer: Christine Walters Director of Informatics/SIRO

Date of meeting: 26th July, 2023

Introduction

As a public authority STHK was required to action and respond to Freedom of Information (FOI) Requests under the legislation 'the Freedom of Information Act 2000.' The public are able to request non personal information about STHK and its activities.

Anyone can make an FOI request and the organisation must respond to the request within 20 working days. Failure to do so could result in a fine or warning from the Information Commissioners Office.

The Chief Executive who had overall responsibility in STHK for the FOI Act delegated the responsibility for the implementation and monitoring of the Act to Anne-Marie Stretch, who was the Deputy Chief Executive and Director of Human Resources (also known as the Executive FOI lead) at STHK. The Executive FOI Lead ensured that STHK was complying with the legislation and took overall ownership of the STHK's FOI Policy, making sure systems and procedures were established and reviewed to support the FOI process.

The Information Governance team through dedicated resources, processed, coordinated, monitored and reported all FOI requests. This included following all administration procedures and record keeping in line with STHK's FOI policy and the FOI Act.

This report is designed to provide the Trust Board with assurance that STHK was compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for 2022-23 will be shown here, with comparisons to previous years where relevant.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

Performance

The overall compliance figure shows a slight decrease on the previous year's compliance levels in terms of completing the requests.

- 730 requests received in total; this is an increase from last year's total of 623.
- The areas of STHK that received the most requests to answer were HR (101), Information (92), Finance (97), Informatics (68) and Estates (48).
- 60% of requests were answered within the 20-working day timescale, this is a decrease on the previous year's 64%.
- September 2022 saw the highest rate of compliance with 80% of requests responded to within 20 working days.
- 98% of all requests received in the financial year have been responded to, the remaining 2 % of requests are still open [1].

[1] For 2022/23: 10 are awaiting Exec approval, 2 are awaiting response from department, and 3 are on hold. Figures correct as of 14.7.23.

- Requests from the Commercial sector accounted for 325 (45%) of all the requests received.

- The top 3 categories of requests that were received were: Lists & Registers (170), Our Services (164) and About the Trust (189) which remains the same as previous years.

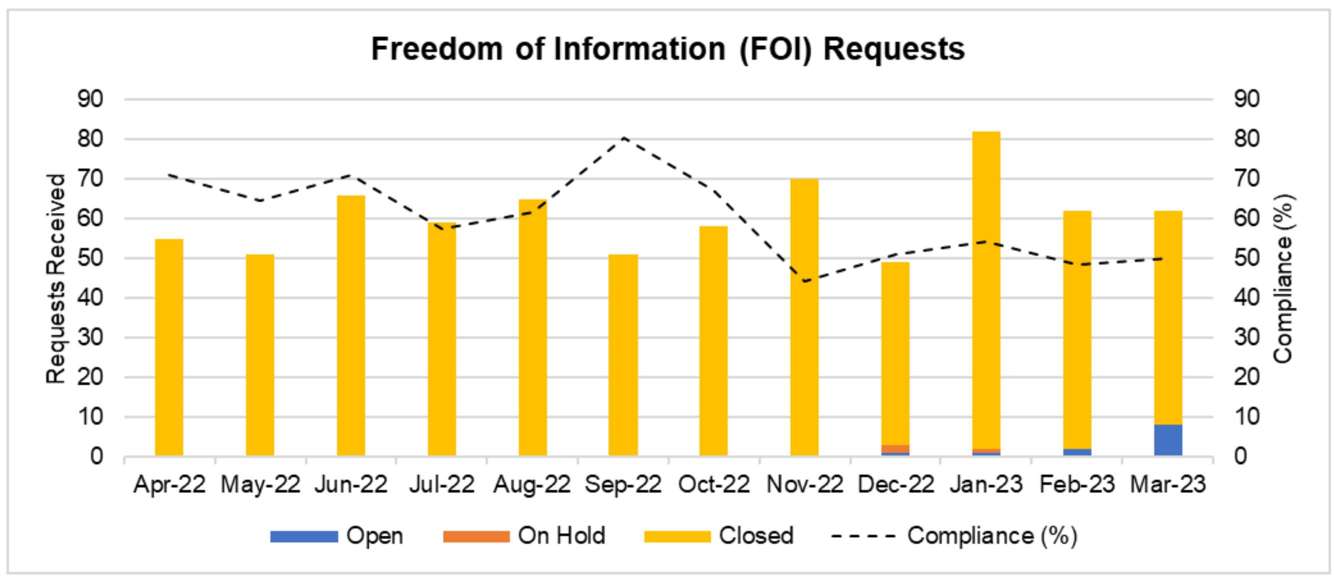
Areas to Note

- The nature of the requests that were being received became more complex which often resulted in 1 FOI request having multiple questions for different departments.

- STHK's and S&O's IG team became one IG team in July 2022. S&O did not have an FOI Officer when they were TUPE over in July 2022. This led to a situation where the FOI staffing resource was spread across two organisations and their respective data sources. This and the rise in requests contributed to the small dip in the compliance figures.

Table 1 below shows the requests completed throughout the year and the monthly compliance with the 20-working daytime scale.

Table 1 – 2022-23



Areas of Improvement in 2022-23

- With the creation of MWL, a full review of the legacy STHK and Southport and Ormskirk information will take place to ensure that the correct services are identified going forward to supply the information and that the correct Executive is identified in order to sign the request off. This will be an ongoing review as department structures are reviewed and amended as MWL matures.

- All existing and new contacts identified to supply information for Freedom of Information requests will receive training and further guidance. This will ensure that they are comfortable with the process and understand the approval process before information is released to the requestor.

- The IG team will work with the Communication team to ensure the new website contains information which will be pertinent to FOI requests and include an FOI Disclosure Log. This will be searchable using key words, helping requesters find the information they require, it should also help in reducing requests relating to the same subject area and being able to respond quicker to requests.

Conclusion

STHK's FOI process which saw each Executive Lead reviewing and approving FOIs for their respective areas certainly resulted in the process becoming more streamlined by making each Executive Lead aware of what information was being requested and released. The rise in FOI requests, plus the fact that a considerable number of requests that were received were not considered 'straight forward' and resulted in multiple departments having to contribute, combined with STHK & S&Os IG teams coming together without an FOI Officer on the S&O side and resources being spread across the two organisations, resulted in a slight decrease in the Trust's overall compliance.

As MWL, the IG Team will carry across the good work in terms of the FOI process and will adopt the former way of processing the requests, which should help in handling the more complex requests. All members of the MWL IG Team have been trained in the FOI process and there is a rota in place to ensure that FOIs are processed on a daily basis going forward.

Report Ends.

TRUST BOARD

Paper No: MWLTB (23)018b
Title of paper: Information Governance Annual Report (including Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that Southport and Ormskirk Hospital NHS Trust had an effective Information Governance Agenda and Framework in place
Summary: This Report is designed to inform and give assurance to the Board of progress made against the Information Governance (IG) work programme for 2022-23. IG is a framework that not only provides a consistent way for staff to deal with the many different information handling requirements but brings together all of the requirements, standards and best practice that apply to the handling of information, specifically information that contains personal confidential information, now referred to as personal data. IG has four fundamental aims: • To support the provision of high-quality care by promoting the effective and appropriate use of information in a secure manner • To encourage staff to work closely together, preventing duplication of effort and enabling more efficient use of resources • To develop an information management structure to provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards • To enable organisations to understand their own performance and manage improvement in a systematic and effective way Southport and Ormskirk Hospital NHS Trust (S&O) had a duty to ensure that it complied with its legal and regulatory obligations, for IG this is data protection legislation, more specifically the UK GDPR and Data Protection Act 2018. S&O was committed to conducting frequent reviews and improvements of its services; this included Information Governance (IG). This report details the progress that has been made against the Information Governance work programme for 2022-23 and provides a 'year ahead' programme of work on areas that are necessary to achieve IG compliancy and to further embed IG within the new Trust 'Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL)'.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: *None directly from this report.*
Stakeholders: *Staff, Patients, Executive Committee, Trust Board and Commissioners.*

Recommendation(s):

- The Trust Board to be assured that robust arrangements were in place to effectively manage the Information Governance Agenda within S&O and these arrangements will be further embedded within MWL.
- The Trust Board to approve the contents of this report.

Presenting officer Christine Walters, Director of Informatics/SIRO

Date of meeting: 26th July, 2023

Introduction

The NHS Information Governance Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. This Framework allowed S&O to ensure that all personal, sensitive and confidential data was handled legally, securely, efficiently and effectively. Information Governance (IG) is an ongoing process which covers many different areas, including records management, data quality, legislative compliance, risk management and information security.

S&O had a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), the Freedom of Information Act 2000 (FOIA 2000), and to meet Information Governance (IG) / Information Security / NHS specifications and requirements, mainly relating to the National Data Guardians Data Security Standards and other related legislation, guidance and contractual responsibilities to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

S&O had its own IG strategy which set out the approach it took in developing and implementing a robust Information Governance Framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further supported the IG work including the Records Management Policy and Procedure, Confidentiality Code of Conduct Policy, Data Security & Protection Breaches / Incident Reporting Policy and Procedure, Freedom of Information Policy, Data Protection Impact Procedure, Data Quality Policy. All of which were made available to staff via the S&O intranet.

