Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 30TH JANUARY 2019
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
		1.1	December 2018		
		1.2	January 2019		
09:40	2.	Patient Story		Verbal	
10:00	3.	Apologies for Absence		Verbal	
	4.	Declaration of Interests		Verbal	
	5.	Minutes of the Previous Meeting held on 28th November 2018		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(19) 1	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Nik Khashu
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.30	7.	Committee Report – Executive		NHST(19) 2	Ann Marr
10:40	8.	Committee Report – Quality		NHST(19) 3	Val Davies
10:50	9.	Committee Report – Finance & Performance		NHST(19) 4	Jeff Kozer
BREAK					
Other Board Reports					
11:05	10.	Corporate Risk Register		NHST(19) 5	Nicola Bunce

11:15	11.	Board Assurance Framework	NHST(19) 6	Nicola Bunce
11.25	12.	Quarter 2 Overview of Complaints, Claims & Incidents	NHST(19) 7	Sue Redfern
11.35	13.	Safeguarding Report (Adults & Children)	NHST(19) 8	Sue Redfern
11.45	14.	HR Indicators Report	NHST(19) 9	Anne-Marie Stretch
11:55	15.	Learning from Deaths Quarterly Update (including guidance on Working with Families)	NHST(19) 10	Kevin Hardy
12:05	16.	Approval of the St Helens Cares Collaboration Agreement and Governance Arrangements	NHST(19) 11	Nicola Bunce
Closing Business				
12:15	17.	Effectiveness of Meeting	Verbal	Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 27th February 2019		

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 28th November 2018 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr D Mahony	(DM)	Non-Executive Director
Members:	Ms A Marr	(AM)	Chief Executive
	Ms S Rai	(SR)	Non-Executive Director
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs J Quinn	(JQ)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Prof K Hardy	(KH)	Medical Director
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mr P Williams	(PW)	Director of Facilities Management/Estates
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Mr K Lomas	(KL)	Local Democracy Reporter for St Helens Reporter, *(Observer)*
	Cllr A Lowe	(AL)	Councillor, Halton CCG
	Mr M Weights	(MW)	Governing Body Lay Member, St Helens CCG
	Mrs K Hughes	(KHu)	Head of Media, PR & Comms *(Observer)*
	Ms S Clark	(SC)	Head of Corporate Finance *(Observer)*
	Ms S Ainsworth	(SA)	Interim Head of Midwifery, Obs and Gynae *(for Patient Story only)*
	Ms H Cain	(HC)	Quality Matron *(for Patient Story only)*
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
Apologies:	Mr R Fraser	(RF)	Chairman
	Mrs C Walters	(CW)	Director of Informatics

1. Patient Story

1.1. RO attended the meeting with SA and HC to share her experience of the Trust's Maternity Service.

1.2. RO had found the birth of her son at another hospital 2 years' earlier to be a very traumatic experience and expressed a wish to have a home birth with her second baby.

1.3. RO engaged with the same midwife from her initial 12 week review, for continuity of care who, in accordance with Trust policy, informed RO of the risks associated with a home birth. Their relationship became strained however, as RO wanted to keep everything as natural as possible and felt the midwife was 'too clinical' by repeatedly pointing out the risks. When RO's pregnancy continued beyond her due date the midwife advised that the risks were increasing and advised that it might be necessary to start her labour. An appointment was made with a Consultant to discuss the birth plan. During this appointment RO again expressed her wish to have a home birth and explained that she was fully informed of the risks and although the Consultant was concerned due to the size of the baby, acknowledged RO's wish and referred her to a specialist midwife. RO had a very positive experience with the second midwife who was able to support her in her wishes and reduce her stress and anxiety. At 42 weeks + 4 days, RO went into labour naturally and the midwife arrived within 20 minutes of RO calling her. RO gave birth to a healthy daughter weighing 10lbs 11oz.

1.4. DM asked RO what she would have liked to have been different about her experience. RO felt that she had wanted to be listened to and feel she was working in partnership with the Midwifery team. She had made an informed decision about the type of birth she had wanted and felt that this could have been better acknowledged and respected throughout her pregnancy.

1.5. AM was pleased that RO had had the birth she wanted in the end but felt she shouldn't have had to work so hard to get it. She suggested the Trust needed to think about what it could do differently to support mothers who were fully informed rather than try to change their mind.

1.6. SR asked, apart from listening more, was there anything else RO would recommend in terms of changing the process.

1.7. RO believed continuity of care with the same midwife was a good thing, although patients should be made aware they had the option to change midwife if necessary, as this was a very important relationship and if it didn't feel right it could impact on the whole experience. RO stated that this was not a criticism of the individuals concerned just an acknowledgement that sometimes people didn't "click".

1.8. SA informed Board members the department was looking to provide continuity of care from a small team of midwives; which would hopefully circumvent any incompatibility issues. SA recognised a different mentality was required by midwifery staff, to accept a less medicalised model of care. Working with midwives on the continuity of care agenda would help move the service towards that.

2. Employee of the Month

2.1. The Employee of the Month Award for November 2018 was presented to Jamie Barnes, Burns and Plastic Surgery Registrar.

3. Apologies for Absence

3.1. Apologies were noted from RF and CW.

4. Declaration of Interests

4.1. There were no declarations of interest.

5. Minutes of the previous meeting held on 31st October 2018

5.1. **Correct Record**

5.1.1. The minutes were accepted as a correct record, once the attendance was amended to include VD, who had been present;

5.1.2. The salutation for TH was changed to 'Dr';

5.1.3. Minute 13.6, add "… and he would provide a consolidated report for the Quality Committee in January".

5.2. **Action List**

5.2.1. Action 7, Minute 4.2.3 (31.10.18) – *SRe to ensure 'back office' departments are included in the 2019 QWR timetable* – SRe confirmed the schedule for 2019 had been finalised and QWRs would resume in the New Year.

5.2.2. Action 10, Minute 7.4 (31.10.18) – *KH to investigate the positive shift in HSMR and report back to Board* – KH had completed the investigation and produced a short report for Board which demonstrated that the reported the improvement in mortality performance was due to the underlying mortality rate falling. The rate had not fallen naturally, so the conclusion was that the outcomes of the care the Trust provided had resulted in less people dying.

In response to a query from AM, KH confirmed the crude mortality rate always fluctuated over the winter months; the important difference to measure was between observed and expected mortality.

SR queried how the Trust compared with its peers. KH confirmed STHK performed consistently better than other local acute Trusts in the North West, and in terms of crude mortality STHK outperformed acute peers nationally. London had a historically low Standard Hospital Mortality Index (SHMI) and the rest of the country was higher.

DM noted the consistent reduction since 2014 and asked whether it was now reaching a plateau. KH stressed that the important thing was the difference between observed and expected mortality rather than the absolute numbers, because the Trust was admitting more people with complicated co-morbidities which was reflected in this ratio.

6. Integrated Performance Report (IPR) – NHST(18)99

The key performance indicators (KPIs) were reported to the Board, following in-depth scrutiny of the full IPR at the Quality and Finance and Performance Committees.

6.1. Quality Indicators

6.1.1. SRe presented the performance against the key quality indicators.

6.1.2. There had been one never event year to date in July.

6.1.3. There had been no MRSA bacteraemia cases in the year to date.

6.1.4. There was 1 C.Diff positive case in October 2018. Year to date there had been 14 cases, of which 1 was still subject to appeal. The annual tolerance for 2018/19 was 40.

6.1.5. There were no grade 3 or 4 avoidable pressure ulcers in the year to date.

6.1.6. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for October 2018 was 95.1% and year to date performance was 96.0%.

6.1.7. There had been 2 patient falls resulting in severe harm in September.

6.1.8. Venous thromboembolism (VTE) performance for September was 95.80%. Year to date performance was 95.81% against a target of 95%.

6.1.9. Year to date Hospital Standardised Mortality Ratio (HSMR) for (April to June) 2018/19 was 94.3.

6.1.10. In response to a query from DM relating to the 2 falls, SRe confirmed one resulted in a fractured neck of femur and the other a fractured arm. The RCA for the neck of femur fracture was complete; the patient had travelled forwards on getting out of bed. The RCA for the fractured arm was still in progress.

6.2. Operational Indicators

6.2.1. RC presented the update on operational performance.

6.2.2. The 62-day cancer standard was achieved in September at 90.7%.

6.2.3. The 31-day cancer target was also achieved with 97.4% performance against a target of 96%.

6.2.4. The 2-week cancer rule compliance had improved but still underperformed at 90.5% against a target of 93%. The underperformance was due to a combination of increases in 2-week wait referrals and patients rearranging their appointments.

6.2.5. A&E access time performance was 84.1% (type 1). The all types mapped footprint performance for September was 91.97%.

6.2.6. Whiston A&E ambulance notification to handover time was 9.29 minutes on average for October, against a target of 15 minutes. The Trust had consistently achieved this target for 7 consecutive months.

6.2.7. The Trust had already achieved a 13% reduction in the number of Super Stranded patients (patients with a length of stay of greater than 21 days) by the end of October and RC reported that the latest data reported that this had now increased to 18%, so the Trust was on track to achieve the 25% (94 patients) reduction target, by December.

6.2.8. RC also reported that outpatient reporting issues on the new patient administration system had now largely been resolved and RTT reporting would resume by the end of Q3 as agreed with commissioners and regulators.

6.2.9. With reference to the 9,888 type 1 A&E attendances recorded for October, DM asked whether the Trust expected to hit 10,000 attendances. RC expected attendances to be more than 10,000 in November, as it had been in several other months this year. Recent performance had also been impacted by the volume of ambulance attendances arriving together in the late evening.

6.3. **Financial Indicators**

6.3.1. NK presented the update on financial performance.

6.3.2. At the end of month 7, the Trust reported a deficit of £0.3m which was £1.4m behind plan. The variance related to failure to achieve Provider Sustainability Fund (PSF) due to A&E performance in Q1 and Q2.

6.3.3. Within the year to date position the Trust had utilised £4.0m of non-recurrent resources, which was offsetting some of the cost pressures and impact from the Medway PAS implementation as well as under-performance in clinical income.

6.3.4. The Trust had delivered £6.8m CIP year to date against a plan of £6.4m. Whilst plans and ideas for delivery of the full £19m CIPs were in place, a significant proportion remained categorised as high risk, and very little progress had been made with the STP level collaboration schemes during the first half of the year.

6.3.5. The Trust cash balances at the end of month 7 were £12.0m. The Trust was yet to receive over-performance payments from some of its main commissioners relating to Q2. The cash risk relating to the payroll for the 9,000 trainee doctors for 5 Health Education England (HEE) contracts, remained significant, although, NHSI had now agreed to support the Trust in ensuring that all host Trusts paid by

the 15th of each month.

6.3.6. As requested at the last Board meeting, the Finance & Performance (F&P) Committee had completed a review of the forecast outturn position and potential for mitigating recovery actions and JK would provide more detail in the F&P Committee Chair's report.

6.3.7. The financial performance in the month delivered a Use of Resources rating of 3.

6.4. **Workforce Indicators**

6.4.1. AMS presented the update on the workforce indicators.

6.4.2. Absence in October was 4.9%. Qualified nursing and HCA sickness had risen to 6.2% in the month and the YTD performance was 5.6%.

6.4.3. Mandatory training compliance for the core skills framework subjects was 95.2% (target = 85%). Appraisal compliance was 82.5% which was below the target of 85% and AMS reported that "hotspots" had been identified for targeted action.

6.4.4. AMS was pleased to report that the Trust had now achieved 87% flu vaccination rates for clinical staff, which was very positive and reflected a very successful campaign.

7. Committee Report – Executive – NHST(18)100

7.1. AM presented the report to the Board, which summarised Executive Committee meetings held during October 2018:

7.1.1. The Executive Committee had agreed, in light of the tight deadlines, to support the programme set up for the New Early Warning Score 2 (NEWS2), which was required to replace eMEWS by March 2019 in line with national CQUIN requirements. The IT solutions and staffing implications remained subject to business case approval.

7.1.2. The electronic prescribing (EPMA) supplementary business case had been approved to enable electronic prescribing to be rolled out across the Trust.

7.1.3. A review of the Trust's telephone service had been initiated following a number of "Ask Ann" queries and, as a temporary measure to increase resilience of the switchboard, additional staff resources were approved. There were also concerns about telephone answering at ward and department level, which was also a cause for concern.

7.1.4. An initial pilot had been approved for the Trust to offer clinical placements to armed forces personnel, which would provide the Trust with additional capacity and support army personnel to maintain their clinical skills.

7.1.5. DM asked about progress in relation to winter bed capacity. AM explained that this was part of the Winter Plan and had been discussed in detail at the Executive Time Out on 4th October. The Trust continued working with CCGs and Local Authorities to identify potential beds in the community that could be available at short notice. Some additional capacity had been identified but it was recognised that more was needed. Some of the initial schemes had not come to fruition but others had been identified. Where refurbishment work was needed the beds would not be available before January 2019.

7.1.6. SR asked if there were any plans to expand the Armed Forces pilot. TH reported that feedback from the initial Health Care Assistant (HCA) placements had been good. There were more HCA placements planned for January and the possibility of providing placements for qualified nurses and physiotherapists was also being explored.

7.1.7. PG had recently attended the NED induction course and a peer had seen a similar scheme in operation, which had worked well.

7.1.8. VD asked for an update on the Mersey Internal Audit Agency (MIAA) internal audit report on the serious incident process. SR apologised for not reporting on this in the previous month's Audit Committee Chair's report and confirmed that the committee had been assured that there was a robust action plan in place that would address the recommendations. The Audit Committee would be monitoring progress and would escalate to the Board if there remained any issues of concern.

7.1.9. VD asked whether the Executive Committee had reviewed the inpatient survey. NB confirmed that there had been an initial review of the action plan at the meeting on 1st November and a progress report was on the agenda for 6th December, so these would be reported on in the next Executive Committee chair's report.

7.1.10. VD expressed disappointment at not being awarded the heathy eating CQUIN on what appeared to be a technicality, especially as the Trust had worked hard to meet the aims of the CQUIN. NK commented that the standard of compliance required by CCGs had increased as a result of the financial constraints and the Trust was reviewing its internal processes to ensure the CQUIN delivery assurance was strengthened.

7.2. The report was noted

8. Committee Report – Quality – NHST(18)101

8.1. VD presented the report to the Board, which summarised the meeting of 20th November 2018.

8.2. VD highlighted some key points for the Board:

8.2.1. The fasting audit had identified that there was further work required to improve documentation completion. An action plan had been developed and a re-audit scheduled for April 2019, so that progress could continue to be monitored.

8.2.2. VD highlighted a slight increase in complaints compared to the previous month, and response performance had decreased to 84.6% for the month.

8.2.3. Safer staffing continued to be above 90% on the majority of wards and departments, although some areas were more challenged. Nurse recruitment was generally improved; however VD brought the Board's attention to a staffing risk in the A&E department in January, due to 11vacancies. RC explained that many of the posts had been filled, but had start dates later in the year and there were actions being taken to secure bank and agency staff during this period to maintain safe patient care.

8.2.4. Safeguarding update – The Trust is now compliant with all safeguarding training except for PREVENT level 3 and 4 due to a change in the national guidance which means far more staff are required to be trained (from 103 to 3282). It is anticipated that completing training for all these additional staff will take up to 18 months.

8.2.5. Maternity Survey – it had been reported that the response rate had increased to 27%. The Trust responses were in the middle 60% compared to other Trusts, with issues still reported regarding choice. It was noted that this survey was undertaken only shortly after the Sapphire Suite (Midwifery Led Unit) had opened. An action plan to address the issues raised had been developed and progress would be reported back to the Committee.

8.2.6. There had been a report on the Quality Ward Round (QWR) process and lessons learnt for next year's programme. The Quality Committee had asked for "you said, we did" to be built into the process going forward. PG commented that his recent attendance at the Diabetes Services QWR had been an excellent experience and had involved patients. The involvement of patients in QWRs was debated, as the core purpose was staff engagement, and patients were involved via other initiatives.

8.2.7. SR asked when the roll out of safe care to all wards would be completed, and SRe confirmed it was scheduled to be completed in January and would then provide real time information about the acuity of patients.

8.2.8. SR asked what work had been done to make the Organ Donation team stand out and could it be rolled out to other Trusts. KH confirmed the new lead clinician had transformed the service and had a national role.

8.3. The report was noted.

9. Committee Report – Finance & Performance – NHST(18)102

9.1. JK presented the report to the Board, which summarised items discussed at the meeting on 22nd November. JK highlighted the key items:

9.1.1. The committee had received a deep dive report on sickness and was assured about the Trust's performance in comparison to its peers and the management processes in place to support staff to remain or return to work.

9.1.2. Budget Planning - the committee reviewed the national indicative planning timetable for 2019/20 and agreed an outline planning and budget paper would be presented to the committee in January in time for a final plan to be presented at March's Trust Board meeting.

9.1.3. Month 7 Finance – The Committee had reviewed the financial position and the forecast outturn position risk range. There had also been scrutiny of the mitigation plans that were being considered. This work was continuing, however it was likely that position would be that the Board would be asked to change the forecast outturn at the end of Q3. It was agreed that there would need to be an extra-ordinary closed Board meeting arranged, as there were no planned meetings in December.

9.1.4. The F&P Committee received monthly reports on CIP delivery and the internal plans were ahead of target, which was encouraging, but the system wide collaboration CIP plans continued to be high risk.

9.1.5. The committee had received a presentation regarding A&E and had asked for more Trust-wide information about the Urgent and Emergency Care Work Programme that was being implemented following the summit in September. The Committee had asked for further assurance on the planned impact of each of the workstreams to improve patient flows, on the 95% access target.

9.1.6. The Surgical Care Group updated the committee on their CIP performance and plans for 2019/20.

9.1.7. In relation to cash flow the Committee had reviewed the position and due to the early payroll dates in December had endorsed a recommendation to take a cash loan of £12m, which had been agreed with NHSI.

9.1.8. The formal board resolution needed to take the loan was approved.

9.2. The report was noted and arrangements for the extra-ordinary closed Board meeting would be made if necessary, once the month 8 position was known.

10. Trust Objectives – Mid Year Review – NHST(18)103

10.1. AM presented the paper which summarised progress achieved to date and an assessment of the likely delivery of the 2018/19 objectives by the end of the financial year.

10.2. The ratings showed that 55% (15) objectives were rated green; 41% (11) objectives were rated amber; and 4% (1) objective was rated as red.

10.3. The red rated objective 1.1. was to improve the effectiveness of discharge planning. Although around 20% of patients were now being discharged by midday, further work was required to achieve the target of 33%. More work was required to improve the communication and information for patients and relatives to reduce the number of complaints associated with discharge processes. A mitigation plan for this objective was being developed.

10.4. Objective 1.3 rated as amber, related to achieving the national 7-day services clinical services across the Trust and AM confirmed that although some progress had been made, the Trust was still not where it needed to be.

10.5. Objective 2.1 rated as amber, aimed to reduce further the rate of avoidable harm from falls, pressure ulcers and medication incidents. SRe explained the Trust had reduced the more serious grade 3 and 4 pressure ulcers, but the less severe grade 1 and 2 had increased. There was an RCA undertaken for all pressure ulcers and changes in practice in relation to orthopaedics had been implemented.

10.6. Objectives 3.1 rated as amber, related to increasing the percentage of e-discharge summaries sent within 24 hours. The Trust was currently achieving 69% so further work was required to achieve the target of 85%.

10.7. Objective 4.3 rated as amber, related to the use of patient feedback to shape future service developments and identify themes. Despite Healthwatch reports for the first 2 quarters of the year being positive and the Family and Friends Test response rates being consistently good, AM had rated progress as amber as she felt the outcome of a recent patient surveys could have been better.

10.8. Objective 5.2 rated as amber, related to making the most effective use of the skills of the nursing workforce by implementing an electronic system (Safe Care) to ensure optimal deployment of resources. Safe Care had been successfully rolled out to 75% of all adult inpatient wards with the remainder due to be live by January 2019.

10.9. Objective 6.2 rated as amber, related to making further improvements to the Trust so it was increasingly recognised as an employer of choice. AM reported the Trust had been recognised as having the best staff survey nationally which she believed went a long way to being best employer. AM added the outcome of the next staff survey was due in February. The amber rating was given to ensure all agreed actions were delivered and having the desired impact.

10.10. In response to a query from JK asking if Lead Employer staff were included in the staff survey, AM confirmed that the survey was only for directly employed staff working at the Trust.

10.11. Objective 7.1 rated as amber, related to achieving national performance access standards. The Trust continued to achieve all national access standards with the exception of A&E 4-hour access.

10.12. Objective 7.2 rated as amber, related to achieving local performance indicators. AM acknowledged there was a risk to achieving the CQUIN for activity plans due to the introduction of Medway, however there was confidence this could be recovered.

10.13. Objectives 9.1 and 9.2, relating to the Trust's strategic plans, were rated as amber as they continued to be work in progress.

10.14. VD asked whether the Trust was able to quantify the numbers and targets in the initiatives so it would know when they were achieved. AM stated the best comparison was the levels of attendance between the different CCGs. The Trust was seeing a lower level of admittance from St Helens than Halton or Knowsley which seemed to be as a result of changes to the community services and integrated pathways. The Trust did not manage the community services in the other two Boroughs and the same level of integration had not yet been achieved.

10.15. DM asked MW how the changes were perceived by the CCG. MW confirmed that it was generally felt that the changes were now starting to make an impact.

10.16. RC suggested splitting the detail so progress with St Helens could be quantified and reported. AL agreed there was merit in doing this as he could then go back to Halton and report the variance.

10.17. The mid-year review and proposed actions were noted.

11. R&D Operational Capability Statement – NHST(18)104

11.1. KH presented the paper which provided assurance that the Trust had the physical and human resource capacity to conduct R&D research.

11.2. SR asked why the statement was needed, and KH explained that it was to provide assurance that the Trust had the capacity and capability to undertake the level of research that the Board wanted the Trust to undertake.

11.3. The Board approved the statement.

12. Research, Development and innovation Annual Report – NHST(18)105

12.1. KH presented the 2017/18 annual report for research, development and innovation. The Trust's R&D department was growing in terms of number of studies and patients recruited. The research network had approached the Trust and asked for support to other Trusts. KH explained there were 2 elements to the funding; discretionary and the amount of research

undertaken.

12.2. DM queried whether R&D generated revenue for the Trust. KH confirmed that there was income but most of this was reinvested into further R&D.

12.3. In relation to primary care, JQ observed when companies approached primary care there tended to be neither the interest nor infrastructure to support research. She wondered if the Trust was working with GP practices to support them, particularly when primary and secondary care could be looking at shared services and pathways in the future. KH clarified that there was no formal arrangement at the present time, but this was a potential development. Pharmacy and medicines management information was an example, where there was considerable potential.

12.4. VD asked whether there was any evidence to suggest the research would be affected by Brexit. KH believed any impact on the Trust programme would be minimal, at this stage as he understood the deal included protection for medical research. There may be an issue in the future for European companies in selecting where they did their research, which would be monitored..

12.5. JK was impressed by the report and congratulated the Trust's Research, Development and Innovation Team.

12.6. The Board received the report.

13. Trust Board Meeting Arrangements – NHST(18)106

13.1. NB presented the proposed Trust Board meeting arrangements for 2019/20, which followed the same format as previous years, and recommended it to Board members for approval. The agreement of the Board dates would enable the committees and councils to agree their work plans for the coming year also.

13.2. AM asked for it to be made clearer that there were to be no meetings in December and August.

13.3. The Board approved the 2019/20 meetings arrangements.

14. Effectiveness of Meeting

14.1. DM asked observers Sarah Clark and Kenny Lomas for feedback on the meeting.

14.2. SC stated the Board papers were clear, there had been engagement from every member of the Board and it had been good to see how messages from finance meetings fed up into Board meetings.

14.3. KL thought it had been a well-run and structured meeting, which ran to schedule. He was surprised there had not been more discussion about the Finance and Performance Committee Chair's Report.

15. Any Other Business

15.1. DM informed members it was PW's last meeting, having worked for the Trust since 2001. He had been an integral part of the planning and construction of the new hospitals and the key link in creating positive and mutually respectful relationships with all PFI partners. On behalf of the Board, DM thanked PW for all his hard work over the last 17 years and wished him well in his retirement.

16. Date of Next Meeting

16.1. The next meeting is scheduled for Wednesday 30th January 2019, in the Boardroom, Level 5, Whiston Hospital.

Chairman: Richard Fraser ………………………………………………………………………………

Date: 30th January 2018 ………………………………………………………………………………

TRUST PUBLIC BOARD ACTION LOG – 30TH JANUARY 2019

No	Date of Meeting (Minute)	Action	Lead	Date Due
1.	25.07.18 (11.5)	KH to review Learning from Deaths policy in light of the Working with Families Guidance and consider the appropriate controls to provide assurance and update the Trust Policy.	KH	~~30.11.18~~ Revised to 30.01.19
2.	25.07.18 (12.7)	AMS to include employee relations' cases time to resolve KPIs in future HR Indicators reports. **To be reported from July. See HR Indicators Reports.**	AMS	~~30.01.19~~ 31.07.19
	~~25.07.18 (15.5)~~	~~The Executive to develop an integration strategy to support the Trust Strategy 2018 to 2021~~. **Discussed at Board Time Out in December 2018. ACTION CLOSED.**	~~NB~~	~~Revised to 30.01.19~~
	~~31.10.18 (4.2.3)~~	~~SRe to ensure 'back office' departments are included in QWR schedule for 2019~~. **ACTION CLOSED.**	~~SRe~~	~~28.11.18~~
3.	31.10.18 (6.8)	AMS to present action plan of how new advanced nurse practitioners will be introduced into the workforce to the February Strategy Board.	AMS	27.02.19
	~~31.10.18 (7.4)~~	~~KH to investigate the positive shift in HSMR and report back to Board.~~ **Completed in November. ACTION CLOSED.**	~~KH~~	~~28.11.18~~
	~~31.10.18 (11.4)~~	~~NB to ensure Board has scheduled time to review the annual plans in accordance with the timetable published by NHSE/NHSI.~~ **COMPLETED. ACTION CLOSED.**	~~NB~~	~~30.01.19~~
	~~31.10.18 (14.3)~~	~~NB to include date of last review and more assurance about where risks are being monitored in the next quarterly Corporate Risk Register Report~~. **COMPLETED. ACTION CLOSED.**	~~NB~~	~~30.01.19~~
	~~31.10.18 (15.2)~~	~~NB to add failure to deliver CIP as a cause to strategic risk 2 in the BAF~~. **COMPLETED. ACTION CLOSED.**	~~NB~~	~~30.01.19~~

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(19)1
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

During April the Trust implemented a new Patient Administration System which has impacted on the timeliness of some indicators.

Patient Safety, Patient Experience and Clinical Effectiveness

England's Chief Inspector of Hospitals (CQC) awarded the Trust an overall rating of **Outstanding** for the level of care it provides across ALL services. St Helens Hospital was rated as **Outstanding.** Whiston Hospital has been rated as **Good with Outstanding Features** placing it amongst the best hospitals in the NHS. **Outpatient and Diagnostic Imaging Services** at **BOTH** hospitals have been given the highest possible rating **Outstanding** – The first Outpatient and Diagnostic service in the country to ever be awarded this rating.

There has been 1 never event year to date (target = 0).

There has been 1 MRSA positive specimen year to date (target = 0). RCA indicated this was a contaminant and patient did not come to harm.

There were 4 C.Difficile (CDI) positive cases in December 2018. YTD there have been 19 cases . The annual tolerance for CDI for 18-19 is 40.

There have been no grade 3 or 4 avoidable pressure ulcers year to date.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2018 was 95.5%. YTD performance is 96.2%

During the month of November 2018 there was 1 fall resulting in severe harm , which occurred in inpatient area
(YTD Severe and above category fall = 10)

Performance for VTE assessment for November 2018 was 96.48%. YTD performance is 96.08% against a target of 95%.

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 18/19 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 30th January 2019

Operational Performance

Performance against the 62 day cancer standard was above target of 85.0% in month (November 2018) at 88.4%.
The 31 day target was achieved with 96.7% performance against a target of 96%. The 2 week rule target was also achieved with 94% against a target of 93.0%.

Accident and Emergency Type 1 performance for December was 68.4%. The all type mapped STHK Trust footprint performance was 84.1%. Type 1 attendances for December 18 were 9,514 compared with 9,782 in November 18. December 18 was 1.4% higher than December 17 (9,381) .

An Executive led urgent and emergency care summit took place on September 12th, which brought together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance;. Five improvement workstreams were established; they are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council.

Whiston ED had the highest volume of ambulances in C+M and GM (3181) in December 18. Ambulance notification to handover time was 16.35 mins on average for the month of December 18 (target 15 mins). The total turnaround time was 35.41 mins (target 30 mins). This is the first time in 8 months that the Trust has not met the target. It should be noted however, that notification to handover in the previous year (December 17) was 26.31 mins, so performance this year was better by 10 minutes.

In line with the national expectation to reduce the number of Super Stranded patients by 25% (patients with a length of stay of greater than 21 days - to achieve a maximum of 94 patients). The average number of super stranded patients during December 2018 was 111 compared with 143 in December 2017, which is a 29% reduction year on year, so although the NHSE 25% challenge was not quite achieved there was still a significant improvement compared with the previous year. Medical and Surgical clinical /managerial teams and all CCG partners are actively engaged in the achievement of the reduction in superstranded and progress is monitored daily and weekly.

Following migration of the Trust patient administration system in April, whilst being successful across the majority of the Trust, the issues within outpatients continue. This has resulted in a continued inability to accurately report RTT performance. The actions to address this situation are ongoing, with a view to return to reporting RTT within Q3.

Financial Performance

At the end of M9 StHK has reported a surplus of £1.0m which is £2.5m adverse variance to agreed plans. The reason for the variance is the NHSI instruction to remove Q1, Q2 & Q3 PSF relating to A&E performance.

Within the YTD position the Trust has utilised £7.4m non-recurrent resources, this is offsetting some of the cost pressures and impacts from Medway as well as under performance in Clinical Income. The non-recurrent nature of this benefit will need to be considered when agreeing future year plans as these benefits will not be available going forward.

The Trust continues to deliver above the YTD CIP target with £9.8m delivered against a plan of £9.4m. Whilst there are plans and ideas for delivery of the full £19m CIPs, the schemes relating to STP delivery (£4.6m) are now highly unlikely to deliver in year but will be kept within the CIP tracker to ensure the schemes remain visible to the organisation and wider stakeholders.

The Trust cash balances at the end of M9 were £19.5m, the Trust had a high cash balance as a result of taking a one month loan of £12m to mitigate and non-payment of lead employer invoices in month. The Trust is yet to receive over performance payments from some of its main commissioners relating to this financial year. The Trust now employs 9,000 trainee Doctors for 5 HEE areas across the country as part of its Carter at scale innovations. If provider organisations fail to pay their invoices in time this puts significant strain on the Trust cash balances. The Trust now shares the non-compliant organisations with regulators to assist in obtaining payment.

The forecast outturn was reviewed during November by the F&P Committee and Board. The Board has agreed to change the outturn position in month 9 (in line with NHSI forecast protocols) to a deficit of £5.994m including PSF. This is adverse to plans by £16.998m, of this £6.987m relates to unachieved PSF funding and £10.000m to pressures within the organisation.

The financial performance in the month delivers a Use of Resources level of 3.

Human Resources

In December overall absence deteriorated from 5.7% to 5.9%. This exceeds the Q3 target of 4.72% and is significantly higher than this time last year. The year to date absence is slightly higher at 4.8% compared to 4.7% in 2017-18. Qualified & HCA sickness has risen slightly from 7.0% to 7.1%. YTD absence has increased to 5.9% against the target of 5.3%.
Mandatory Training compliance is 95.3% (target = 85%). Appraisal compliance is 89.1% (target = 85%).