S&O completed and submitted the Data Security and Protection Toolkit (DSPT) on an annual basis. The DSPT enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. To provide assurance that S&O DSPT was of a good standard it was audited by Mersey Internal Audit Agency. For 2022-23 S&O received the rating of Substantial Assurance.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2022-23.

This section will provide assurance, from the SIRO, that S&O:

- Had a sufficient framework in place to ensure compliance with all elements of the Information Governance Agenda
- Had an active and effective Information Governance Steering Group forum, meeting regularly
- Managed and investigated any Information Governance / Confidentiality incidents and issues

Roles and Responsibilities

The Role of the SIRO

John McLuckie, Director of Finance, was S&O's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

A SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to a Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the organisation's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within a Trust and advise the Board on the effectiveness of information risk management across a Trust.

The SIRO has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The focus of the DSPT is on setting standards and providing tools to achieve them. The SIRO authorises the DSPT Self-Assessment annual submissions once the relevant assurances have been provided by the Information Governance and IT Security teams. The data security standards provide assurance across ten areas.

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection

10 Accountable Suppliers

Christine Walters will be the SIRO for MWL.

The Role of the Caldicott Guardian

Dr Kate Clark was S&O's registered Caldicott Guardian. Dr Clark was tasked with ensuring that the personal information about those who use its services was used legally, ethically and appropriately, and that confidentiality was maintained. Dr Clark provided leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader information governance agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that all NHS organisations achieve the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance to the Trust Board that the Caldicott Guardian function within S&O operated at a satisfactory level and that it was appropriately supported within the existing Information Governance structure.

S&O's Caldicott Guardian was supported by S&O's Director of Finance in his role as Senior Information Risk Owner (SIRO) and S&O's Head of Information Governance & Data Protection Officer and her team.

Alex Benson will be the Caldicott Guardian for MWL and will be supported by MWL's Director of Informatics as SIRO and MWL's Head of Information Governance / Data Protection Officer and her team.

Data Protection Officer

Camilla Bhondoo was S&O's Data Protection Officer. New to Data Protection legislation under the UK General Data Protection Regulation 2018 (UK GDPR) are Data Protection Officers (DPO's).

DPO's are at the heart of this legal framework for many organisations, facilitating compliance with the provisions of the UK GDPR. It is therefore mandatory for certain Data Controllers and Processors to designate a DPO (Article 37, UK GDPR).

This will be the case for all public authorities and bodies (irrespective of what data they process). S&O was therefore required to appoint a DPO.

The named DPO must be:

- Independent
- An expert in data protection
- Adequately resourced
- Report to the highest management level

As per Article 39 of the UK GDPR the DPO tasks are to:

- inform and advise you and your employees about your obligations to comply with the UK GDPR and other data protection laws
- monitor compliance with the GDPR and other data protection laws, and with your data protection polices, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits
- advise on, and to monitor, Data Protection Impact Assessments
- cooperate with the supervisory authority and
- be the first point of contact for supervisory authorities and for individuals whose data is processed (employees, customers etc).

Camilla Bhondoo will be the Data Protection for MWL.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) was a standing committee which was accountable to S&O's Risk and Compliance Committee and ultimately S&O's Board. The Group oversaw the implementation of the IG Agenda throughout the organisation.

Its main purpose was to support and drive the broader Information Governance Agenda and provide the S&O's Board with the assurance that effective Information Governance best practice mechanisms were in place within S&O.

The IGSG was chaired by S&O's SIRO John McLuckie, with S&O's Caldicott Guardian as Deputy Chair. Core membership included S&O's Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG saw the Group address the following topics in addition to achieving DSPT compliance –

- Becoming one IG Team with STHK to provide resources and resilience in terms of appointing a DPO and support from the wider IG team, implementing one rota across the Trusts to ensure key duties such as training, FOIs, data breaches and IG enquiries were always covered. Aligning processes using best practice from each organisation to make these processes better and more efficient i.e. DPIA and Data Breaches.

- For the first time implementing an IG Workplan for 2022-23 that detailed the IG tasks that were required for the year, not only listing DSPT requirements but areas that are required as part of the data legislation (not included in the DSPT). The aim was to provide assurance to the Group (including the SIRO, Caldicott Guardian and DPO) that all areas of data protection law were being addressed and therefore S&O were complying with this law.

- Implementing STHK's Data Security and Protection Breaches / Incident Reporting Policy and Procedure, in particular adopting the IG Incident Investigation proforma and completing when data breaches scored highly and those that scored low but deemed complex in nature and required further action. The completed proformas detailed the data breach, findings, lesson learned and an action plan with action owners all in one place.

- Gaining approval from the Information Asset Register workstream across S&O and establishing key Information Asset Owners (each Exec) and Information Asset Managers and Administrators (delegated responsibility from the Exec to a senior member/s of their team) to support this piece of work

- The introduction of the Data Protection Impact Assessment (DPIA) Procedure which documents S&O's approach to securely implementing new projects / systems / initiatives that require personal data to be processed. There was a need to formalise and document the DPIA process at S&O. A DPIA procedure was created based on STHK's and was approved (April's IGSG). The process became robust and clear and also saw Due Diligence Questionnaires being introduced and completed.

- Review of key policies and procedures, such as; Freedom of Information Policy, Registration Authority Policy, Document and Record Retention Policy, Access to Information Standard Operating Procedure, IT Log Retention Policy, Acceptable Use Policy, IG Training Needs Analysis.

- Continued with monthly confidentiality audits around all hospital sites. The audits were designed to give S&O's Board assurances that S&O, and its staff, were acting in accordance with Information Governance principles when on-site. This included ensuring identification badges are worn, clear desk policies are adhered to, secure areas are kept locked when unoccupied, and so on. The Group were presented with a number of actions that will continue to be monitored.

- Establish a working relationship with the IT Security Team, in particular the new IT Security Officer dedicated to looking after S&O's IT and Cyber function. This helped to complete a successful DSPT and ensure links were made for the DPIA process (when required to review the IT Security elements of a system / project).

MWL will establish an Information Governance Steering Group as a standing forum which will report to MWL's Risk Management Council.

Reportable Incidents

S&O had a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2022/23 there was one incident. This incident required no further action from ICO and S&O were informed to manage it locally

A breakdown of the reported incident to the ICO is below:

December 2022	The Trust was going through the legal checks before potentially merging with St Helens and Knowsley Hospitals NHS Trust. A HR business partner was asked by the Trust Solicitor, who was completing the due diligence exercise, to provide some further information regarding the outcomes of current HR Cases. The HR business partner was also asked to provide the contact details of the Freedom to Speak Up lead. At that point, the HR business partner searched for the email address of the Freedom to Speak Up lead in the open email to the Trust Solicitor which included the outcomes of staff tribunals. Before sending the email

	to the Trust solicitor, the HR business partner did not delete the email. address of the Freedom to Speak Up Lead from the distribution list and their admin support, consequently the email was also sent to them in error. Neither the Freedom to Speak Up Lead or their admin support read the email and both deleted it from their mailboxes.

There have been no fines issued by the ICO to S&O in 2022-23 and no areas of concern raised.

Reporting & Monitoring

Progress against S&O's DSPT and compliance with relevant legislation was monitored by the Head of Risk Assurance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports were presented to the IG Steering Group and subsequently to the Risk Management Council, then ultimately to the S&O's Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met required action plans to be prepared, which were then monitored to ensure improvement and compliance.

Progress reports will also be part of MWL's IG Steering Group agenda.

The Year Ahead

The next 12 months will see MWL continue to build upon the former Information Governance strategy of STHK and Southport and Ormskirk, and will ensure it remains compliant with the DSPT, data protection legislation and its own IG framework. Maintaining compliance will occur through planning and day to day activities, which will need to be balanced against the needs of the organisation.

It is important that any outstanding IG actions from S&O are fully completed and not lost (this will be monitored by MWL's IG Steering Group) and all processes are monitored, revisited and updated where necessary. This ensures that they remain relevant and work in line with other MWL policies.

In 2022-23 an Information Governance Workplan was introduced which was monitored by the IGSG and highlighted the progress in each area, required to ensure S&O adhered to not only the DSPT but Data Protection law as a whole. It was presented at the IGSG in June to show the final status of each area for 2022-23 – all complete. The IG Workplan details what work the hospital will need to carry out during the course of this financial year to ensure it remains on track with its compliancy. A new IG Workplan for 2023-24 for MWL is now in place.