The following key applies to the Integrated Performance Report:

▲ = 2018-19 Contract Indicator
▲£ = 2018-19 Contract Indicator with financial penalty
● = 2018-19 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Dec-18	2.9%	2.0%	No Target	2.4%		Further improvement in SHMI (governments preferred measure). HSMR YTD higher than in recent months, but still better than England. Weekend mortality is a noisy metric.	Patient Safety and Clinical Effectiveness	Continue measures to improve clinical effectiveness and reduce unwarranted variation.	KH
Mortality: SHMI (Information Centre)	Q	▲	Jun-18	1.00		1.00						
Mortality: HSMR (HED)	Q	▲	Aug-18	110.7	97.4	100.0	99.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Aug-18	117.0	101.7	100.0	95.8					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jul-18	100.9	101.2	100.0	101.2		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Year to date performance remains stable.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust is conducting an internal analysis of emergency readmissions and taking part in a district audit with CCG partners.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Aug-18	90.9	91.6	100.0	90.6		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. This includes robust management of delayed patients and scrutiny of superstranded patients.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Aug-18	103.0	108.5	100.0	99.2					
% Medical Outliers	F&P	T	Dec-18	1.7%	0.6%	1.0%	2.3%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in reconfiguration of some surgical beds to medical thus significantly reducing outliers to almost zero through recent months. Medical cover plans are in place ahead of winter increases expected.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Dec-18	39.7%	41.3%	52.5%	48.7%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Nov-18	70.7%	70.5%	90.0%	69.5%		eDischarge performance remains poor. Inpatient performance is stable and is not expected to improve until new (pending) electronic solutions are implemented. Outpatient performance requires investigation if it persists after MEDWAY stabilisation.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. We have been advised by CCGs to stagger release of historic discharge summaries which is delaying performance catch-up.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Nov-18	88.1%	86.1%	95.0%	89.5%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Nov-18	95.9%	97.0%	95.0%	99.1%					

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Nov-18	97.8%	86.8%	83.0%	90.3%		Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement.	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲ £	Dec-18	0	1	0	2		1 Never event in July 2018 (theatres).	Quality and patient safety	Immediate actions implemented and formal RCA underway. The National safety standards for invasive procedures will provide further mitigation against future never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Dec-18	98.4%	98.9%	98.9%	98.9%		Achieving standard YTD	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Dec-18	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Dec-18	0	1	0	2		RCA conducted on MRSA positive specimen (Nov 18), indicated this was a contaminant and patient did not come to harm. Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Dec-18	4	19	40	19					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Dec-18	2	24	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Nov-18	0	0	No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Nov-18	1	10	No Contract target	22		1 severe harm fall reported in November 2018 (Ward 1B)	Quality and patient safety	RCA is currently being undertaken. Falls action plan progressing and monitored through Strategic Falls Group. New initiatives and awareness session programmes planned.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Nov-18	96.48%	96.08%	95.0%	93.67%		VTE performance monitored since implementation of Medway and newly introduced ePMA. An electronic solution is in the IT pipeline. Performance remains above target.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Oct-18	2	13	No Target	31					
To achieve and maintain CQC registration	Q		Dec-18	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Dec-18	95.5%	96.2%	No Target	93.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety		SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Dec-18	0	0	No Target	1					

Dec-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Nov-18	94.0%	90.8%	93.0%	95.0%		Targets achieved in month	Quality and patient experience	1. All DMs producing speciality level action plans to provide 2 week capacity 2. Capacity demand review on going at speciality level	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Nov-18	96.7%	98.0%	96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Nov-18	88.4%	88.9%	85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-18	93.7%	93.7%	92.0%	94.0%		The level of scrutiny and validation of PTL reports required post go live with Medway, has lead to an inability to accurately report RTT performance within the required timescales to report the monthly position. On going backlog clearance plans continue with good effect but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	Surgical Beds have now been converted to Medical bed capacity. Bed availability to manage the Surgical demand could result in backlog increasing. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Mar-18			99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Dec-18	0.9%	0.8%	0.8%	0.6%		Slight under achievement of cancelled ops target for December although the Trust is continuing to achieve overall year to date. One patient breached the 28 day re-list target in July due to the procedure being deemed to be more complex than anticipated.	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Nov-18	100.0%	99.6%	100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Dec-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Dec-18	68.4%	75.7%	95.0%	78.2%		Accident and Emergency type 1 performance was 72.3%, a decrease on Octobers performance of 84.1%. The all type mapped STHK Trust footprint performance for November, was 85.8% a decrease on 91.9% for October 18. Type 1 attendances for November 18 was 9,782 a decrease of 106 on October 18 but a 1.5% increase on November 17 attendances. An executive led urgent and emergency care summit took place on September 12th, which brought together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance; five workstreams have been developed, which are governed through the Urgent and Emergency Care Council. This council has now met twice; 18 October and 15 November to provide updates on the workstreams. Whiston ED ambulance notification to handover time was 14.10 mins on average for the month of November 18 (target 15 mins) The Trust has consistently achieved this target for 8 consecutive months. In line with the national expectation to reduce the number of Super Stranded patients (patients with a length of stay of greater than 21 days) by 25%, the trust continues to focus on this target with clinical and management teams. Work has continued to maintain low numbers of 'good to go' patients as well as ensuring effective MDT management of clinically unwell patients.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place. New COPD pilot in place from December.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Dec-18	84.1%	88.0%	95.0%						
A&E: 12 hour trolley waits	F&P	▲	Dec-18	0	0	0	0					

Dec-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Dec-18	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Dec-18	16	189	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall although there was a dip in September, October and November, which was recovered to 100% responded to within agreed timescales in December.	Patient experience	The Complaints Team continue to work hard to respond to complaints within agreed timescales and to proactively monitor each complaint that is likely to exceed this. The backlog of overdue complaints continues to remain very low.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Dec-18	15	176	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Dec-18	100.0%	90.3%	No Target	67.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Nov-18	24	18	No Target	20		In November 2018 the average number of DTOCS (patients delayed over 72 hours) was 24.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Dec-18	316	308 *Jun-Dec							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Dec-18	111	117 *Jun-Dec							
Friends and Family Test: % recommended - A&E	Q	▲	Dec-18	85.8%	86.0%	90.0%	87.5%		The YTD recommendation rates remain slightly below target for A&E but improved slightly in December; inpatients, maternity (antenatal and postnatal community)are above target. All saw a slight in-month improvement other than maternity - birth which saw a slight dip.	Patient experience & reputation	Feedback from the FFT responses continues to be fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback to improve morale. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement, which are then displayed as 'you said, we did' posters. Easy to use guides were issued to each ward for completion of these posters. The posters are now distributed centrally to ensure that each ward has up-to-date posters. Significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Dec-18	93.5%	94.8%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Dec-18	100.0%	99.2%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-18	96.8%	97.8%	98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Dec-18	94.8%	95.3%	95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Dec-18	100.0%	97.6%	98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-18	94.5%	94.1%	95.0%	94.5%					

Dec-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Dec-18	5.9%	4.8%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		In December overall absence deteriorated from 5.7% to 5.9%. This exceeds the Q3 target of 4.72% and is significantly higher than this time last year. The year to date absence is slightly higher at 4.8% compared to 4.7% in 2017-18. Qualified & HCA sickness has risen slightly from 7.0% to 7.1%. YTD absence has increased to 5.9% against the target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	A Workforce Wellbeing action plan based on NHS Employers and NHSI recommendations was approved by November Workforce Council to drive an improvement in attendance levels and processes have been reviewed to increase rigour of management against the policy. Monthly meetings take place in wards/departments to support line managers to deliver their action plans. Deep dives by HRBP's with support including OD plans, stress and resilience support for wards continue with a detailed report going to F&P in January 2019. A large scale review of the current policy has started in line with "Just Culture" with the aim of driving improvements in engagement levels and attendance.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Dec-18	7.1%	5.9%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	Dec-18	89.1%	89.1%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 10.3% and has improved by 0.5% from November. Appraisal compliance is above the target by 4.1% and has improved by 3.3% from November.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The HRBP's alongside Education, Training & Development and Workforce Planning teams continue to work with managers to ensure on-going maintenance of compliance for Mandatory Training & Appraisals with non-compliance being reviewed by the Trusts Executive Committee on a monthly basis and also at department level finance & performance meetings.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Dec-18	95.3%	95.3%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	92.6%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	The Q3 survey in the form of the National staff survey has now closed, with results expected to be published on 26th February 2019 .	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	83.6%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Dec-18	0.7%		No Target			Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. The Trust is undertaking a project with NHSE regarding retention of Nurses and this is part of our wider retention strategy and action plan for 2018/19 for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P UOR	T	Dec-18	3.0	3.0	3.0	3.0		At the end of M9 StHK has reported a surplus of £1.032m which is £2.499m adverse variance to agreed plans. The reason for the variance is the NHSI instruction to remove Q1, Q2 & Q3 PSF relating to A&E performance. Better payment compliance is currently not being achieved on invoice numbers but is being achieved on value.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Dec-18	9,767	9,767	19,000	12,325					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Dec-18	1,032	1,032	10,993	5,001					
Cash balances - Number of days to cover operating expenses	F&P	T	Dec-18	19	19	2	12					
Capital spend £ YTD (000's)	F&P	T	Dec-18	4,816	4,816	9,516	9,180					
Financial forecast outturn & performance against plan	F&P	T	Dec-18	(5,994)	(5,994)	10,993	5,001					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Dec-18	91.5%	91.5%	95.0%	91.4%					

APPENDIX A

			Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	2018-19 YTD	2017-18 Target	FOT	2017-18	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	95.7%	88.9%	100.0%	100.0%	100.0%	98.0%	85.0%		97.0%		
	Total > 62 days		0.0	0.0	0.0	2.5	0.0	0.0	0.0	0.0	0.5	1.5	0.0	0.0	0.0	2.0			3.5		
Lower GI	% Within 62 days	▲ £	82.4%	78.6%	80.0%	91.7%	75.0%	100.0%	76.5%	100.0%	100.0%	92.3%	100.0%	36.4%	88.9%	87.7%	85.0%		84.0%		
	Total > 62 days		1.5	1.5	2.0	0.5	1.5	0.0	2.0	0.0	0.0	0.5	0.0	3.5	1.0	7.0			12.5		
Upper GI	% Within 62 days	▲ £	86.7%	100.0%	100.0%	63.6%	100.0%	80.0%	77.8%	80.0%	66.7%	62.5%	77.8%	66.7%	33.3%	72.0%	85.0%		87.2%		
	Total > 62 days		1.0	0.0	0.0	2.0	0.0	1.0	1.0	0.5	0.5	1.5	1.0	0.5	1.0	7.0			5.0		
Urological	% Within 62 days	▲ £	90.2%	96.6%	60.9%	96.8%	86.2%	93.8%	90.2%	78.8%	80.7%	97.1%	80.6%	90.3%	75.0%	85.0%	85.0%		82.5%		
	Total > 62 days		2.0	0.5	9.0	0.5	2.0	1.0	2.0	3.5	5.5	0.5	3.0	1.5	3.5	20.5			37.0		
Head & Neck	% Within 62 days	▲ £	83.3%	80.0%	33.3%	66.7%	100.0%	50.0%	66.7%	33.3%	62.5%	42.9%	83.3%	50.0%	80.0%	58.5%	85.0%		64.6%		
	Total > 62 days		0.5	0.5	1.0	0.5	0.0	0.5	0.5	2.0	1.5	2.0	0.5	1.0	0.5	8.5			8.5		
Sarcoma	% Within 62 days	▲ £		50.0%	33.3%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	0.0%	100.0%	87.5%	85.0%		66.7%		
	Total > 62 days			0.5	1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	1.5			2.5		
Gynaecological	% Within 62 days	▲ £	94.1%	55.6%	90.9%	66.7%	77.8%	87.5%	72.7%	75.0%	100.0%	72.7%	50.0%	62.5%	100.0%	77.8%	85.0%		78.2%		
	Total > 62 days		0.5	2.0	0.5	0.5	1.0	0.5	1.5	0.5	0.0	1.5	0.5	1.5	0.0	6.0			12.0		
Lung	% Within 62 days	▲ £	66.7%	100.0%	80.0%	100.0%	100.0%	87.0%	95.8%	88.9%	100.0%	100.0%	81.8%	66.7%	94.1%	90.0%	85.0%		84.7%		
	Total > 62 days		3.0	0.0	1.5	0.0	0.0	1.5	0.5	0.5	0.0	0.0	1.0	2.0	0.5	6.0			11.5		RC
Haematological	% Within 62 days	▲ £	85.7%	76.9%	100.0%	88.9%	83.3%	100.0%	100.0%	100.0%	100.0%	66.7%	90.9%	50.0%	85.7%	88.4%	85.0%		80.6%		
	Total > 62 days		0.5	1.5	0.0	0.5	1.0	0.0	0.0	0.0	0.0	1.0	0.5	1.0	1.0	3.5			9.5		
Skin	% Within 62 days	▲ £	98.2%	97.7%	100.0%	95.5%	92.5%	100.0%	91.2%	97.6%	93.8%	98.1%	93.3%	84.6%	90.2%	93.3%	85.0%		95.2%		
	Total > 62 days		0.5	0.5	0.0	1.0	2.0	0.0	2.5	0.5	1.5	0.5	3.0	4.0	2.5	14.5			13.0		
Unknown	% Within 62 days	▲ £	100.0%	100.0%	100.0%		75.0%	100.0%	100.0%		100.0%	75.0%	100.0%	100.0%	100.0%	96.0%	85.0%		78.4%		
	Total > 62 days		0.0	0.0	0.0		1.0	0.0	0.0		0.0	0.5	0.0	0.0	0.0	0.5			4.0		
All Tumour Sites	% Within 62 days	▲ £	90.3%	90.6%	85.2%	89.1%	89.6%	94.1%	90.1%	90.3%	89.0%	89.1%	90.9%	77.8%	88.4%	88.9%	85.0%		87.4%		
	Total > 62 days		9.5	7.0	15.0	8.0	8.5	4.5	10.0	8.0	9.5	9.5	9.5	16.0	10.0	77.0			119.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%	100.0%					100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	85.7%	85.0%		100.0%		
	Total > 31 days			0.0	0.0					0.0	0.0	0.0	1.0	0.0	0.0	1.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £	100.0%						100.0%			0.0%	100.0%			66.7%	85.0%		100.0%		
	Total > 31 days		0.0						0.0			1.0	0.0			1.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

TRUST BOARD

Paper No: NHST(19)2
Title of paper: Executive Committee Chair's Report – January 2019
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.

Summary:

The paper provides a summary of the issues considered by the Executive Committee at the meetings held during November and December 2018.

There were a total of 7 Executive Committee meetings held during this period. There was a Board Time Out and Extraordinary Board meeting on 13th December and no meeting held on 27th December.

The Executive Committee agreed:

- revised e-Prescribing implementation support costs
- proposals for introducing patient and public Wi-Fi with extended access in selected areas
- proposals to move the Trust to the NHS mail system
- the business case to implement NEWS2 patient monitoring system by March 2019
- to recommend the 5 year Allocate HR systems contract
- to recommend the proposed Lead Employer contract
- proposals to update the mandatory training systems and governance
- the business case to expand the Palliative Care service capacity in response to increased demand

The Executive Committee also considered regular assurance reports covering; the Integrated Performance Report, above framework cap agency and locum request Chief Executive approvals, agency and locum staff usage, appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register, and the Board Assurance Framework. There was also a weekly progress report on the action taken to resolve the Medway PAS implementation issues.

There were no specific issues that required escalation to the Board, not already considered at the November Board meeting or covered on the agenda of the January meeting.

Trust objectives met or risks addressed: All 2018/19 Trust objectives.

Financial implications: None arising directly from this report.
Stakeholders: Patients, Patients Representatives, Staff, Commissioners, Regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 30th January 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
November and December 2018

1. Introduction

There were 7 Executive Committee meetings in November and December 2018.

2. 1st November

2.1 Medway

The Director of Informatics and Director of Operations and Performance provided the weekly update. The Director of informatics gave an update on the Phlebotomy solution being trialed, the recruitment of Clinical Leads to support changes in practices and the work being undertaken to improve outpatient letters.

The Director of Operations and Performance reported that the waiting list validation was nearing completion and the current RTT position was 92.42% with a waiting list of 23,500. This is in line with NHSI requirements.

2.2 E- Prescribing Business Case Costs

Additional information on the costs of the ePrescribing implementation was presented to the Committee. There were several changes to the assumptions since the original business case for funding had been developed in 2012. The calculation of cash releasing and qualitative benefits had been revised, and the capital requirement had also been updated based on learning from the pilot. The changes were agreed on the basis that project KPIs and a benefits realisation plan are to be presented in the New Year.

2.3 Contract queries

The Medical Director provided feedback from the recent contract monitoring meeting and reported that the commissioners wished to review consultant to consultant referrals, zero day length of stay patients and re-admissions. It was agreed that the work undertaken on behalf of the A&E Delivery Board, showing the Trust's effective bed utilisation should also be shared.

2.4 Inpatient Survey Action Plan

The Committee reviewed the action plan developed in response to the findings of the national inpatient survey for 2017, which had been published in June 2018. The initial action plan had been presented to the Quality Committee in July, but had required more work to provide assurance that the identified issues were being addressed. The revised action plan and progress to date were acknowledged by the Executive Committee and further reports were requested to focus on the priority areas of; patient information, patient moves during the night, call bell answering, assisted dining and named nurses.

3. 8th November 2018

3.1. Winter Bed Capacity Progress Report

The Director of Operations and Performance introduced the update report on each of the options being actively pursued and the new options that had recently been identified. The need for additional system bed capacity had been further illustrated by the findings of the report by the Venn Group undertaken on behalf of the A&E Delivery Board. The timescales for some options meant they could not be available for winter 2018/19, but others were more immediate.

The Director of Operations and Performance reported that the Trust had been successful in its bid for central capital to develop ambulatory care solutions, which would mean a larger number of patients could be treated without admission to an inpatient bed. The health system had also recently agreed that patients could be discharged to any community bed, not just those in their host CCG, which would create more flexibility and flow.

3.2 Trust Board Agenda

The Committee reviewed the draft Trust Board agenda for November.

3.3 eRostering KPI Report

The Deputy CEO/Director of HR presented the regular KPI report for eRostering. The original KPIs were showing a continued improvement, however it was agreed that it was now appropriate for some new KPIs be introduced to monitor that eRostering was being used consistently across all areas. The Executive Committee also discussed the potential for different shift patterns and the Director of Nursing was asked to undertake an evaluation and provide a report on the advantages and disadvantages.

3.4 Medway

The weekly update on the RTT performance and waiting list figures was presented, which provided assurance that the patient booking system issues were being addressed and external reporting could recommence at the end of Q3.

3.5 Primary Care Developments

Updates were provided in relation to the planned Primary Care developments, with additional capacity and expertise now being in place, and further work undertaken on the financial model. It was agreed that the due diligence process could now commence.

4. 15th November 2018

4.1 Risk Management Council (RMC) and Corporate Risk Register (CRR) Report

The Director of Corporate Services presented the chair's report from the November RMC and the CRR. There remained a number of risks where a review on the nominated review date had not been recorded in DATIX and action was being taken to remind managers. The review and closure of actions was also not being consistently recorded in DATIX and the Council had also agreed actions to support

an improvement. Two new high scoring risks had been added to the CRR, relating to cash flow as a result of the Lead Employer contract and unplanned in year expenditure. One risk had been removed from the CRR, relating to Medway and patient booking which would continue to be monitored via the Care Group risk register.

4.2 Mandatory Training and Appraisal Monthly Report

The Deputy CEO/Director of HR presented the report for October for the staff managed by each Director. All were achieving the mandatory training targets, but in some areas 85% of staff had not completed an appraisal. Improvement actions were in place.

4.3 Public/Patient Wi-Fi

The Director of Informatics informed the Committee that the Trust had received national funding to install Wi-Fi throughout Whiston to enable patient and visitor access. This would allow patients and visitors to browse the internet, connect to apps and download emails in line with the NHS Digital criteria. The programme to enable this access was underway and planned for completion early in 2019. There were also proposals to enable enhanced access for some in-patient areas that would allow patients and visitors to download and stream content. The committee reviewed which of the inpatient areas should be prioritised in this first stage. It was agreed that the paediatric wards and ward 2A (Haematology and Oncology) would be prioritised. It was confirmed that patients at St Helens Hospital could already access Wi-Fi.

4.4 Secure e-mail

The Director of Informatics presented options to move the Trust to an email system that met the required standards of a secure email platform (ISO 27001 & ISB 1596 standard). The least disruptive and most cost effective option was to move to NHSmail2. This solution was agreed with a migration plan, scheduled for completion by Q2 2019/20.

4.5 Blood Sciences Equipment Procurement Update

The Director of Operations and Performance introduced a presentation setting out the progress of the replacement equipment procurement process and the plans of the Cheshire and Merseyside (C&M) Pathology Network. The Trust could not delay any further the procurement of new equipment, without the risk of service disruption because the existing equipment was now obsolete and no longer reliable. The Trust was however committed to working with the C&M Pathology Network and aligning equipment across all providers. The options and their implications were each reviewed and it was agreed that there would be further discussions with NHSI/C&M Pathology Network before a recommendation was made to the Trust Board at the November meeting.

4.6 Bank and Agency Staff Report

The Deputy CEO/Director of HR presented the monthly report on bank and agency staff expenditure position for month 6. The committee asked that further triangulation be included between requests, activity, vacancies and sickness levels by staff group to better understand the drivers for bank and agency staff. The reducing number of vacancies and increasing amount of shifts covered by the Trusts staff bank were noted.

4.7 NEWS2 – IT Solution

The Director of Informatics presented the proposed IT solution to enable the Trust to implement the New Early Warning Score (NEWS2) by March 2019, to achieve the CQUIN target. Funding had been secured from NHSE to support the implementation and suitable handheld devices had now been identified.

4.8 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for October, for review by the Committee and to agree commentary. Further work was required on falls and a deep dive into sickness absence management was being presented at the Finance and Performance Committee.

4.9 Winter Beds Update

The Director of Operations and Performance reported that the reablement staff were now providing the equivalent capacity of 13 additional beds and 27 further beds had now been opened in the community. There was concern that the commissioners continued to query the costs of these additional beds, which were part of the agreed system winter plans. Further bed options were being progressed to make up the 78 system shortfall identified by the Venn Group analysis.

4.10 Allocate HR System Business Case

The Executive Committee reviewed the option appraisal for entering into a new 5 year contract with Allocate to provide the Trusts HR systems. The full business case was subject to Trust Board approval, due to the value of the contract. Subject to some minor amendments and clarification the committee agreed to recommend that the Trust extend to the full suite of Allocate products for all staff, with a supporting programme to maximise the utilisation and benefits realisation from all the capability e.g. eRostering, eJob planning

4.11 Lead Employer Contract

The Deputy CEO/Director of HR presented a paper detailing the terms of the contract documentation for the North West Lead Employer Contract. This was reviewed by the committee and the clauses and penalties for late payment of payroll costs discussed in detail. It was agreed to recommend the contract to the Trust Board for formal approval.

5. 22nd November 2018

5.1 Review of Mandatory Training

The Deputy CEO/Director of HR introduced the report which summarised the review that had been undertaken of core mandatory and other required staff training. The report recommended that the Trust move to the UK core skills framework subjects and intervals for core mandatory training. Training would fall into 3 categories, for all staff, for clinical staff and job/role specific requirements. The majority of the core skills framework could be undertaken once every 3 years, but there were some clinical competencies that needed to be repeated more frequently. Wherever possible e-learning modules were being developed, however for some subjects there was still a national requirement for face to face and practical training as the mode of delivery. Each role would have a specific training profile so every member of staff would understand the training that was required and the frequency of refresher training.

More detailed reporting would ensure that there was oversight of overall training compliance and breakdowns for each subject area.

In addition, a new governance structure was proposed to ensure that there was a regulated process for adding subjects or changing the content of mandatory training.

The proposals were agreed.

5.2 Palliative Care Services Business Case

Members of the Palliative Care team presented a business case to increase the capacity of the team in response to the increased demand and developments in end of life care. The Executive Committee approved an increase in specialist nursing capacity to ensure 24/7 cover could be provided by the service.

5.3 Safer Staffing & Vacancy Dashboard Report

The Director of Nursing, Midwifery and Governance presented the monthly report for October, which showed a nurse fill rate of 95.10% and a reduction in the number of ward staff vacancies.

5.4 Medway Update

A further issue had been identified with one of the planned "fixes" for the patient booking system, which had not performed in the live environment as it had during testing. This was a disappointment to everyone involved but the supplier and local teams were now working on a solution and had increased validation to ensure all patients were correctly recorded.

5.5 Board Time Out Agenda

The Director of Corporate Services presented proposals for the Board time out agenda. Additional items were agreed and it was decided to use part of the time for an extraordinary closed Board meeting, in order that the whole Board could review the financial position and any changes to the forecast outturn. An update on the

Blood Sciences procurement would also be given to the Board at this time, so that a formal decision on awarding the contract could be taken.

6. 29th November 2018

6.1 NEWS2 Business Case – Clinical Services

The Director of Nursing, Midwifery and Governance presented a business case which outlined the clinical implications of implementing NEWS2 and the proposed response. The increased sensitivity and thresholds in NEWS2 were predicted to increase the workload of the Medical Emergency Team (MET). Additional nurse staffing for the team was agreed, with a review planned for 6 months to fully evaluate the impact of NEWS2.

6.2 Falls Data Reporting

The Director of Finance and Information presented a paper that explained why there appeared to be a discrepancy between the falls data reported on the Model Hospital and in the Trusts IPR. This was because the Model Hospital data was derived from the Safety Thermometer reporting which is a 72 hour snapshot each month, rather than complete reporting of all falls occurring during the month.

6.3 Falls Review and Strategy

The Director of Nursing, Midwifery and Governance introduced the report. Although, there has been a sustained reduction in the overall number of falls reported at the Trust over a 3-4 year period, audit and thematic review of the 22 root cause analysis' undertaken highlighted common contributory factors that led to the fall including: delayed or lack of referral to the hospital falls team; medication reviews; accuracy of falls risk assessments; care planning; patient cognition; patient mobility and assistance; and lying and standing BP. Further analysis was requested to understand if there were any patterns to when in the day falls were occurring. A new Falls Strategy has been developed to address these issues and continue the work to further reduce patient falls.

6.4 CQPG Feedback

The Director of Nursing, Midwifery and Governance provided feedback on the recent CQPG meeting with commissioners. A simpler Provider Quality Assurance report was being introduced alongside service impact reporting, which would showcase different services and provide case studies. There had also been a presentation on the introduction of telehealth follow up consultations for stroke patients.

6.5 Medway Update

Further upgrades to Medway to resolve the outstanding issues with outpatient booking were now planned for week commencing 10th December. This would not prevent the resumption of RTT reporting from Q3, as planned.

6.6 Halton Urgent Treatment Centre (UTC) Procurement

The Director of Operations and Performance provided an update on the Halton UTC procurement process, and discussions that had been held with a range of different

partners about bidding to deliver this service. The Executive Committee reviewed the Trusts bidding strategy and the process for submitting the PQQ information by the deadline of 14th December.

7. 6th December 2018

7.1 Agenda for Change (AfC) – closure of band 1

The Deputy CEO/Director of HR introduced the paper which detailed the process for implementing the national pay deal agreed in April 2018, and closing AfC band 1to new applicants. A consultation was due to commence with existing band 1 post holders employed by the Trust on the individual implications and choices that were available to them.

7.2 Brexit – Workforce Implications

Updates had been received from the DHSC on the proposals to help retain EU staff who worked for the NHS. There were 75 staff identified currently working for StHK who could apply for the EU Settlement Scheme, and the Trust was working with these staff to provide support.

7.3 Brexit – Procurement Implications

The Head of Procurement provided a briefing on the latest guidance received from the DHSC on how the NHS was planning in case of a no deal EU exit. The majority of the mitigating actions for supplies and medical equipment were being centrally coordinated, but the Trust had completed a review of all its suppliers and submitted this for collation and review nationally. A separate workstream was coordinating the plans for essential supplies of medicines, and this was being led internally by the Chief Pharmacist, and there are regional networks in place where all the Trusts in Cheshire and Merseyside are working together. It was agreed that the situation would be kept under close review, depending on the outcome of the parliamentary vote on the negotiated Brexit deal.

7.4 Inpatient Survey Action Plan – Update

The Director of Nursing, Midwifery and Governance gave an update on the progress in delivering the inpatient survey action plan priority areas of improved communications with patients, night moves, call bells and discharge planning. The impact of staffing levels was discussed, which had improved, due to reduced vacancies. Further investigations in to how other Trusts manage ward moves at night were requested, and a further update was scheduled for February.

7.5 PFI Quarterly Performance Report

The Director of Estates and Facilities Management presented the quarterly performance report and update on current capital schemes. Performance across all KPIs remained excellent. The A&E extension, Delph Lane car park and the combined heat and power schemes were all nearing completion and would be ready for handover early in 2019. The Radiology Managed Equipment Service schedule for 2018/19 had been agreed to ensure minimal service disruption. The committee also reviewed the current variation requests received from services.

7.6 Medway Update

The Director of Operations and Performance reported that the waiting list stood at 23,500 patients and validation was continuing. Capacity planning for Q4 included additional outpatient appointments to ensure patients could be seen within 18 weeks, and the RTT performance maintained.

7.7 Winter Pressures

The Directors of Operations and Finance had worked with the Care Groups to assess any additional requirements to ensure patient safety over the winter period, and this list was reviewed by the Committee. This expenditure had been included in the revised financial forecast, and would enable the Trust to maximise all bed capacity and respond to periods of extreme demand pressures.

The Director of Operations reported that an alternative source of additional community bed capacity had been identified and was currently being explored.

Changes to the escalation protocol for on call managers were also discussed.

8. 20th December 2018

8.1 Runcorn Primary Care Network

Dr Gary O'Hare attended the Committee to provide a briefing on the development of the Runcorn Primary Care Network, which was a national initiative as part of the GP Five Year Forward View to help GP practices work more closely together and improve sustainability. The Committee offered to assist the Network with its work.

8.2 Appraisal and Mandatory Training

The Deputy CEO/Director of HR presented the mandatory training and appraisal figures for November split by Director. Improvement was noted on appraisals and the mandatory training performance remained above target.

8.3 Local Clinical Excellence Awards Scheme (LCEAs)

The Deputy CEO/Director of HR presented a briefing paper detailing the new LCEAs which had been agreed as part of the national changes to the Medical and Dental staff terms and conditions. The Trust needed to develop a local process in conjunction with the Local Negotiating Committee (LNC) for making awards to recognise outstanding contributions to the safe delivery of excellent care, by eligible consultants. The process was to be put in place early in 2019, so that the 2018 awards could be made before the end of the financial year.

8.4 Risk Management Council (RMC) Chair's Report

The Director of Corporate Services presented the RMC chairs report and Corporate Risk Register (CRR) for December. There were a total of 780 reported risks of which 13 had been escalated to the CRR. The number of risks with an overdue review date had reduced significantly and actions were being put in place to remind risk owners to update actions in Datix. There was one unapproved high risk which had required further follow up.

8.5 MBRRACE National Audit Report

The Medical Director introduced members of the Obstetrics and Gynaecology team, who presented to the Committee on the Trusts results in the national MBBRACE Perinatal Mortality Surveillance Report. The standardised and risk adjusted data for 2016 showed how the Trust compared to other maternity units in Cheshire and Merseyside, the north of England and nationally. There was a discussion about the capacity of the Trust's neonatal unit to cope with increasingly complex births, and it was agreed that as the Trust was now the 2nd largest maternity unit in Cheshire and Merseyside, this needed to be raised with the NHSE Specialist Commissioning team.

8.6 CQPG Feedback

The report summarised the actions resulting from the CQPG meeting held on 18th December. There had been a presentation by the Trauma and Orthopaedic service, which had been well received.

8.7 Medway

The Director of Operations and Performance presented the weekly update and confirmed that the patient booking systems had improved but were not yet fully resolved. The RTT position was currently 92.98% with a waiting list of 23,455. Although the issues with the cancellation and rebooking of patients had significantly reduced, the impact was still being felt via the PALs and Ask Ann feedback routes and would need to continue to be closely monitored.

ENDS

TRUST BOARD

Paper No: NHST(19)3

Title of paper: Committee Report – Quality Committee Chair's Report

Purpose: To summarise the meeting papers from the 22 January 2019 and escalate issues of concern.

Summary:

QC(19)001 Complaints Update Report: 68 1st stage complaints were received and opened in Q3, 8 less than Q2. The Trust responded to 84.2% of 1st stage complaints within the agreed timescales in Q3, a decrease compared to 96.3% in Q2. Clinical treatment was the primary cause of complaints. There was 1 new PHSO case received in Q3 however they discontinued their investigation and closed the complaint.

CQC Update: the final CQC report remains outstanding, AM meeting with CQC shortly to discuss.

QC(19)003 IPR:

- 1 never event has been reported year to date against a target of 0
- There has been 1 MRSA bacteraemia case reported against a target of 0. The RCA indicated this was a contaminant and the patient came to no harm.
- There were 4 C.difficile positive cases reported against a tolerance of 40. YTD there have been 19 cases.
- No grade 3/4 pressure ulcers reported.
- Safer staffing fill rate was 95.5%. YTD performance is 96.2%.
- There was 1 inpatient fall in November resulting in severe harm; 10 YTD in the severe category. RCA indicates that patient fell prior to the risk assessment being performed.
- VTE assessment performance was 96.48%, YTD performance is 96.08% against a target of 95%.

QC(19)004 Safer Staffing Reports:

- M8 demonstrated an improvement on M7 with a RN overall fill rate of 97.73% and care staff overall fill rate of 110.98%. Month 9 saw a slight deterioration on the previous month for RN and Care Staff but remained within target.
- M8 saw no wards with an RN day fill rate of <90% which is a significant improvement from M7. This downward trend continued for nights with only 2 wards not achieving the target.
- Thornbury has not been used this winter.

QC(19)005 Medicines Optimisation Strategy inc HPTP: A summary of the current Pharmacy & Medicines Dashboard from the NHSI Model Hospital to 10 January 2019 was provided. Overall performance on the benchmarks is good.

NWB CQC Feedback: The outcome of the Well Led inspection from May to July 2018 resulted in a 'Good' overall rating. Only the Responsive element 'requires improvement'.

QC(19)006 Safeguarding Quarterly Report: Q2 Safeguarding KPI 100% compliance achieved. Safeguarding training L3 & 4 has increased dramatically from 103 to 3282 due to a change in the TNA following a recommendation from the CCG. The trust will require at least 18 months to achieve compliance (85%).There are no outstanding allegations against staff.

QC(19)007 Maternity Survey Action Plan: Improved action plan noted. The service received 12 recommendations compared with 18 the previous year.

QC(19)008 Continuity of Carer Report: Two pathways are currently being developed: Midwifery Led Care and Next Birth After Caesarean Section, each with a dedicated team to ensure that focus in maintained to achieve the aims. Progress is being made on both pathways however plans are in place to achieve a higher percentage than the 20% target identified going forward.

Feedback from Councils/Committees:

QC(19)009 Patient Safety Council: The summary page was noted, the following was highlighted:

- Audit of the use of MEWS and EMEWS and escalation compliance with in AED was conducted in November 2018.
- It was noted that actions have been undertaken in relation to never event assurance processes to ensure patients requiring oxygen will not be unintentionally connected to an air flow meter.

QC(19)010 Patient Experience Council: The summary page was reviewed and noted by the Committee. The following was highlighted:

- Following the recent Patient Story to Board which highlighted concerns raised by a patient whose needs were not met on two separate occasions, wards are being reminded of the need to meet individual communication needs as specified by the patient, including British Sign Language interpreters.
- Work is ongoing to monitor the number of DOLs applications to ensure these are appropriate and within expected levels.

QC(19)011 Clinical Effectiveness Council: The summary page was noted. The following issues were identified for escalation:

- The deadline is looming in relation to the policy for Nurse Prescribing. SR confirmed she is meeting with Debbie Stanway and the team to discuss.
- Resuscitation survivors beyond discharge, Paul Craven to review 14 cases, feedback will be provided once complete.
- The January meeting was not quorate. Administrative issues are to be addressed. It was agreed the timing of the meeting on a Monday morning may need to be reviewed due to operational pressures.
- Mortality ratios have been flagged, KH to review and feedback to the Council.
- The number of stop smoking referrals have dropped from 75% to 50%. JK confirmed this is due to the changes in reporting which means they can now only report women who actually say yes to the offer of a referral rather than the number of women who are offered a referral. Two levels of reporting are required.
- Relevant policies and procedures are being reviewed to reduce the risk of patients having undelivered IV medications that remain in giving sets when the fluid has finished and the sets are disconnected and discarded.

QC(19)012 CQPG: The summary page was noted, the following issues were identified for escalation:

- The Orthopaedic department provided a service update highlighting changes in the capacity and ward configuration and innovations within the service. The commissioners asked the trust to explore if the community services treatment rooms should be offering clinical support to patients instead of attending ward for wound checks.
- The committee noted the positive trust performance in relation to complaints when benchmarked against local peer organisations.
- It was noted that a number of mechanisms are in place for capturing and monitoring NICE guidance published and compliance.