This year the following areas will be of primary focus:

- **Complete any outstanding S&O IG actions** – There are actions that existed when S&O was a Trust as part of the IG Steering Group work and also of the DSPT audit. These will be monitored under MWL's IG Steering Group

- **To create and implement an Information Governance Workplan for the new Trust** – The IG Workplan details what work the new Trust will need to carry out during the course of this financial year to ensure it remains on track with its compliancy. This will keep us in line with the DSPT. To include the review and merging of IG policies and procedures to be brought to the subsequent IGSGs for approval. The IG Team will ensure continuous review of the IG workplan throughout the year and provide assurance via the IGSG.

- **Continue to engage with IAOs (Information Asset Owners) and IAMs (Information Asset Managers) ensuring they understand and comply with their responsibilities across the new Trust** – specific IAO training has been developed and after a review ensuring it is suitable for the new Trust, the IG Team will continue to arrange training sessions to all MWL IAOs to ensure they understand their IG responsibilities and how an IAO provides support to the SIRO and the IG Team. IAOs are the Executive Team who delegate responsibility to a nominated Information Asset Manager (IAM) for each individual Asset. Dependent on the size of the division there may be multiple IAMs. There is a need to understand they are responsible for the information in their area, specifically personal data and to ensure its protected at all times – this is highlighted through completed Information Asset Registers (IARs) see next bullet point This aligns with a requirement in the DSPT.

- **Continue to implement Information Asset Registers (IARs) across the new Trust** – The IAR was revamped last year under STHK and was developed incorporating ICO and data protection legislation requirements. There is a need to understand where in the new Trust the personal data is located that is being processed and to ensure this data can be processed legally, is being held as securely as possible and to identify any risks. The completion of IARs will continue and any high risks will be highlighted to the SIRO. Required by the DSPT.

- **Continued use of the Data Breach Investigation Report** – This was implemented last year and saw the IG Team completing a full report on data breaches and near miss data breaches working with the teams involved to understand where processes could be improved. It is important that a full report continues to be carried out with lessons learned and an action plan. In liaison with the IAO/IAM the reports will provide the SIRO and Caldicott Guardian (and any relevant parties) with assurance that the breach was fully investigated. The data breach and incident reporting proforma has recently been implemented at S&O. A review of the Data Breach process has occurred in advance of being one Trust and the team complete a report when required.

- **Review of Mandatory IG Training** – The training package that was being delivered varied slightly across STHK and Southport and Ormskirk. There is a need for a full review of the Mandatory IG Training to ensure the new Trust will benefit from a fresh package. In addition there will be a review of the suite of training packages the IG Team delivers to ensure the same message is being delivered i.e. to volunteers, estates and facilities teams.

- **Continue to work with the IT Security Team** – the DSPT will continue to want IT evidence and it is important that the IG Team work closely with the IT Security Team

to ensure actions that are produced due to the audit are completed, continue to collate evidence for the new version on the DSPT. Required to ensure completion of the DSPT.

Conclusion

S&O continued to build and improve on the Information Governance foundations which were previously embedded. This has been demonstrated by the completion of the Data Security and Protection Toolkit and the robust processes it had in place in terms of reporting data breaches, data sharing agreements, data processor agreements, delivering training and awareness, providing advice and guidance on a range of data protection queries.

This year as MWL, we will build on what S&O had implemented and as part of becoming one organisation, we will align our processes so we can continue to see new innovative systems and initiatives / processes being put in place that will involve the use of the personal data not only for use at MWL but wider across the Cheshire and Mersey Health Care Partnership and the North West. This is welcomed and required for cross organisational and collaborative working. It is therefore important that MWL's IG Steering Group continue to monitor the progress of MWL's Information Governance Agenda, to ensure the IG team receive full support, so that compliance can be maintained, processes are embedded and improved upon and proactive involvement occurs as a new organisation.

TRUST BOARD

Paper No: MWLTB (23)018b - Appendix

Title of paper: Freedom of Information Act Annual Report 2022/23

Purpose: To provide the Trust Board assurance that Southport and Ormskirk Hospital NHS Trust (S&O) strived to comply with the Freedom of Information Act.

Summary: This report is designed to give the Trust Board assurance that S&O was compliant with the Freedom of Information Act. This report summarises the key points of FOI compliance for 2022-23

For the 2022-23 financial year S&O received 605 requests, at the time of writing the report, 95% of the requests received were completed, of those completed requests, 53% were completed within the 20 working day time frame.

	2021/22	2022/23
Requests received	562	605
Requests completed	100%	95%
20 working day compliance	70%	53%

The number of requests received compared to the previous year has increased by 43 requests.

Corporate objectives met or risks addressed: Systems, Communications

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.

- **Recommendation(s):**
- The Trust Board to note and approve the content of this report

Presenting officer: Christine Walters, Director of Informatics/SIRO

Date of meeting: 26th July, 2023

Introduction

As a public authority S&O was required to action and respond to Freedom of Information (FOI) Requests under the legislation 'the Freedom of Information Act 2000.' The public are able to request non personal information about S&O and its activities.

Anyone can make an FOI request and the organisation must respond to the request within 20 working days. Failure to do so could result in a fine or warning from the Information Commissioners Office.

The Chief Executive who had overall responsibility in S&O for the FOI Act delegated the responsibility for the implementation and monitoring of the Act to the Director of Finance, SIRO. The Executive FOI Lead ensured that S&O was complying with the legislation and took overall ownership of the S&O's FOI Policy making sure systems and procedures were established and reviewed to support the FOI process.

The Information Governance team through dedicated resources, processed, coordinated, monitored and reported all FOI requests. This included following all administration procedures and record keeping in line with S&O's FOI policy and the FOI Act.

This report is designed to provide the Trust Board with assurance that S&O was compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for 2022-23 will be shown here, with comparisons to previous years where relevant.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

Performance

- The overall compliance figure shows a decrease on the previous year's compliance levels in terms of compliance with the 20-working day timescale.
- 605 requests received in total; this is an increase from last year's total of 562.
- The areas of Southport and Ormskirk received the most requests to answer were HR (86) Information (60), IT (57) and Finance (53).
- 53% of requests were answered within the 20-working day timescale.
- May 2022 saw the highest rate of compliance with 71% of requests responded to within 20 working days.
- 95% of all requests received in the financial year of 2022-23 have been responded to. The outstanding 5% are currently being followed up and the expectation is that this will be completed by the end of August.

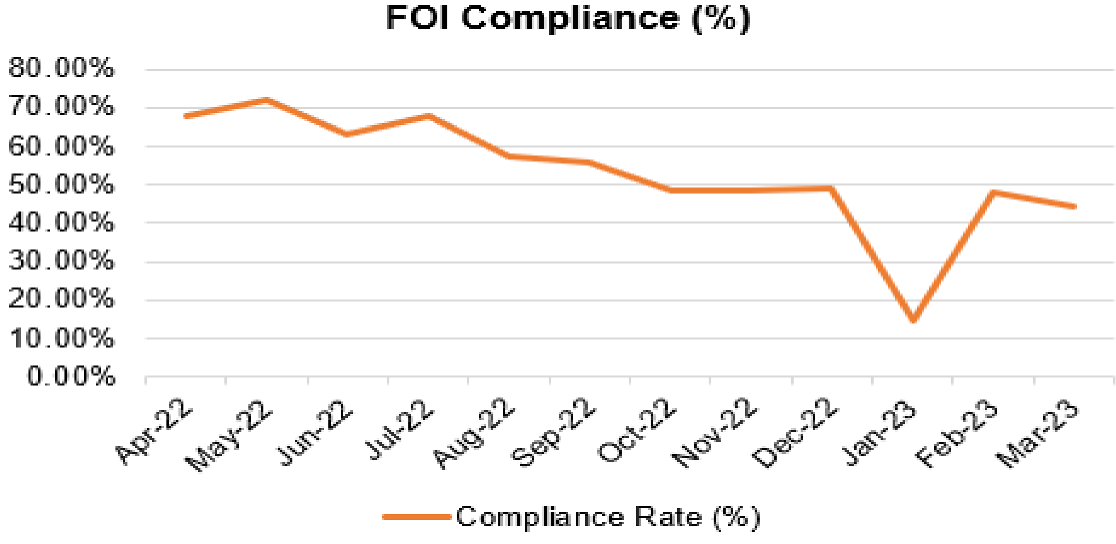
Areas to Note

- The nature of the requests that were being received became more complex which often resulted in 1 FOI request having multiple questions for different departments.

- STHK's and S&O's IG team became one IG team in July 2022. S&O did not have an FOI Officer when they were TUPE over in July 2022. This led to a situation where the FOI staffing resource was spread across two organisations and their respective data sources. This and the rise in requests contributed to the dip in the compliance figures.

Table 1 below shows the performance made throughout the year.

Table 1 – 2022-23



Areas of Improvement in 2022-23

- With the creation of MWL, a full review of the legacy STHK and Southport and Ormskirk information will take place to ensure that the correct services are identified going forward to supply the information and that the correct Executive is identified in order to sign the request off. This will be an ongoing review as department structures are reviewed and amended as MWL matures.