QC(19)013 Workforce Council: The summary page was noted by the Committee, the following issues were escalated:

- Work is required to review gaps in Doctors training rotas to mitigate the risk of any potential safety issues.
- Delays in HWWB referrals and pre-employment checks due to HWWB resources no longer being aligned to the workforce are having an impact on service delivery. Head count has increased by more than 100WTE in the last 5 years and growth of bank staff by 600 in 2018. A business case is required to address this issue.

Policies/Documents for Approval:

QC(19)014 Quality Account Timetable: The timetable was noted by the Committee.
QC(19)015 Safeguarding Annual Report: The report was approved subject to the addition of a comment regarding the delay with data capture.

Policies/Documents for Approval by Councils: None received.

Items to be brought to the attention of the Board:

- Improving Cancer performance, particularly from a Quality and Safety point of view.
- North West Boroughs (NWB) rated 'Good' CQC report.
- Clinical Negligence Scheme for Trusts (CNST) Maternity recommendations, action plan in place to address.
- Violence & Aggression Data and National Developments: In response to a request made at the October Trust Board, the Committee was briefed on incidents of violence and aggression over the last 3 years. In 2016-2018 violence and aggression incidents data analysis demonstrates that there has been a reduction in the number of physical assaults against staff over the last 3 years (the vast majority of the perpetrators being patients).The majority of physical assaults at Whiston occur in Accident and Emergency and 5B (Care of the Elderly). Physical assaults at St Helens have shown a decrease.

Corporate objectives met or risks addressed: Five star patient care and operational performance.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners

Recommendation(s): It is recommended that the Board note this report.

Presenting officer: Chair of Committee

Date of meeting: 30 January 2019

TRUST BOARD

Paper No: NHST(19)4
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance and Performance Committee, 24th January 2019

Summary:

Agenda Items

For Information

- Integrated Performance Report
    - The committee were informed that the Trust was now reporting RTT performance in line with time scales agreed. The RTT performance was in excess of 92% reporting a compliance with statutory standards.
    - The Trust has reduced super stranded by 29% year on year which is in excess of national expectations.
    - Staff sickness deteriorated in December from 5.7% to 5.9%.
    - Cancer targets were achieved in December.
- Finance Report
    - The Trust has delivered the YTD annual plan excluding the PSF element linked to A&E.
    - Cash balances remained strong at the end of the year as a result of the short term loan that was drawn down to support any operational pressures as a result of the early payroll in December. The loan has now been repaid in full.
    - The committee informed that the financial outturn was in line with plans submitted to the Board in December.

For Assurance

- A&E Performance
    - The Committee reviewed the presentation from the ADO for Urgent Care. Deputy Director of Ops, Emergency Department Clinical Director, ADO from Medical Care and Associate Medical Director.
    - The Committee praised the continued work of the team to support performance in A&E especially the work that has been carried out in getting patients home before 12 but required further assurance on the outcomes expected from the work streams implemented in the department including timescales for delivery.
- CIP Programme update
    - The committee noted the improvement in green rated schemes and that the forecast delivery of c£14,5m in line with previously agreed forecasts.
- CIP Programme update – CSS
    - The committee received a tabled presentation that demonstrated the progress on the CIP within the Care Group.

For Approval

- Draft Annual Plan

- The committee discussed reviewed the one year planning guidance and the respective impacts that this would have on the Trust.
- The committee reviewed the financial bridge identifying that the Trust would need to deliver a CIP of 3.5% in order to deliver the issued control total.
- The committee discussed and reviewed the indicative savings plan to support the CIP in 2019/20 and took reassurance from the high number of schemes already identified to deliver the plan.
- The committee agreed that they should recommend to the Board the acceptance of the control total for 2019/20 noting that there are potential changes that could occur before the final submission in April.

Risks noted

- Forecast outturn – Although in line with previous reported positions this is off the agreed 2018/19 plan.
- Non-recurrent measures utilised within financial position and forecast
- A&E performance
- Underlying financial position

Items to be raised at Board

- The acceptance of the issued control total for the draft financial plan submission on the 12th February 2019.

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: Jeff Kozer, Non-Executive Director
Date of meeting: 24th January 2019

TRUST BOARD

Paper No: NHST(19)5
Title of paper: Corporate Risk Register– January 2018
Purpose: To inform the Board of the risks that have currently been escalated to the Corporate Risk Register (CRR) from the Care Groups via the Trusts risk management systems.
Summary: The CRR is reported to the Board 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 Trusts risk grading matrix. • Any risks initially rated as high or extreme or increasing to high /extreme have been reviewed by the appropriate Executive 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 covers the risks reported and reviewed in December 2018 and is a snap shot, rather than a summary of the quarter. The report shows; • The total number of risks on the risk register is 778 (of which 774 had been reviewed and graded at the time of this report). • 44% (340) of the Trusts risks are rated as Moderate or High. • There are 12 high/extreme risks that have been escalated to the CRR. The spread of CRR risks across the organisation is; • 3 in the Medical Care Group • 0 in the Surgical Care Group • 2 in Clinical Support Care Group • 7 in Corporate Services • 0 in Marshalls Cross (Primary Care) The CRR risk categories of the CRR risks are; • 4 x Patient Care • 4 x Money • 2 x Governance • 2 x Staff
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, Commissioners, 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: 30th January 2019

CORPORATE RISK REGISTER REPORT – JANUARY 2019

1. Purpose

The purpose of this report is to provide an overview of the changes to the Trust's risks and to focus on those risks which score 15 or above and included on the Corporate Risk Register (CRR) – appendix 1. This report is based on DATIX data extracted on 2nd January 2019 and covers changes to the Risk Register made in December 2018.

2. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 02/01/2019	Previous Reporting Period 03/12/2018	Previous Reporting Period 07/11/2018
Number of new risks reported	43	6	27
Number of risks closed or removed	46	10	33
Number of increased risk scores	8	0	2
Number of decreased risk scores	12	8	8
Number of risks overdue for review	60	75	119
Total Number of Datix risks	**778***	**780**	**784**

**Includes 2 new risks not yet scored and 2 unapproved high risk*

3. Trust Risk Profile

Based on 774 scored risks

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
54	**65**	**24**	**130**	**13**	**148**	**62**	**119**	**40**	**107**	**3**	**7**	**2**	**0**
143 = 18.48%			**291 = 37.60%**			**328 = 42.38%**				**12 = 1.55%**			

The risk profiles for each of the Trust's Care Groups are:

3.1. Surgical Care Group

265 risks reported (34.24%)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**20**	**9**	**45**	**3**	**52**	**24**	**56**	**17**	**33**	**0**	**0**	**0**	**0**
35 = 13.21%			**100 = 37.74%**			**130 = 49.06%**				**0**			

3.2. Medical Care Group

193 risks reported (24.93%)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
26	**27**	**2**	**42**	**1**	**28**	**9**	**20**	**13**	**22**	**1**	**1**	**1**	**0**
55 = 28.50%			**71 = 36.79%**			**64 = 33.16%**				**3 = 1.55%**			

3.3. Clinical Support Care Group

57 risks reported (7.36%)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**5**	**1**	**5**	**0**	**8**	**4**	**8**	**3**	**15**	**1**	**1**	**0**	**0**
12 = 21.05%			**13 = 22.81%**			**30 = 52.63%**				**2 = 3.51%**			

3.4. Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR and Medicine Management)

227 risks reported (29.33%)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
16	**11**	**12**	**35**	**8**	**55**	**23**	**30**	**1**	**29**	**1**	**5**	**1**	**0**
39 = 17.18%			**98 = 43.17%**			**83 = 36.56%**				**7 = 3.08%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	Total
Health Informatics/ Health Records & IG	1	17	4	0	**22**
Facilities (Medirest/FM)	0	3	12	7	**22**
Nursing, Governance, Quality & Risk	0	16	11	6	**33**
Finance	3	4	16	15	**38**
Medicines Management	0	18	45	7	**70**
Human Resource	3	25	10	4	**42**
Total	**7**	**83**	**98**	**39**	**227**

3.5. Marshalls Cross GP Surgery & Community Services

32 risks reported (4.13%)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**2**	**0**	**3**	**1**	**5**	**2**	**5**	**6**	**8**	**0**	**0**	**0**	**0**
2 = 6.25%			**9 = 28.13%**			**21 = 65.63%**				**0**			

ENDS

Appendix 1 - Corporate Risk Register – January 2019

KEY	Medicine		Surgical		Clinical Support		Corporate	

New Risk Category	Datix Ref	Risk	Current Risk Score I x L	Date of last review and Executive Lead	Target Risk Score I x L	Action plan in place	Monitoring and Governance
Governance	222	Risk of failure to ensure delivery of national performance targets	4 x 4 = 16	16/07/2018 Rob Cooper	4 x 2 = 8	Action plan in place	Finance and Performance Committee
Governance	1772	Risk of Malicious Cyber Attack	4 x 4 = 16	21/12/2018 Christine Walters	4 x 3 = 12	Action plan in place	Executive Committee
Money	1555	Risk of not receiving apprenticeship levy payments for Lead Employer Doctors in Training.	4 x 5 = 20	31/12/2018 Anne-Marie Stretch	3 x 4 = 12	Action plan in place	Finance and Performance Committee
Money	1152	Risk to the quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	31/12/2018 Anne-Marie Stretch	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1569	Risk to consultant recruitment for Clinical Support Services, due to national staff shortages	3 x 5 = 15	31/12/2018 Anne-Marie Stretch	3 x 4 = 12	Action plan in place	Quality Committee
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C	4 x 5 = 20	28/11/2018 Sue Redfern	2 x 2 = 4	Action plan in place	Quality Committee
Staff	762	Risk that 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	31/12/2018 Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Quality Committee
Staff	2370	Risk to safe levels of medical cover, if consultant medical staff cannot be recruited to critical care vacancies	4 x 4 = 16	28/11/2018 Kevin Hardy	3 x 2 = 6	Action plan in place	Executive Committee
Patient Care	2502	The potential impact of Brexit No Deal on the supply of medical consumables and devices	4 x 4 = 16	11/12/2018 Nik Khashu	3 x2 = 6	Action plan in place	Finance and Performance Committee
Money*	2518	Risk to cash flow if other Trusts do not pay for their lead employer junior medical staff	5 x 3 = 15	18/12/2018 Nik Khashu	4 x 3 = 12	Action plan in place	Finance and Performance Committee
Money*	2521	If the Trust cannot deliver its agreed activity and CIP then there is a risk to the forecast outturn and the achievement of PSF funding	4 x 4 =16	18/12/2018 Nik Khashu	4 x 3 = 12	Action plan in place	Finance and Performance Committee
Patient Care*	767	If ED are unable to recruit to nursing vacancies and maintain nursing establishment then there is a risk to patient safety	3 x 5 = 15	31/12/2018 Sue Redfern	4 x 2 = 8	Action plan in place	Quality Committee

*New CRR risks since the last Board report

TRUST BOARD

Paper No: NHST(19) 6
Title of paper: Review of the Board Assurance Framework (BAF) – January 2019
Purpose: For the Board to review the BAF and agree any changes.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in October 2018. 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 level of risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Recommended changes** There are no proposed changes to the overall risk scores.
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: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 30th January 2019

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 be the hospital 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 2018/19 Objectives and Long Term Strategic Aims

2018/18 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 be the hospital 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						

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.

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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 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	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Ward Rounds • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI 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 Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine annual PIR return • Medicines Optimisation Strategy • Learning from deaths policy	To Board; • IPR • Patient Stories • Quality Board Rounds • 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 • National Inpatient Survey Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Report • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5 x 2 = 10	Routine reporting of quality and performance of community and primary care services delivered by the Trust	~~Plans to~~ Routinely achieve 30% of discharges by midday Delivery of the improvement plans for Falls, Infection Control and Pressure Ulcers in 2018/19 Embedding and sharing lessons learnt from never events, inquests and mortality reviews	Implementation plans for the four key 7-day service standards by 2020 Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2018/19 Targeted improvement work to increase FFT response rates (March 2019) Implementation of NEWS2 (March 2019) Risk assessment of critical suppliers in the event of a no-deal Brexit	5 x 1 = 5	KH/ SR

Risk 2 –-Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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 two year operational plans and the agreed control total • 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 respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	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 • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	4 x 5 = 20	Develop 2019 -20 detailed CIP plans and strengthen QIA monitoring to mitigate additional risk ~~Establish a benchmarking and reference cost group~~ Continue collaboration across C&M to deliver transformational CIP contribution to the organisations overall CIP target Management plans to deliver GIRFT recommendations	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 Cash flow and prompt payment of invoices from other NHS providers ~~Agreement of loans facility with NHSI~~ ~~Agreement with NHSI to underwrite any HEE contract cash shortfall~~ ~~Strengthen HEE contract T&Cs re payments~~	~~Develop a detailed Health and Care Partnership implementation plan with C&M partners in line with the priorities outlined in the Next Steps FYFV plan~~ Develop a 5 year plan to deliver the NHS long term plan with C&M partners for submission in July 2019 Secure maximum PSF funding in 2018/19 to achieve revised forecast outturn ~~control total.~~ Agree acceptable funding flows across St Helens health and social care economy and its partners (April 2019) Seek all possible sources of capital funding including national bids to support capacity planning	5 x 2= 10	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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	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 • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	4 x 5= 20	~~Theatre productivity improvement plan monitoring.~~ Implementation of routine capacity and demand modelling	Long term health economy emergency access resilience and urgent care services plans re NEL admissions and DTOC ~~Health economy winter resilience plan for 2018/19 which identifies additional capacity requirements - Sept 2018~~ Monitor the effectiveness of the 2018/19 health economy winter plans Achieve target to reduce bed occupancy to 92% in 2018/19 ~~Action plan to achieve BAU operational functionality for out-patients and Patient booking services following introduction of new Medway PAS (December 2018 as agreed with NHSI)~~ Resolve residual Medway and operational issues with OP patient booking systems	Urgent and Emergency Care Summit improvement programme – March 2019 Delivery of the ECIP concordat 5 key targets for 2018/19 Full Implementation of the new frailty pathways for Knowsley and Halton CCGs following the allocation of transition funding and the successful introduction in St Helens (March 2019) ~~Action Plan to reduce super stranded patients by 25% - December 2018~~ RTT waiting list to not exceed the 2017/18 closing level. (march 2019)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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/Good 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 • Delay in FT application timetable Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • 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 Other; • Health Watch • CQC • NHSI Segmentation Rating	4 x 3 = 12	Regular media activity reports , including social media, to the Executive Committee Development of a new Patient Experience Strategy (March 2019)	Action plan to improve understanding of patients and carers' views (January 2019)	Update Trust internet site ~~Delivery of the Well Led Action Plan – on going~~	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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 • Inability to secure support for IBP/LTFM • 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 • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending STHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Health and Care Partnership 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 • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN • Annual staff engagement events programme	4 x 3 = 12	~~Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning~~	C&M Health and Care Partnership performance and accountability framework ratings and reports	St Helens Cares - development of financial and governance models – Now planned for April 2019 Participation in One Halton Programme Board Continue working with Knowsley to support the development of place based integrated care plans	4 x2 = 8	AMS

Risk 6 - Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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 • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR 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 • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR - HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES report and action plan • Quality Ward Rounds • FTSU Self-Assessment and action plan Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream	5 x 4 = 20		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's ~~Risk assessment in relation to the impact of Brexit on recruitment and retention of EU staff~~ Monitoring of take up of the UK Settlement Scheme by EU staff Plans to optimise opportunities from the apprenticeship levy to create new roles and qualifications to address skills and capacity gaps (March 2019)	Development of a C&M collaborative staff bank – Revised to March 2019 ~~Maximise the benefits of the apprenticeship levy – December 2018~~ Implementation of the NHSI Recruitment and Retention Framework and evaluation of the return on investment (March 2019) Develop workforce strategy in relation to new roles e.g. Nurse Associates to maximise potential – September 2019	5 x 2 = 10	AMS

Risk 7 - Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual 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 Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric of 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 Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • Capital programme • 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 5-year forward view programme strategic estates workstream	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • 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 2 = 8	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.	Maximise the potential from the GP Streaming investment to improve the A&E department flows.	~~Delivery of additional car parking capacity to improve patient and staff experience (Revised to November 2018)~~	4 x 2 = 8	NB

Risk 8 - Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	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	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • ~~HIS~~ performance framework and KPIs • ~~HIS~~ customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board	To Board; • ~~HIS~~ Board Reports • IM&T Strategy delivery and benefits realisation plan reports (5YFV) • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics 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 • External sources of assurance – CareCert, Cyber Essentials, External Penetration Test	4 x 4= 16	Annual Cyber Security Business Case approval Annual Infrastructure Replacement Programme to be agreed Annual Corporate Governance Structure review Staff Development Plan Technical Development Annual programme of audit	ISO27001 Cyber Essentials Plus Service Improvement Plans Communications Strategy Digital Maturity Assessment	ISO27001 (August 2020) Cyber Essentials Plus (revised to August 19) Approval of draft Cyber Security Strategy (July 2019) Benefits realisation programme following PAS replacement (March 2019) Delivery of Penetration Test Action Plan (August 2019) Information asset owner/administrator work programme (Tier 1 systems) (revised to March 2019) Information security management framework (revised to March 2019) Capital Investment Action Plan (March 2019) Maintaining and enhancing essential IT Systems (March 2019)	4 x 2 = 8	CW

TRUST BOARD

Paper No: NHST(19)7

Title of paper: Overview of complaints, claims and incidents report for quarter 2 2018-19

Purpose: The purpose of this paper is to present an overview of incidents, complaints, PALS and claims activity and performance during quarter 2 2018-19 to identify if there are any key themes or trends that need further investigation.

Summary for 1st July 2018 to 30th September 2018 - quarter 2 (Q2)

Q2 2018-19 activity compared to Q2 2017-18 (Q2 2018-19 figures shown in brackets)

- 3.8% increase in spells (including well babies) (30,309)
- 1.4% increase in ED attendances (28,497)
- 3.4% decrease in outpatient visits (110,313)

Q2 2018-19 compared to Q2 2017-18	Q2 2018-19	Q2 2017-18	% change
Total incidents	3783	3734	1% increase
Patient harms, rated moderate & above	68	60	13% increase
Patient incidents per 1,000 bed days	59.42	61.62	4% decrease
Patient harms, rated moderate & above per 1,000 bed days	7.07	9.64	27% decrease
First stage complaints opened	64	75	15% decrease
PALS	723	618	17% increase
Clinical negligence claims	36	22	64% increase

Q2 2018-19 compared to Q1 2018-19	Q2 2018-19	Q1 2018-19	% change
Total incidents	3783	3633	4% increase
Patient harms, rated moderate & above	68	59	15% increase
Patient incidents per 1,000 bed days	59.42	57.66	3% increase
Patient harms, rated moderate & above per 1,000 bed days	7.07	7.64	7% decrease
First stage complaints opened	64	63	2% increase
PALS	723	795	9% decrease
Clinical negligence claims	36	40	11% decrease

Corporate objectives met or risks addressed: Safety – We will embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience.

Financial implications: There are no direct financial implications arising from this report

Stakeholders: Patients, carers, commissioners, regulators and Trust staff.

Recommendation(s): Members are asked to review the report and consider if there are any issues that need to be referred to the Quality Committee for further investigation.

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

Date of meeting: 30th January 2019

1. Introduction

The Trust uses the Datix to record incidents, complaints, PALS enquiries and claims to enable related occurrences to be linked.

The information includes all reported incidents, complaints, PALS and litigation (claims and inquests) and identifies any trends and learning.

The data included in this report covers Q2 2018-19.

2. Governance of complaints, incidents and claims

The Quality Committee receives a monthly report on complaints management, with a more detailed report submitted monthly to the Patient Experience Council. The Patient Safety Council receives a monthly report on incidents and a quarterly report relating to claims. Each of these Councils provides a chair's report, escalating any areas of concern, to the Quality Committee. The Claims Governance Group meets monthly and reviews new and high value claims and lessons learned as a result of investigations. A chair's report is submitted to the Risk Management Council, which reports to the Executive Committee.

3. Reasons and themes for incidents, complaints, PALS and claims

The table below compares the reasons for incidents, complaints, PALS contacts and claims reported during Q2, by theme.

Table 1: Top themes from incidents, complaints, PALS and claims - Q2 2018-19

Rank	Themes for Q2 2018-19
1st	Clinical care
2nd	Access/admission/discharge issues
3rd	Communication and records
4th	Attitude/behaviour/competence

Incidents	Q2	Complaints	Q2	PALS	Q2	Clinical negligence claim	Q2
Accident that may result in a personal injury	912	Clinical treatment	28	Communications	145	All specialities - failure to diagnose or delay in diagnosis	7
Implementation of Care or ongoing Monitoring	650	Patient Care Nursing Care	11	Appointments	128	Fail/delay treatment	7
Clinical Assessment (Investigations images and lab tests)	377	Communications	7	Clinical treatment	68	Failure to recognise complications of treatment	3
Medication	357	Values and staff behaviour	6	Patient Care Nursing Care	62	Failure to warn (informed consent)	0
Access, appointment, admission, transfer, discharge	354	Admission & discharges (excl. delayed discharged re: care packages)	3	Admission & discharges (excl. delayed discharged re: care packages)	58	Delay in performing an operation	0

Note: The table above should be used as guidance only as the claims and complaints received often fall into more than one category; for example, there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding the care received. The categories used for reporting are indicated by external bodies, for example the clinical negligence ones are set by NHS Resolution and the complaints codes are used to report the KO41 via NHS Digital as required by the Department of Health.

The top category in each of the 4 areas has been consistent for the last five quarters.

From this analysis it can be seen that the most common theme across all areas is clinical care, followed by access/admission/discharge issues. This analysis will be repeated each quarter to see if the profile changes over time.

4. Incidents

There were 3783 incidents reported by staff during Q2, with 9 incidents reported to StEIS and 68 categorised as moderate, severe harm or death.

Charts 1 and 2 below show the Trust's incident reporting activity from Q2 2016-17 to Q2 2018-19. This shows an increase in incident reporting but a downward trend in levels of significant harm resulting from the incidents. This indicates an improving culture of reporting.

Chart 1: total incidents reported

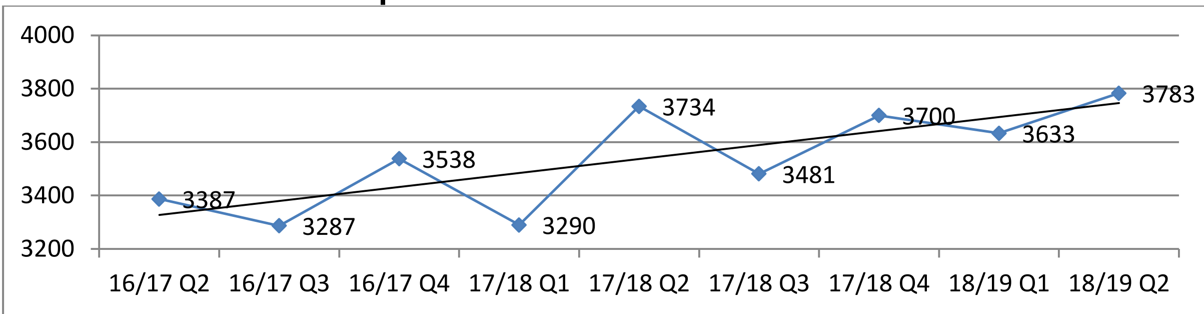
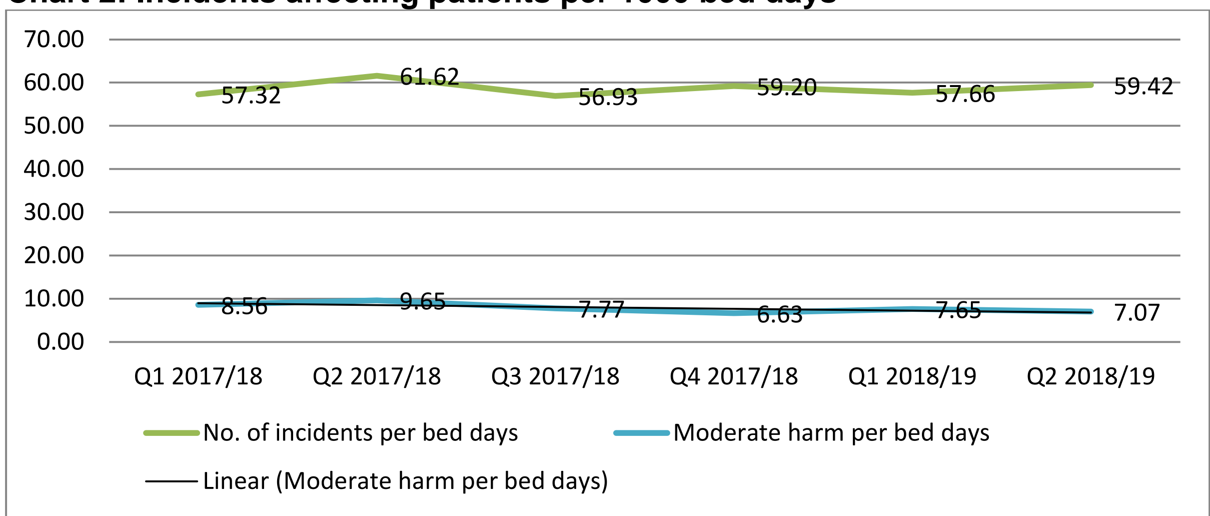


Chart 2: Incidents affecting patients per 1000 bed days



4.1. Thematic analysis of incidents reported to StEIS* in Q2 2017/18

In Q2 the Trust reported 9 incidents to StEIS.

*Only those incidents outlined in the Serious Incident Reporting Framework are reported on StEIS. These include any incident where the Trust causes severe harm or death, IG breaches, allegations of abuse and a number of other categories.

Table 2: incidents reported to StEIS in Q2 2018/19

Incident category	Number
Slips, trips & falls	3
Sub-optimal care of the deteriorating patient	3
Diagnostic incident	1
Never event – retained object	1
Absconded patient	1

Four patient safety root cause analysis (RCA) and three allegation of abuse reports were submitted to the CCG in Q2 of these six were submitted on time (86%).

4.2. Actions taken as a result of serious incidents

An RCA investigation is undertaken for each serious incident, with recommendations and an action plan produced to reduce the risk of a reoccurrence. The four RCAs submitted included a number of actions and examples of these include:

Sub-optimal care of a deteriorating patient (delay in receiving antibiotics)

- North west Ambulance Service have implemented a sepsis screening tool as a result of this and other similar incidents that have occurred in the North West
- The previous sepsis screening tool sticker used on the documentation in ED has now been embedded and encompasses a broader set of flags to include blood pressure

Sub-optimal care of a child with sepsis

- Current guidance in relation to moving out of the ED patients requiring review by Paediatric Inpatient Team has been reviewed
- A business case developed to increase junior doctors and nurses in ED to address increasing demand

Fall resulting in a fractured neck of femur

- Local action has been taken following this fall which will be implemented in conjunction with the Trust Falls Strategy 2018-2021

Difficult delivery and resuscitation of a neonate

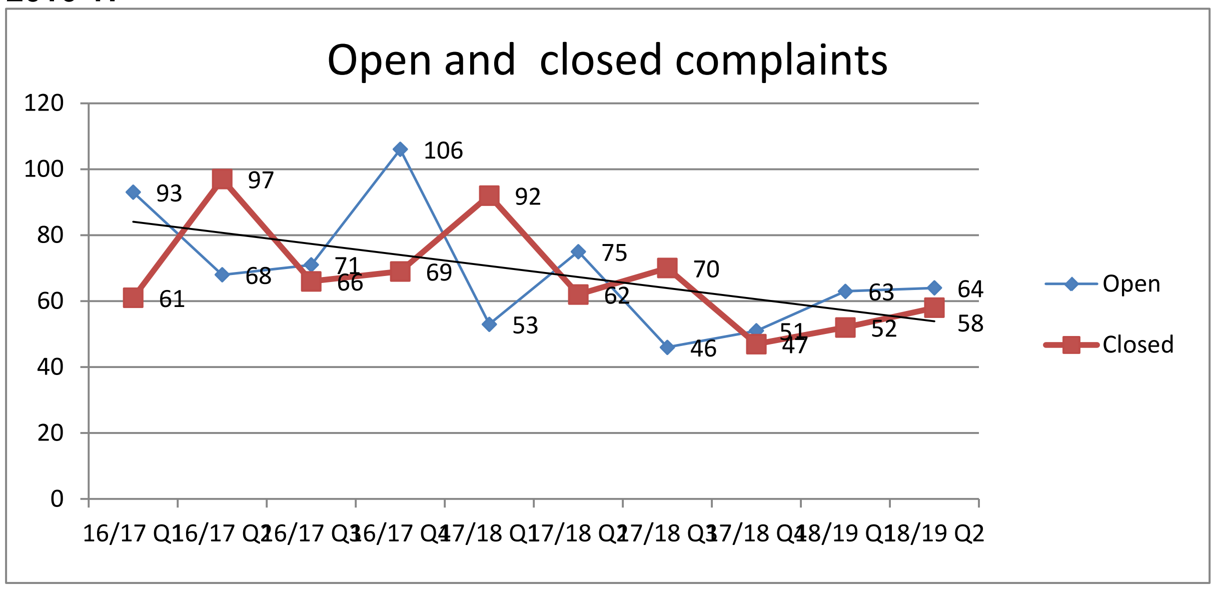
- Maternity plans to formulate training simulation scenarios that involve situational awareness and prompts to limit the influence of human factors in poor decision making

5. Complaints

In Q2, 64 1st stage complaints were received and opened; an increase of 1 compared to the previous quarter. The Trust closed 58 1st stage complaints in Q2 compared to 52 in Q1. There were 2 overdue complaints at the end of Q2 compared to none at the end of Q1, with 57 open complaints compared to 51 at the end of the previous quarter, reflecting the increase in complaints.

The chart below contains 1st stage complaints (written and verbal) received by quarter, since April 2016, showing the reduction in the number of complaints over this period.

Chart 3: Open and closed first stage complaints received each quarter from Q1 2016-17



5.1. Complaints – local and national comparison

NHS Digital collates details of trust written complaints (which are a sub set of all the complaints received and recorded) via a quarterly return (KO41a).

Chart 4: Other trust comparison – written complaints Q2

	Warrington Hospital NHS Trust	Wrightinton, Wigan & Leigh NHS Trust	Southport & Ormskirk Hospital	Aintree University Hospital FT	Royal Liverpool & Broadgreen Hospitals NHS Trust	St Helens & Knowsley NHS Trust
Total New	130	130	71	49	68	57
Total Resolved	139	136	77	79	74	47
Total Upheld	16	134	20	8	23	6
Total Partially Upheld	81	0	37	60	15	23
Total Not Upheld	42	2	20	11	36	18
Total Carried Forward	72	61	115	12	3	45

The Q2 figures indicate that the Trust received less written complaints compared to four of the five trusts above. In addition, the Trust has the lowest level of complaints upheld.

5.2. Actions taken as a result of complaints

Each complaint response includes any learning that has been identified and the necessary actions for each area. A summary of lessons learned and actions taken from incidents and complaints across the Trust is shared at the Matron and Ward Manager meetings for onward cascade to each department/ward. In addition, complaints are a standing agenda item on the Care Group and ward governance meetings to ensure that lessons are shared and to embed any actions taken to improve the quality of patient care. The following are examples of actions in Q2:

Values & behaviours

- Staff member has reflected and acknowledged that the care provided was not to the usual standard or Trust standard and that the documentation was poor
- On-going support to be provided to staff member to ensure standards are maintained

Appointments

- Open appointments were reinstated, with a plan in place to see the patient on the same day (for biopsy)
- Review appointments for the patient to be every 5 months and if an appointment is cancelled the patient advised to contact the secretary to ensure a suitable appointment is reinstated

Communications

- Staff were reminded that effective communication is essential with parents at all times
- Issues raised in the complaint were discussed with all staff and at the Maternity and Paediatric Working Well Together meeting
- Staff were reminded of the importance of escalating issues appropriately
- Admissions team to discuss the importance of clear and concise information to all patients
- Staff to ensure they update patients about any changes in their treatment plan and that this is communicated accordingly. This will be addressed through the Trauma Meeting and Directorate Meeting

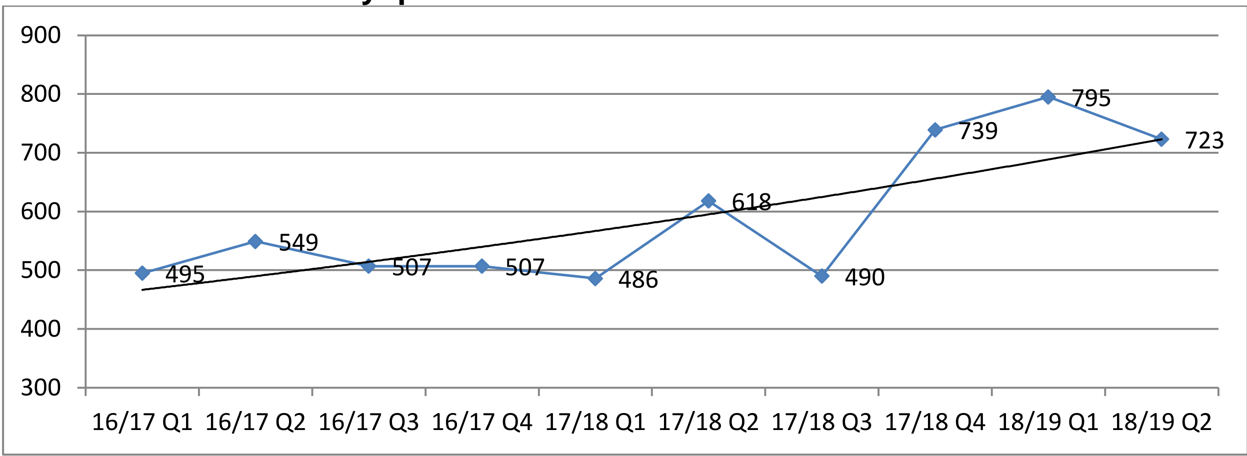
Clinical Treatment

- Sonographer to provide a portfolio of evidence to demonstrate that she is assessing the upper extremities consistently. During the period of remedial training the sonographer will provide images of both upper extremities
- Discussion of anonymised case at sonographer audit meeting
- Annual peer audit of obstetric images and reports to ensure that performance remains at an acceptable level
- Teams to ensure a full and thorough history is obtained including any past post cystoscopy urinary tract infections which should be considered before performing cystoscopy
- Staff to explain in detail what to expect during the cystoscopy procedure including some discomfort. Patient leaflet to be given to all patients explaining what to expect
- Training sessions and patient leaflet regarding therapy/social care including who is who in the teams to be devised

6. PALS

There were 723 PALS contacts/enquiries during Q 2 2018-19. This represents a 9% decrease compared to the previous quarter, and a 14.5% increase compared to the equivalent quarter in 2017-18.