- All existing and new contacts identified to supply information for Freedom of Information requests will receive training and further guidance. This will ensure that they are comfortable with the process and understand the approval process before information is released to the requestor.

- The IG team will work with the Communication team to ensure the new website contains information which will be pertinent to FOI requests and include an FOI

Disclosure Log. This will be searchable using key words, helping requesters find the information they require, it should also help in reducing requests relating to the same subject area and being able to respond quicker to requests.

Conclusion

S&O's FOI process which saw each Executive Lead reviewing and approving FOIs for their respective areas certainly resulted in the process becoming more streamlined by making each Executive Lead aware of what information was being requested and released. The rise in FOI requests, plus the fact that a considerable number of requests that were received were not considered 'straight forward' and resulted in multiple departments having to contribute, combined with STHK & S&Os IG teams coming together without an FOI Officer on the S&O side and resources being spread across the two organisations, resulted in a slight decrease in the Trust's overall compliance.

As MWL, the IG Team will carry across the good work in terms of the FOI process and will adopt the former way of processing the requests, which should help in handling the more complex requests. All members of the MWL IG Team have been trained in the FOI process and there is a rota in place to ensure that FOIs are processed on a daily basis going forward.

Report Ends.

<u>Trust Board</u>

Paper No: MWLTB (23)019a
Title of paper: Data Security and Protection Toolkit (DSPT) - Final Submission Report 2022/23 for St Helens and Knowsley Hospitals NHS Trust
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Hospitals NHS Trust (STHK) operated within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.
Summary: This Report summarises STHK's status of the Data Security and Protection Toolkit (DSPT) for its 2022 – 23 submission. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to and process patient / personal data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly and in line with data protection legislation. When considering data security as part of the 'Well Led Key Line of Enquiry' as part of the Care Quality Commission (CQC) inspections, they will consider how organisations are assuring themselves against these standards. The submission date for the DSPT is now the end of June and there are no plans to move it back to the month of March (as it was up until 2020). STHK submitted the DSPT assessment at the end of June 2023 for the 2022-23 submission and was able to submit evidenced items for all the assertions as required as part of the submission, STHK achieved a "standards met" rating for the submission. Mersey Internal Audit Agency (MIAA) audited a number of the assertions and evidenced items. STHK has received the rating of 'Substantial Assurance' against its DSPT.
Financial implications: • *None directly from this report.*
Corporate objectives met and risks addressed : STHK were responsible for ensuring compliance with Data Protection / UK GDPR and Data Security requirements and were required to demonstrate annual compliance through the DSPT. This was achieved.
Stakeholders: *Staff, Patients, Executive Committee, Trust Board and Commissioners.*

Recommendation(s): • The Board to note and approve the contents of this report.
Presented by: Christine Walters**,** Director of Informatics
Date of meeting: 26th July, 2023

Introduction

The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. It is based on the National Data Guardian ten data security standards (covering topics such as staff responsibilities and continuity planning (National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) and legal rules relevant to IG and personal data (UK General Data Protection Regulation 2016 and the Data Protection Act 2018).

All organisations that have access to and process patient / personal information must provide assurances that they are practising good information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The DPST this year contained 113 mandatory 'assertions' that required evidencing. Each mandatory requirement has to be addressed in order to submit a successful assessment - if this was not achieved STHK would have been considered non-compliant.

The DSPT submission date up until 2020 had always been the end of March, this has now changed and is the end of June. STHK submitted a successful DSPT before the deadline and met all mandatory requirements.

Larger organisations, such as Acute Trusts, are also required to have their DSPT submission externally audited to ensure the accuracy of their submission. The objective of this exercise is to provide independent assurance over a nationally determined sample of evidence items and to highlight areas for improvement to inform the 2022-23 DSPT submission.

Failure to complete the DSPT can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact STHK's ability to bid for new services in the future. In addition this could have placed STHK's reputation at risk. The Information Commissioner has also indicated that satisfactory completion of the DSPT can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2022/23Submission

Evidence has been provided for the self-assessment against the 10 National Data Guardian Standards and the associated assertions that sit under each standard. These items are recorded under assertions and represent an indicator of maturity in that area. There are in 113 mandatory assertion items that require evidence.

For example, in order to comply with Standard 1 for 'Personal Confidential Data', STHK has to provide evidence for the assertions as detailed below:

1.1	**The organisation has a framework in place to support Lawfulness, Fairness and Transparency**		
1.1.1	State your organisation's Information Commissioner's Office (ICO) registration number.	Mandatory	**COMPLETED**
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Mandatory	**COMPLETED**
1.1.3	Transparency information (e.g. your Privacy Notice and Rights for individuals) is published and available to the public.	Mandatory	**COMPLETED**
1.1.4	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Mandatory	**COMPLETED**
1.1.5	List the names and job titles of your organisation's key staff with responsibility for data protection and data security.	Mandatory	**COMPLETED**
1.1.6	Your organisation has reviewed how it asks for and records consent to share personal data.	Mandatory	**COMPLETED**
1.1.7	Data quality metrics and reports are used to assess and improve data quality.	Mandatory	**COMPLETED**
1.1.8	A data quality forum monitors the effectiveness of data quality assurance processes.	Mandatory	**COMPLETED**

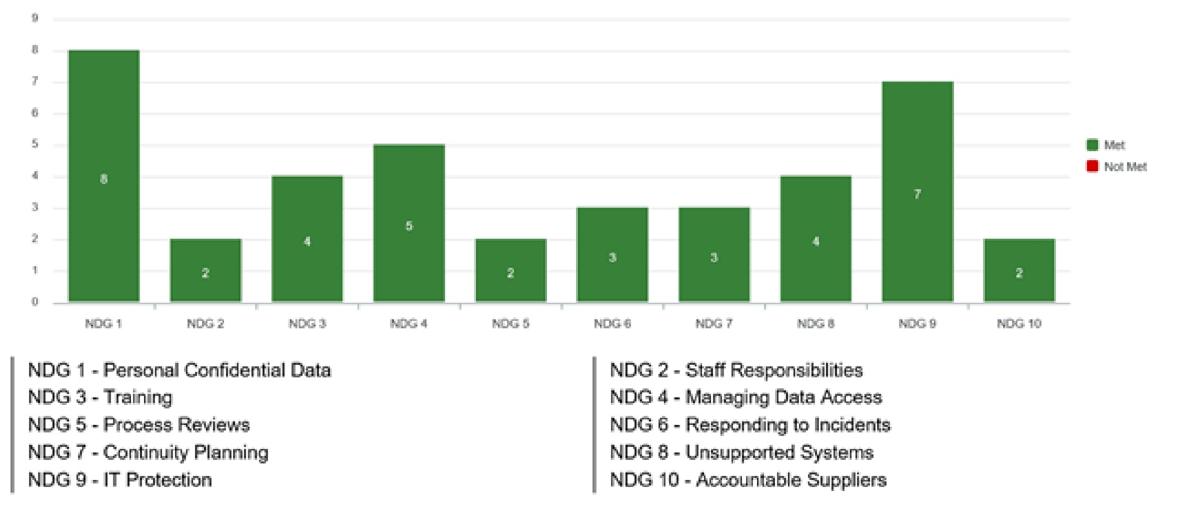
1.2	**Individuals' rights are respected and supported**		
1.2.2	Your organisation has processes in place to deliver individuals rights including to handle an individual's objection to the processing of their personal data.	Mandatory	**COMPLETED**
1.2.3	Your organisation has a process to recognise and respond to individuals' requests to access their personal data.	Mandatory	**COMPLETED**
1.2.4	Your organisation is compliant with the national data opt-out policy.	Mandatory	**COMPLETED**

1.3	Accountability and Governance in place for data protection and data security		
1.3.1	There are board-approved data security and protection policies in place that follow relevant guidance.	Mandatory	**COMPLETED**
1.3.2	Your organisation monitors your own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	Mandatory	**COMPLETED**
1.3.3	SIRO responsibility for data security has been assigned.	Mandatory	**COMPLETED**
1.3.4	There are clear documented lines of responsibility and accountability to named individuals for data security and data protection.	Mandatory	**COMPLETED**
1.3.5	Your organisation operates and maintains a data security and protection risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility.	Mandatory	**COMPLETED**
1.3.6	List your organisation's top three data security and protection risks.	Mandatory	**COMPLETED**
1.3.7	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	Mandatory	**COMPLETED**
1.3.8	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to your existing risk management and project management, to action this.	Mandatory	**COMPLETED**
1.3.9	Data security and protection direction is set at board level and translated into effective organisational practices.	Mandatory	**COMPLETED**

1.4	Records are maintained appropriately		
1.4.1	The organisation has a records management policy including a records retention schedule.	Mandatory	**COMPLETED**

For STHK to have achieved "standards met", all of the mandatory items with the DSPT had to be completed. Our baseline assessment was submitted to NHS Digital in February 2023.

STHK successfully completed the DSPT in time for the end of June 2023 submission date. A summary of how the 2022/23 submission looked is shown below:

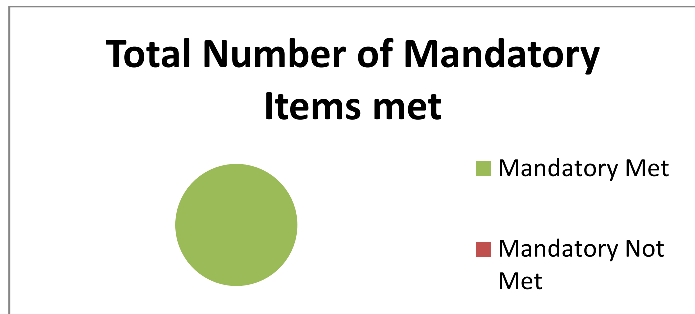


The table below shows the status of **Mandatory** evidence items met applicable for STHK:

Data Standard	Number of Requirements	IT Sec Owner	IG Owner	DQ Owner	Total Evidence item provided
1	21	4	15	2	21/21
2	2	0	2	0	2/2
3	7	2	5	0	7/7
4	12	12	0	0	12/12
5	1	1	0	0	1/1
6	13	10	3	0	13/13
7	9	9	0	0	9/9
8	16	16	0	0	16/16
9	29	29	0	0	29/29
10	3	2	1	0	3/3
Total	113	85	26	2	113

Evidence was required from STHK's IT Security, Information Governance (IG) and Data Quality (DQ) teams. The table above shows that IT Security were required to provide 85 mandatory items of evidence, IG – 26 and finally DQ providing 2 items.

The chart below shows the Mandatory evidence items met:



Summary of Results:
Total Number of Data Standards = 10
Total Number of Mandatory Evidence Items required = 113
Total Number of Mandatory Evidence Items achieved = 113

DSPT Approval

In order to submit and publish the DSPT once all evidence has been provided the SIRO must provide final approval. On the 27th of June, the IG Team presented the SIRO with the evidence that had been provided for STHK's DSPT. The SIRO has approved the submission of the DSPT for 2022/23, subject to recommendation from MIAA being actioned.

Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of STHK's DSPT submission (as required of larger NHS organisations) during two visits in February and June 2023 to assess STHK's compliance against these standards. MIAA audited assertions which covered each data security standard of the DSPT including, Personal Confidential Data, Staff Responsibilities, Business Continuity Planning and Unsupported Systems. These areas cover thirteen assertions (see below) which this year have been selected by NHS Digital. Due to the involvement of NHS Digital the audits have changed significantly with additional evidence and assurance required in all areas being reviewed. The scope of the review included mandatory elements only.

Area	Description
1.3	Accountability and Governance in place for data protection and data security
2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards
3.4	Leaders and Board members receive suitable data protection and security training

4.1	The organisation maintains a current record of staff and their roles
4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems
4.5	You ensure your passwords are suitable for the information you are protecting
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents.
6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents.
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.
8.3	Supported systems are kept up-to-date with the latest security patches.
9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities
10.1	The organisation can name its suppliers, the products and services they deliver and the contract durations

STHK received the audit report from MIAA in June which has confirmed a rating of ‘Substantial Assurance,’ this is the same as the previous year.

Substantial Assurance

STHK was also assessed against the risk rating score at the National Data Guardian Standard level.

National Data Guardian Standard level	Overall assurance rating at the National Data Guardian level
1. Personal Confidential Data	● Substantial
2. Staff Responsibilities	● Substantial
3. Training	● Substantial
4. Managing Data Access	● Substantial
5. Process Reviews	● Substantial
6. Responding to Incidents	● Substantial
7. Continuity Planning	● Substantial
8. Unsupported Systems	● Substantial
9. IT Protection	● Substantial
10. Accountable Suppliers	● Substantial

An assessment as to the veracity of the organisation's self-assessment / DSPT submission and the assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

As a result of the above, the overall assurance level across all 10 National Data Guardian Standards is rated as:

Substantial Assurance

Areas of Good Practice received from MIAA Audit Report

Assertion	Areas of Good Practice
1.3.1	Key policies and procedures were in place, in date and evidence of ratification provided

1.3.4, 1.3.9	The Information Governance Policy sets out the framework on how data security and protection is translated into effective organisational practices. This included, key roles and responsibilities, governance bodies, compliance, and training requirements.
1.3.5, 1.3.6	The Trust demonstrated its arrangements for corporate risk management that was operating through strategy, policy and procedures. Risks were captured through the risk management solution, Datix and subject to ongoing monitoring at the Risk Management Council
1.3.8	Processes were in place for ensuring compliance with data protection by design and default principles.
4.5.1, 4.5.2, 4.5.3, 4.5.4	Password policies and supporting processes, including those for privileged users were found to be strong. There were technical controls and solutions in place to enforce policies settings, privileged users were required to sign up to acceptable use and checks were included in the monthly cyber assurance checks. Multi-Factor authentication (MFA) was in place for administrators and a privileged access management (PAM) solution was also deployed.
5.1.1	Data security and protection incidents were being reported and investigated with evidence of root cause analysis and lessons learned demonstrated
7.3.4, 7.3.5, 7.3.6	The Trust confirmed how it was managing its backups, the cyber quality checks included confirmation of monthly test restores taking place. Immutable / offline backups were in place to enable disaster recovery and protection from ransomware
8.3.1, 8.3.2, 8.3.3, 8.3.4, 8.3.5	A documented process was in place and operating for applying security updates (patching), including management of NHS Cyber Alerts (CareCERTs). Key performance indicators had been agreed, with compliance reported within the monthly cyber assurance checks
9.3.8	A solution, Armis, was in use to enable monitoring and management of smart / connected medical devices, with processes maturing.
10.1.1	Details relating to IT suppliers / contracts were held within a centralised register

Recommendations received from MIAA Audit Report

MIAA have identified the following areas that will require further attention in2023-24. An action plan is in place with assigned owners and dates to ensure these areas are actioned. The action plan specific to STHK will be presented to the SIRO at the Information Governance Steering Group in July:

Assertion	Recommended Areas of Improvements
1.3.2	The Trust should develop a schedule of compliance audits and seek approval to demonstrate coverage across the Trust and provide a broader view on compliance with Trust IG and security policies.
2.1.1	As planned, continue to track completion of the Trust's induction / IG training issues with follow up e mails and contact with the line manager, to ensure full compliance with the 30 day policy.
3.4.2	Confirm that all Board members have received the appropriate Cyber training in line with the training needs analysis
4.2.3	Consider developing Standard Operating Procedures (SOP) around the management of the logs and alerts received to demonstrate that they are being managed comprehensively between the teams
4.5.2	Consider deploying a password deny solution that can be customised e.g. denial of geographical location / references
4.5.3	Include the plan for the deployment of MFA across the Trust in the Cyber Strategy currently being developed.
7.2.2	Complete the Action Plan arising from the 15 June 2023 Table Top exercise, assigning actions to named individuals with defined timescales for completion.
9.3.9	Develop a medical devices policy and procedures that articulate how the Trust manages the data security and connectivity of medical devices throughout their lifecycle

Conclusion

Mersey and West Lancashire Teaching Hospitals NHS Trust will continue to build and improve on the Information Governance and IT Security foundations which have been embedded previously by STHK, ensuring that any recommendations provided by MIAA to STHK are completed. STHK have demonstrated they had excellent IG and IT Security processes in place by the successful completion of the Data Security and Protection Toolkit and a positive audit.

Report Ends.

Trust Board

Paper No: MWLTB (23)019b
Title of paper: Data Security and Protection Toolkit (DSPT) - Final Submission Report 2022/23 for Southport and Ormskirk Hospital NHS Trust
Purpose: To provide the Trust Board with assurance that Southport and Ormskirk Hospital NHS Trust (S&O) operated within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.
Summary: This Report summarises S&O's status of the Data Security and Protection Toolkit (DSPT) for its 2022 – 23 submission. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to and process patient / personal data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly and in line with data protection legislation. When considering data security as part of the 'Well Led Key Line of Enquiry' as part of the Care Quality Commission (CQC) inspections, they will consider how organisations are assuring themselves against these standards. The submission date for the DSPT is now the end of June and there are no plans to move it back to the month of March (as it was up until 2020). S&O submitted the DSPT assessment at the end of June 2023 for the 2022-23 submission and was able to submit evidenced items for all the assertions as required as part of the submission, S&O achieved a "standards met" rating for the submission. Mersey Internal Audit Agency (MIAA) audited a number of the assertions and evidenced items. S&O has received the rating of 'Substantial Assurance' against its DSPT.
Financial implications: • *None directly from this report.*
Corporate objectives met and risks addressed : S&O were responsible for ensuring compliance with Data Protection / UK GDPR and Data Security requirements and were required to demonstrate annual compliance through the DSPT. This was achieved.
Stakeholders: *Staff, Patients, Executive Committee, Trust Board and Commissioners.*

Recommendation(s): • The Board to note and approve the contents of this report.
Presented by: Christine Walters, Director of Informatics
Date of meeting: 26th July, 2023

Introduction

The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. It is based on the National Data Guardian ten data security standards (covering topics such as staff responsibilities and continuity planning (National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) and legal rules relevant to IG and personal data (UK General Data Protection Regulation 2016 and the Data Protection Act 2018).