Chart 5: PALS contact by quarter



The main themes for PALS contacts are shown in Table 1 above and remain generally consistent other than appointments, which now features in the top 5. Nineteen PALS contacts were converted to complaints, which represents 2.6% of PALS contacts. The table below provides additional detail relating to the reasons for PALS contacts and the Care Group or Directorate involved, noting that not all PALS contacts relate to a specific area.

Table 3: PALS enquiries by themes and area

	Medical Care Group	Surgical Care Group	Clinical Support Services	Health Informatics/ Health Records	Facilities (Medirest /TWFM)	Nursing, Governance Quality & Risk	Meds Man.	HR	Total
Access to Treatment or Drugs	5	9	2	0	0	1	0	0	17
Admissions and Discharges (excl. delayed discharge re care package)	38	16	2	0	0	2	0	0	58
Appointments	45	70	5	1	0	7	0	0	128
Clinical Treatment	26	40	2	0	0	0	0	0	68
Commissioning	1	0	0	0	0	0	0	0	1
Communications	82	49	3	0	3	7	0	1	145
End of Life Care	11	0	0	0	0	2	0	0	13
Facilities	0	2	0	0	8	0	0	0	10
Patient Care/ Nursing Care	47	12	1	0	0	2	0	0	62
Prescribing	2	0	1	0	0	0	3	0	6
Privacy and Dignity	1	1	0	0	0	0	0	0	2
Transport (Ambulances)	1	0	1	0	0	0	0	0	2
Trust Admin/ Policies/ Procedures	1	1	0	3	0	2	0	0	7
Values and Behaviours (Staff)	14	6	4	0	0	0	0	0	24
Waiting Times	5	40	3	0	0	0	0	0	48
Other (e.g. abuse/ behaviour/Theft/Benefits)	7	1	1	0	1	3	0	0	13
Total	286	247	25	4	12	26	3	1	604

7. Legal Services

7.1. Clinical negligence claims

In Q2, the Trust received 36 new claims, representing a decrease compared to the 40 new claims in Q1. Nineteen of the new claims were received by the Surgical Care Group (a 17.4% decrease on the previous quarter) and fourteen by the Medical Care Group (a 12.5% decrease on Q1). Three claims were received that related to Clinical Support Services in Q2 in comparison to Q1 when none were received. Medicines Management received no claims in Q2 but one in Q1. As shown in the table below, the amount of new claims received in Q1 & Q2 are the highest received by quarter in the last 18 months and this will be monitored going forward.

Table 4: Quarterly clinical negligence claim by Care Group

	2017-18			2018-19			
	Q1	Q2	Q3	Q4	Q1	Q2	Total
Medical Care Group	9	9	9	9	16	14	66
Surgical Care Group	12	13	13	19	23	19	99
Clinical Support Services	1	0	2	2	0	3	8
Medicines Management	0	0	0	0	1	0	1
Nursing, Governance, Quality & Risk	0	0	0	0	0	0	0
Total	22	22	24	30	40	36	174

There was a decrease of 11.3% in active clinical negligence claims (320) in Q2 in comparison to 361 open clinical negligence claims in Q1. The numbers of clinical negligence claims (with and without damages) that closed increased in Q2 compared to Q1, with an increase in damages paid. There was a 42.8% (4) decrease in new employer liability and public liability claims compared to Q1 (7).

7.2. Actions taken as a result of claims

Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of closed claims in Q2:

Failure to act on abnormal test result

- Since 2009 the systems of communication has changed and improved between the Trust and the Walton Centre in cases when the Trust's clinicians require advice on neurosurgical issues
- Physical scans can be accessed anywhere electronically and this is particularly helpful when a patient presents at ED following treatment at another hospital and supports more effective clinical decision-making
- Abnormal scan reports are emailed to the referring doctor to prevent delays in treatment

Failures/delays in treatment

- All staff have undergone an implant insertion assessment in the last 12 months with experienced faculty of sexual and reproductive health trainer, with staff acquiring letters of competence for sub-dermal implants from faculty of reproductive health - gold standard.

- Teaching for chemotherapy nurses emphasising the importance of documentation
- Change in Extravasation Policy to ensure infusions are done correctly

7.3. Benchmarking data for claims

Quarterly benchmarking data is not available for NHS Trusts. However, NHS Resolution does produce annual figures for claims notified in previous financial years. The data for 2016-17 and 2017-18 was presented in the previous report to the Board.

7.4. Maternity Incentive Scheme Benchmarking

The maternity elements of CNST contributions for 2018-19 were increased by 10% to create a maternity incentive fund. Maternity services were required to demonstrate achievement of the criteria below in order to be eligible for a share of that incentive fund of at least 10% of the base contribution together with a share of the balance of undistributed funds.

1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths
2. Submitting data to the Maternity Services Data Set to the required standard
3. Demonstrating transitional care facilities are in place and operational to support implementation of the ATAIN programme
4. Demonstrating an effective system of medical workforce planning
5. Demonstrating an effective system of midwifery workforce planning
6. Demonstrating compliance with the four elements of the Saving Babies' Lives Care Bundle
7. Demonstrating a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership forum, and regularly acting on feedback
8. Evidencing that 90% of each maternity staff group have attended an in-house multi-professional maternity emergencies training session within the last training year
9. Demonstrating that Trust safety champions are meeting bi-monthly with Board-level champions to escalate locally identified issues
10. Reporting 100% of qualifying 2017-18 incidents under NHS Resolution Early Notification scheme

The Trust met all the 10 standards above and has received a share of the incentive fund at 10% of the base contribution together with a share of the balance of undistributed funds.

The chart below compares the Trust with other maternity services within the region:

Chart 6: Comparison of compliance with Maternity Incentive Fund Safety Standards

9/10
10/10
10/10
7/10
10/10
7/10

Liverpool Womens Hospital
St Helens and Knowsley Teaching Hospitals
Wirral Teaching Hospital
Southport & Ormskirk Hospital
Warrington Hospital
Wrightington, Leigh & Wigan Hospital

5.5. Inquests

The Trust, via the Legal Department, proactively manages non-routine inquests. These inquests are when members of Trust staff are called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned which require a corporate witness to inform the Coroner of what action has been taken to prevent recurrence. The Communications Team informed if there is any potential for media interest and, therefore, a risk to the organisation's reputation.

Currently there are 23 open inquests that fall within the above criteria.

Five inquests were held in Q2. Four of the five inquests were third party inquests where the Trust had no involvement at the time of the patients' deaths, but assisted the Coroner because the patients had received treatment at the Trust at one time. Three cases related to industrial injury and one was identified as natural causes. The Trust was directly involved in one case that had a finding of neglect. A level two root cause analysis was completed and an action plan implemented as a result of the incident, which included incorrect dosage of medication.

8. Conclusion

The number of incidents reported shows a slight increase quarter on quarter, with a reduction in moderate harms and above.

The number of open complaints increased to 57 (from 51) and the total number of overdue complaints rose from 0 to 2. The number of first stage complaints continues to show an overall decreasing trajectory.

PALS decreased in Q2 compared to Q1, but continues to show an overall increasing trajectory. Communications remains the leading reason for enquiries to PALS.

The numbers of clinical negligence claims received in Q2 were lower in comparison to Q1, however shows a significant increase from the previous year, which will require close monitoring.

ENDS

TRUST BOARD

Paper No: NHST(19)8
Title of paper: Safeguarding Adults & Children Annual Information & Assurance Reports 2017/18
Purpose: To provide the Trust Board with information and assurance that it effectively discharged its safeguarding adults' and children's responsibilities during 2017/8.
Summary: The report provides information and assurance for all aspects of safeguarding adults and children during the financial year 2017/18.
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust Board, Commissioners, Patients
Recommendation(s): Members are asked to approve the report.
Presenting officer: Sue Redfern, Executive Director of Nursing, Midwifery and Governance, Executive Lead for Safeguarding
Date of meeting: 30th January 2019

Safeguarding Adult

Annual Information and Assurance Report

2017 - 2018

Completed by:

Anne Monteith Named Nurse Safeguarding Children

CONTENTS

No.	Item	Page
	Introduction	4
Section 1	**Safeguarding Adults**	4
1.1	Safeguarding Adults Policy	4
1.2	Governance Processes	5
1.3	Safer Recruitment	5
1.4	Training	5
1.5	Prevent Training	5
1.6	Policy Compliance	6
1.7	Allegations of Abuse Against Professionals	6
1.8	Multi-Agency Working	6
1.9	Safeguarding Activity	7
1.10	Safeguarding Incidents	7
1.11	External Assurance	7
1.12	Summary of Achievements Future Developments	8
1.13	Future Developments	8
Section 2	**Supporting Adults with Additional Needs**	9
	Overview	9
2.1	Mental Capacity Act 2005	9
2.2	Deprivation of Liberty Safeguards (DOLS)	9
2.3	Learning Disability	10
2.4	Mental Health Liaison	11
2.6	Summary of Achievements Future Developments	11
2.7	Future Developments	11

Safeguarding Adults Annual Information and Assurance Report

2017-2018

Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust has a statutory responsibility to safeguarding adults at risk from harm across all service areas in accordance with the Care Act 2014. This activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Adult Boards (LSABs). It is everybody's business to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The purpose of this Annual Report is to provide an overview of safeguarding adult activity across the Trust for the last financial year (April 2017 – March 2018) and to provide assurance to the Trust Board.

Safeguarding Adult arrangements include:

- Robust internal governance processes to safeguard adults at risk including an executive lead, Named Professional and Specialist Staff in post.
- Safer recruitment
- Training of all staff as appropriate for role
- Policies for safeguarding adults and managing allegations of abuse against a professional
- Effective supervision arrangements
- Working in partnership with other agencies

This report combines adult safeguarding activity with the Trust's wider remit of supporting adults with additional needs. The report details achievements in both areas and lays out our plans for the coming year.

This report is in two sections:-

- ➢ **Section 1** details the work undertaken around the formal safeguarding process.
- ➢ **Section 2** details the work around supporting adults who have additional needs.

SECTION 1: SAFEGUARDING ADULTS

1. Assurance of compliance with the Trust's Safeguarding Adult Responsibilities

1.1 Safeguarding Adult Policy

The Trust's Safeguarding Adults Policy is available on the Trust Intranet for all staff to access and contains Standard Operating Procedures to cover all areas of safeguarding adults. The Policy was reviewed and amended in January 2018.

1.2 Internal Governance Processes to Safeguard Adults

The Executive Director of Nursing, Midwifery and Governance is the Executive lead responsible for Safeguarding. There was a change in the structure of the Safeguarding team in 2016, when the Head of Safeguarding post was replaced with a substantive Named Professional post to lead on the Safeguarding adult agenda. The Safeguarding Adults team consists of a Named Professional supported by specialist nurses and administrators. The Named Nurse for Safeguarding Children

and Named Professional for Safeguarding Adults now report directly to the Deputy Director of Nursing.

The Trust's Safeguarding Adults Steering Group, which reports to the Patient Safety Council, has responsibility for ensuring the Safeguarding adults agenda is achieved. The group was established in September 2009 with representatives from all service areas within the Trust and met four times during 2017 - 2018 to review the overarching work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made. The Patient Safety Council reports into the Trust's Quality Committee which is a sub-group of the Trust Board. In addition to this, a quarterly Safeguarding Adult Report containing commissioner feedback from the CCG's Safeguarding Designated Professionals reviewed at the joint commissioner and Trust's Clinical Quality Performance Group.

1.3 Safer Recruitment including Trust Volunteers

The Trust complies with the NHS Recruitment Standards. The Human Resources IT TRAC Recruitment system supports this, ensuring every step required to recruit safely is complied with prior to start date. Appointment to the Trust's volunteer service, during 2015, was also moved to the TRAC system to ensure the same robust standards apply to the voluntary workforce.

1.4 Safeguarding Adult Training

The Trust's Safeguarding Adults Training Strategy and Training Needs Analysis (TNA) sets out which staff groups are to achieve which of the 3 levels of Safeguarding Adults training according to their role.

Level 1 training is delivered as part of the Trust's Induction Programme for all new starters, then bi annually within the Trust's mandatory training for all staff. This is a face to face session delivered by a member of the Trust's Safeguarding Team. This training is combined with the safeguarding children's' awareness training.

Level 2 Safeguarding Adults training is delivered via a workbook and assessment that is completed by individual staff members every 3 years.

Level 3 training is delivered internally by the Safeguarding Adults Specialist Nurses as one full day course every 3 years.

Level 4 is for highly specialist staff and is delivered externally.

Safeguarding Compliance figures as of the end of March 2018 are listed below against a target of 90%.

- Level 1 95.4%
- Level 2 90.1%
- Level 3 93.3%
- Level 4 100%

1.5 PREVENT Training

Prevent is part of the UK's counter terrorism strategy and is firmly embedded into safeguarding practice.
The Prevent TNA is included in the main Safeguarding Adult TNA and staff are assigned a training level according to job role.
Level 1+2 training is delivered to all staff as part of induction and mandatory training. It is also included in all other levels of safeguarding training.
Level 3 training is a face to face session delivered by a Home Office approved facilitator (Trust staff have been trained to deliver).

Prevent Compliance figures as of the end of March 2017 are listed below against a target of 85%.

- Level 1+2 95.4%
- Level 3 98.3%

1.6 Safeguarding Adults Policy and Assurance of Compliance

Evidence of compliance with the policy and Trust Safeguarding procedures was provided by the completion of audits of health records to review compliance with safeguarding processes. The audits findings and associated actions were progressed via the adult steering group.

1.7 Allegations of Abuse against a Professional Policy Activity

In addition to employing STHK staff, the Trust is also lead employer to over 3500 doctors in training covered by this policy. There were 7 cases of alleged abuse against adults during the year, all made in respect of nursing staff. All cases were managed appropriately as per the relevant policy.

1.8 Effective (Multi-agency) Partnership working

1.8.1 Safeguarding Adult Review (SAR) Involvement

A Safeguarding Adults Review (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

They are commissioned when:

- there is reasonable cause for concern about how Safeguarding Adults Board members or other agencies providing services, worked together to safeguard an adult,

and

- The adult has died, and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

or

- The adult is still alive, and the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

During 2017 / 2018 the Trust were involved in no SARs.

Their Trust contributed to one Domestic Homicide Review Commissioned by St Helens Community Partnership, however there was minimal involvement and no specific actions identified.

1.8.2 Multi-agency working

The Trust is an active partner in three Local Safeguarding Adults Boards (LSABs) in St Helens, Halton and Knowsley (which is now part of a pan-Mersey SAB). The minutes from each of the Boards are provided to the Trust's Adult Safeguarding Steering Group and through to the Trust Board.

The safeguarding adults team participate when requested in meetings and discussions, 100% compliance with the KPI was achieved in relation to attendance at multi-agency meetings for adults at risk.

1.8.3 Information Sharing

Effective information sharing between agencies is essential for effective identification of need, assessment and provision of relevant services for adults at risk. Early sharing of information is the key to providing effective early help where there are emerging problems or concerns. Sharing information can also be essential for protecting an adult at risk. Safeguarding Adult Reviews (SARs) continue to highlight information sharing as an area of concern when reviewing deaths and serious harm to adults at risk.

The Safeguarding Adult Team work alongside partner agencies to ensure that information about adults at risk is shared in a proportionate and timely manner

1.9 Safeguarding Adults Activity

The Safeguarding Adults Team provides support and advice to all Trust staff who have concerns about an adult at risk. This activity is called a contact. A referral is when the contact generates a formal safeguarding referral to the local authority. The data shows a high level of contacts between areas of the Trust and the Trust's Adult Safeguarding Team which is viewed as being very positive. The data also shows a number that are formally referred to the local authority.

Table 1 below shows comparison of Contacts and Referrals to Adult Social Care in each quarter of 2017/2018.

Quarter	Contacts	Referrals
1 – 2017	172	44
2 - 2017	124	49
3 - 2017	135	66
4 - 2018	147	59

Table 2 below shows comparison of Contacts and Referrals from 2012-2017

Period	Total Contacts	Total Referrals
April 2012- March 2013	458	206
April 2013- March 2014	510	194
April 2014- March 2015	798	177
April 2015- March 2016	961	241
April 2016- March 2017	936	199
April 2016 – March 2017	578	218

1.10 Safeguarding Adults Incidents

There have been no significant incidents relating to Safeguarding Adults in 2017 / 2018 which required an internal review, RCA or SIRI.

1.11 External Assurance of Effective Processes during 2017 / 2018

1.11.1 Safeguarding Adult Commissioner Assurance

The Trust's safeguarding adult systems and processes are monitored externally by achieving key performance indicator requirements which are submitted monthly in the Trust's Integrated Performance Report and quarterly to St Helens CCG who, in turn, provides assurance to Knowsley and Halton CCG.

Overall the Trust received reasonable assurance due to some outstanding actions from the Commissioning standards audit. Significant assurance was achieved in the individual areas of training, policies and partnership working.

1.11.2 Mersey Internal Audit Agency Safeguarding Audit

Mersey Internal Audit Agency (MIAA) audited the safeguarding adult and children procedures within the Trust during January 2018. This was a very positive audit with only 3 medium risk actions as detailed below:

- The Safeguarding Steering Groups need to ensure that actions are more robustly documented within the body of the minutes and that any actions documented within an action log can be traced back to source with supporting evidence provided prior to being marked as complete.

- the Trust should review the breadth of information escalated and monitored by the Patient Safety Council and Quality Committee and the priorities and focus for the Safeguarding Service should be clearly defined and the annual work plan of these groups should be amended to ensure appropriate coverage of these priorities to ensure that appropriate updates and assurance are being provided in relation to all Safeguarding duties and priorities. These should be informed by risk and also support the KPI framework that is operating within the Trust.

- The Trust should review the membership of the Patient Safety Council to ensure that it is appropriate and the Safeguarding Service is appropriately represented to ensure appropriate updates and assurances are provided and also that effective and informed decisions can be made.

All actions were implemented on receipt of the Audit Report.

1.12 Summary of Achievements 2016/2017

- Reasonable assurance has been received from the CCG in relation to Safeguarding Adult KPI compliance.
- The principles of the Care Act 2014 have been firmly embedded into practice.
- The Safeguarding Team has continued to actively participate at the LSAB activity in the three main local areas.

1.13 Future Developments

- The Trust Safeguarding will endeavour to maintain KPI compliance
- There will be a focus on improving and sustaining Safeguarding Adult training compliance
- Safeguarding Audit will continue to monitor compliance to trust process.

SECTION 2: Supporting Adults with Additional Needs

Overview

A high number of our patients have additional needs and require support to complete their acute journey and to protect themselves. The way that we identify and support this group of patients is key to achieving positive outcomes for the patients, their carers, families and representatives, avoiding harm and, at the same time, improving Trust performance. The ability to identify patients with additional needs, risk assessing and managing these needs, involves making reasonable adjustments. Whilst the implementation of these 'reasonable adjustments' and provision of support for individual patients is a legal obligation, the manner in which the Trust undertakes the process and the confidence it has in all staff complying to this obligation requires monitoring and oversight.

The Safeguarding Adult Team provides support to all staff in the Trust in relation to supporting patients with additional needs who have increased vulnerabilities such as

- Mental Capacity challenges
- Deprivation of Liberty Safeguards
- Learning Disability
- Mental Health issues

2.1. Mental Capacity Act (MCA)

The management of patients who may lack mental capacity is a key area of the Trust's ability to manage patients with additional needs and who may be at risk. The MCA provides a statutory framework for the management of patients who may lack mental capacity requiring a formal process to be undertaken and recorded.

The Trust Mental Capacity Act Steering Group meets regularly to review practice and discuss any issues; there is regular representation from local Supervisory Authorities.

The Trust's MCA Training Strategy is embedded within the overall Safeguarding Adults Training Strategy which details the competences expected of staff and compliance was monitored through the Key Performance Indicator throughout 2017/2018.

2.2 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) was introduced as an addendum to the Mental Capacity Act 2005. This process involves the Trust identifying patients who lack capacity and need restrictions to be put into place to ensure their safety. This requires the Trust, as the 'managing authority', to request an authorisation from the patient's supervisory authority, a role which transferred to the local authority in April 2013. A series of assessments of the patient's needs are then undertaken to determine the patient's best interests.

.
The table below provides a detailed record of the Trust DoLS activity. This shows a decrease in applications which is contradictory to the expectation that activity would increase following the 2015 Cheshire West ruling which broadened the criteria for urgent authorisations. The Safeguarding Team will continue to support staff with this decision making process through training and supervision.

Year	DoLS Applications
2012/13	13

2013/14	12
2014/15	69
2015/16	190
2016/17	191
2017/18	162

The table below details the outcome of the applications. A significant number of patients subject to an Urgent authorisation are discharged prior to the completion of the assessment.

	Authorised	Unauthorised	D/C prior to assessment	Awaiting Outcome	Total
St Helens	12	35	18	0	65
Knowsley	12	9	17	0	38
Halton	9	14	7	0	30
Liverpool	2	12	5	0	19
Out of Area	2	3	5	0	10
Total	37	73	52	0	162

2.3 Learning Disability

The Trust Learning Disability Steering Group meets quarterly to discuss national and local agenda items and maintain links with community partners. This group has been poorly attended this year and will, in 2018/19 be dissolved and absorbed into the Adult Steering Group Agenda. The Trust will be represented at the Cheshire and Merseyside Acute LD Network forum and the St Helens Learning Disability Partnership board.

The Safeguarding Adults team continues to support the improvement of access to healthcare provision and patient experience for people with a learning disability and/or autism who access our hospitals and services. There were 153 patients referred for support with reasonable adjustments and for multi-agency liaison requirements.

The Safeguarding Adults Team audits the range of reasonable adjustments made to the patient journey and takes place annually. The audit outcomes demonstrate improving awareness and quality in our work with adults who have a learning disability and/or autism.

The Safeguarding Adults team continues to be an active partner in multi-agency work to support people with a learning disability and/or autism, their families and carers. Representatives from the team have attended the Cheshire and Merseyside Acute LD Network forum and the Learning Disability Partnership board in St Helens on behalf of the Trust this year and continue to do so. Partnership working with our local community LD nursing colleagues continues to strengthen and arrangements are now in place for St Helens and Knowsley teams to attend the wards on a fortnightly basis, offering additional specialist support and guidance to patients with a learning disability, their families and carers and Trust staff.

The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It identifies any potentially modifiable factors associated

with a person's death, and works to ensure that these are not repeated and that learning is shared nationwide. The Safeguarding Adults Team is working alongside partner agencies to facilitate reviews of the deaths of those with a learning disability as well as performing internal reviews on behalf of the Trust.

2.4 Mental Health Liaison

The Trust has a fully commissioned Acute Adult Mental Health Liaison Team based in the Emergency Department, working 24/7, undertaking assessments both in the Emergency Department and across all inpatient areas. This service is run by North West Boroughs Partnership NHS Foundation Trust.

There is also a fully commissioned Older Peoples Mental Health Liaison Service working over a seven day period working to extended hours and including the Emergency Department. It is well established and is continuing to make a significant contribution to identifying and managing older patients with mental health needs.

The Safeguarding Adult Team is an active member of the multi-agency Mental Health Steering Group held monthly in the Emergency Department.

2.5 Summary of Achievements 2017/18

- Reasonable assurance has been received from the CCG in relation to Safeguarding Adult KPI compliance.
- The Safeguarding Team has continued to actively participate at the LSAB activity in the three main local areas.
- Positive support has been provided to adults with additional needs which has led to improved patient experience.

2.6 Future Developments

- The Trust Safeguarding will endeavour to maintain KPI compliance
- There will be a focus on improving and sustaining Safeguarding Adult training compliance
- Safeguarding Audit will monitor compliance to trust process
- The Safeguarding Adult Team will continue to update the Trust on changes in legislation and national guidance for adults with additional needs and will update Policy and training in line with such developments.

END

Safeguarding Children

Information and Annual Assurance Report

2017 - 2018

Completed by: Anne Monteith, Named Nurse Safeguarding Children

CONTENTS

No.	Item	Page
1.	**Introduction**	4
2.	**Assurance of compliance with the Trust's Safeguarding Children Responsibilities**	4
2.1	Safeguarding Children Policy	4
2.2	Internal Governance Processes to Safeguarding Children	4
2.3	Safeguarding Recruitment including Trust Volunteers	5
2.4	Safeguarding Children Training	5
2.5	Safeguarding Children Policy & Assurance of Compliance	5
2.6	Allegation of Abuse against a Professional Policy Activity	5
2.7	Safeguarding Children Supervision Policy	6
2.8	Effective (Multi-agency) Partnership Working	6
	2.8.1 Serious Case Review Involvement	6
	2.8.2 Multi-agency working	6
	2.8.3 Information Sharing	6
	2.8.4 Local Safeguarding Children Board Activity Sharing	7
3.	**Safeguarding Children Activity and Social Care Referrals**	7
3.1	Paediatric and Emergency Department Activity	7
3.2	Maternity Activity	8
3.3	Safeguarding Children Incidents	8
4.	**External Assurance of Effective Processes**	8
4.1	Safeguarding Children CCG Assurance	8
4.2	Section 11 Audit	9
4.3	Safeguarding Children CQC Assurance	10
5.	**Summary of Achievements**	11
6.	**Future Developments**	11

Safeguarding Children Annual Information and Assurance Board Report

2017 - 2018

1. Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguarding children and young people at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004. This activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Children Boards (LSCBs). Safeguarding children is everybody's business to help prevent abuse and to act quickly and proportionately to protect children where abuse is suspected whether staff are working directly or indirectly (with children's parents or carers) with children and young people. The purpose of this Annual Report is to provide an overview of safeguarding children activity across the Trust for the last financial year (April 2017 – March 2018) and to provide assurance to the Trust Board.

Safeguarding Children arrangements include:

- Robust internal governance processes to safeguard children including an Executive lead, a Named Doctor, Named Nurse and Named Midwife in post.
- Safer recruitment
- Training of all staff as appropriate for role
- Policies for safeguarding children and allegations of abuse against a professional
- Effective supervision arrangements
- Working in partnership with other agencies

2. Assurance of compliance with the Trust's Safeguarding Children Responsibilities

2.1 Safeguarding Children Policy

The Trust Safeguarding Children Policy is available on the Trust Intranet for all staff to access and contains individual Standard Operating Procedures to cover many areas of safeguarding and child protection. The Policy was reviewed and minor amendments made in 2016 to reflect the revised Working Together to Safeguard Children Statutory Guidance 2015.

2.2 Internal Governance Processes to Safeguard Children

The Executive Director of Nursing, Midwifery and Governance is the Executive lead with overall responsibility for Safeguarding, supported by a Named Nurse and Named Midwife.
A substantive Named Midwife Post was created and successfully recruited into in 2017 following a recommendation from the 2016 CQC Inspection (Knowsley CCG).

The Trust's Safeguarding Children Steering Group, which reports to the Patient Safety Council, has responsibility for ensuring the Safeguarding children agenda is achieved. The group was established in September 2009 with representatives from all service areas within the Trust and met four times during 2017 - 2018 to review the overarching SC work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made. The Patient Safety Council reports into the Trust's Quality Committee which is a sub-group of the Trust Board. In addition to this, a quarterly Safeguarding Children report containing commissioner feedback from the CCG's Safeguarding Designated Professionals is reviewed at the joint commissioner and Trust's Clinical Quality Performance Group.

2.3 Safer Recruitment including Trust Volunteers

The Trust complies with the NHS Recruitment Standards. The Human Resources IT TRAC Recruitment system supports this, ensuring every step required to recruit safely is complied with prior to start date. Appointment to the Trust's volunteer service was also moved to the TRAC system in 2015 to ensure the same robust standards apply to the voluntary workforce.

2.4. Safeguarding Children Training

The Trust's Safeguarding Children Training Strategy and Training Needs Analysis sets out which staff groups are to receive which of the 3 levels of Safeguarding Children training according to their role, as set out in the Intercollegiate Safeguarding Children training standards, last updated in 2015. This update has resulted in a substantial broadening of the staff groups requiring 'Level 2' training to all Trust clinical staff.

Level 1 training is delivered as part of the Trust's Induction Programme for all new starters, and is then included in the mandatory training programme for all staff. This is a face to face session delivered by a member of the Trust's Safeguarding Team. This training is combined with the vulnerable adults' awareness training. Attendees receive additional safeguarding children information in a Level 1 reader distributed following mandatory and induction training by email.

Level 2 Safeguarding Children training is delivered via a workbook and assessment that is completed by individual staff members every 3 years.

Level 3 training is delivered internally by the Named Nurse Safeguarding Children as one full day course every 3 years. Level 3 specialist training is accessed via the LSCB every 3 years. This is a 2 day 'Working Together to Safeguard Children' Course provided as part of their multi-agency training programme and is accessed only by staff who are involved in care planning and case management of children subject to child protection procedures.

Safeguarding Compliance figures as of the end of March 2018 are listed below against a target of 90%

- Level 1 95.4%
- Level 2 90.8%
- Level 3 90.5%

2.5. Safeguarding Children Policy and Assurance of Compliance

Evidence of compliance with the policy and Trust Safeguarding procedures was provided by the completion of audits which reviewed process within paediatrics, maternity, emergency department and sexual health services.

Audit findings and actions are reviewed and progresses via the Safeguarding Children Steering group.

2.6 Allegation of Abuse against a Pofessional Policy Activity

In addition to employing STHK staff, the Trust is also lead employer to over 3500 doctors in training covered by this Allegations policy. It incorporates the process for making referrals to the Local Authority Designated Officer (LADO) when an allegation is made against a member of staff involving children. During the reporting period, the Safeguarding Team and the Human Resources (HR) department were involved with 6 LADO referrals, 3 in relation to Trust employees and 3 in relation to Lead Employer Doctors in training. All cases were managed appropriately in accordance with Trust Policy.

STHK also has in place a HR/ Lead Employer / Safeguarding group which meet on a bi-monthly basis to review cases that are subject to LADO referral as well as any other cases involving an allegation or complaint requiring a joint approach.

2.7. Safeguarding Children Supervision Policy

Supervision activity is monitored through the Trust's KPIs. 100% compliance was achieved for staff directly involved with the case management of children made subject to safeguarding procedures.

2.8. Effective (Multi-agency) Partnership working

2.8.1 Serious Case Review (SCR) Involvement

A SCR should take place if abuse or neglect is known, or suspected, to have been involved and a child has died or has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child A SCR should also be considered if a child dies in custody or by suspected suicide. During 2017 /2018 the Trust were not directly involved in any Serious Case Reviews. Actions form previous reviews are managed via a SCR work plan which is reviewed by the Safeguarding Children Steering Group.

2.8.2. Multi-agency working

There is significant involvement from the paediatric and maternity departments with multi agency planning for children and unborns with identified needs, ranging from early help to child protection cases. Meeting attendance is monitored through the KPIs and cases are reviewed regularly at the Children's Safeguarding Steering Group. There were some areas of non-compliance for attendance at meetings (target 90%); however the actual numbers were very small. These incidents have been reviewed by the Safeguarding Team and where necessary action taken to improve compliance, this included working with the Local Authority to ensure meeting invitations were sent to a central point to ensure acknowledgement and monitoring by the Safeguarding Team.

2.8.3 Information Sharing

Effective information sharing between agencies is essential for effective identification of need, assessment and provision of relevant services for children. Early sharing of information is the key to providing effective early help where there are emerging problems or concerns. Sharing information can also be essential for protecting a child who is at risk of neglect or abuse. Serious Case Reviews (SCRs) continue to highlight information sharing as an area of concern when reviewing child deaths.

STHK has a dedicated Paediatric Liaison Team which ensures information in relation to attendances for all children and young people up to the age of 18 are shared with relevant community practitioners, including school nurses and health visitors, as well as social workers when indicated. The team also processes information from the maternity department when a safeguarding cause for concern has been raised and across the trust when adults present and concerns are raised in relation to their children.

2.8.4 Local Safeguarding Children Board (LSCBs) Activity Sharing

The Trust is an active partner at the three Local Safeguarding Children Boards (LSCBs) in St Helens, Halton and Knowsley with representation at several sub groups. The minutes from

each of the Boards are provided to the Trust's Children Safeguarding Steering Group. The Trust also has representation and contributes when appropriate to LSCB multi agency audits.

3. Safeguarding Children Activity and Social Care Referrals

3.1 Paediatric and Emergency Department Activity

The table below shows the number of attendances where a safeguarding concern was noted for a child and information shared with the Trust's Safeguarding Children Team for the last 5 years. These attendances vary from low levels of concern e.g. notification of a child with current or historical social care involvement, to a child who is thought to have suffered significant harm e.g. attended with a non-accidental injury, who require an immediate social care referral. The numbers continue to increase year on year.

Year	No of attendances with recorded safeguarding concern
2013/2014	1251
2014/2015	1560
2015/2016	1641
2016/2017	1860
2017/ 2018	2129

The table below is the number of actual referrals made to Children's Social Care, requesting assessment under the guidance of the Children Act 1989.

Year	No of referrals to Children's Social Care
2013/2014	98
2014/2015	84
2015/2016	101
2016/2017	115
2017/2018	101

A large percentage of safeguarding activity is generated by children and young people attending with mental health problems, such as low mood, self-harm and attempted suicide. The Trust has a clear self-harm pathway, which covers all aspects of mental health and ensures these young people are assessed by both the paediatric medical team and the CAHMS Assessment and Response Team (CART, an in-reach service provided by 5 Boroughs Partnership Trust)). This pathway complies with current NICE guidelines and was shared across a regional mental health network, and highlighted as good practice. The table below represents the number of attendances for young people with mental health problems.

The numbers of young people attending the Trust with associated mental health problems is recorded in the table below and shows a 5 year comparison.

Year	No of attenders with mental health problems
2013/2014	419
2014/2015	454
2015/2016	528

2016/2017	481
2017/2018	411

3.2 Maternity Safeguarding Activity

When a safeguarding concern is noted in the Maternity Department a "Cause for Concern Form" is completed by a member of the midwifery team in relation to mental health, drug and alcohol misuse, domestic abuse or anything else that may affect a mother's ability to care for the baby without additional support or monitoring. This is shared with the Safeguarding Specialist Midwife, G.P, Health Visitor and if necessary Children's Social Care and actions and plans implemented accordingly to maintain the new-born's safety.

The table below represents the number of Cause for Concerns initiated during the last 5 years. There has been a notable increase since 2013 /2014.

Year	No of Cause for Concern Forms initiated
2013/2014	645
2014/2015	961
2015/2016	1109
2016/2017	1190
2017/2018	1374

3.3 Safeguarding Children Incidents

There have been no significant incidents relating to Safeguarding Children during 2017/2018 which required an internal review, RCA or SIRI.

4. External Assurance of Effective Processes during

4.1. Safeguarding Children CCG Assurance

The Trust's safeguarding children systems and processes are monitored externally by achieving key performance indicator requirements which are submitted monthly in the Trust's Integrated Performance Report and quarterly to the CCGs designated nurses who commission children's safeguarding. KPIs and are monitored by St Helens CCG who provide assurance to Halton and Knowsley CCG. The quarterly submissions in 2017/2018 provided significant assurance in all areas except for Partnership Working, the 95% meeting attendance target was not achieved consistently within the maternity Department due to a number of missed meetings. The Named Midwife is reviewing the Meeting Invitation/ Attendance process to ensure compliance is achieved and maintained.

4.2 Mersey Internal Audit Agency Safeguarding Audit

Mersey Internal Audit Agency (MIAA) audited the safeguarding adult and children procedures within the Trust during January 2018. This was a very positive audit with only 3 medium risk actions as detailed below:

- The Safeguarding Steering Groups need to ensure that actions are more robustly documented within the body of the minutes and that any actions documented within an action log can be traced back to source with supporting evidence provided prior to being marked as complete.

- the Trust should review the breadth of information escalated and monitored by the Patient Safety Council and Quality Committee and the priorities and focus for the Safeguarding Service should be clearly defined and the annual work plan of these groups should be amended to ensure appropriate coverage of these priorities to ensure that appropriate updates and assurance are being provided in relation to all Safeguarding duties and priorities. These should be informed by risk and also support the KPI framework that is operating within the Trust.

- The Trust should review the membership of the Patient Safety Council to ensure that it is appropriate and the Safeguarding Service is appropriately represented to ensure appropriate updates and assurances are provided and also that effective and informed decisions can be made.

All actions were implemented on receipt of the Audit Report.

4.3 Section 11 Audit

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

An online Section 11 audit is completed and submitted to the LSCBs which include self-assessment and the submission of supporting information to evidence compliance in the following areas:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;

- A senior board level lead to take leadership responsibility for the organisation’s safeguarding arrangements;

- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;

- Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);

- A designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including responding to possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;

- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- Appropriate supervision and support for staff, including undertaking safeguarding training;

- Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and

creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;

- Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and

- All professionals should have regular reviews of their own practice to ensure they improve over time.

- Clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

In January 2018 the Named Nurse Safeguarding and Deputy Director of Nursing attended the St Helens LSCB Section 11 Scrutiny Panel. Significant assurance was accepted by the panel in all areas with the only recommendation to ensure that E Safety Training is reviewed with the upcoming plans to provide Wi-Fi to patients in all areas, and to ensure compliance with Safe Sleep Guidance in the Maternity Department.

4.3. CQC Assurance

In November 2017 the CQC carried out a "Review of Children looked after and safeguarding in St Helens."

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

The review focussed on:

- The role of healthcare providers and commissioners.

- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.

- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

- Whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.

The aim of the review was to follow the Child's Journey, recording their experience of health services within the following domains:

- Early help
- Child in Need
- Child protection
- Looked after Children

The Trust review was carried out by three CQC inspectors who visited the Emergency Department, Paediatric and Maternity Unit, as well as Sexual Health.

There were minimal recommendations for the Trust which will be progressed within the CQC Safeguarding action plan. The recommendations are to:

- Ensure that, particularly where more complex family structure or risk is indicated, that practitioners within midwifery services use chronologies to assist them identify and record risk.

- Ensure prompts on Emergency Department records are used to their fullest extent to provide a more holistic approach to safeguarding vulnerable children and young people and further that that all those children and young people who attend the Emergency Department benefit from comprehensive screening of their vulnerability to identify safeguarding or child protection needs.

- Oversee the quality of work and safeguarding responsibilities of non-case holding midwives by way of improved supervision so that all have access to that safeguarding supervision.

- Strengthen processes and quality assurance methods within midwifery services to assure themselves that record keeping and patient records are complaint with NMC guidance and are complete at all times.

All actions have been progressed through the CQC Action plan which is monitored by the Safeguarding Children Steering Group.

5. Summary of Achievements

- The Trust has achieved significant progress in Safeguarding Children Compliance across all 3 levels, meeting KPI compliance levels by the end of the financial year.

- There has been a positive feedback form the CCQ as part of the local CCG Review of Safeguarding Processes

- Significant assurance has also been received from the Annual Section 11 Audit reviewed by

6. Future Developments

- The Trust Safeguarding will endeavour to maintain KPI compliance.
- There will be a focus on maintaining Safeguarding Children training compliance.

- A revised version of Working Together to Safeguarding Children is due to be published in 2018, following this all relevant polices, processes and training material will be reviewed to reflect the new guidance.
- Safeguarding Audits will continue with the completion of individual audits in maternity, paediatrics and the sexual health service to monitor compliance to trust process
- There will be a focus on emerging themes in safeguarding, particularly Harmful Sexual Behaviour (HSB). The Safeguarding Children Policy will be amended to reflect processes required to support children and families in this area.

TRUST BOARD

Paper No: NHST(19)9
Subject: HR/Workforce Strategy & Workforce Indicators Report
Purpose: To provide assurance to the Trust Board of the progress workforce indicators that support, the delivery of the Trust's Corporate Objectives specifically to developing organisation culture and supporting our workforce.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. This paper summarises achievements/progress to date.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Staff Side Colleagues and Patients
Recommendation(s): The Trust Board is requested to accept the report and to note the areas of achievement/progress against corporate objectives.
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Board date: 30th January 2019

HR/Workforce Strategy & Workforce Indicators Report

January 2019

1.0 Purpose of the Paper

The paper provides an update on a number of workforce indicators which contribute towards the achievement of the Trusts corporate objectives. The 2018/19 objectives focus on the challenges of recruitment and retention, being an employer of choice for staff and optimising technology to support more efficient working.

2.0 Staff In Post

Since December 2017, staff in post has increased overall by 275.73 wte. Increases in Nursing & Midwery staff account for the 81.63 wte of the increase. The Trust has expanded the provision of a number of additional HR and Payroll services which has contributed to an increase in admistration posts.

Whole Time Equivalents by Staff Group			
Staff Group	Dec-17	Dec-18	Difference
Add Prof Scientific and Technic	168.69	180.96	12.27
Additional Clinical Services	967.44	993.27	25.83
Administrative and Clerical	1070.03	1169.39	99.36
Allied Health Professionals	253.68	278.37	24.69
Estates and Ancillary	298.21	292.34	-5.87
Healthcare Scientists	187.21	191.9	4.69
Medical and Dental	421.45	454.37	32.92
Nursing and Midwifery Registered	1426.96	1508.59	81.63
Grand Total	4793.67	5069.2	275.53

Workforce challenges continue across the NHS with reports of an excess of 100,000 vacancies across the NHS.

2.1 The NHS Long Term Plan and Workforce

To ensure the NHS can achieve the ambitious improvements that it wants to see for patients over the next ten years, the NHS plan sets out how it can overcome the challenges that the NHS faces, such as staff shortages and the growing demand for services. It is expected this can be achieved by; "continuing to increase the NHS workforce, training, recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds, more medical school places, and more routes into the NHS such as apprenticeships". The plan also describes the aspiration of making the NHS a better place to work, so that more staff stay in the NHS and feel able to make better use of their skills and experience for patients. The following areas are key themes that are to be described in further detail by NHSI over the coming which will include a workforce implementation plan developed by national workforce groups:

- Increase numbers of nurses, midwives, Allied Health Professionals and other staff.

- Grow the medical workforce with a focus on more generalist roles and increase number of doctors working in general practice.
- New arrangements to support international recruitment.
- Focus on staff retention through workforce development and multi-professional credentialing.
- Make the NHS a consistently great place to work and shape a modern employment culture.
- Zero tolerance on violence towards NHS staff.
- Increased focus on respect, equality and diversity.
- Improved mental health support to doctors.
- Productive working through electronic rosters and job planning.
- New focus on leadership and talent management.
- Encouragement for and investment in volunteering initiative

2.2 Local Context

Our specific Trust challenges continue to reflect the national picture i.e. shortages in:

- Qualified nursing specifically general ward nursing
- Consultants in dermatology, radiology, histopathology, paediatrics & cardiology
- Doctors in training in paediatrics, obstetrics and gynaecology, general surgery and emergency medicine
- Biomedical scientists, specifically Blood sciences

The table below provides a breakdown of the Trusts vacancy rate by staff group. There is currently no national benchmark data for comparison.

	Oct-18	Nov-18	Dec-18
Staff Group	**%**	**%**	**%**
Add Prof Scientific and Technic	2.44%	1.37%	1.70%
Additional Clinical Services	2.56%	3.49%	3.56%
Administrative and Clerical	0.00%	0.00%	0.00%
Allied Health Professionals	0.00%	0.00%	0.00%
Estates and Ancillary	0.16%	0.23%	0.56%
Healthcare Scientists	5.85%	6.34%	5.47%
Medical and Dental	3.27%	3.75%	2.43%
Nursing and Midwifery Registered	5.20%	4.67%	4.66%
Grand Total	**1.72%**	**1.95%**	**2.20%**

3.0 Brexit

The impact of Brexit with regards to the workforce, at the time of writing lacks clarity. However, Trusts have been advised that in advance of Brexit, the Home Office has committed to protect the rights of EU citizens and their family members currently living in the UK to retain these rights after 31st December 2020. EU citizens must therefore apply for UK immigration status under the EU Settlement Scheme.

A recent report published by the Cavendish Coalition (Brexit and the Health & Social Care Workforce in the UK), suggests that 5% of the regulated nursing profession, 9% of doctors, 16% of dentists and 5% of allied health professionals were from inside the European Economic Area (EEAA). A pilot of the Settlement scheme for applications was open to the 58 employees of the Trust who are EU nationals (excluding Irish nationals who are exempt) from December 2018. The scheme opens fully from 30 March 2019).

The Trust communicated to the affected staff and held 4 drop in sessions to support them in making an application to the EU Settlement Scheme. 10 employees attended the sessions and a further 3 contacted the team to seek further information. An impact assessment is underway to review any change in staff numbers as a consequence of Brexit.

4.0 Recruitment

4.1 International Recruitment

The Trust's Recruitment Strategy includes the utilisation of international recruitment, for both nursing and medical staff. In the summer of 2018 there was the helpful removal of the Tier 2 visa cap will enables the Trust to access candidates from outside the EU quicker without the visa allocation restrictions.

The Trust continues to use the Global Learners Programme, Search consultancy and direct referrals to bring in international Registered Nurses (RN's). We are also looking to add a further agency to our supply pipeline to ensure that we continue to have steady numbers of recruits moving forwards.

The Trust welcomed 8 international RN's in September/October 2018 and a further 4 in December 2018. An additional 10 are scheduled to arrive in February 2019. This brings the Trust total of international nurses to 56. To further support international recruitment of nurses, the Nursing & Midwifery Council (NMC) have recently commenced a review of their entire registration process for nurses and midwives trained outside of the EEA. They have already made some changes to support this including a slight relaxation of the pass mark for the English language test and the practical tests that international recruits have to pass.

The recruitment of medical staff via international recruitment continues to be a challenge. Recent international recruits to the Trust include:

- 1 Locum appointment for service (LAS) in Paediatrics
- 2 Training Fellows in Orthopaedics
- 1 Locum Consultant in Radiology
- 1 Senior Clinical Fellow in Burns & Plastics
- 1 Senior Clinical Fellow in Paediatrics
- 1 Clinical Fellow in Paediatrics

Offers have also been made in the following areas:

- Urology (Specialty Dr) –March start
- Paediatrics (LAS ST3) – March start

- Burns & Plastics (Senior Clinical Fellow) –April start
- ED (Senior Clinical Fellow) - April start (Junior Clinical Fellows x2) – Feb start
- Radiology (Locum Consultant) - end Jan start

We are currently awaiting confirmation of applications to join the Medical Training Initiative (MTI) scheme for Obstetrics & Gynaecology.

4.2 Nursing

The national issue of demand outstripping supply for qualified nursing is well documented and this continues to present the Trust with challenges. Whilst the number of applications to nurse degree programmes continue to exceed available places the introduction of tuition fees has seen the number of applications drop particularly from more mature applicants. Another element of the Trust recruitment strategy is to 'grow our own' and the apprenticeship levy is supporting:

- 20 of our unqualified nursing staff to train as registered nurses
- 17 of our unqualified nursing staff to train as nurse associates
- 4 of our staff to train as Operating department practitioners
- 85 nurse cadets from St Helens and Cowley colleges who are being supported in undertaking a Level 3 BTEC in Healthcare for progression to train as registered nurses

The Trust continues to have close working relationships with local universities and colleges to promote the Trust as an employer of choice.

4.3 Medical Workforce

The Resourcing Team continues to work alongside external partners and agencies to tackle shortages in the medical workforce. Our current priorities are:

- Emergency Department
- Cardiology
- ICU
- Radiology
- Histopathology
- Acute Medical Unit

4.4 Strategic Workforce Development group

A new group is being established and chaired by one of the Trusts medical managers to develop a long term Workforce Development Strategy. The group will be multi-disciplinary and will consider what our future care models will look like and therefore what our workforce requirements will be within the context of predicted national workforce shortages. The group will develop new roles rather than be constrained by traditional roles such as doctor, nurse, allied health professional. The outputs will include clarity of what role development we need to be undertaking now to produce the workforce needed for the future. This could be brand new roles or the expansion of advanced roles in nursing and other staff groups.

5.0 Armed Forces

The Trust is supporting the NHS Employers initiative “Step into Health,” which is a programme to support veterans in transitioning to an NHS career as they leave the armed forces. The Trust has been able to support the recruitment of a veteran who is now employed in the HR Department and brings many transferrable skills from the armed forces into the NHS.

Discussions have also started with some of our reserve forces staff to better understand the “offer” that would appeal to reservists or those leaving the armed forces so that we can tailor our attraction to these groups.

The Trust is also engaged in a programme working with 3 Medical Regiments based at Fullwood Barracks in Preston. The programme supports the Armed Forces in maintaining clinical skills of their medical staff across all grades and roles. The support is in the form of clinical attachments where they will spend blocks of time within the Trust working through a matrix of clinical competencies alongside our clinical staff. The first attachment started on the 5th November 2018. We are working very closely with the armed forces staff to ensure that the experiences they have meet their needs as well as those of Trust.

6.0 Retention

A key way to support recruitment and reduce vacancies is to actually retain the staff that we have and whilst a number of staff will inevitably leave for one reason or another, the aim of the retention strategy is to stop staff leaving for reasons that are within our control.

An engagement session was held earlier in January 2019 with the Retention Project Group the following initiatives will be implemented whilst wider analysis is undertaken of retention information held:

- Review the “welcome” to the Trust to ensure that the working relationship starts on a positive basis for all staff including pre-arrival communications and local induction and orientation.
- Introduce “check-in” reviews with new starters to ensure that they have everything they need to undertake their role.
- Introduce career coaching with staff to review their aspirations.
- Introduce “itchy feet” conversations to reduce the number of staff who may be considering moving to another organisation.
- Review the support provided to staff that may be having difficulties – covering services we provide and signposting to partners and other external organisations.

Following the engagement session a wider action plan utilising Trust retention data will be created for review by the Retention Project Group.

The table below shows our current turnover rates compared with a peer group of North West and national Trusts.

Staff Group	Trust	National	North West
Add Prof Scientific and Technic	8.61%	16.88%	14.00%
Additional Clinical Services	9.10%	16.55%	12.55%
Administrative and Clerical	11.78%	18.84%	14.49%
Allied Health Professionals	12.49%	15.64%	10.90%
Estates and Ancillary	7.09%	13.88%	10.73%
Healthcare Scientists	8.70%	12.49%	10.07%
Medical and Dental	10.35%	19.06%	26.37%
Nursing and Midwifery Registered	10.11%	12.66%	10.15%
Grand Total	**10.17%**	**12.83%**	**10.12%**

The Trust generally compares favourably with regards to turnover of staff in what is a very competitive market for some staff groups.

6.1 Careers & Engagement Hub

The Trust, as the lead for the Merseyside NHS Careers & Engagement Hub, has developed the Empower Programme which aims to support autistic students with information and guidance on applying for University, with the intention that they will progress to careers in the NHS.

On the 12 December 2018, the Trust, as the Lead for the Merseyside career and engagement hub held an event in Liverpool to support those on the autistic spectrum to consider careers in health and social care. This was done in partnership with local further and higher education institutes and the Anna Kennedy Foundation and was supported by Steve Rotherham, Liverpool City Region Mayor. This will be followed in the spring with support to complete application forms and interview skills. In the summer of 2019, a small cohort will undertake paid internships with a number of Trusts including STHK.

6.2 Staff Friends & Family Test

In October 2018, the Trust received the results of its quarter 2 Staff Friends and Family Test (SFFT), which was undertaken across the Surgical Care Group. The overall response rate was 9% of staff completing the survey which although low is comparable with other trusts both locally and nationally. The results are positive, with 84% of respondents recommending the Trust as a place to work, placing St Helens and Knowsley NHS Trust as the best acute Trust in Cheshire and Merseyside and sixth nationally against its peers.

In addition, 93% of respondents would recommend the Trust as a place to receive care or treatment, again placing the organisation as best acute Trust in Cheshire and Merseyside and sixth nationally.

According to the survey results, the general work environment and staff's overall attitude are the top reasons to recommend the Trust as a great place to work, whilst staff attitude and the level of care received by staff, or their relatives, were the most frequently cited reasons supporting recommendation of the Trust as a place to receive care. The results for quarter 3 are determined from the recently completed 2018 Staff Survey (response rate 51%) for which will be released on 26th February 2019.

6.3 Retirement Age

A significant retention issue is being able to retain those staff who wish to change their work/life balance and utilise the flexibilities of the NHS pension scheme. The retire and return option offered by the Trust is proving partiularly popular and we need to continue to promote and improve upon such flexibilities. The table below shows the numbers of staff who theoretically could retire over the next 5 years.

Staff Group (Aged 65+)	Can Retire within 3 Months	Can Retire within 6 Months	Can Retire within 9 Months	Can Retire within 12 Months	Can Retire within 5 Years
Add Prof Scientific and Technic	6	7	7	7	15
Additional Clinical Services	58	65	74	81	224
Administrative and Clerical	48	52	61	65	173
Allied Health Professionals	2	2	3	4	11
Estates and Ancillary	30	34	38	40	90
Healthcare Scientists	6	6	7	7	18
Medical and Dental	22	23	25	28	51
Nursing and Midwifery Registered	26	29	31	40	119
Grand Total	**198**	**218**	**246**	**272**	**701**

Staff Group	3 Months	6 Months	9 Months	12 Months	5 Years
Nursing and Midwifery Aged 55+	361	374	398	411	676

7.0 Attendance Management

Attendance management requires a collaborative approach from managers, HR and Health work and well being teams to ensure that there is consistent application of the Trust's Attendance Management policy.

Benchmarking of Cumulative Absence 1st January 2018 to December 2018			
Staff Group	**St Helens and Knowsley**	**North West (Latest Data)**	**National (Latest Data)**
Add Prof Scientific and Technical	4.49%	4.18%	3.39%
Additional Clinical Services	7.40%	6.88%	5.82%
Administrative and Clerical	3.76%	3.49%	3.64%
Allied Health Professionals	3.57%	2.53%	2.54%
Estates and Ancillary	7.04%	5.57%	5.91%
Healthcare Scientists	2.97%	3.31%	2.48%
Medical and Dental	1.61%	1.22%	0.98%
Nursing and Midwifery Registered	5.18%	4.95%	4.18%
Trust Total	**4.89%**	**4.04%**	**3.83%**

The table shows the areas requiring particular attention. e.g.,registered nursing, estates and ancillary and additional clinical services (HCAs).

7.1 Application of Attendance Management Policy

The application of the Attendance management policy is discussed regularly at Finance and Performance committee. The policy distinguishes between those staff who have an underlying medical condition (placed on levels) and those who do not (placed on stages). If staff hit a series of 'triggers' relating to absence then their attendance is managed and targets set for improvement. Failure to improve over a number of occasions can ultimately lead to termination of employment. This usually occurs at Stage3/Level 3 but the policy does allow for further targets for improvement if required depending on the circumstances.

The Absence Support Team support managers with their application of the policy, including any legacy policies that have moved alongside employees TUPE transferring into the organisation, and ensuring Trust procedure and toolkit are adhered to. This includes ward audits regarding compliance with the policy and on-going training for managers.

The Trust sickness absence table below confirms a pattern of sickness absence deteriorating between October-December of each of the years identified, which is to be expected as sickness levels do dip in winter months. However sickness has also deteriorated overall year on year between 2016 and 2018. Care groups with sickness absence levels consistently of concern are Medical Care Group, Medirest and Patient Access St Helens.

Care Group	Oct 2016	Nov 2016	Dec 2016	Oct 2017	Nov 2017	Dec 2017	Oct 2018	Nov 2018	Dec 2018
409 Clinical Support Services Total	3.76%	4.10%	4.37%	3.37%	3.83%	4.41%	4.11%	5.59%	5.91%
409 Medicines Management Total	2.80%	3.81%	3.42%	3.84%	5.05%	5.12%	3.62%	4.52%	6.62%
409 Corporate Services Total	4.48%	4.13%	3.93%	2.59%	3.07%	4.79%	3.12%	3.87%	3.96%
409 Medical Care Group Total	5.75%	6.28%	6.82%	5.24%	4.85%	5.70%	5.43%	6.35%	6.55%
409 Medirest Total	7.36%	6.31%	6.57%	10.32%	9.05%	8.23%	6.28%	7.31%	9.49%
409 Non Clinical Support Services Total	0.00%	0.92%	1.29%	0.00%	0.00%	0.76%	0.46%	0.00%	0.00%
409 Surgical Care Group Total	3.83%	4.77%	4.64%	4.46%	3.83%	4.28%	4.87%	5.52%	5.31%
409 Patient Access St Helens Total	5.43%	6.96%	7.71%	7.49%	9.02%	9.15%	6.58%	6.07%	7.04%
409 Community Care Services Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.94%	7.61%	6.35%
Grand Total	4.77%	5.27%	5.48%	4.85%	4.82%	5.48%	4.85%	5.67%	5.95%

Care Group sickness activity is detailed in the table above for ease to aid comparison to the table below, which shows how the Managing Attendance policy stages and levels have been applied in September-December 2018:

Division	Stage/ Level 1	Stage/ Level	Stage/ Level 3	Pending/ Adjourned*
CSSG	17	6	0	35
Pharmacy	3	2	0	
Corporate	5	1	0	
SCG	39	7	3	3
MCG	18	4	2	31
St Helen's	13	4	0	2

* Pending/ Adjourned cases include those where dates are booked or staff member has received formal letter advising of stage or level, but meeting has not yet taken place

Processes to reinforce application of the policy have been reviewed again to further enhance levels of scrutiny within the Care Groups. Regular monthly meetings take place within the Care Group wards/ departments alongside the nominated HR Advisor to support line managers to deliver local action plans. The HR Policy Review Group is also reviewing the Managing Attendance Policy.

7.2 Sickness Reasons by Care Group

The top 3 reasons for sickness absence across the Trust are consistent with the national picture. In December 2018 30.36% of all sickness days lost were for stress, anxiety and depression, 17% was coded to either 'Back Problems' or 'any other musculoskeletal problem' and 10% for gastrointestinal problems.

8.0 Improving the Health and Wellbeing of our Workforce

A key element of the Trusts retention strategy includes ensuring that staff have access to excellent health and well-being services. Throughout 2018/2019 there have been a number of Well Being activities to encourage staff to improve their well-being. During the month of June 2018 'A Summer Health Education and Promotion Campaign' was undertaken by the Health Work and Wellbeing Team supported by external speakers (subject matter experts), the campaign included:

- Positive mental health support – which included mindfulness and meditation
- Drug and alcohol awareness
- Skin care
- Sun safety
- Sexual health
- Healthy lifestyle
- Promoting physical activity.

September 2018 saw the annual HWWB Open Day which attracted in excess of 600 staff from all over the Trust, who could access information on a range of health and wellbeing topics, for example, mental health support (mindfulness, employee assistance programme, counselling), increasing physical activity, healthy eating.

8.1 Flu Vaccination Programme

The flu vaccination programme was launched on the 27th September 2017.The national CQUIN target requires 75% of front line healthcare workers to be vaccinated. The campaign has been a huge success with 90% of frontline healthcare workers being vaccinated, currently being rated as 'top' for all Trusts nationally.

8.2 Service Level Agreements (SLA's)

Due to the increase in the demands from Lead Employer within Health Work and Well Being, SLA's have been set up to carry out duties due to the geographical spread of trainees. A Hub and spoke model has been established with St Helens and Knowsley being the hub. In West Midlands there are four spokes, in East of England three and there are two in East Midlands. We have recently introduced an online management referral process to support the Case Management Team in

Lead Employer and are looking to pilot Telehealth to support trainees who work geographically away from the Trust.

8.3 Health & Well Being Action Plan

NHS England has worked with twelve NHS organisations to create a new Health and Wellbeing Framework and accompanying diagnostic tool which helps NHS organisations plan and implement their own approach for improving staff health and wellbeing. When assessed against the tool, the Trust overall performs well and developed an action plan that was presented to the Workforce Council in November 2018. This includes new ideas such as Health Champions in clinical areas who can help sign post staff to the relevant services is they become aware that colleagues require support. The Trust will also launch awareness programme in April reminding staff how to improve their resilience.

8.4 Health and Safety Executive (HSE) talking toolkit

The HSE has launched a new Talking toolkit to help employers prevent work-related stress. Developed to mark National Stress Awareness Day the toolkit encourages conversations between managers and employees about the causes of work-related stress. Six conversation templates have been designed to support managers and employees to talk about issues which may be causing work-related stress or which could have potential to become future causes if not managed properly. The HWWB Department will be attending Team meetings across the Trust in the next few months to coach and advise manager how to make best use the toolkit.

9.0 Temporary Staffing

The Trust continues to utilise temporary workers through a range of sources such as bank, agency and locum contracts. The Temporary Staffing Team has been successful in growing the number of bank staff available for work through a mixture of internal staff requesting to join the bank and new starters external to the Trust. The bank now has in excess of 600 registered nurses.

The team consistently fill over 70% of shifts requested and of those filled more than 80% are filled internally via the Trust bank. This is a significant increase in fill rate compared to the 2017/18 financial year. There are a number of steps being taken to reduce agency spend these are:

- Meetings with agencies regarding fill rates and costs to encourage them to reduce their commission rates and not charge different rates pay for the same locum workers across the region
- We have established a Cheshire & Mersey wide cluster meetings with Healthcare Trust Europe (HTE) framework, agencies and direct engagement suppliers to look at driving down costs and hold the agencies to account for rates of pay to reduce rate inflation due to competition for the same workforce
- Growth of individual Trust banks through the Grow Your Own Bank toolkit. The toolkit, produced by STHK has been shared nationally as an example of good

practice and looks at maximizing the advertising and marketing channels/opportunities available to support local Trust bank growth.

9.1 Seasonal Planning

Work has been underway and continues with the Care Groups to prepare for winter pressures. A number of steps are being taken as part of this planning:

- Securing long term bookings for positions we know will need to be filled
- Reviewing the bank and agency use from winter 2017/18 to predict requirements for this year
- Advertising a number of winter pressures shifts for both RNs and HCAs which are to be allocated on arrival for shift

9.2 Collaborative Banks

The Cheshire & Merseyside Workforce Collaborative Programme looks at the ways in which Trusts across the STP can work together to improve our temporary staffing and agency position through a number of different projects. Key STP challenges that have been identified are:

- Trust and Regional Agency Spend and Agency Reliance
- The slow growth of local Trust banks and recruitment pressures in relation to maximizing bank recruitment
- Challenges in optimising system capabilities to allow for collaboration
- Temporary Staffing (bank and agency) rates of pay due to a lack of regional pay alignmentThe Trust has been instrumental in establishing the Workforce Collaborative Programme workstreams and continue to play an influential role in driving this very important agenda forward.

Cheshire and Mersey plans are in place the address these issues in collaboration led by STHK as an STP project.

10.0 Systems Development
10.1 E-Rostering & Job Planning

Roster Period	Trust Roster Approval Lead Time (Days)	Trust Filled Duty Count	Trust Hours Balances %	Trust Bank/Agency Use %	Trust Annual Leave %
Compliant Target (Green)	*56 or more*	*90% or more*	*2% or less*	*10% or lower*	*Between 11% and 17%*
02/09/2018 - 29/09/2018	43	79.2	2.3	10.1	15.1
30/09/2018 – 27/10/2018	46	79.2	1.9	7.8	12.7
28/10/2018 – 24/11/2018	50	81.4	1.5	8.3	10.1
25/11/2018 – 22/12/2018	52	80.4	1.2	8.4	13.2

The Trust continues to monitor performance against the following 5 KPI's:

Roster Approval Time – Target – 56 days or more
During Q2 there was a specific focus in improving this KPI and the results of this are showing in the above table for Q3 roster periods with a continuous improvement in approval lead times.

Filled Duty Count % – Target – 91% or more
The rostering team continue to work with operational departments regarding this KPI. There are some slight improvements against this KPI and work is ongoing to continue an upward trend.

Hours Balances (4 wk) % – Target – 2% or lower
The data above shows that the trust has maintained compliance against this target throughout October, November and December. The rostering team is focussing on supporting operational colleagues in maintaining and improving this in Q4.

Bank and Agency Usage – Target – 10% or lower
The above table shows bank and agency usage for rostered units. The data shows that, despite winter pressures starting to affect the Trust, we are maintaining compliance against target.

Annual Leave Rates – Target – 11-17%
The data shows that, aside from a drop in November, the Trust is compliant against target for annual leave rates within rosters.

In November 2018 NHSI published guidance on E-Rostering for the clinical workforce to support NHS organisations in implementing and utilising rostering software to its full potential. The paper identifies five 'levels of attainment' in using rostering systems and the Trust has designed an action plan which is currently being used to assess our position and create a plan for improving attainment levels moving forwards.

The e-Rostering team has been focussing on performance improvement throughout Q3 looking specifically at hours balances and reducing the number of unused contracted hours. The team will then focus on a separate KPI for Q4.

10.2 Doctors in Training

The Trust now has 18 out of 24 units fully implemented on the e-rostering system for Doctors in Training. This means that they have full daily rotas on the system including any time that they are away from the Trust (i.e. annual leave, study, sickness). The remaining 6 are live but only for unavailability for duty at present. This means that absences including sickness, annual leave and study leave are held in the system but they do not presently have daily rotas showing. The team are working closely with these units to understand their rostering requirements and to move them to full utilisation as soon as possible.

The implementation has also included the introduction of “Medic-On-line” and “Medic-On-Duty” which allow the doctors to manage their working lives easier by having the ability to view their individual and team rosters, view and request annual leave and study leave, and also organise shift swaps with colleagues.

10.3 SafeCare

“SafeCare” is the Trusts patient acuity and real time staff available system which operatives as part of the nursing e-rostering system. “Safecare” has now been successfully implemented on all wards with effect from the 13th December 2018. This software packages acuity software will allow the Trust to compare staffing levels, skill mix and the patient demand in real time to support better resource management and should have a positive impact on reducing bank and agency spend when fully embedded. A system utilisation review will take place to ensure that the software is fully embedded and being used to maximum effect in Q1 2019.

10.4 e-Rostering and e-Job planning

Following approval of the business case procure a range of Allocate software packages across Trust at the Trust Board in November 2018. The Trust will be developing a 5 year benefits realisation plan to ensure that workforce utilisation financial benefits are derived. This will build upon the 2018/19 objective of implementing e-rostering and e-job planning for Allied Professional and extending these systems to other staff groups. The 2019/20 plan will include e-job planning ad e-rostering for Specialist Nurses and the implementation of an Activity management system in theatres. The 5 year plan will be presented to the Workforce Council in March 2019 with deliverables and outcomes monitored by the Trusts Executive Committee

10.5 NHSI Orthopaedic Flexible Workforce Project

As part of the Trusts pilot sponsored by NHS Improvement, the e-Rostering team are looking to implement e-job planning and e-rostering to AHP’s, Pharmacy, and Specialist Nursing as part of “speciality focused“ integrated workforce planning process. The project will also see the implementation of Activity Manager which overlays the specific work being undertaken as part of a job plan to support capacity and demand modelling for service delivery.

10.6 Allied Health Professionals

The Trust's corporate objective to implement e-Rostering for the AHP workforce commenced in June 2018. All rosters have been built and go live 8 weeks before the shift is due to be worked in line with Trust roster approval lead times. The percentage of staff now live by staff group are; Therapies (55%) and Radiology (38%) and the remaining 7% will be implemented by the end of Q4 2018/19.

10.7 Workforce Safeguards

In October 2018 NHSI published new guidance on developing Workforce Safeguards. The guidance emphasises that safe, sustainable and productive workforce planning is critical for Trusts and shares best practice on workforce decision making, including stronger Board engagement and is set against the existing safe staffing guidance and resources and will also include both nursing and medical workforce. Trusts will be expected to comply with the recommendations from April 2019. A paper will be presented to the Quality Committee detailing the duties of the Board as soon as the requirements are published.

10.8 Volunteering

The Trust has maintained a high level of volunteer activity with 370 active volunteers within the Trust. We continue to place our volunteers in new areas within the Trust most recently placing volunteers in wards answering telephones and with patients who require end of life companionship. The Trust volunteers regularly undertake a range of roles including Meet & Greet, dining companions, emergency department and Prevention of Delirium.

The recent volunteer annual survey provided great feedback from our volunteers with 98.57% saying that they would recommend for others to volunteer at the Trust.