All organisations that have access to and process patient / personal information must provide assurances that they are practising good information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The DPST this year contained 113 mandatory 'assertions' that required evidencing. Each mandatory requirement has to be addressed in order to submit a successful assessment - if this was not achieved S&O would have been considered non-compliant.

The DSPT submission date up until 2020 had always been the end of March, this has now changed and is the end of June. S&O submitted a successful DSPT before the deadline and met all mandatory requirements.

Larger organisations, such as Acute Trusts, are also required to have their DSPT submission externally audited to ensure the accuracy of their submission. The objective of this exercise is to provide independent assurance over a nationally determined sample of evidence items and to highlight areas for improvement to inform the 2022-23 DSPT submission.

Failure to complete the DSPT can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact S&O 's ability to bid for new services in the future. In addition this could have placed S&O 's reputation at risk. The Information Commissioner has also indicated that satisfactory completion of the DSPT can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2022/23Submission

Evidence has been provided for the self-assessment against the 10 National Data Guardian Standards and the associated assertions that sit under each standard. These items are recorded under assertions and represent an indicator of maturity in that area. There are in 113 mandatory assertion items that require evidence.

For example, in order to comply with Standard 1 for 'Personal Confidential Data', S&O has to provide evidence for the assertions as detailed below:

1.1	**The organisation has a framework in place to support Lawfulness, Fairness and Transparency**		
1.1.1	State your organisation's Information Commissioner's Office (ICO) registration number.	Mandatory	**COMPLETED**
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Mandatory	**COMPLETED**
1.1.3	Transparency information (e.g. your Privacy Notice and Rights for individuals) is published and available to the public.	Mandatory	**COMPLETED**
1.1.4	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Mandatory	**COMPLETED**
1.1.5	List the names and job titles of your organisation's key staff with responsibility for data protection and data security.	Mandatory	**COMPLETED**
1.1.6	Your organisation has reviewed how it asks for and records consent to share personal data.	Mandatory	**COMPLETED**
1.1.7	Data quality metrics and reports are used to assess and improve data quality.	Mandatory	**COMPLETED**
1.1.8	A data quality forum monitors the effectiveness of data quality assurance processes.	Mandatory	**COMPLETED**

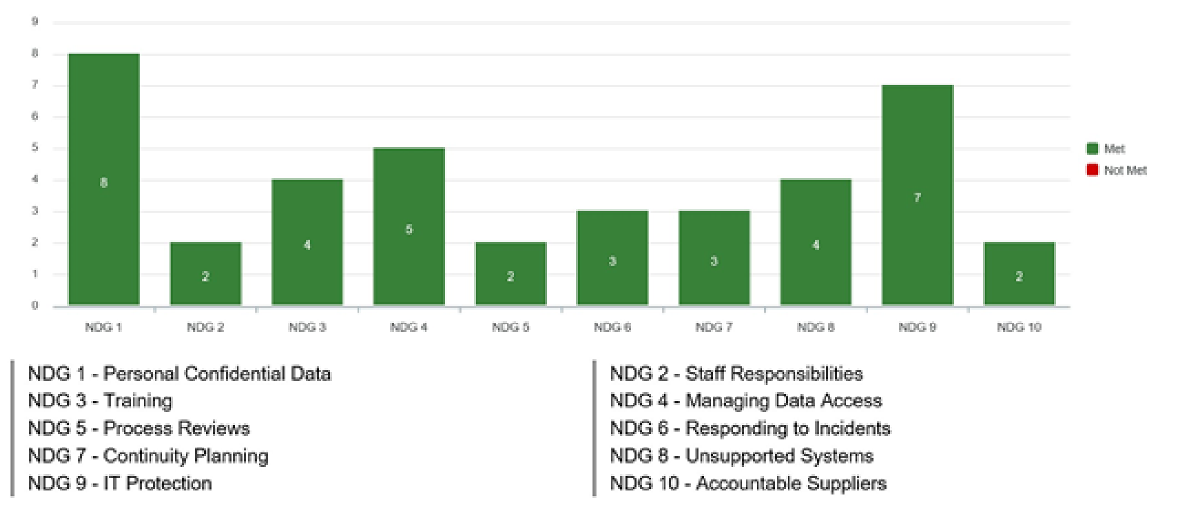
1.2	**Individuals' rights are respected and supported**		
1.2.2	Your organisation has processes in place to deliver individuals rights including to handle an individual's objection to the processing of their personal data.	Mandatory	**COMPLETED**
1.2.3	Your organisation has a process to recognise and respond to individuals' requests to access their personal data.	Mandatory	**COMPLETED**
1.2.4	Your organisation is compliant with the national data opt-out policy.	Mandatory	**COMPLETED**

1.3	Accountability and Governance in place for data protection and data security		
1.3.1	There are board-approved data security and protection policies in place that follow relevant guidance.	Mandatory	**COMPLETED**
1.3.2	Your organisation monitors your own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	Mandatory	**COMPLETED**
1.3.3	SIRO responsibility for data security has been assigned.	Mandatory	**COMPLETED**
1.3.4	There are clear documented lines of responsibility and accountability to named individuals for data security and data protection.	Mandatory	**COMPLETED**
1.3.5	Your organisation operates and maintains a data security and protection risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility.	Mandatory	**COMPLETED**
1.3.6	List your organisation's top three data security and protection risks.	Mandatory	**COMPLETED**
1.3.7	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	Mandatory	**COMPLETED**
1.3.8	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to your existing risk management and project management, to action this.	Mandatory	**COMPLETED**
1.3.9	Data security and protection direction is set at board level and translated into effective organisational practices.	Mandatory	**COMPLETED**

1.4	Records are maintained appropriately		
1.4.1	The organisation has a records management policy including a records retention schedule.	Mandatory	**COMPLETED**

For S&O to have achieved “standards met”, all of the mandatory items with the DSPT had to be completed. . Our baseline assessment was submitted to NHS Digital in February 2023.

S&O successfully completed the DSPT in time for the end of June 2023 submission date. A summary of how the 2022/23 submission looked is shown below:

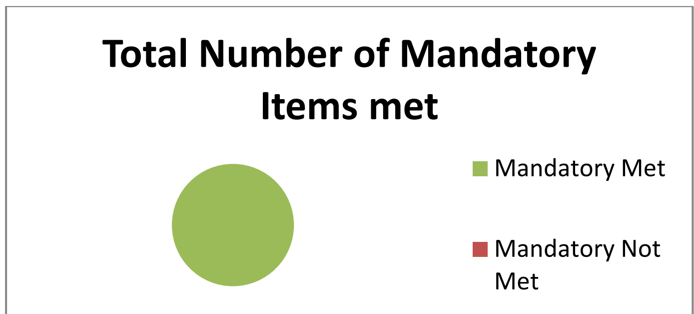


The table below shows the status of **Mandatory** evidence items met applicable for S&O :

Data Standard	Number of Requirements	IT Sec Owner	IG Owner	DQ Owner	Total Evidence item provided
1	21	4	15	2	21/21
2	2	0	2	0	2/2
3	7	2	5	0	7/7
4	12	12	0	0	12/12
5	1	1	0	0	1/1
6	13	10	3	0	13/13
7	9	9	0	0	9/9
8	16	16	0	0	16/16
9	29	29	0	0	29/29
10	3	2	1	0	3/3
Total	113	85	26	2	113

Evidence was required from S&O's IT Security, Information Governance (IG) and Data Quality (DQ) teams. The table above shows that IT Security were required to provide 85 mandatory items of evidence, IG – 26 and finally DQ providing 2 items.

The chart below shows the Mandatory evidence items met:



Summary of Results:
Total Number of Data Standards = 10
Total Number of Mandatory Evidence Items required = 113
Total Number of Mandatory Evidence Items achieved = 113

DSPT Approval

In order to submit and publish the DSPT once all evidence has been provided the SIRO must provide final approval. On the 27th of June, the IG Team presented the SIRO with the evidence that had been provided for S&O's DSPT. The SIRO has approved the submission of the DSPT for 2022/23, subject to recommendation from MIAA being actioned.

Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of S&O 's DSPT submission (as required of larger NHS organisations) during two visits in February and June 2023 to assess S&O 's compliance against these standards. MIAA audited assertions which covered each data security standard of the DSPT including, Personal Confidential Data, Staff Responsibilities, Business Continuity Planning and Unsupported Systems. These areas cover thirteen assertions (see below) which this year have been selected by NHS Digital. Due to the involvement of NHS Digital the audits have changed significantly with additional evidence and assurance required in all areas being reviewed. The scope of the review included mandatory elements only.