Helpforce has launched a national campaign in partnership with the Daily Mail inviting readers to pledge their time to be a volunteer in the NHS in 2019. We have registered the Trusts interest in the initiative and our Volunteer Manager will be attending an event in January to learn more.

The Trust will be refreshing its Volunteer strategy in February 2019 to ensure its compliance with the new NHS Long Term plan and will include a new action plan for 2019/20.

11.0 Developing Our Workforce

11.1 Mandatory Training

Development work remains on-going with the Cheshire & Mersey Streamlining group to ensure a reduction in the time committed to training by new employees. Latest developments have seen the introduction of the nationally specified refresher periods and minimum content, in line with the NHS Core Skills Framework, creating a standardised framework for delivery across the Northwest.

The group have experienced problems following the national up-grade to the ESR Portal in July 2017, with Trusts, including STHK, experiencing a variety of issues with the implementation of the revised E-learning platform. Workforce Planning Team are in discussions with the Informatics Team on how the required technical specification can be met.

Once fully implemented the current 2 day induction will be reduced by a day and mandatory training for most subjects will be available to staff at their desks, in the education centre and on personal mobile devices. These changes will maintain the Trust's commitment high quality training, patient safety and achieving the 85% compliance rate. Compliance currently exceeds this at 95.29%.

A review of mandatory training has recently been undertaken and agreed by the Trusts Executive Committee which includes a revised reporting and monitoring process. A robust communication plan is required to communicate these changes to staff and managers.

11.2 Apprenticeships Status

The Trust continues to actively promote the use of Apprenticeships in the development of its workforce, with 155 staff currently on an Apprenticeship programme. The most recent additions have included 17 Nursing Associate, 4 ODP and 10 payroll apprenticeships recruited in December.

Full utilisation of the Levy continues to present a challenge both for the Trust and NHS in general, with no acute trust having achieved this. A recent report from the Department for Education has confirmed that of the £1.39 billion paid in to the Levy nationally, just £108 million has been spent. Contributory factors are the limited range of suitable Apprenticeships available and the strict rules governing its use.

11.3 Organisational Development – Cultural Surveys

Services are being supported to fully utilise cultural and 'pulse' surveys as a key tool to support improvements, identify development opportunities and engage staff to share their views and opinions with the Trust.

Cultural surveys provide a comprehensive picture of the culture within a service and provide detailed information used to establish appropriate interventions, such as focus groups, individual/ team coaching, HR interventions and service redesign to address any issues that are highlighted. Cultural Surveys are a key tool in the Organisational Development planning process.

Pulse surveys are used to measure the impact of any planned interventions following a full cultural survey. These are much shorter surveys comprising of just a few key questions designed to identify where progress is being made and where further work may be necessary.

Recent work has been undertaken on new or ongoing OD plans within Medical & Surgical Care Group specialties as follows:

- Paediatrics
- Emergency Department
- Maternity
- Theatres
- MCG Rota Co-ordinators

Departments within Clinical Support Services Care Group are currently updating their OD plans.

11.4 Leadership Coaching

The Trust continues to support a coaching culture through the delivery of a rolling coaching programme to c.40 leaders within the Trust at Bands 8b and above. In recognition of the value that coaching provides to support individuals in the workplace, a Coaching & Mentoring webpage has been implemented in the Education, Training & Development Hub. There is a direct link to the NHS Leadership Academy registration for access to coaching. During the first two-months of the page becoming live we have seen an increase in the number of requests for coaching support.

11.5 Core Management & Leadership Development

A range of internal Management & Leadership Development modules continues to be provided to enhance and build management and leadership competence across all areas of the Trust. These modules are offered, either as a “stand-alone” option, or as an end to end programme to meet the diverse needs of individuals. In March 2018 a further Coaching module was added to the programme, to develop and encourage the application of coaching to support development across the organisation. During the reporting period a further 45 managers attended one or more of the modules. Feedback from attendees remains extremely positive.

12.0 Organisational Workforce Transformation and Change Update

The HR Advisory Team continues to support and manage a wide range of organisational change and workforce transformation projects involving services across the Trust. A significant change has been Lead Employer contracts for Pennine and Thames Valley.

12.1 TUPE

Recent TUPE transfers are detailed below, together with those that are proposed to take place in early 2019.

	Service Transferred In
1	Payroll & HR Transactional Services from Merseycare and LCH, Transact
2	HR Transactional Services from Liverpool Community Care
3	Cytology Service
4	Lead Employer – Palliative Care, London
5	Lead Employer HR, ESR, OH & Payroll services to support Pennine

	Due to Transfer In or Out/Service Redesign
1	Lead Employer HR, ESR, OH & Payroll services to support Thames Valley
2	Palliative Care Medical Secretaries from Bridgewater

12.2 Employee Relations

The HR Advisory Team facilitate the management of employee relations cases across the care groups for all staff groups. There are increasing cases involving external agencies such as safeguarding and police resulting in a number of lengthy and complex investigations and regional union representative involvement. The team are currently managing a wide range of employee relations cases, including investigation, grievances and mediation.

12.3 Case Management Data

Live cases as at December 2018:

Care Group	Disciplinary	Grievance	Respect at Work	Capability
Medical Care Group	7 2 (Medical)	2 (1 Medical)		
Surgical Care Group	4 (2 Medical)		1 (Medical)	
Corporate and Clinical/ Non-Clinical Support Services	7		2	1 (Stage 2)

Closed cases as at December 2018:

Care Group	Disciplinary	Grievance	Respect at Work	Capability
Medical Care Group	1 Fast Track			
Surgical Care Group	3			
Corporate and Clinical/ Non-Clinical Support Services	3			

12.4 Just Culture

A piece of work is being led jointly by the Assistant Director of Patient Safety and the Assistant Director of HR to engage with staff at all level across the Trust about the benefits to staff and patient care of developing a “Just Culture” in line with NHSI guidance which encourages supporting consistent and fair evaluation of the action of staff involved in patient safety incidents. This project will include a review of the Trusts polices on Attendance Management, Disciplinary Grievance and Respect and Dignity at Work to align the language and approach to that of a “Just Culture.”

"A Just culture accepts nobody's account as "true" or "right" and other wrong… Instead it accept the value of multiple perspectives and used them to encourage both accountability and learning;" (Sidney Dekker)

The engagement process will take place January and February following which a recommendation will be made to the Trust Board for the launch of a Just Culture from April 2019 supported by an action plan to be monitored by the Workforce Council.

12.5 Forthcoming Policy Reviews

The Policy Review Group has commenced a significant piece of work to review the Managing Attendance Policy in line with Just Culture. Nominated staff side colleagues will work in tandem with HR leads to glean feedback from users of the policy and engage with staff who have experienced the policy via focus groups. This will feed into the policy refresh.

A significant review has been completed into the Handling Medical Concerns Policy and the revised policy was published following approval at Trust Joint Local Negotiating Committee (TJLNC).

A review is nearing completion on the Medical Workforce Job Plan Policy which will then go to TJLNC. Reviews are planning in 2019 for the following:

- Introduction of a Medical Workforce Leave Policy
    - To incorporate annual leave and study leave
- Review of the Disciplinary Policy in line with Just Culture
- Review of the Grievance Policy and Procedure in line with Just Culture
- Review of the Respect and Dignity at Work Policy in line with Just Culture

12.6 Equality, Diversity & Inclusion

The Trusts 3 year Workforce Equality, Diversity and Inclusion Strategy 2018 – 2021 was approved by Workforce Council in July 2018 on behalf of the Quality Committee. It is supported by a 3 year Programme Action Plan that incorporates in one place, all the actions that the Trust has committed to such as in the:

- Equality Delivery System 2 (EDS2)
- Workforce Race Equality Standard (WRES)
- The forthcoming Workforce Disability Equality Standard (WDES)
- Gender Pay Gap

The Workforce Council monitors the detailed implementation of the action plan and receives quarterly progress reports from the Equality, Diversity & Inclusion Steering Group. The Trusts Non-Executive Director for workforce and E,D & I champion is also engaged in the assurance process to the Board on the national standards and action plans.

The Trust Quality Committee received the first quarterly update on progress made against key actions contained within the Workforce Equality, Diversity & Inclusion 3 year programme of work at the Quality Committee on the 23rd October 2018. An

integral component of the action plan is the requirement to undertake the annual Workforce Race Equality Standard (WRES) and incorporate any actions into the wider programme of work. The Quality Committee also received a quarterly update on the annual WRES action plan for 2018/19 following the provision of WRES to the Trust Board in August 2018.

NHS England has just released the 2018 data report publication for the NHS WRES with 2 additional publications; *"A model employer; increasing black and minority ethnic representation at senior levels across the NHS"* and *"A quality improvement (QI) methodology report"* which outlines the findings and outcomes of the 5 pilot NHS Trusts across England. Any key actions or points of learning from the publications will be captured and included within the 3 year workforce ED&I programme plan.

To date good progress is being made against the ambitious programme of work. The Quality Committee will receive the next quarterly update in February following the Workforce Councils report in January 2019.

The Trust has been invited to take part in a GMC commissioned research programme to better understand why statically more BME doctors are subject to disciplinary or grievance procedures than white staff. This work will be led by Roger Kline, Research Fellow from Middlesex University and the author of "Snowy White Peaks of the NHS". The Trusts Divisional Medical Directors are also conducting similar research as part of a Leader Academy, clinical leadership programme. The learning and any action required will be built into the E, D & I action plan and we will share our learning collaboratively.

Future developments may be introduced this year relating to proposals to introduce the requirement to report nationally on ethnicity pay gap data in the same way as for gender pay.

12.7 Agenda for Change Pay Deal

The national NHS Terms and Conditions 2018 Pay Award was implemented in July 2018. A Task and Finish group including stakeholders from HR, Estates & Facilities management, management and HR, Payroll, Learning & OD, Staff Side colleagues has been implementing the local changes.

12.7.1 Closure of Band 1

The task and finish group is focussing on the implications of the new pay structure:

- Closure of Band 1 to new starters from 01 December 2018.
- New system of pay progression from 01 April 2019

The decision to close the band 1 pay scale directly impacts on a number of existing staff members. Existing band 1 Job Descriptions and Person Specifications have been reviewed and updated to reflect any changes in duties or responsibilities that elevate the roles to band 2. A consultation exercise will take place with existing staff members to understand their aspirations to either move into a band 2 role or to remain on a 'closed spot salary' in their current role.

13.0 Payroll Services

STHK Payroll Services currently process c.60,000 payslips a month to 25 monthly payroll clients and 3 weekly clients across Cheshire and Merseyside, East of England, West Midlands, East Midlands and London. The Payroll service catalogue includes end to end payroll processing, pensions, expenses and salary sacrifice. Recent key achievements have included:

- Development of a HR Transactional service catalogue for current and future clients
- Increase in of number of payslips processed
- Significant assurance from MIAA audit
- Developing and sharing best practice with the wider roll out of Standard Operating Procedures (SOP's)

14.0 Lead Employer Services

Following a successful tender process and a very short lead time, LE successfully transferred c.3,500 speciality Doctors in Training from Pennine Acute Trust on 1st October 2018. Despite legislative requirements, such as ID and Right to Live & Work checks for all transferring Trainees and some very challenging legacy issues to deal with, LE alongside colleagues in Payroll and Workforce Intelligence, received some very positive feedback from Host Trusts and Trainees alike. The Trust has received feedback from a range of stakeholders that the Lead Employer service has delivered a very successful transfer.

The future continues to bring expansion and change for LE. On 1st April 2019, a further c.440 speciality Doctors in Training are planned to transfer from Pennine Acute Trust, as a result of StHK being awarded the Thames Valley contract following Pennine's request to relinquish the contract early. Planning for the transfer has already commenced.

15.0 Carter at Scale

The Trust is actively engaging with the Workforce Streamlining North West programme. The programme supports the delivery of Carter at Scale within HR services through the removal of unwarranted variation and duplication in workforce processes and improving productivity and efficiency.

16.0 Conclusion

The Trust Board are asked to note the contents of this paper and progress against achievement following of the Trust objectives:

- The implementation of innovation approaches to recruitment and retention
- Improving the experience of working for the Trust, so that we are recognised as being an employer of choice
- Optimising the use of the apprenticeship levy to support staff in realising their potential

- Expanding the use of e-rostering to allied health professionals to support the effective use of resources across all staff group

Anne-Marie Stretch
Deputy Chief Executive and Director of HR
January 2019

TRUST BOARD

Paper No: NHST(19)10
Title of paper: Learning from Deaths Quarterly Report 2018/19 Q2
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. Also attached is a revised 'Learning from Inpatient Deaths policy' (v3) and a new 'Good Practice Guide and Standard Operating Procedure for Care of the Bereaved' to reflect guidance issued by NHS National Quality Board on working with bereaved families and carers.
Summary: Data is given for Quarter 2 2018/19 and key learning described
Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners
Recommendation(s): To approve the report, policy and good practice guide
Presenting officer: Prof Kevin Hardy, Medical Director
Date of meeting: 30th January 2019

STHK Learning From Deaths Board Report

	Deaths in Scope[1]	Specified Groups: Learning Difficulties Death	Severe Mental Illness Death[2]	Child Death	Neonatal Death or Stillbirth	Maternal Death	CQC Alert Death	Diagnosis Group Death[3]	Post-Op Death	SIRI Death	Concern Death[4]	Total[5]
Apr-18	114	2	1	0	2	0	0	4	10	0	5	24
May-18	133	3	0	0	0	0	0	5	5	0	2	15
Jun-18	118	1	0	0	0	0	0	2	6	0	5	14
Jul-18	119	4	0	0	0	0	0	2	12	0	4	21
Aug-18	135	3	2	0	0	0	0	4	10	0	10	27
Sep-18	119	2	3	0	0	0	0	3	10	0	4	21
Grand Total	738	15	6	0	2	0	0	20	53	0	30	122

	Specified Groups: Total[5]	Reviewed	% Reviewed	Non-Specified Groups: Total	Reviewed	% Reviewed (Target 25%)
Apr-18	24	24	100.0%	90	23	25.6%
May-18	15	15	100.0%	118	30	25.4%
Jun-18	14	14	100.0%	104	28	26.9%
Jul-18	21	21	100.0%	98	24	24.5%
Aug-18	27	27	100.0%	108	28	25.9%
Sep-18	21	21	100.0%	98	25	25.5%
Grand Total	122	122	100.0%	616	158	25.6%

% of Reviews with RAG Rating[6]	Total RAG Reviewed	Total Reviewed	% RAG Reviewed
Apr-18	42	47	89.4%
May-18	42	45	93.3%
Jun-18	41	42	97.6%
Jul-18	42	45	93.3%
Aug-18	50	55	90.9%
Sep-18	42	46	91.3%
Grand Total	259	280	92.5%

Outcome of RAG Reviewed Deaths	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation	Grand Total
Apr-18	40	0	2	42
May-18	42	0	0	42
Jun-18	40	1	0	41
Jul-18	37	3	2	42
Aug-18	47	3	0	50
Sep-18	37	5	0	42
Grand Total	243	12	4	259

Outcome % of RAG Reviewed Deaths	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation
Apr-18	95.2%	0.0%	4.8%
May-18	100.0%	0.0%	0.0%
Jun-18	97.6%	2.4%	0.0%
Jul-18	88.1%	7.1%	4.8%
Aug-18	94.0%	6.0%	0.0%
Sep-18	88.1%	11.9%	0.0%
Grand Total	93.8%	4.6%	1.5%

[1] This includes all inpatient deaths at STHK and all stillbirths. If a patient was transferred and died at another provider then they are out of the scope of this data - even if the cause of death relates to care at STHK.

[2] For the purpose of this report SMI is defined as DOLs or patients under the Mental Health Act during the spell

[3] Diagnosis groups under internal monitoring

[4] Any death associated with a complaint, PALs or an expression of concern by a member of staff

[5] If a patient is attributed to more than one specified group, the Total will only count each patient once

[6] Some nationally specified review processes don't include RAG rating.

Learning & Sharing 2018/Q1

2018/Q2 Key Priorities

1) Patients who fall in hospital frequently have incomplete falls risk assessments. It is vital that nursing staff complete the risk assessments fully and individualise the care plans to protect patients and the staff caring for them, ensuring the communication works to deliver the right plan for each patient.

2) When a patient is suspected of having a GI bleed, review their medications and temporarily withhold antiplatelets (including aspirin) and anticoagulants till they have had the endoscopy. When in doubt, consult a senior. People with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved at endoscopy are advised to continue on low-dose aspirin.

Assurance

Sharing: (Current Q1) Board (mins) ■, Quality Committee (mins) ■, F&P (mins) □, CEC (mins) □, PSC (mins) ■, PEC (mins) ■, MCG Governance (mins) □, SCG Governance (mins) ■, Grand Rounds (mins) □, ED Teaching (record) ■, FY Teaching (record) □, Team Brief (record)■, Intranet Message Board (record) ■, Global Email (record) ■, Directorate meetings (mins) ■.

List any policies/procedures or guidelines changed: Learning from Inpatient Deaths (Revision 3); Good Practice Guide and SOP for Care of the Bereaved (new)

Effectiveness: (Current Q-1) Audit of DATIX □, SIRIs □, Complaints □, PALS □, Litigation □, Mortality Reviews for evidence of failure to deliver these priorities □.

Comments:

Learning from Inpatient Deaths

Version No: 3

Document Summary:

This policy outlines the updated policy on Learning from Deaths in response to the *National Guidance on Learning from Deaths* published by the National Quality Board in March 2017.

Document type	Policy
Document number	STHK0605
Approving body	STHK Trust Board
Date approved	27th September 2017
Date implemented	1st October 2017
Next review date	**31st January 2020**
Accountable director	Professor Kevin Hardy
Policy author	Dr Terence Hankin (amended by Professor Hardy and revised by Dr Julie Hendry)
Applies to	STHK Trust Staff

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments.

Quick Reference Guide

Total Deaths in Scope[1]

Check	Review
Check against NWB downloaded LD List **'Learning Difficulties Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 years, 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' **'Alert Death'**[4]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns[5] **'Concern Death'**	SJR
Check against Surgical Procedures List[6] **'Post-op Death'**	SJR
25% Sample, include all low risk deaths[7] **'Sample 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 although the Trust may move to RCP SJR in due course.
4. Alert deaths include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.
5. Concern deaths may be reported via PALS or formal complaints several months after the patient has died. In this event, the case will be allocated to a reviewer for SJR in the next allocation.
6. Post-operative deaths will be identified by linking a list of all inpatient deaths to the OPERA Theatres system. The cases identified will then be screened by the Assistant Director for Clinical Improvement or their deputy to discriminate between cases that need a surgical or medical mortality reviewer.
7. Low risk deaths as defined by Dr Foster/HED grouping.

Version Control

Version	Date Approved	Brief Summary of Changes	Author (Title)
V1	27.09.17	Learning from Deaths	Dr Terence Hankin (Deputy Medical Director)
V2	28.02.18	Learning from Inpatient Deaths	Prof Kevin Hardy (Medical Director)
V3	xx.xx.19	(i) Inclusion of how post-operative deaths are defined and captured; (ii) Inclusion of working with bereaved families and medical examiner guidance.	Prof Kevin Hardy (Medical Director)/ Dr Julie Hendry (Assistant Director of Clinical Improvement)

Document Control

<table>
<tr><td>Document Number:</td><td>STHK0605</td><td>Title:</td><td colspan="3">Learning from Inpatient Deaths</td></tr>
<tr><td colspan="2">Equality analysis completed?</td><td>Yes</td><td colspan="2">Sent for 2 week consultation on Trust intranet and to relevant staff:</td><td></td></tr>
<tr><td>Approving Body:</td><td colspan="2">STHK Trust Board</td><td>Date of Approval:</td><td colspan="2">27th September 2017</td></tr>
<tr><td>Author:</td><td colspan="2">Dr Terence Hankin</td><td>Status:</td><td colspan="2"></td></tr>
<tr><td colspan="6">Brief Description of Amendments (if applicable):
This policy outlines the updated policy on Learning from Deaths in response to the National Guidance on Learning from Deaths published by the National Quality Board in March 2017.</td></tr>
<tr><td colspan="5">Does the document follow the Trust agreed format?</td><td>Yes</td></tr>
<tr><td colspan="5">Are all mandatory headings completed?</td><td>Yes</td></tr>
<tr><td colspan="5">Does the document outline clearly the monitoring compliance and performance management?</td><td>Yes</td></tr>
<tr><td colspan="5">Approved?</td><td></td></tr>
<tr><td colspan="5">Approved after minor amendments?
Any amendments to be submitted to Approving Body Chair for final sign off</td><td></td></tr>
<tr><td colspan="5">Not Approved?</td><td></td></tr>
<tr><td colspan="2">Policy Author Signature:</td><td colspan="2"></td><td colspan="2">Date: 28th February 2018</td></tr>
<tr><td rowspan="2">Chair of Approving Body</td><td>Name / Title:</td><td colspan="2">Richard Fraser, Chairman</td><td colspan="2" rowspan="2">Date:</td></tr>
<tr><td>Signature:</td><td colspan="2"></td></tr>
<tr><td colspan="2"></td><td colspan="2">Review Date:</td><td colspan="2">dd.mmmmm.2019</td></tr>
</table>

Withdrawal of Document

To be completed if a document has been superseded or no longer required

Date Document Withdrawn:		**Reason:**	No longer required/superseded
Policy Author Signature:			**Date:**
Lead Executive Director Signature:			**Date:**

Contents

Quick Reference Guide 2
Version Control 3
Document Control 3
Withdrawal of Document 3
Contents 4
1. Scope 6
2. Introduction 6
3. Statement of Intent 6
4. Definitions 6
5. Duties, Accountabilities and Responsibilities 8
6. Process 9
6.1 The Process for Recording Deaths in Care 9
6.2 Selecting Deaths for Case Record Review 9
6.3 Total Deaths in Scope[1] 10
6.4 Principles to be applied for case record reviews 11
6.5 Structured Judgement Reviews (SJRs) 11
6.6 Actions following SJR 12
6.7 Mortality Monitoring and Links with Existing Procedures 12
6.8 Clinical Effectiveness Committee (CEC) 12
6.9 Mortality Surveillance Group (MSG) 12
6.10 Trust Board 12
6.11 Process for managing serious incidents resulting in death not within the scope of the SJR 13
7. Training (including Learning & Sharing) 13
7.1 Training for Reviewers 13
7.2 Learning and Sharing 13
7.3 Reviewing Outputs to inform Quality Improvement 14
8. Support 14
8.1 Supporting and Involving Families and Carers 14
8.2 Supporting and Involving Staff 15
9. Monitoring Compliance 15
9.1 Key Performance Indicators (KPIs) of the Policy 15
9.2 Performance Management of the Policy 15

10. References/Bibliography 16
11. Related Trust Documents 16
12. Equality Analysis Form 17
Appendix 1 – Example of Quarterly Trust Board Report 18
Appendix 2 – Feedback from Mortality Surveillance Group 19
Appendix 3 – Mortality structured judgement review 20

1. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

2. Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust has an established mortality review process. The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* was published in late 2016 and found that learning from deaths across UK trusts was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The National Quality Board issued guidance in March 2017, following the CQC report and the process at STHK has been amended (and updated) to meet these new standards. Further amendments have been made following the publication of the National Quality Board guidance for NHS trusts on working with bereaved families and carers in July 2018.

This policy sets out how the Trust will implement the national guidance and describes the governance that will assure consistency, reliability and resilience of delivery.

3. Statement of Intent

The Trust will implement requirements outlined in the Learning from Deaths framework to supplement the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, reviewing and investigating the deaths of people in the care of the Trust.

It describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff that may have been affected by the death of someone in the Trust's care.

It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

4. Definitions

Case screening

A review of all deaths in scope to help identify those that are more likely to generate learning from a more detailed structured judgement review (defined in the national guidance on learning from deaths as: deaths in people with learning difficulties, in serious mental illness, child deaths, neonatal deaths & stillbirths, maternal deaths, surgical deaths, 'alert deaths' (CQC mortality alerts and internal diagnostic groups or procedure groups under close monitoring), deaths subject to StEIS reporting or serious incident investigation and deaths where relatives, carers or staff have

raised concerns). In addition, STHK has added a 25% sample of all other deaths in scope, including 'low risk' deaths as defined by Dr Foster or HED.

Death certification

The process of certifying, recording and registering death and the causes of death. This process includes identifying deaths for referral to the coroner and is likely to be revised with the national rollout of a new process associated with the Medical Examiner role.

Death due to a problem in care or systems of health care delivery

A death that has been clinically assessed using a structured method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery and or service provision. (Note: this is not a legal term and is not the same as cause of death). NHSI and the Royal College of Physicians have stated that the term 'avoidable mortality' should not be used, as it has a specific meaning in public health that is distinct from 'death due to problems in care'.

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided or systems of care. Investigations draw on evidence, which may include physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by or follow case record review or may be initiated without a preceding case record review.

Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led to, or did lead to, harm for one or more patients receiving NHS care.

Quality improvement

A systematic approach to achieving better patient outcomes and system performance typically using defined change methodologies and strategies to alter behaviour, systems, processes and/or structures.

Serious Incident

Serious Incidents in healthcare are adverse events where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or potentially avoidable death, unexpected or potentially avoidable injury resulting in serious harm (including those where the injury required treatment to prevent death or serious harm), abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Severe Mental Illness
There is no clinically practicable definition of severe mental illness (SMI) for the purpose of this work (and NHSI were unable to provide a definition). Until a national definition is forthcoming, it is proposed to pragmatically define SMI for the purpose of this policy as any patient who for part or all of their index inpatient stay was detained under the Mental Health Act or Deprivation of Liberties legislation.

Structured Judgement Review (SJR)
A systematic retrospective case record review using a structured or semi-structured methodology, to identify problems in care or healthcare systems with the aim of finding learning to improve future care.

5. Duties, Accountabilities and Responsibilities

Role	Responsibility
Trust Board	The National Guidance on Learning from Deaths places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the National Guidance on Learning from Deaths.
Chief Executive	Ultimate accountability for all care and activities undertaken within the organisation.
Medical Director	The executive director with delegated accountability for compliance with this policy and the learning from deaths agenda.
Director of Nursing, Midwifery and Governance	Patient safety director responsible for serious incident investigations and Duty of Candour.
Non-executive Director	Responsibility for oversight of the investigation, review and learning process. In summary, non-executive director responsibilities relating to the framework include: understanding the review process; ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny; championing quality improvement that leads to actions that improve patient safety; assuring that published information fairly and accurately reflects the organisation's approach, achievements and challenges.
Mortality Surveillance Group (MSG)	A multi-disciplinary, multi-professional group responsible for overseeing the process of mortality reviews and learning.
Principal Analyst	Senior Analyst responsible for identifying all in scope deaths and collating review data for Learning from Deaths report. In addition, reports mortality indices and trends in HED data, etc to Clinical Effectiveness Council.
Chair Clinical Outcomes Group (COG)	To investigate deaths and other incidents (excluding SIs) referred to it by any member of Trust staff.
Paediatrics/children and young people clinical lead	Is informed of the death of any infant or child as defined in annex F of the national guidance.
Lead Clinician Palliative Care	To help inform the MSG of issues that may have influenced 'death' expectancy in palliative care patients.
Head of Maternity	To help inform the MSG of issues related to stillbirth or maternal death as defined in annex G of the national guidance.

Mental Health Lead	To help inform MSG in the assessment of deaths in LD & SMI.
Safeguarding Lead	To help inform MSG in the assessment of deaths in patients with LD (specifically) and all other deaths. The Learning Disabilities Mortality Review (LeDeR) Programme delivered by the University of Bristol is used to investigate LD deaths.
Patient Safety Manager	To ensure DATIX provides data to inform investigation of deaths associated with serious investigations, complaints, PALS or where staff or carers have expressed concerns.
Assistant Director of Patient Safety	To identify and report any patient safety concerns possibly leading to the death of a patient in the Trust's care so they get SJR.
All staff	All staff have a responsibility to report concerns (including patient, relative or carer concerns) to their line manager or the Trust Executive regarding perceived failures of care, in reference to this policy.

6. Process

6.1 The Process for Recording Deaths in Care

Currently all inpatient deaths are captured from the PAS system and reported monthly in the Integrated Performance Report (IPR) and also on Qlikview.

6.2 Selecting Deaths for Case Record Review

Cases will be identified for investigation using the algorithm in 6.3 below derived from national guidance and where appropriate, assigned to a trained consultant reviewer. Special group deaths will be reviewed by the appropriate nationally specified methodology.

Post-operative deaths will be identified by linking a list of all inpatient deaths to the OPERA Theatres system. The cases identified will then be screened by the Assistant Director for Clinical Improvement or their deputy to discriminate between cases that need a surgical or medical mortality reviewer.

6.3 Total Deaths in Scope[1]

Check	Review
Check against NWB downloaded LD List **'Learning Difficulties Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 years, 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' **'Alert Death'**[4]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns[5] **'Concern Death'**	SJR
Check against Surgical Procedures List[6] **'Post-op Death'**	SJR
25% Sample, include all low risk deaths[7] **'Sample 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 although the Trust may move to RCP SJR in due course.
4. Alert deaths include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.
5. Concern deaths may be reported via PALS or formal complaints several months after the patient has died. In this event, the case will be allocated to a reviewer for SJR in the next allocation.
6. Post-operative deaths will be identified by linking a list of all inpatient deaths to the OPERA Theatres system. The cases identified will then be screened by the Assistant Director for Clinical Improvement or their deputy to discriminate between cases that need a surgical or medical mortality reviewer.
7. Low risk deaths as defined by Dr Foster/HED grouping.

6.4 Principles to be applied for case record reviews

A bespoke SJR within Datix, consistent with the Royal College of Physicians tool, will be used to complete case record reviews

Mortality Reviewers will be recruited by MSG from senior clinicians (fully registered for more than 5 years) working in any discipline. Surgical cases will be reviewed by those reviewers with surgical knowledge and expertise and medical cases will be reviewed by those reviewers with medical knowledge and expertise.

Reviewers will be trained in the use of the methodology by attending Royal Colleges of Physicians validated courses or via cascaded training within the Trust undertaken by RCP validated trainers.

Case record reviews will be carried out by clinicians not directly involved in the care of the patient unless the expertise resides only in that specialty, in which circumstances the review should include clinicians not involved in the care of the deceased.

A quality assurance framework is in place by virtue of multi-professional, multi-disciplinary group discussion of reviews referred to Mortality Surveillance Group.

6.5 Structured Judgement Reviews (SJRs)

The sampled deaths will be reviewed using the STHK adaptation of the RCP SJR template (see Appendix 3). The SJR is a critical evaluation of the clinical record by an experienced clinician, which includes a section for lessons to be learned, and assessments of documentation and clinical practice. Each SJR will be RAG rated as follows:

Balance of probability is that death did NOT result from problems in care delivery/service provision – Close.	☐
Significant doubt about whether or not, problems in care delivery/service provision contributed to death – reviewed by MSG	☐
Balance of probability is that death may have resulted from problems in care delivery/service provision – refer to Director of Nursing for SI investigation and assess for StEIS	☐

*NHS Improvement and the Royal College of Physicians advise **NOT** to use the term ‘avoidability’.*

6.6 Actions following SJR

Outcome	Actions
Balance of probability is that death did NOT result from problems in care delivery/service provision.	• Lessons learned added to database; Case is closed and actions captured and monitored via Mortality Surveillance Group
Significant doubt about whether or not problems in care delivery/service provision contributed to death.	• Second review undertaken by multi-professional Mortality Surveillance Group; • Action Plan created and monitored via MSG • Lessons learned added to database.
Balance of probability is that death may have resulted from problems in care delivery/service provision.	• Referred to Director of Nursing for full SI investigation and StEIS reporting where appropriate in line with the Trust's Incident Policy: http://nww.sthk.nhs.uk/PoliciesGuidelinesDocuments/Incident Policy.pdf Lessons learned added to database.

6.7 Mortality Monitoring and Links with Existing Procedures

The Trust has an established governance system for managing untoward incidents.

There are systems in place for capturing, reporting and escalating untoward incidents via Datix, Serious Incident (SI) reporting and Strategic Executive Information System (StEIS).

6.8 Clinical Effectiveness Committee (CEC)

CEC will continue to monitor and gain assurance about the wide range of mortality KPIs reported in the IPR, most notably, SHMI, HSMR and standardised mortality ratios broken down by condition (or group of conditions), procedure and directorate.

6.9 Mortality Surveillance Group (MSG)

The NED-chaired, multi-professional MSG will no longer duplicate this work, but will focus on evaluation of amber SJRs. The Mortality Surveillance Group (MSG) reports to the Board.

RAG ratings for amber and red SJRs must be ratified by MSG, and any further suggested amendments to the agreed group RAG rating must be agreed by MSG.

Mortality reviews graded as Amber by MSG will be recorded on Datix as moderate harm incidents and the Duty of Candour Process will be initiated.

6.10 Trust Board

In accordance with the National Quality Board guidance, from Q3 2017-18 a report will be published through a standard agenda item to a Public Board meeting each quarter (see Appendix 1 for sample report). This report will include:

- Total number of the Trust's inpatient deaths (including patients who die in the Emergency Department classified as inpatients in the following areas: ED OBS/EAU/ED EA);
- Number of deaths that the Trust has subjected to case record review;

- An estimate of how many deaths reviewed were judged more likely than not to have been due to failures in care;
- The number of adult inpatient deaths for patients with identified learning disabilities and the number reviewed through the LeDeR methodology;
- The total number of deaths reviewed through the LeDeR methodology that was considered potentially avoidable.

In addition, the report will detail how we have responded to the requirements to learn from deaths in individuals with learning disabilities, mental health needs or from an infant or child death, a stillbirth or maternal death.

The report will also detail how the results of investigations have been shared with the bereaved family and carers.

From June 2018, a summary of the data collected and lessons learnt will be published in the Trust's Quality Account.

6.11 Process for managing serious incidents resulting in death not within the scope of the SJR

Any serious incident resulting in death will be managed via the Trust Incident Reporting and Management Policy. Upon completion of the RCA, the report will be shared with Mortality Surveillance Group and actions and learning will be captured, shared and monitored.

7. Training (including Learning & Sharing)

7.1 Training for Reviewers

All reviewers will be trained in the use of relevant tools, eg LeDeR, SJR, etc.

7.2 Learning and Sharing

Much learning and sharing has been relatively ad hoc and difficult to substantiate. Ad hoc learning and sharing should continue, but this new process will systematise and standardise the STHK approach to learning and sharing and create an audit trail to substantiate its effectiveness.