Area	Description
1.3	Accountability and Governance in place for data protection and data security
2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards
3.4	Leaders and Board members receive suitable data protection and security training

4.1	The organisation maintains a current record of staff and their roles
4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems
4.5	You ensure your passwords are suitable for the information you are protecting
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents.
6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents.
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.
8.3	Supported systems are kept up-to-date with the latest security patches.
9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities
10.1	The organisation can name its suppliers, the products and services they deliver and the contract durations

S&O received the audit report from MIAA in June which has confirmed a rating of ‘Substantial Assurance,’ this is the same as the previous year.

Substantial Assurance

S&O was also assessed against the risk rating score at the National Data Guardian Standard level.

National Data Guardian Standard level	Overall assurance rating at the National Data Guardian level
1. Personal Confidential Data	Substantial
2. Staff Responsibilities	Substantial
3. Training	Substantial
4. Managing Data Access	Substantial
5. Process Reviews	Substantial
6. Responding to Incidents	Substantial
7. Continuity Planning	Substantial
8. Unsupported Systems	Substantial
9. IT Protection	Substantial
10. Accountable Suppliers	Substantial

An assessment as to the veracity of the organisation's self-assessment / DSPT submission and the assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

As a result of the above, the overall assurance level across all 10 National Data Guardian Standards is rated as:

Substantial Assurance

This was an improvement on last year, where the overall rating was 'Moderate Assurance.' Although 8 and of 10 NDG Standards received 'Substantial Assurance,' NDG Standard 9 – IT Protection and NDG Standard 10 – Accountable Suppliers were rated as 'Moderate Assurance' which lowered the assurance.

Areas of Good Practice received from MIAA Audit Report

Assertions	Areas of Good Practice
1.3.1 & 1.3.2	There was a range of IG policies and procedures in place which were all within their review period. The Trust had in place a process to monitor compliance with the policies.
1.3.3 & 1.3.4	The Trust's SIRO role and responsibility was clearly defined. There was a defined organisational structure in place for the management of information governance and data security at the Trust.
1.3.5 & 1.3.6	It was identified that data security and protection risks were being managed in line with the risk management policy.
1.3.9	Responsibility for data protection and security had been delegated by the Board to the Quality and Safety Committee and ultimately the IGSG.
4.2.1 & 4.2.4	Testing undertaken on a sample of leavers identified that each had their access removed in line with the IT Standard Operating Procedure for Managing Leaver Accounts. None of the sampled leavers had accessed their accounts subsequent to their termination date.
4.2.3	The Trust had a Logging and Monitoring Standard which governed the review and collection of activity logs. We were provided evidence that user activity logs were retained for at least 2 years.
4.5.1 & 4.5.2	There were password controls in place at the Trust including password deny lists, password management tools and multi-factor authentication (MFA).
5.1.1	There was a robust incident management and root cause analysis (RCA) process in place at the Trust. Since July 2022, there had been no incidents that required an RCA to be undertaken 5.1.1.
6.3.1	Furthermore, we were informed that there were no data security incidents that had resulted from a known vulnerability.

7.3.6	The Trust had a tape backup solution that provide an immutable version of the Trust's critical systems backup.
6.3.2	Review of the Trust's Cyber Alert KPI report identified that every cyber alert had been responded to within 48 hours.
8.3.2	We were provided evidence that the Trust had the ability to automatically deploy patches to endpoints.
8.3.3, 8.3.4 & 8.3.5	We tested a sample of high risk vulnerabilities issued by the NHS Cyber Alert service and identified that each had been remediated within 14 days of issue.
8.3.6	There was evidence that the Trust was actively using Advanced Threat Protection (ATP) and Microsoft Defender for Endpoint (MDE) as a key part of the cyber security monitoring tooling.
8.3.7	Evidence was provided that the Trust's server and endpoint estate was above 95% and 98% respectively.
8.3.8 & 9.3.7	The Trust was registered for and was actively using the NCSC's suite of services including the early warning service and the Webcheck service.

Recommendations received from MIAA Audit Report

MIAA have identified the following areas that will require further attention in2023-24. An action plan is in place with assigned owners and dates to ensure these areas are actioned. The action plan specific to S&O will be presented to the SIRO at the Information Governance Steering Group in July:

Assertions	Area requiring improvement
3.4.1 & 3.4.2	The Training Needs Analysis (TNA) could be improved by including the frequency of additional training for specialist roles such as the SIRO and Caldicott Guardian.

4.1.1 & 4.5.3	The Trust should continue to develop plans to undertake a key system review and implementation of multifactor authentication (MFA) following the proposed merger with St Helens and Knowsley Hospitals NHS Trust
4.5.4	As planned, the Trust should undertake a penetration test which includes default passwords on infrastructure components. Any actions should be reported to a relevant group or committee for oversight
6.3.3	The Trust should develop a cyber security strategy with consideration of the proposed Cheshire and Merseyside Integrated Care System (ICS) Cyber Security Strategy. The Trust should consider documenting any gaps in the cyber security monitoring processes once the strategy is in place
6.3.4	It was identified that the Trust could make improvements to its fraud risk assessments process. For example, include documenting which systems have been assessed to be attractive to cyber criminals and the controls in place to mitigate the risk posed
6.3.4	As planned, the Trust should complete, document and report the completion of a disaster recovery and business continuity exercise ahead of submission

Conclusion

Mersey and West Lancashire Teaching Hospitals NHS Trust will continue to build and improve on the Information Governance and IT Security foundations which have been embedded previously by S&O, ensuring that any recommendations provided by MIAA to S&O are completed. S&O have demonstrated they had excellent IG and IT Security processes in place by the successful completion of the Data Security and Protection Toolkit and a positive audit.

Report Ends.

Title of Meeting	**TRUST BOARD**	**Date**	**26th July 2023**
Agenda Item	**MWLTB (23)020**	**FOI Exempt**	**YES / NO**
Report Title	**S&O EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT (APRIL 2022 to MARCH 2023)**		
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance		
Lead Officer	Sharon Gibson-Clarke, Emergency Preparedness, Resilience and Response Manger		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose
To approve the Emergency Preparedness, Resilience and Response (EPRR) Annual Report.
Executive Summary
The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be presented to the governing committee which will ultimately report to Trust Board.
Recommendations
Once approved, the EPRR Annual Report be retained as evidence for the Core Standards Self-assessment process.

Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	☐ **Quality & Safety Committee** ☐ **Workforce Committee** ☐ **Audit Committee**

Strategic Objectives
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
☐ **SO3** Efficiently and productively provide care within agreed financial limits
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Sharon Gibson-Clarke, EPRR Manager	Sue Redfern, Director of Nursing, Midwifery and Governance

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT 2022/2023

1. EXECUTIVE SUMMARY

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be produced for the Trust Board to assure them that the organisation is meeting its obligations.

This report will cover the period 1 April 2022 to 31 March 2023.

Responsibility for Resilience within the UK sits with the Civil Secretariat. Failure to meet the set-out obligations can lead to prosecution via relevant Government agency. NHS England oversees the arrangements within NHS England organisations and provides assurance to the Local Resilience Forum via the Local Health Resilience Partnership. This body of work is known as Emergency Preparedness, Resilience and Response (EPRR).

The Trust must be able to continue to deliver key services during times of disruption as part of the wider health economy. In doing so it must ensure patient and staff safety and take into account stakeholder considerations.

This report aims to update the Board on progress in this matter and sets out how the Trust meets its obligations. The Trust is required to have an up-to-date Major Incident Plan and Business Continuity Plan. These must be updated following a major incident, exercises and/or other learning.

The responsibility for EPRR sits within the portfolio of the Chief Operating Officer (COO). The work is managed on a daily basis by the EPRR Manager and supported by an Associate Specialist from the Emergency Department. The work programme is managed through the Resilience Group, which is chaired by the COO. The Resilience Group meets monthly with representatives from across the organisation and during the reporting period, reports directly via the Alert, Advise, Assure (AAA) report into the Risk and Compliance Group.

2. LEGAL OBLIGATIONS

As a Category 1 responder, the Trust has the following legal obligations:

a) Co-operation with other responders
b) Risk Assessment
c) Emergency Planning
d) Communicating with the public
e) Sharing information
f) Business Continuity Management

Ways that the Trust is meeting these obligations are listed below:

a) Co-operation with other responders

The Trust is represented by the COO and EPRR Manager at the Local Health Resilience Partnership (LHRP) Strategic and Tactical meetings and relevant sub groups.

The Trust has participated in various exercises and meetings with multi agency partners, including NHS England, provider Trusts, commissioners and other partners including the Police, Fire Service and NWAS.

On 29 November 2022, the ICB arranged a Table Top exercise - Exercise Arctic Willow. This involved all Trusts in the Cheshire & Mersey region. The aim of the exercise was to explore the health response to multiple concurrent operational and winter pressures in England and the interdependencies with Local Resilience Forum partners in responding to these pressures. The pressures consisted of:

- Potential medical supply disruption.
- Energy supply disruption.
- Adverse winter weather
- Prolonged and significant industrial relations action including strikes.
- Reduced staffing numbers resulting from multiples concurrent operational issues and winter pressures.

As part of the exercise, EPRR arrangements were reviewed which included the practicalities of mutual aid from resilience partners, business continuity arrangements and options available to maintain patient flow.

Key Managers from the Trust participated in the preparation for Arctic Willow and the EPRR Manager was in attendance on the day.

b) Risk Assessment

Under the CCA 2004 the Trust has a statutory obligation as a Category 1 responder “from time to time to assess the risk of an emergency occurring” (CCA 2004 Part 1, Section 2).

EPRR risk assessments are completed in line with the National Risk Register (NRR) and Community Risk Registers (CRR) and apply to any risk to our patients, staff and premises or at-risk areas.

Pandemic Influenza remains the top national risk, followed by Cyber Attack, Climate Change (ie, Flooding, Heatwave, etc) and Loss of Critical Infrastructure (ie, national power loss, water and telecoms).

There is also a Local Resilience Forum (LRF) Community Risk Register which shows that the highest risks are the same as those on the National Risk Register.

Any items of concern or risk to the Trust will be received at the Resilience Group (RG) meeting and added to the Trust Risk Register if required.

c) Emergency Planning

The Major Incident Plan and the Business Continuity Management Plan require Board approval. Emergency Plans are reviewed three yearly as a minimum and shared with multi agency partners. Once developed, plans are exercised to ensure they are fit for purpose.

The Major Incident Plan has been fully reviewed and amended following an audit by MIAA which identified one ‘low’ risk rated recommendation (reference to CCGs to be changed to ICBs).

With effect from 29 March 2023 the UK Covid-19 alert level system was suspended. The suspension of the system reflects the transition to Living with Covid-19 and this has been achieved due to the success of the vaccination programme and availability of treatments for those who need them.

The UK Health Security Agency (UKHSA) continues to track the latest Covid-19 epidemiology through numerous surveillance systems.

The Trust's Vaccination Centre, housed in the Corporate Management Office on the Southport Hospital Site, was dismantled on 23 April 2022.

d) Communicating with the public

The Trust continues to explore ways of communicating with the public. Social media has enormous potential to help the NHS reach patients and service users who do not use traditional communications and engagement channels. During the year, the Trust has used a range of methods to communicate with the public, including local radio, local TV, local press, Facebook, Twitter and a public facing Trust website.

e) Sharing information

Under the CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of co-operation.

The Trust receives alerts from an online private network called Resilience Direct, which is run by the Cabinet Office and enables civil protection practitioners to work together, across geographical and organisational boundaries, during the preparation, response and recovery phases of an event or emergency. The network helps organisations fulfil their obligations under the Civil Contingencies Act to co-operate and share information to ensure that action is co-ordinated.

f) Business Continuity Management

The Trust Business Continuity Management Plan is updated as a minimum every three years. This is due to be updated in April 2025. The Plan sets out the framework that the Trust should follow when responding to disruption in line with legal obligations and EPRR guidance. Wards and Departments are responsible for developing their own plans and updating them annually as a minimum and immediately post incident or if there is a change of service. If support is required, this will be provided by the EPRR Manager.

The Trust experienced disruption to its business continuity through various incidents such as power outages, imaging equipment failures, IT downtime and is continually looking at ways to minimise the impact these incidents have. Debriefs are held to ensure valuable learning and information to help improve performance. Action plans are drawn up following the debrief to address the issues raised. Incidents are discussed and recorded at the Resilience Group meetings and actions taken as appropriate.

The Trust implemented its Business Continuity Plans (BCPs) on several occasions when planned downtimes were requested and agreed via the Resilience Group or the Senior Operational Leadership Team meeting (SOLT). Additionally, unplanned outages affected a number of areas on occasions across both Southport and Ormskirk hospital sites requiring Wards/Departments to revert to BCPs (see Appendix A).

Following the MIAA audit a selection of BCPs were reviewed which resulted in one 'low' risk rated recommendation - two plans did not include a review date – this has since been rectified.

3. TRAINING

Training and awareness sessions have been held with various groups across the Trust including staff who cover on call at Tactical and Operational levels. Training held within the Trust during the period 1 April 2022 – 31 March 2023 are listed at Appendix A.

4. EXERCISES

A requirement of NHS England Emergency Preparedness,
Resilience and Response Core Standards requires Acute Trusts to participate in planned exercises with external partner organisations. Exercises held are listed in Appendix A.

Given the impending transaction with St Helens & Knowsley (StHK), the EPRR Training and Exercise Plan was produced based on future exercises potentially needing to be aligned with StHK.

In this reporting period a Trust-wide Mass Casualty Table Top Exercise - Exercise Florence took place (28 September 2022). This exercise was held off site at The Bliss Hotel in Southport. External partners from NHS England, Cheshire & Merseyside ICB, NWAS and Merseyside Fire & Rescue Service were invited to observe, provide advice and offer suggestions/feedback. Along with the external partners, 55 Trust staff members from various roles and level of authority were in attendance.

The exercise was successful and the feedback from all that attended was extremely positive.

A live Lockdown Exercise is planned once the new Access Control system is in place at the Ormskirk Hospital Site.

5. GOVERNANCE AND OVERSIGHT

The workplan for EPRR is managed through the Resilience Group which reports on progress, through the AAA reporting system, to the Risk and Compliance Group. The workplan and actions are managed within that meeting.

As a Category 1 responder the Trust must report progress and provide assurance with regard to emergency planning to Trust Board.

6. COMPLIANCE WITH STATUTORY AND NON-STATUTORY REGULATIONS

The Trust is required to complete an annual EPRR Core Standards self-assessment to NHS England and submit a statement of compliance to the Trust Board. Compliance levels are *Full, Substantial, Partial* and *Non-compliant*.

In the submission for 2022/23, NHSE assigned the Trust an EPRR Assurance Rating of SUBSTANTIAL as the Trust achieved 97% compliance (see Appendix B).

7. RECOMMENDATIONS

In line with our legal obligations as a Category 1 responder to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place, the Trust Board is asked to acknowledge this Annual Report on Emergency Preparedness, Resilience and Response (EPRR).

The arrangements the Trust has in place as outlined in this Annual Report are in line with our legal obligations as set out in the Civil Contingencies Act 2004 and NHS England EPRR guidance.

Sharon Gibson-Clarke
EPRR Manager
06/06/23 (Version 3)

APPENDIX A

Incidents, Exercises and Training between 1 April 2022-31 March 2023

	INCIDENTS
29/04/22	Crane lift at SDGH to remove damaged chimney stacks
20/07/22	New Discharge Lounge opened
10/08/22	Aintree Hospital Incident - Electrical Fire in Plant Room impacting Critical Care and ED
08/09/22	Critical IT Incident
27/10/22	Power Incident Failure on the Southport Hospital Site
05/12/22	Increase in Invasive Group A Strep (GAS)
13/12/22	Trust Full to Capacity and declared Opel Level 4
20/12/22	Trust Full to Capacity and declared Opel Level 4
28/12/22	Trust Full to Capacity and declared Opel Level 4
30/12/22	Trust Full to Capacity and declared Opel Level 4
03-06/01/23	Trust Full to Capacity
18/01/23	Upgrade to Ormskirk Telephone System
26/01/23	Chartered Society of Physiotherapists Industrial Action
01/02/23	Upgrade to Southport Telephone System
21/02/23	Trust Full to Capacity
14-16/03/23	Junior Doctors' Industrial Action

	TRAINING AND EXERCISES
28/04/22	Loggist Train the Trainer delivered by NHS England
03/05/22	Ward Managers - EPRR Awareness (as part of Development Away Day)
25/05/22	Bed Managers' Training - Major Incident, Evacuation, Lockdown, CBRNe, etc.
23/06/22	ODGH Bleep Holders Major Incident Awareness Training
03/08/22	Bed Managers' Major Incident Response Awareness
07/09/22	Major Incident Training to ED Staff
08/09/22	Decontamination Tent Training
08/09/22	PRPS Training
28/09/22	Major Incident Table Top Exercise - Bliss Hotel, Southport
06/10/22	PRPS Training
06/10/22	Decontamination Tent Training
12/10/22	ODGH Bleep Holders Major Incident Training
19/10/22	PRPS Training
20/10/22	PRPS Refresher Training
08/11/22	PRPS Training
16/11/22	PRPS Training
08/01/23	Major Incident Triage Training
22/02/23	Major Incident Triage Training
08/03/23	Major Incident Triage Training
08/03/23	PRPS Training
2022/2023	External Training to General Manager On Call Team covering Tactical Command and Control
2022/2023	External Training to Executive Team covering Strategic Command and Control

Summary of 2022/23 Self-Assessment

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Acute Trusts	Compliance Level	Compliance Trend from 2021/22	Fully compliant standards	Partially compliant standards	Non-compliant Standards	Overall compliance percentage
Southport and Ormskirk	Substantial	Reduced	62	2	0	97%