Inevitably, there is a delay between identifying learning, demonstrating sharing and demonstrating effectiveness of 'lessons learned'. The Board report will describe deaths and their evaluation one quarter in arrears; sharing lessons from the previous quarter and learning effectiveness from the quarter before that.

The NHS is poor at learning. This is not because of any lack of desire to learn and improve, but because messages are often lost in the myriad of priorities and day-to-day pressures. The Board will require staff to concentrate on just two key priorities per report and to publicise them everywhere so that all staff know and can act upon current priorities.

All lessons learned from SJRs will be coded thematically and recorded in the lessons learned database.

Thematic analysis of all lessons learned in the database incorporating mortality reviews, complaints, PALS, litigation and serious incidents will be undertaken quarterly and incorporated into the Aggregated Incidents, Complaints & Claims report. In turn, this report will be cascaded via Care Group Governance Meetings (using a similar structure to that described in *Fig.1* below). Care Group Governance Leads will be responsible for undertaking an annual audit of this learning and sharing to be reported to Mortality Surveillance Group.

Fig. 1

Sharing: Board (mins) □, Quality Committee (mins) □, F&P (mins) □, CEC (mins) □, PSC (mins) □, PEC (mins) □, MCG Governance (mins) □, SCG Governance (mins) □, Grand Rounds (mins) □, ED Teaching (record) □, FY Teaching (record) □, Team Brief (record) □, Intranet Message Board (record) □, Global Email (record) □, Directorate meetings (mins) □, Policies/procedures/guidelines changed:

Effectiveness: (Q2) Audit of lessons learned database□, SIRIs □, Complaints □, PALS □, Litigation □, Mortality Reviews for evidence of failure to deliver these priorities □.

7.3 Reviewing Outputs to inform Quality Improvement

The Chair of the MSG will review and agree the lessons learned for circulation to the relevant groups or individuals using established pathways and forums.

Clinical Directors will be accountable for ensuring that speciality-specific lessons learned are embedded in the practice of that speciality and provide assurance to the MSG to that effect via the Divisional Medical Director and Heads of Quality and Nursing.

Doctors should consider reflecting on lessons learned as a result of the learning from deaths process and discuss their learning with their appraiser. The Responsible Officer will be informed if a significant concern about a doctor's practice is identified during the mortality review process.

Divisional Directors will ensure that 'learning from deaths' is a fixed agenda item at all Care Group Governance Meetings and cascaded to the speciality governance and ward meetings.

8. Support

8.1 Supporting and Involving Families and Carers

The *National Guidance on Learning from Deaths* specifies that providers should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death, and details the key principles that trusts should follow.

We will deliver the key principles that bereaved families can expect as laid out in Learning from Deaths NQB 2018. There is a standard operating procedure to accompany this policy that details the procedures to be followed after the death of a patient in hospital.

8.2 Supporting and Involving Staff

Where appropriate, staff involved in the care of a patient who may have died following a failure of care will be debriefed by their line manager and offered support by the Health, Work and Wellbeing Service.

9. Monitoring Compliance

9.1 Key Performance Indicators (KPIs) of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Review of random 25% sample of inpatient deaths	Assistant Director of Clinical Improvement	STHK-adapted RCP SJR	3-monthly	Trust Board	Assistant Director of Clinical Improvement (MSG Medical Vice Chair) Divisional Medical Directors Divisional Heads of Quality & Nursing
All deaths mandated to be reviewed such as death of a patient with a learning disability will have been captured and reviewed	Principal Analyst/ Director of Nursing, Midwifery & Governance	STHK-adapted RCP SJR	6-monthly	Board	Assistant Director of Clinical Improvement (MSG Medical Vice Chair) Divisional Medical Directors Divisional Heads of Quality & Nursing
Time from identification of a case for detailed review by the MSG to informing the bereaved where a failing of care has been identified by said review no more than 6 months in 90% of cases	Assistant Director of Clinical Improvement (MSG Medical Vice Chair)	STHK-adapted RCP SJR	6-monthly	MSG	Assistant Director of Clinical Improvement (MSG Medical Vice Chair) Patient Safety Manager

9.2 Performance Management of the Policy

Responsibility for the operational performance management and reporting on the effectiveness of the policy will lie with the Assistant Director of Clinical Improvement.

10. References/Bibliography

No	Author	Year	Title	Edition	Place of Publication	Publisher
1	NHS England Patient Safety Domain	2015	Serious Incident Framework *"Supporting Learning to Prevent Recurrence"*	https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf	Internet	-
2	NHS National Quality Board	2017	National Guidance of Learning from Deaths	https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning- from-deaths.pdf	Internet	-
3	Care Quality Commission	2016	Learning, Candour & Accountability	https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf	Internet	-
4	NHS National Reporting & Learning Service	2009	Being Open "saying sorry when things go wrong"	http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726	Internet	National Patient Safety Agency
5	NHS Resolution	2017	Saying Sorry	http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf	Internet	-

11. Related Trust Documents

No.	Related Document
1.	Incident Reporting and Management Policy
2.	Being open: A Duty to be Candid
3.	MCG Incident/Near Miss Management
4.	Advance decision to refuse treatment
5.	Care of the deceased patient
6.	C018 learning from incidents, complaints & claims
7.	Claims and inquest policy
8.	Incident reporting and management policy inclusive of serious incident
9.	Managing concerns and complaints
10.	M003 policy for maternal death
11.	Patient experience strategy
12.	Policy to meet the communication needs of patients
13.	Procedure for requesting an autopsy policy
14.	Procedure for the cremation of stillborn infants
15.	S008 guide for supporting parents in event of a poor outcome
16.	Safeguarding adults policy
17.	Visiting the deceased body in the bereavement centre

12. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

Equality Analysis			
Title of Document/proposal /service/cost improvement plan etc:	Learning from Trust Inpatient Deaths		
Date of Assessment	1st February 2018	**Name of Person completing assessment /job title:**	T Hankin
Lead Executive Director	Prof Kevin Hardy		Deputy Medical Director

	Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:	**Yes / No**	**Justification/evidence and data source**
1	Age	No	
2	Disability (including learning disability, physical, sensory or mental impairment)	Yes	Favourably: all LD and Mental Health deaths are subject to full screening and further investigation where required
3	Gender reassignment	No	
4	Marriage or civil partnership	No	
5	Pregnancy or maternity	Yes	Favourably: all Paediatric and neonatal deaths are subject to full screening and further investigation where required
6	Race	No	
7	Religion or belief	No	
8	Sex	No	
9	Sexual Orientation	No	
	Human Rights – are there any issues which might affect a person's human rights?	**Yes / No**	**Justification/evidence and data source**
1	Right to life	No	
2	Right to freedom from degrading or humiliating treatment	No	
3	Right to privacy or family life	No	
4	Any other of the human rights?	No	

Lead of Service Review & Approval	
Service Manager completing review & approval	Dr Terence Hankin
Job Title:	Deputy Medical Director

Appendix 1 – Example of Quarterly Trust Board Report

STHK Learning From Deaths Board Report

	Deaths in Scope [1]	Learning Difficulties Death	Severe Mental Illness Death [2]	Child Death	Neonatal Death or Stillbirth	Maternal Death	CQC Alert Death	Diagnosis Group Death [3]	Post-Op Death	SIRI Death	Concern Death [4]	Total [5]
		Specified Groups										
Apr-18	114	2	1	0	2	0	0	4	10	0	4	23
May-18	133	3	0	0	0	0	0	5	5	0	2	15
Jun-18	118	1	0	0	0	0	0	2	6	0	5	14
Grand Total	365	6	1	0	2	0	0	11	21	0	11	52

	Specified Groups			Non-Specified Groups		
	Total [5]	Reviewed	% Reviewed	Total	Reviewed	% Reviewed (Target 25%)
Apr-18	23	23	100.0%	91	23	25.3%
May-18	15	15	100.0%	118	30	25.4%
Jun-18	14	14	100.0%	104	27	26.0%
Grand Total	52	52	100.0%	313	80	25.6%

	% of Reviews with RAG Rating [6]		
	Total RAG Reviewed	Total Reviewed	% RAG Reviewed
Apr-18	41	46	89.1%
May-18	42	45	93.3%
Jun-18	40	41	97.6%
Grand Total	123	132	93.2%

	Outcome of RAG Reviewed Deaths			
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation	Grand Total
Apr-18	39	0	2	41
May-18	41	1	0	42
Jun-18	37	3	0	40
Grand Total	117	4	2	123

	Outcome % of RAG Reviewed Deaths		
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation
Apr-17	95.1%	0.0%	4.9%
May-17	97.6%	2.4%	0.0%
Jun-17	92.5%	7.5%	0.0%
Grand Total	95.1%	3.3%	1.6%

[1] This includes all inpatient deaths at STHK and all stillbirths. If a patient was transferred and died at another provider then they are out of the scope of this data - even if the cause of death relates to care at STHK.
[2] For the purpose of this report SMI is defined as DOLs or patients under the Mental Health Act during the spell
[3] Diagnosis groups under internal monitoring
[4] Any death associated with a complaint, PALs or an expression of concern by a member of staff
[5] If a patient is attributed to more than one specified group, the Total will only count each patient once
[6] Some nationally specified review processes don't include RAG rating.

Learning & Sharing 2018/Q1

2018/Q1 Key Priorities

(1) Where there is concern that a patient is at risk of falling out of bed, a low rise bed must be used. Bedrails are likely to introduce more risk and should never be used as a form of restraint;

(2) If a patient has a suspected hip fracture, the plain XR is normal, but the patient cannot mobilise, request a CT scan within 24 hours. After a normal CT scan if the patient can still not mobilise, please ask the responsible consultant to speak to a Radiologist to discuss MRI scan.

Assurance

Sharing: (Current Q-1) Board (mins) ■, Quality Committee (mins) ■,F&P (mins) ☐, CEC (mins)■, PSC (mins) ■, PEC (mins) ■,MCG Governance (mins) ■, SCG Governance (mins)☐ , Grand Rounds (mins) ☐, ED Teaching (record) ☐, FY Teaching (record) ☐, Team Brief (record) ■, Intranet Message Board (record) ■, Global mail (record) ■, Directorate meetings (mins) ☐. List any policies/procedures or guidelines changed:

____

____

Effectiveness: (Current Q-1) Audit of DATIX ☐, SIRIs ☐, Complaints ☐, PALS ☐, Litigation ☐, Mortality Reviews for evidence of failure to deliver these priorities ☐.

Comments:

Appendix 2 – Feedback from Mortality Surveillance Group

Feedback from Mortality Surveillance Group

Red/Amber and Green with Learning - Mortality Reviews during Reporting Period

RAG Rating (Red/Amber/ Green with learning)	Month of Death	Department	Clinical Summary of Case and Concerns	SIRI		StEIS	
				Yes	No	Yes	No

Issues escalated to CCGs from Mortality Reviews

RAG Rating (Red/Amber/ Green with learning)	Month	Issue	Action Taken	CCG Response

Assurance of Completion of Actions from Previous Reports

Board Report	Oct-18
Reporting Period	Q1 (Apr to Jun 18)
Total No of Actions	
Number Open	
Number Closed	

Board Report	Jul-18
Reporting Period	Q4 (Jan to Mar 18)
Total No of Actions	
Number Open	
Number Closed	

Appendix 3 – Mortality structured judgement review

- Name and reference
- SIRS (Security Incident Reporting System)
- Duty of Candour
- Root Cause Analysis for Needlestick Injuries
- 12 hour trolley waits in A & E and lengthy ambulance handovers
- Obstetric / Gynaecology Review
- Mortality structured judgement review
- My reports
- Design a report
- New search
- Saved queries
- Show staff responsibilities
- Help

Mortality structured judgement review

Field	
Age at death (years)	
Sex	
Social deprivation indicator (first 3/4 alphanumeric items of postcode)	
Date of admission	
Time of admission	
Date of Death	
Specialty Team at time of death	
Recorded cause of death	
Type of admission	
Did the patient have a learning disability?	
1) Admission and initial assessment (approx. the first 24 hours) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
1) Please rate the care received by the patient during this phase	
2) Ongoing care Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
2) Please rate the care received by the patient during this phase	
3) Care during a procedure Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
3) Please rate the care received by the patient during this phase	
4) Perioperative Care Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
4) Please rate the care received by the patient during this phase	
5) End of life care / discharge care Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
5) Please rate the care received by the patient during this phase	
6) Overall assessment Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
6) Please rate the care received by the patient during this overall phase	
Please rate the quality of the patient record in enabling a good quality of care to be provided	
SJR Rating	

Search Cancel

Good Practice Guidance and Standard Operating Procedure for care of the Bereaved

Version No: 1.0

Document Summary:
The guidance describes the process that should be followed with the bereaved in an in-patient setting

Document status	Draft	
Document type	Standard Operating Procedure (SOP)	**Trust wide**
Document number	Document Control will provide document number if a new document	
Approving body	Mortality Surveillance Group	
Date approved	02/12/2018	
Date implemented	01/01/2019	
Review date	**01/12/2021**	
Accountable Director	Medical Director	
Policy Author	Dr Julie Hendry	
Target audience	All staff	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments.

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information		
Title	Standard Operating Procedure for care of the Bereaved	
Directorate	Quality & Risk	
Brief Description of amendments		
New procedure ***Please state if a document has been superseded.***		
Does the document follow the Trust agreed format?	Yes	
Are all mandatory headings complete?	Yes	
Does the document outline clearly the monitoring compliance and performance management?	Yes	
Equality Analysis completed?	Yes	

Section 2 – Consultation Information			
Consultation Completed	☑ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	12/11/2018	**Consultation end date**	10/12/2018

Section 3 – Version Control		
Version	**Date Approved**	**Brief Summary of Changes**
1	01/12/2018	New procedure
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	

Section 4 – Approval – *To be completed by Document Control*			
Document Approved	☐ Approved ☐ Approved with minor amendments		
Assurance provided by Author & Chair	☐ Minutes of Meeting ☐ Email with Chairs approval		
Date approved	Click here to enter a date.	**Review date**	Click here to enter a date.

Section 5 – Withdrawal – *To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by Author & Chair	☐ Minutes of Meeting ☐ Email with Chairs approval
Date Withdrawn:	Click here to enter a date.

Contents

Document Control ... 2
1. Scope ... 4
2. Introduction ... 4
3. Statement of Intent ... 4
4. Definitions ... 4
5. Duties, Accountabilities and Responsibilities ... 4
5.1 Chief Executive ... 4
5.2 Medical Director ... 4
5.3 Assistant Director for Clinical Improvement ... 4
5.4 Trust Board ... 5
5.5 All staff ... 5
6. Process ... 5
6.1 Equal Partners ... 5
6.2 Honesty, Compassion and Sensitivity ... 5
6.3 High Standard of Bereavement Care ... 5
6.4 Right to Raise Concerns ... 6
6.5 Timely, Responsive Contact and Support ... 6
6.6 Working in Partnership ... 6
6.7 Contacting the Bereavement Office ... 6
6.8 Bereavement Office Process ... 6
6.9 Inquests ... 6
7. Training ... 7
8. Monitoring Compliance ... 7
8.1 Key Performance Indicators (KPIs) of the Policy ... 7
8.2 Performance Management of the Policy ... 7
9. References ... 7
10. Related Trust Documents ... 7
11. Equality Analysis Form ... 8

1. Scope

This procedure provides information and guidance to STHK staff for the care of the bereaved.

2. Introduction

The eight principles for the care of families who are recently bereaved is laid down in the NQB document "Learning from Deaths. Guidance for NHS trusts on working with bereaved families and carers". These principles are:

(i) Bereaved families and carers should be treated as equal partners;
(ii) Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
(iii) Bereaved families should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
(iv) Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to a loved one;
(v) Bereaved families' and carers' views should help inform decisions about whether a review or investigation is needed;
(vi) Bereaved families and carers should be partners in an investigation to the extent and whichever stage they wish to be involved;
(vii) Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process with a single point of contact and liaison;
(viii) Bereaved families and carers who have experience in the investigation process should be supported to work in partnership with trusts to deliver training for staff regarding family and carer involvement.

3. Statement of Intent

All bereaved people will be supported in line with the procedures laid out in this document.

4. Definitions

Definition	Meaning

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Trust's accountable officer, responsible for ensuring that the organisation has a robust process for the management of bereaved persons.

5.2 Medical Director

Responsible for ensuring all bereaved persons are managed as per the procedures laid down in this document.

5.3 Assistant Director for Clinical Improvement

Responsible for informing the HR Director, Responsible Officer and Post-Graduate Dean if a problem in healthcare contributes to a death and involves a member of the medical staff or doctor in training.

5.4 Trust Board

Will review all serious incidents via a quarterly report to Board and make recommendations where appropriate.

5.5 All staff

Must report serious incidents, potential serious incidents, or concerns about the death of a patient to their line manager.

6. Process

NB Each step is either a point of good practice or an essential procedural step and these are indicated with either a **G** bullet point for good practice or **P** bullet point for procedural step.

6.1 Equal Partners

Bereaved families and carers should be treated as equal partners following bereavement:

- **P** Ensure we tell family members and carers that they are able to be as involved as they wish to be in decisions made immediately following a death;
- **P** Ask family members and carers if they have any spiritual or cultural wishes;
- **P** Ensure the privacy and dignity of the deceased person and their family members/carers should be maintained;
- **P** Any information given to the family members/carers should be clear and unambiguous and presented in a manner/format that they can understand.

6.2 Honesty, Compassion and Sensitivity

Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment:

- **P** Conversations with family members and carers must always be conducted in private;
- **P** Where there are no suitable facilities for this to happen, Ward Managers' offices should be vacated to facilitate these discussions and must be maintained in a state of preparedness for this use.

6.3 High Standard of Bereavement Care

Bereaved families should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support:

- **P** The Trust Bereavement booklet will be made available to relatives and carers at the time their loved one dies (before leaving the ward);
- **P** Staff must check whether family/carers require the information in other languages or formats, eg large print, Braille, audio or email (for people who use adaptive technology);
- **P** Families and carers must be must be made aware of the process to follow and what to expect when they attend the bereavement office;
- **P** Where appropriate bereaved carers and families will be signposted to appropriate bereavement support services and counselling, including spiritual support and specialist suicide bereavement support;
- **P** Interpretation service must be offered to facilitate discussions about end of life care or death with relatives or carers who do not speak fluent English.

6.4 Right to Raise Concerns

Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to a loved one. Bereaved families' and carers' views should help inform decisions about whether a review or investigation is needed:

- **P** Bereaved carers and families should be notified who to contact if they have any concerns regarding the care of loved ones.

6.5 Timely, Responsive Contact and Support

Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process with a single point of contact and liaison. Bereaved families and carers should be partners in an investigation to the extent, and at whatever stage, that they wish to be involved, as they offer a unique and equally valid source of information that can better inform investigations:

- **P** Please see the Being Open: A Duty of Candour Policy and Incident report policy for details of how patients and families are supported and communicated with during investigations;
- **P** If a patient death results in a SI investigation, the relatives and carers may invited to attend the first 20 minutes of the panel meeting to allow them to articulate their concerns about care. The family will receive help and support from PALs or Health Watch in when preparing for the meeting during the meeting itself. However, if the family/carers feel unable to attend the SI Panel meeting, the Lead Investigator will contact the carers / family and ensure that any question raised by the family / carers will be taken into consideration by the Panel. This will be agreed as part 2 of the rapid review (see Incident Reporting Policy).

6.6 Working in Partnership

Bereaved families and carers who have experience in the investigation process should be supported to work in partnership with trusts to deliver training for staff regarding family and carer involvement:

- **G** Families and carers of patients that have died and who may have been involved in an investigation may be invited to provide feedback to the Trust via Patient Experience Council and/or Trust Board;
- **G** In some specialities bereaved relatives may be offered opportunities to interact in structured meetings with the multidisciplinary clinical teams who provided care in order to provide feedback;
- **G** Families/carers who attend incident panel meetings will be offered the opportunity to provide feedback that can be used for staff training.

6.7 Contacting the Bereavement Office

- **P** Ward staff must notify the Bereavement Office of a death by telephone (0151 430 1412). This has the facility to leave voice messages which staff check throughout the day.

6.8 Bereavement Office Process

- **P** Staff in the Bereavement Office will use sensitive language to make relatives aware that if they (as the person arranging the funeral) are on the correct qualifying benefits they will be able to ask for financial assistance from the Social fund if they are facing financial pressures;
- **P** Staff in the Bereavement Office must ensure that the communication needs of families/carers as met.

6.9 Inquests

- **P** Once it has been identified that an inquest has been requested, all contact with the family must first be discussed with the Trust Legal Department team.

7. Training

- Advanced communication skills training will offered to all members of cancer MDTs;
- All staff working in the Bereavement Office will complete the Bereavement training with 12 months from the approval of this guidance / procedure.

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1	All families/carers have received a bereavement booklet
2	All Bereavement staff have received communications training

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Families/carers have received a bereavement booklet	Palliative Care Team	Monitor number of booklets printed	Annually	Policy Governance Group and Quality Committee	Author(s) Policy Governance Group Members
Bereavement staff have received communications training	Bereavement Office Manager	Training records to be submitted annually to Mortality Surveillance Group	Annually	Mortality	Bereavement Office Manager

9. References

No	Reference
1	Learning from Deaths. Guidance for NHS trusts on working with bereaved families and carers, National Quality Board, July 2018

10. Related Trust Documents

No.	Related Document
1.	Being open: A Duty to be Candid
2.	Care of the deceased patient
3.	Managing concerns and complaints
4.	Procedure for requesting an autopsy policy
5.	S008 guide for supporting parents in event of a poor outcome
6.	Visiting the deceased body in the bereavement centre

11. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required.

This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes. cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

Equality Analysis Form			
Title of Document/proposal /service/cost improvement plan etc:	Click here to enter text.		
Date of Assessment	Click here to enter a date.	**Name of Person completing assessment /job title:**	Click here to enter text.
Lead Executive Director	Choose an item.		Click here to enter text.

	Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:	**Yes / No**	**Justification/evidence and data source**
1	Age	Choose an item.	Click here to enter text.
2	Disability (including learning disability, physical, sensory or mental impairment)	Choose an item.	Click here to enter text.
3	Gender reassignment	Choose an item.	Click here to enter text.
4	Marriage or civil partnership	Choose an item.	Click here to enter text.
5	Pregnancy or maternity	Choose an item.	Click here to enter text.
6	Race	Choose an item.	Click here to enter text.
7	Religion or belief	Choose an item.	Click here to enter text.
8	Sex	Choose an item.	Click here to enter text.
9	Sexual Orientation	Choose an item.	Click here to enter text.
	Human Rights – are there any issues which might affect a person's human rights?	**Yes / No**	**Justification/evidence and data source**
1	Right to life	Choose an item.	Click here to enter text.
2	Right to freedom from degrading or humiliating treatment	Choose an item.	Click here to enter text.
3	Right to privacy or family life	Choose an item.	Click here to enter text.
4	Any other of the human rights?	Choose an item.	Click here to enter text.

Lead of Service Review & Approval	
Service Manager completing review & approval	Click here to enter text.
Job Title:	Click here to enter text.

TRUST BOARD

Paper No: NHST(19)011
Title of paper: St Helens Cares Collaboration Agreement
Purpose: For the Trust Board to approve the St Helens Cares Collaboration Agreement to establish a governance structure to facilitate the next stage in the development of a place based approach to healthcare delivery, with the Trust identified as the Provider System Lead.
Summary: This Paper sets out the proposed arrangements for the development of a "Provider System Lead" approach in St Helens, underpinned by a governance structure and a Collaboration Agreement between NHS St Helens CCG, St Helens Council, St Helens & Knowsley Teaching Hospitals NHS Trust, North West Boroughs Healthcare NHS Foundation Trust and Bridgewater Community NHS Foundation Trust. The aim of the arrangements is to bring together the key health and social care commissioners and providers in St Helens to develop and deliver sustainable, quality, health, care and support to the population of St Helens within the context of cost and demand challenges. The arrangements seek to implement changes to the way in which system partners work together and with citizens in order to create a place-based approach to health, care and support to foster a culture of independent, resilience and self-care. The Collaboration Agreement sets out an initial governance framework for the "Provider System Lead" arrangements, with St Helens & Knowsley Teaching Hospitals NHS Trust identified as the provider system lead. The objectives of the Agreement include the development of the model including the role of the provider system lead over the next 12 – 15 months focusing initially on four "Key Priority Areas". The following documents are attached to this paper for consideration by the Board*:* Appendix 1 - Draft Collaboration Agreement (which includes Terms of Reference for each of the proposed governance groups to be established) Appendix 2 - Draft amended Terms of Reference for the St Helens Cares Executive Board
Corporate Objective met or risk addressed: We will work closely with NHS Improvement, and commissioners, local authority and provider partners across Cheshire and Merseyside to develop proposals to improve the clinical and financial sustainability of services.
Financial implications: The Trust will chair and administer the St Helens Cares Provider

Board.
Stakeholders: St Helens Cares partner organisations, Cheshire and Merseyside Health and Care Partnership, Staff, Patients, NHSI.
Recommendation(s): The Board is asked to: 1. Note the progress made to date by the Trust and its partners in establishing the St Helen Cares local care partnership; 2. Note the development of the Collaboration Agreement, which sets out the values, principles and shared ambition of the Trust and its partners and their respective roles and responsibilities, and the "provider system lead" structure proposed; 3. Note the proposed framework for the governance of St Helens Cares, which has been developed alongside the preparation of the proposed Collaboration Agreement; 4. Note the proposed governance structure and establishment, under the St Helens Cares governance arrangements, of the Provider Board, the Finance and Contracting Group and Stakeholder Reference Forum; 5. Note the proposed Terms of Reference for the governance groups (including the draft amended Terms of Reference for the St Helens Cares Executive Board which are to be agreed by the St Helens Peoples Board); 6. Note the Operational Planning and Integrated Delivery Group, which does not form part of the St Helens Cares governance structure but which will report to the Executive Board and link to the Finance and Contracting Working Group, and which will provide financial modelling information to it as required, and engage with the Stakeholder Reference Forum in respect of its transformational priorities; 7. Approve the terms of the Collaboration Agreement annexed to this report and agree to delegate authority to the Chief Executive to agree any necessary, inconsequential amendments to the final version, and to enter into the Collaboration Agreement on behalf of the Trust; and 8. Note that the Board will receive updates on progress with the St Helens Cares provider system lead arrangements regularly and no less than once every 6 months.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 30th January 2019

St Helens Cares Collaboration Agreement

1. INTRODUCTION

This paper has been prepared to support the St Helens Cares Collaboration Agreement that is being considered for agreement by the key partners who constitute the commissioners and NHS Trust providers of health and social care services in St Helens.

The attached paper is being considered and approved by the Governing Body of NHS St Helens Clinical Commissioning Group, the Cabinet of St Helens Council, the Trust Boards of the three NHS provider Trusts operating within St Helens, namely, North West Boroughs Healthcare NHS Foundation Trust, Bridgewater Community NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust.

The attached collaboration agreement has been developed by partners with the support of Hill Dickinson LLP.

2. ST HELENS CARES – THE LOCAL CARE SYSTEM FOR ST HELENS

St Helens Cares brings together key partners across the Borough of St Helens to develop and deliver sustainable, quality health, care, support and community services to the population of St Helens.

In the 'St Helens People's Plan', the People's Board signified their intention to work together as a partnership to bring together the statutory functions of the Health and Wellbeing Board and the Community Safety Partnership.

This new partnership agreed a new and ambitious shared vision of *"Improving the lives of people in St Helens together by tackling the challenge of cost and demand"*

A key enabler to the delivery of this ambitious vision is the establishment of St Helens Cares, a Local Care Management System for St Helens, in conjunction with other closely aligned major transformational strategies overseen by the People's Board.

The St Helens Cares model acknowledges that, in order to achieve sustained improvement in population outcomes whilst also achieving system financial balance, significant change is required in the relationship between system partners to create a place-based health, care and community model, and between services and citizens to foster a culture of independence, resilience and self-care.

The Local care system, St Helens Cares, will bring together all local service providers, who will, over time, become jointly responsible for the quality and costs of care for local people, working together within agreed budgets as far as permissible within existing legal frameworks.

3. PROGRESS TO DATE

The St Helens Peoples Board has agreed that a 'provider system lead' approach should be developed within the Borough. St Helens and Knowsley Teaching Hospitals NHS Trust have been identified as the provider system lead.

The Collaboration Agreement recognises the progress to date of St Helens Cares and sets out the initial governance framework for the provider system lead arrangements (including terms of reference). The Agreement further recognises that although a provider system lead has been identified in principle, there is still work to do to agree the underpinning contractual and financial principles to support any lead provider contractual model in the future.

The Agreement is therefore the first step towards developing the provider system lead approach and focuses initially on the four key priority areas of frailty; respiratory; children's mental health; and community mental health (crisis support). This first phase of development will take place over the next 12 months, with the initial term of the Agreement expiring on 31 March 2020 (subject to extension).

The Agreement itself is based on a Memorandum of Understanding (MOU) type approach, and provides an overarching arrangement. It is designed to work alongside existing services contracts and arrangements for the delivery of non-NHS care, support and community services via the Council. It is important to note that the Agreement does not vary or supersede in any way existing services contracts between the commissioners and providers who are parties to the Agreement.

The St Helens Cares governance structure has been refreshed as part of the development of the Collaboration Agreement.

In addition to the already existing People's Board (formerly Health and Wellbeing Board), St Helens Cares Executive Board (which brings together key senior leaders from St Helens to drive the St Helens Cares agenda) and the Operational Planning & Delivery Group (which supports the St Helens Cares Executive Board) it is proposed that the following will be established:

- A Provider Board which will bring together Executive and senior clinical representatives from the three NHS providers in St Helens who are parties to the Agreement, together with attendance from representatives of primary care and the voluntary sector services. The Provider Board will be able to establish working groups with representation from clinicians and others to focus on the four key priority areas (initially).

- A Stakeholder Reference Forum which will build and sustain meaningful engagement with a broad range of stakeholders including service users, the public, volunteers, carers and voluntary organisations and provide feedback to the Provider Board and the Executive Board on proposals for change.

- A Finance and Contracting Group, which will develop potential financial and contracting structures to underpin future Lead Provider models of care for St Helens, reporting to the Executive Board.

The details of these initial governance arrangements are contained within the Agreement and the terms of reference.

The terms of reference for the St Helens Cares Executive Board have been revised (in draft) to reflect these developments and are expected to be approved at the next meeting of the St Helens People's Board. The draft amended terms of reference are included within the papers for reference.

4. NEXT STEPS

Following endorsement and agreement to the Collaboration Agreement partners in St Helens will work towards:

- Agreeing the detail of the provider system lead role and how this model might operate within St Helens;

- Embedding the new governance arrangements and reviewing their impact;

- Developing the contractual and financial underpinning structures required to support a lead provider model for the Borough

- Developing plans for the transformation of services in the four priority areas, to increase collaboration and improve the quality of care for service users.

END

Appendix 1

ST HELENS CARES COLLABORATION AGREEMENT

DATE 2019

DRAFT

1. **NHS ST HELENS CLINICAL COMMISSIONING GROUP**
2. **ST HELENS BOROUGH COUNCIL**
3. **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**
4. **NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST**
5. **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**

COLLABORATION AGREEMENT FOR ST HELENS CARES

© Hill Dickinson LLP 2019

ST HELENS CARES COLLABORATION AGREEMENT

Contents

1. DEFINITIONS AND INTERPRETATION....3

2. STATUS AND PURPOSE OF THIS AGREEMENT....3

3. ACTIONS TO BE TAKEN ON OR POST THE COMMENCEMENT DATE....4

4. DURATION....4

SECTION A: OBJECTIVES AND PRINCIPLES....4

5. THE OBJECTIVES FOR ST HELENS CARES....4

6. THE PRINCIPLES FOR ST HELENS CARES....5

7. PROBLEM RESOLUTION AND ESCALATION....6

SECTION B: OPERATION OF AND ROLES IN THE SYSTEM....7

8. RESERVED MATTERS....7

9. TRANSPARENCY....8

10. OBLIGATIONS AND ROLES OF THE PARTIES....9

SECTION C: GOVERNANCE ARRANGEMENTS....11

11. ST HELENS CARES GOVERNANCE....11

12. CONFLICTS OF INTEREST....13

SECTION D: FINANCIAL PLANNING....14

13. PAYMENTS....14

14. EXCLUSION AND TERMINATION....14

15. INTRODUCING NEW PROVIDERS....15

16. LIABILITY....15

17. VARIATIONS....15

18. CONFIDENTIALITY AND FOIA....15

19. INTELLECTUAL PROPERTY....16

20. GENERAL....17

SCHEDULE 1....19

Definitions and Interpretation....19

SCHEDULE 2....23

Key Priority Areas....23

SCHEDULE 3....24

St Helens Cares Areas for Development....24

SCHEDULE 4....26

Governance....26

Part 1 – St Helens Cares Provider Board - Terms of Reference....28

© Hill Dickinson LLP 2019

Part 2 – St Helens Cares Finance & Contracting Group – Terms of Reference 34
Part 3 – St Helens Cares Stakeholder Reference Forum - Terms of Reference 38
SCHEDULE 5 45
Dispute Resolution Procedure 45

© Hill Dickinson LLP 2019

Overarching Note – Collaboration Agreement for St Helens Cares

This Agreement provides an overarching framework for the development of a population, outcomes based approach to integrated health and social care in St Helens, known as 'St Helens Cares'. The arrangements set out are intended to further strengthen relationships between the Parties, all of whom are commissioners or providers of health and care services in St Helens, for the benefit of the St Helens population.

The Parties intend the arrangements to allow for the establishment and development over time of a 'System Lead' integrated approach, together with the further development of an outcomes framework for St Helens Cares. This Agreement sets out the Parties' approach to the first phase of development, during which the Parties will collaborate to further develop the St Helens Cares model. Initially, this Agreement will cover the agreed first phase Key Priority Areas and such other priority areas / services as may be agreed by the Parties from time to time.

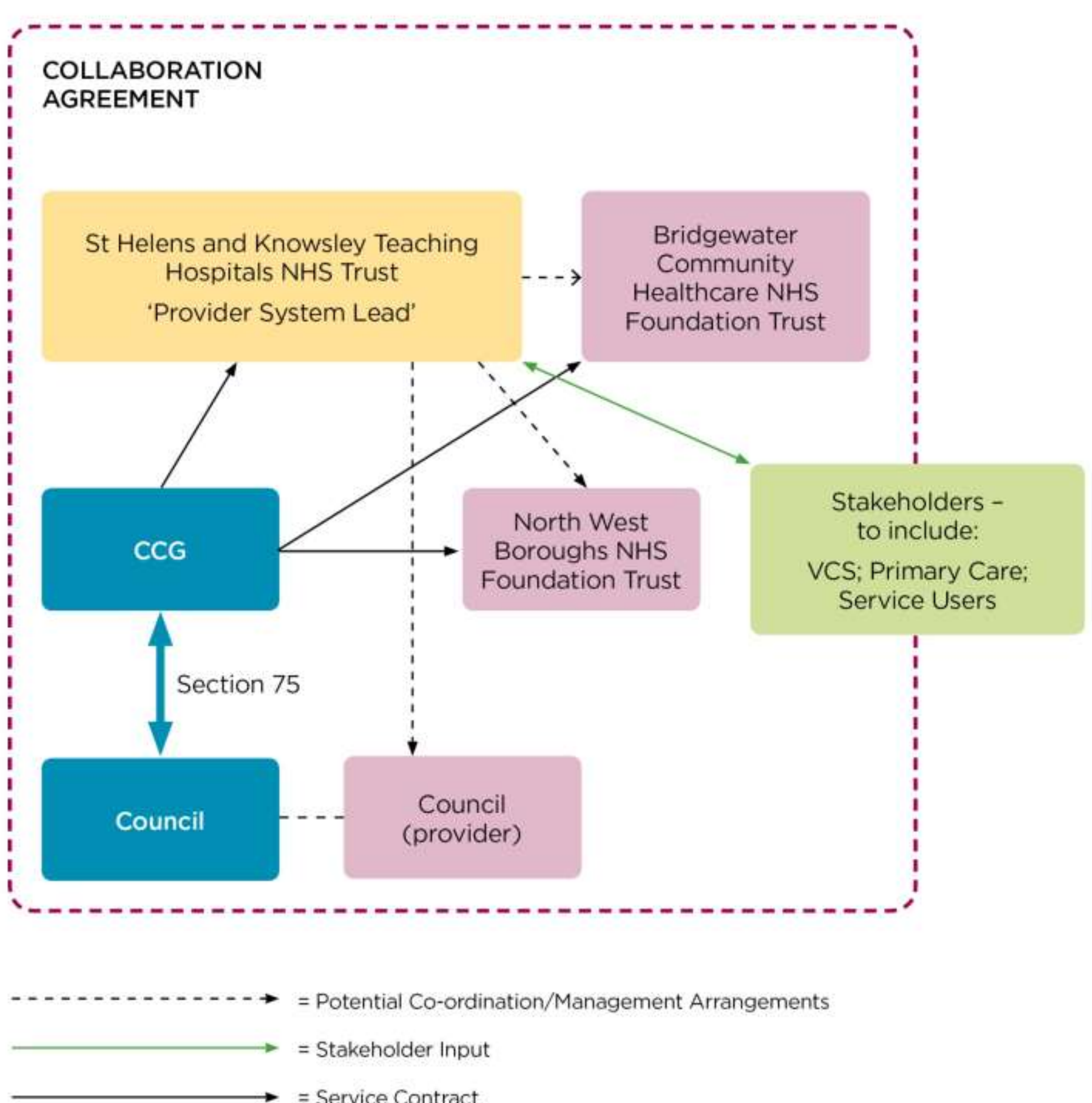
This Agreement is based on a Memorandum of Understanding (MOU) approach, and provides an overarching arrangement. It is designed to work alongside existing NHS Standard Contracts (commonly the Services Contract) and arrangements for the delivery of non-NHS care, support and community services via the Council to the extent such services are within the scope of the Agreement. The Agreement is only intended to be legally binding for specific elements, which are identified, such as confidentiality and intellectual property.

The intention is that the Parties will work together under the governance framework set out in this Agreement to develop the St Helens Cares approach to ultimately include requirements in relation to outcomes, risk/gain share, financial and contract management and regulatory requirements, together with a clear role for the 'Provider System Lead' organisation (St Helens & Knowsley Teaching Hospitals NHS Trust) (referred to as Phase 2). Schedule 4 includes a diagram illustrating the governance arrangements for St Helens Cares as at the Commencement Date. The ultimate 'System Lead' approach that the Parties are working towards through this Agreement is illustrated in Figure 1 below. The Parties will review progress made and the terms of this Agreement at six monthly intervals from the Commencement Date and may agree to either vary the Agreement to reflect developments or enter into a new agreement in respect of Phase 2.

DRAFT

© Hill Dickinson LLP 2019

FIGURE 1 - ST HELENS CARES – ILLUSTRATION OF POTENTIAL SYSTEM LEAD STRUCTURE



ST HELENS CARES COLLABORATION AGREEMENT

DATE: 2019

This Collaboration Agreement (the **Agreement**) is made between:

1. **NHS ST HELENS CLINICAL COMMISSIONING GROUP** of The Gamble Building, Victoria Square, St Helens WA10 1HP (the "**CCG**");

2. **ST HELENS BOROUGH COUNCIL** of Town Hall, Victoria Square, St Helens WA10 1HP (the "**Council**");

3. **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST** of Whiston Hospital, Warrington Road, Prescot, Merseyside L35 5DR ("**STHK**");

4. **NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST** of Hollins Park House, Hollins Lane, Winwick, Warrington WA2 8WA ("**NWB**");

5. **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST** of 17 Smithy Brook Rd, Wigan WN3 6PR ("**BCH**"); and

together referred to in this Agreement as the "**Parties**".

The CCG and the Council (in its role as commissioner of social care and public health services) are together referred to in this Agreement as the "**Commissioners**".

STHK, NWB, BCH and the Council (in its role as provider of social care services, whether directly or through contracting arrangements with third party providers) are together referred to in this Agreement as the "**Providers**".

RECITALS

a) The NHS Five Year Forward View (the "**Forward View**") set out a clear goal that *"the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".*

b) This Agreement set out the values, principles and shared ambition of the Parties in supporting work towards the transformation and better integration of health and care services for the people of St Helens. In entering into and performing their obligations under this Agreement, the Parties are working towards the development and ultimate implementation of a population health management approach for St Helens through a 'system lead' structure, with STHK taking a lead role in coordinating the 'system' response.

© Hill Dickinson LLP 2019

DRAFT

c) The Commissioners are the statutory bodies responsible for planning, organising and buying social care, NHS-funded healthcare, support and community services for people who live in St Helens.

d) The Providers (including the Council in its provider role) are together providers of social care, NHS funded healthcare services, community and support services to the population of St Helens.

e) The Parties acknowledge that the Council has a dual role within the St Helens health and care system as both a commissioner of social care and public health services but also as a provider of social care services either through direct delivery or through contracts with third party providers. In its role as commissioner of social care services the Council shall work in conjunction with the CCG and in its role as a provider of social care services the Council shall work in conjunction with the Providers. The Council recognises the need to and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified and managed.

f) This Agreement sets out the St Helens Cares collaboration and planning for the health and care system whilst the Providers will also collaborate (through either existing collaborative arrangements between some or all of them and/or an organisational form/contract to be agreed between them) to improve the delivery of the Services, improve the Outcomes and remove duplication.

g) This Agreement is an overarching agreement setting out how the Parties will work together in a collaborative and integrated way in respect of the Key Priority Areas from the Commencement Date in accordance with the Principles. The Parties have committed to collaborate in respect of four initial Key Priority Areas through which they will work together in accordance with the Principles to achieve the Objectives. The initial Key Priority Areas are:

   a. Frailty;
   b. Respiratory;
   c. Children's Mental Health;
   d. Community Mental Health (Crisis Support).

h) The intention is that the Parties will evolve the arrangements for St Helens Cares as set out in this Agreement in phases, including developing and implementing the role of the Provider System Lead (STHK). Further Key Priority Areas will be added by agreement of the Parties as required to further the collaborative work of the Parties for the benefit of the St Helens population.

i) This Agreement is intended to work alongside:

© Hill Dickinson LLP 2019

DRAFT

a. the St Helens Cares Clinical and Support Strategy;
b. the Services Contracts between the CCG and the Providers and between the Council and the Providers; and
c. the Section 75 Agreement between the CCG and the Council.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a "Provider" or a "Commissioner" or any Party includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Parties have agreed to work together to develop the St Helens Cares provider system lead arrangements in order to establish an improved financial, governance and contractual framework for delivering integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the Population.

2.2 This Agreement sets out the key terms that the Parties have agreed.

2.3 The Parties have agreed in principle that STHK will act as the Provider System Lead for St Helens Cares in accordance with Schedule 3. The role of the Provider System Lead

© Hill Dickinson LLP 2019

will be further developed and agreed by all Parties in accordance with Clause 10.4 and Schedule 3 during the Initial Term.

2.4 Notwithstanding the good faith consideration that each Party has afforded the terms set out in this Agreement, the Parties agree that save as provided in Clause 2.5 below this Agreement shall not be legally binding. The Parties each enter into this Agreement intending to honour all of their respective obligations.

2.5 This Clause 2.5, Clauses 9 (*Transparency*), 16 (*Liability*), 18 (*Confidentiality and FOIA*), 19 (*Intellectual Property*), 20.4 (*Counterparts*) and 20.5 (*Governing Law and Jurisdiction*) shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2.6 Each of the Providers has one or more individual Services Contracts (or where appropriate combined Services Contracts) with the CCG or the Council. This Agreement will work alongside these Services Contracts and the Section 75 Agreement as appropriate.

2.7 Each of the Commissioners and the Providers agree to work together in a collaborative and integrated way on a Best for St Helens basis and the Services Contracts set out how the Providers provide Services to the Population. This Agreement is not intended to conflict with or take precedence over the terms of the Services Contracts unless expressly agreed by the Parties.

3. ACTIONS TO BE TAKEN ON OR POST THE COMMENCEMENT DATE

Each Party acknowledges and confirms that as at the date of this Agreement, it has obtained all necessary authorisations to enter into this Agreement.

4. DURATION

4.1 This Agreement shall take effect on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with the terms of this Agreement.

4.2 At the expiry of the Initial Term this Agreement shall expire automatically without notice unless, no later than 3 months before the end of the Initial Term, the Parties agree in writing that the term of the Agreement shall be extended for a further term to be agreed between the Parties (the “**Extended Term**”).

SECTION A: OBJECTIVES AND PRINCIPLES

5. THE OBJECTIVES FOR ST HELENS CARES

5.1 The Objectives agreed by the Parties for St Helens Cares are intended to deliver sustainable, effective and efficient health and care, support and community services

© Hill Dickinson LLP 2019

with significant improvements underpinned by collaborative working. The Parties have agreed to work together and to perform their duties under this Agreement in order to achieve the following Objectives:

5.1.1 to develop a way of working which provides sustainable, quality health, care, support, and community services to the Population;

5.1.2 to establish and operate collaborative governance arrangements in respect of St Helens Cares and, initially, the Key Priority Areas;

5.1.3 to develop an Outcomes framework for the Key Priority Areas and an implementation plan in respect of these Outcomes;

5.1.4 to develop the role of STHK as the Provider System Lead; and

5.1.5 to consider and work towards developing payment systems for services across St Helens to develop and ultimately achieve the Outcomes.

5.2 The Parties acknowledge that they will have to make decisions together in order for the St Helens Cares arrangements to work effectively. The Parties agree that they will work together and make decisions on a Best for St Helens basis in order to achieve the Objectives and the Outcomes, save for the Reserved Matters listed at Clause 8. The Parties acknowledge that STHK, NWB and BCH also provide services in areas outside of St Helens which they may need to take into account when taking decisions in respect of St Helens in the context of this Agreement.

6. THE PRINCIPLES FOR ST HELENS CARES

6.1 The Principles underpin the delivery of the Parties' obligations under this Agreement and set out key factors for a successful relationship between the Parties.

6.2 The Parties acknowledge and confirm that the successful development and delivery of the Objectives and, ultimately, the Outcomes will depend on the Providers' ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the development of the Key Priority Areas (together with the Council as a Provider) under this Agreement in conjunction with the CCG and Council (as a Commissioner).

6.3 The Principles are that the Parties will work together in good faith and, unless the provisions in this Agreement state otherwise, the Parties will:

6.3.1 genuinely collaborate with honesty, trust and understanding in working towards the success of St Helens Cares;

© Hill Dickinson LLP 2019

DRAFT

6.3.2 work together to develop over time and adopt, where appropriate and reasonable, mechanisms for collective ownership of risk and reward, including identifying, managing and mitigating specific risks and the implementation of an outcomes framework in respect of their performance of the obligations under Service Contracts;

6.3.3 achieve continuous, measurable and measured improvement in Outcomes. Agree improvements which are specific, challenging, add value and eliminate waste; and

6.3.4 always demonstrate that the best interests of people resident within St Helens are at the heart of the activities which they undertake under this Agreement and the Services Contracts and not organisational interests, and engage effectively with the Population,

(together these are the "**Principles**").

6.4 The Parties acknowledge that STHK, NWB and BCH also provide services in areas outside of St Helens which they may need to take into account when seeking to act in accordance with the Principles.

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Providers and the Commissioners agree to adopt a systematic approach to problem resolution which recognises the Objectives and the Principles set out in Clauses 5 and 6 above and which:

7.1.1 seeks solutions without apportioning blame;

7.1.2 is based on mutually beneficial outcomes;

7.1.3 treats Providers and the Commissioners as equal parties in the dispute resolution process; and

7.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

7.2 If a problem, issue, concern or complaint comes to the attention of a Party in relation to the Objectives, Principles or any matter in this Agreement and is appropriate for resolution between the Commissioners and the Providers such Party shall notify the other Parties and the Parties each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion within 20 Operational Days of such matter being notified.

© Hill Dickinson LLP 2019

7.3 Any Dispute arising between the Parties which is not resolved under Clause 7.2 above will be resolved in accordance with Schedule 5 (*Dispute Resolution Procedure*).

7.4 If any Party receives any formal enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this Agreement) the receiving Party will liaise with the other Parties as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE SYSTEM

8. RESERVED MATTERS

8.1 The Parties acknowledge that each of the Commissioners is required to comply with certain statutory duties as statutory commissioners and will be required to act in accordance with their statutory duties in relation to certain matters. Consequently, the Commissioners each reserve the matters set out in Clause 8.2 for their respective determination as they see fit in accordance with Clause 8.3.

8.2 Each of the Commissioners shall be free to determine the following Reserved Matters:

(a) making any decision or action where necessary to ensure compliance with their respective statutory duties, including the powers and responsibilities conferred on each of the Commissioners respectively by Law, its constitution or the Section 75 Agreement; or

(b) any matter upon which they may be required to submit to public consultation or in relation to which they may be required to respond to or liaise with a Local Healthwatch organisation.

8.3 The Parties agree that:

(a) the Reserved Matters are limited to the express terms of Clause 8.2 above; and

(b) the Executive Board may not make a final recommendation on any of the matters set out in Clause 8.2 above, which are reserved for determination by either Commissioner respectively.

8.4 Where determining a Reserved Matter, subject to any need for urgency because to act otherwise would result in the relevant Commissioner breaching their statutory obligations, the relevant Commissioner will first consult with the Executive Board in respect of their proposed determination of a Reserved Matter in line with the Objectives and the Principles.

DRAFT

© Hill Dickinson LLP 2019

9. TRANSPARENCY

9.1 The Parties will provide to each other all information that is reasonably required in order to achieve the Objectives.

9.2 The Parties have responsibilities to comply with Law (including Competition Law). The Parties will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Executive Board and the Provider Board will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

9.2.1 it is essential;

9.2.2 it is not exchanged more widely than necessary;

9.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

9.2.4 it may not be used other than to achieve the Objectives in accordance with the Principles.

9.3 Subject to compliance with Clause 9.2 above, the Parties will ensure that they provide the Finance & Contracting Group (FCG) with financial cost resourcing, activity or other information as may be reasonably required so that the FCG can assure the Executive Board that the Objectives in respect of the development of outcomes and payment systems are being met.

9.4 The Commissioners will make sure that the Provider Board and the FCG establish appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Objectives and for no other purpose whatsoever so that the Parties do not breach Competition Law.

9.5 It is accepted by the Parties that the involvement of the Providers in the governance arrangements for St Helens Cares is likely to give rise to situations where information will be generated and made available to the Providers which could give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the CCG and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in St Helens Cares, other than as a result of a breach of this Agreement, does not preclude

© Hill Dickinson LLP 2019

DRAFT

the CCG and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations.

9.6 Notwithstanding Clause 9.5 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law (for example, the Public Contracts Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013) which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

10. OBLIGATIONS AND ROLES OF THE PARTIES

Commissioners' obligations and role

10.1 Each Commissioner will:

10.1.1 help to establish an environment that encourages collaboration between the Providers where permissible;

10.1.2 provide clear system leadership to the Providers, clearly articulating health, care and support outcomes for the Providers, performance standards, scope of services and technical requirements;

10.1.3 support the Providers in developing links to other relevant services;

10.1.4 comply with their statutory duties;

10.1.5 seek to commission the services within the Key Priority Areas in an integrated, effective and streamlined way to meet the Objectives;

10.1.6 work collaboratively with the Providers to develop the St Helens Cares approach for the Key Priority Areas in accordance with Schedule 3 (*St Helens Cares Areas for Development*); and

10.1.7 work together with the other Parties to define the role of the Provider System Lead using the potential roles set out in Schedule 3 (*St Helens Cares Areas for Development*) as a starting point.

Providers' obligations and role

10.2 Each Provider will:

© Hill Dickinson LLP 2019

10.2.1 act collaboratively and in good faith with each other in accordance with the Law and Good Practice to achieve the Objectives, having at all times regard to the best interests of the Population;

10.2.2 co-operate fully and liaise appropriately with each other Provider in order to ensure a co-ordinated approach to promoting the quality of patient care across the Key Priority Areas and so as to achieve continuity in the provision of services within the Key Priority Areas that avoids inconvenience to, or risk to the health and safety of, Service Users, employees of the Providers or members of the public; and

10.2.3 through high performance and collaboration, unlock and generate enhanced innovation and better outcomes and value for the Population in line with the Objectives.

10.3 Each Provider acknowledges and confirms that:

10.3.1 it remains responsible for performing its obligations and functions for delivery of services to the CCG and/or the Council in accordance with its Services Contracts;

10.3.2 it will be separately and solely liable to the CCG or the Council (as applicable) under its own Services Contracts;

10.3.3 it remains responsible for its own compliance with all relevant regulatory requirements and remains accountable to its board/cabinet and all applicable regulatory bodies; and

10.3.4 it will work collaboratively with the Commissioners and the other Providers to develop the St Helens Cares approach for the Key Priority Areas in accordance with Schedule 3 (*St Helens Cares Areas for Development*).

.

Provider System Lead obligations and role

10.4 The role of STHK as Provider System Lead will be developed by the Parties over the Initial Term and may, over time, include the elements outlined in Schedule 3 (*St Helens Cares Areas for Development*).

10.5 The Parties recognise that the development of the Provider System Lead role over time may evolve ultimately to a revised contracting model which the Commissioners would need to approve in line with their commissioning intentions and which may impact on the Commissioners' procurement obligations.

© Hill Dickinson LLP 2019

10.6 STHK will comply with the Principles in undertaking its role as Provider System Lead during the term of this Agreement.

SECTION C: GOVERNANCE ARRANGEMENTS

11. ST HELENS CARES GOVERNANCE

11.1 The Parties must communicate with each other and all relevant staff in a clear, direct and timely manner. In addition to the Parties' own Boards / Cabinet / Governing Body, which shall remain accountable for the exercise of each of the Parties' respective functions, the governance structure for the St Helens Cares arrangements will comprise:

11.1.1 the Health and Wellbeing Board for St Helens (known as the "People's Board");

11.1.2 the St Helens Cares Executive Board (Executive Board);

11.1.3 the St Helens Cares Provider Board (Provider Board);

11.1.4 the St Helens Cares Finance & Contracting Group (FCG); and

11.1.5 the St Helens Cares Stakeholder Reference Forum (SRF).

11.2 The diagram in Schedule 4 (*Governance*) sets out the governance structure and the links between the various groups in more detail.

St Helens Cares People's Board

11.3 The St Helens Cares People's Board is the Health and Wellbeing Board for St Helens, and committee of St Helens Council, charged with promoting greater health and social care integration in St Helens. The People's Board will receive reports from the Executive Board as to the development of the St Helens Cares arrangements under this Agreement and progress against the areas for development in Schedule 3 (*St Helens Cares Areas for Development*).

St Helens Cares Executive Board

11.4 The Executive Board reports to the People's Board and is the group responsible for:

11.4.1 overseeing the St Helens Cares arrangements under this Agreement;

11.4.2 reporting to the People's Board on progress against the Objectives; and

11.4.3 liaising where appropriate with:

(a) national stakeholders (including NHS England and NHS Improvement); and

© Hill Dickinson LLP 2019

(b) the Cheshire and Merseyside Health & Care Partnership,

to communicate the views of St Helens Cares on matters relating to integrated care.

11.5 The Executive Board will act in accordance with its terms of reference and will:

11.5.1 promote and encourage commitment to the Principles and Objectives amongst all the Parties;

11.5.2 ensure alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the Population;

11.5.3 agree policy as required, including values to be adopted and annual and short term performance outcomes/targets;

11.5.4 oversee the implementation of this Agreement;

11.5.5 in undertaking its role, consider recommendations from the Provider Board and the FCG in respect of the development and operation of St Helens Cares, the delivery of the Objectives and the development of the Key Priority Areas; and

11.5.6 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 11.5.

St Helens Cares Provider Board

11.6 The Provider Board is the group responsible for managing the collaborative operation of the Providers and developing proposals for the delivery of services in the Key Priority Areas. The Provider Board will report to the Executive Board, acting in accordance with its Terms of Reference set out in Schedule 4 (*Governance*) Part 1 and will:

11.6.1 make recommendations to the Executive Board in relation to changes to the Key Priority Areas in respect of Service User pathways / services;

11.6.2 develop and implement strategies for closer collaborative working between the Providers, in order to achieve the Objectives and ultimately the Outcomes;

11.6.3 seek and reflect the views of the Stakeholder Reference Forum in drawing up recommendations to the Executive Board;

11.6.4 make recommendations to the Executive Board as to the addition of new parties to the arrangements under this Agreement, including new providers of services in the Key Priority Areas; and

11.6.5 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 11.6.

© Hill Dickinson LLP 2019

DRAFT

St Helens Cares Finance & Contracting Group (FCG)

11.7 The FCG is the group responsible for developing potential financial and contractual structures to underpin future models of care for St Helens. The FCG will report to the Executive Board, acting in accordance with its terms of reference set out in Schedule 4 (*Governance*) Part 2 and will:

11.7.1 develop proposals as to future financial / contractual models for St Helens Cares for recommendation to the Executive Board;

11.7.2 provide input on an ad hoc basis to the Provider Board in respect of financial and/or contractual considerations related to proposals being worked up by the Provider Board; and

11.7.3 discharge the other functions set out in its terms of reference, to the extent that they are not set out in this Clause 11.7.

St Helens Cares Stakeholder Reference Forum

11.8 The SRF will comprise Service Users, carers and representatives from other groups and organisations that represent them or that have an interest in the specific area of the St Helens Cares arrangements. The SRF will act in accordance with its terms of reference set out in Schedule 4 (Governance) Part 3 and will provide views and feedback to the Executive Board and the Provider Board in respect of the development of St Helens Cares and proposals to integrate care in respect of the Key Priority Areas developed by the Provider Board. The SRF also has a broader role to consider transformational priorities identified by the Executive Board.

11.9 The Parties will communicate with each other clearly, directly and in a timely manner to ensure that the Parties (and their representatives) present at the Executive Board, the Provider Board and the FCG are able to represent their nominating organisations to enable effective and timely recommendations to be made in relation to the Key Priority Areas.

11.10 Each Party must ensure that its appointed members of the Executive Board, the Provider Board and /or the FCG (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for St Helens basis and in accordance with Clause 5 (*Objectives*) and Clause 6 (*Principles*).

12. CONFLICTS OF INTEREST

12.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Parties agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

© Hill Dickinson LLP 2019

DRAFT

12.2 The Parties will:

12.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the Executive Board, the Provider Board or the FCG immediately upon becoming aware of the conflict of interest whether that conflict concerns the Party or any person employed or retained by them for or in connection with the performance of this Agreement;

12.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Parties) before they participate in any decision in respect of that matter; and

12.2.3 use best endeavours to ensure that their representatives on the Executive Board, Provider Board and/or the FCG also comply with the requirements of this Clause 12 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

13. PAYMENTS

13.1 The Parties will continue to be paid in accordance with the mechanism set out in their respective Services Contracts.

13.2 The Parties have not agreed as at the Commencement Date to share risk or reward in the financial years 2018/19 or 2019/20, however the Parties will work together during the Initial Term to consider the development of risk/reward sharing mechanisms with the aim of achieving the Objectives, and ultimately the Outcomes. Any future introduction of such a mechanism would require additional legally binding provisions to be agreed between the Parties and incorporated into this Agreement in accordance with Clause 17.

SECTION E: GENERAL PROVISIONS

14. EXCLUSION AND TERMINATION

14.1 A Party may be excluded from this Agreement on notice from the Commissioners (acting in consensus) in the event of:

14.1.1 the termination of their Services Contract; or

14.1.2 an event of Insolvency affecting them.

© Hill Dickinson LLP 2019

14.2 A Party may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Parties' representatives.

14.3 A Party may be excluded from this Agreement on written notice from all of the remaining Parties in the event of a material or a persistent breach of the terms of this Agreement by the relevant Party which has not been rectified within 30 days of notification issued by the remaining Parties (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Party.

14.4 The Executive Board may resolve to terminate this Agreement in whole where:

14.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

14.4.2 where the Parties agree for this Agreement to be replaced by a formal legally binding agreement between them.

14.5 Where a Provider is excluded from this Agreement, or withdraws from it, the excluded or withdrawing (as relevant) Party shall procure that all data and other material belonging to any other Party shall be delivered back to the relevant Party or deleted or destroyed (as instructed by the relevant Party) as soon as reasonably practicable.

15. INTRODUCING NEW PROVIDERS

Additional parties may become parties to this Agreement on such terms as the Parties shall jointly agree in writing, acting at all times on a Best for St Helens basis. Any new Party will be required to agree in writing to the terms of this Agreement before admission.

16. LIABILITY

The Parties' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this Agreement.

17. VARIATIONS

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Parties.

18. CONFIDENTIALITY AND FOIA

18.1 Each Party shall keep confidential all Confidential Information that it receives from the other Parties except to extent such Confidential Information is required by Law to be

© Hill Dickinson LLP 2019

DRAFT

disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Party to this Agreement.

18.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Party or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Party may have in respect of such Confidential Information.

18.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 18 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

18.4 Nothing in this Clause 18 (*Confidentiality and FOIA*) will affect any of the Parties' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

18.5 The Parties acknowledge that they are each subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that each Party is able to comply with their statutory obligations.

18.6 Each Party will hold harmless each other and will indemnify and keep indemnified each of the other Parties, in full and on demand, against all Claims (and related costs, charges and reasonable legal expenses) which the other Parties to this Agreement may incur or suffer, arising from any claim at law (including in negligence of any degree or other tort, or collateral contract or otherwise at law) by any of the other Parties for any direct, indirect, incidental or consequential or other loss or damage of whatsoever kind, arising from any breach by such a Party to this Agreement of the obligations under this Clause 18 (*Confidentiality and FOIA*) or otherwise.

19. INTELLECTUAL PROPERTY

19.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Party grants each of the other Parties a fully paid up, non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Party's obligations under this Agreement.

19.2 If any Party creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Party which creates the new Intellectual Property will grant to the other Parties a fully paid up, non-exclusive licence to use the

© Hill Dickinson LLP 2019

new Intellectual Property for the sole purpose of the fulfilment of that Party's obligations and the development and delivery of the arrangements under this Agreement.

20. GENERAL

20.1 Any notice or other communication given to a party under or in connection with this Agreement shall be in writing, addressed to that Party at its principal place of business or such other address as that Party may have specified to the other Party in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1 above; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

20.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Parties, constitute any Party the agent of another Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party except as expressly provided in this Agreement.

20.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Party has executed at least one counterpart.

20.5 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Parties irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

20.6 A person who is not a Party to this Agreement shall not have any rights under or in connection with it.

This Agreement has been entered into on the date stated at the beginning of it.

DRAFT

© Hill Dickinson LLP 2019

DRAFT

Signed by [insert]

for and on behalf of **NHS ST HELENS CLINICAL COMMISSIONING GROUP**

....

[ ]

Signed by [insert]

for and on behalf of **ST HELENS BOROUGH COUNCIL**

....

[ ]

Signed by [insert]

for and on behalf of **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

....

[ ]

Signed by [insert]

for and on behalf of **NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST**

....

[ ]

Signed by [insert]

for and on behalf of **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**

....

[ ]

© Hill Dickinson LLP 2019

SCHEDULE 1

Definitions and Interpretation

1. The following words and phrases have the following meanings:

Agreement	this agreement incorporating the Schedules.
Best for St Helens	best for the achievement of the Objectives and the Outcomes for the St Helens population on the basis of the Principles.
Claims	any claims, actions, demands, fines or proceedings.
Commencement Date	the date entered on page one (1) of this Agreement.
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Party, its intellectual property rights or its business or which a Party has indicated would cause that Party significant commercial disadvantage or material financial loss.
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector by Monitor in accordance with the Health and Social Care Act 2012.
Competition Sensitive Information	Confidential information which is owned, produced and marked as Competition Sensitive Information by one of the Providers and which that Provider properly considers is of such a nature that it cannot be exchanged with the other Providers without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Party, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
Confidential Information	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business

© Hill Dickinson LLP 2019

	methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information.
Dispute	any dispute arising between two or more of the Parties in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 5 for the resolution of disputes which are not capable of resolution under Clause 7 (*Problem Resolution and Escalation*).
Executive Board	the St Helens Cares Executive Board, the terms of reference of which are available from the CCG.
Extended Term	has the meaning set out in Clause 4.2.
Finance & Contracting Group or FCG	the St Helens Cares Finance & Contracting Group, the terms of reference of which are set out in Part 2 of Schedule 4 (*Governance*).
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Services Contracts), as appropriate.
Initial Term	the period from and including the Commencement Date until 31 March 2020.
Insolvency	(as may be applicable to each Party) a Provider taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information

© Hill Dickinson LLP 2019

	and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.
Key Priority Area	one of the key priority areas set out in Schedule 2 (*Key Priority Areas*) as may be amended or added to by agreement of the Parties from time to time.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; c) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; d) Guidance (as defined in the NHS Standard Contract); e) National Standards (as defined in the NHS Standard Contract); and f) any applicable code.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for St Helens Cares set out in Clause 5.1.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Outcomes	the outcomes for St Helens Cares, which are to be further developed during the term of this Agreement in accordance with Schedule 3 (*St Helens Cares Areas for Development*).
People's Board	has the meaning set out in Clause 11.1.1.
Population	the population of St Helens covered by each of the Commissioners.
Principles	the principles for St Helens Cares set out in Clause 6.3.
Provider Board	the St Helens Cares Provider Board, the terms of reference of which are set out in Part 1 of Schedule 4 (*Governance*).
Provider System Lead	the provider system lead, to be STHK during the Initial Term, the role of which is to be developed during the Initial Term in accordance with Schedule 3 (*St Helens Cares Areas for Development*).

© Hill Dickinson LLP 2019

Reserved Matter	has the meaning set out in Clause 8.2.
Section 75 Agreement	the agreement relating to 2019/20 to be entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement.
Service Users	people within the St Helens population served by the Commissioners and who are in receipt of the Services;
Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Services Contract.
Services Contract	a contract entered into by one of the CCG or the Council and a Provider for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires.
Stakeholder Reference Forum or SRF	the St Helens Cares Stakeholder Reference Forum, the terms of reference of which are set out in Part 3 of Schedule 4 (*Governance*).

© Hill Dickinson LLP 2019

SCHEDULE 2

Key Priority Areas

The Parties have identified the initial Key Priority Areas during the Initial Term (as may be agreed and amended from time to time) as:

1. Frailty;
2. Respiratory;
3. Children's Mental Health; and
4. Community Mental Health (Crisis Support).

© Hill Dickinson LLP 2019

SCHEDULE 3

St Helens Cares Areas for Development

1. The Parties will work together, through the governance structures set out in this Agreement to develop proposals for changes to operational pathways and service models of delivery for the Key Priority Areas to include the following areas for development:

(a) Key Priority Areas from the Commencement Date and delivery plans for each;

(b) outline plans (if any) for the addition of new Key Priority Areas over the Initial Term of this Agreement;

(c) the development of the Provider System Lead role for STHK (using the potential areas for development set out in paragraph 4 below as a starting point);

(d) principles and milestones for the development of a detailed Outcomes framework;

(e) principles and milestones for the development of a framework for a potential risk / reward sharing or other financial arrangements between the Parties in respect of the Key Priority Areas and future Key Priority Areas (if any).

2. The Parties have agreed in principle that the St Helens Cares arrangements under this Agreement will develop over the Initial Term to include consideration and development of the potential role of STHK as Provider System Lead.

3. A representative from STHK as Provider System Lead will chair the Provider Board and will administer and coordinate meetings of the Provider Board as set out in the Provider Board terms of reference.

4. The Parties have agreed that the following potential roles could, subject to further development, form part of the STHK's role as Provider System Lead:

   (a) developing new clinical models and pathways with the other Providers (through the Provider Board) in line with the St Helens Cares clinical model (for Commissioner approval);

   (b) managing any cultural divides between Providers effectively to ensure integrated working;

   (c) reporting to the Executive Board on any potential changes required to the St Helens Cares clinical model including where new providers may need to be incorporated into the arrangements.

   (d) performing some contract management activities on behalf of the CCG / Council (to be agreed) which may include:

© Hill Dickinson LLP 2019

- monitoring performance against existing Services Contracts on behalf of the Commissioners;
- coordinating reporting to the Commissioners on the performance of the services under existing Services Contracts.

(e) working with the Commissioners through the FCG to collate and review activity levels between Services and Providers to monitor and report on the impact of the Provider System Lead arrangements; and/or

(f) receiving and distributing payments from the Commissioner on behalf of the Providers in respect of the performance of agreed outcomes.

SCHEDULE 4

Governance

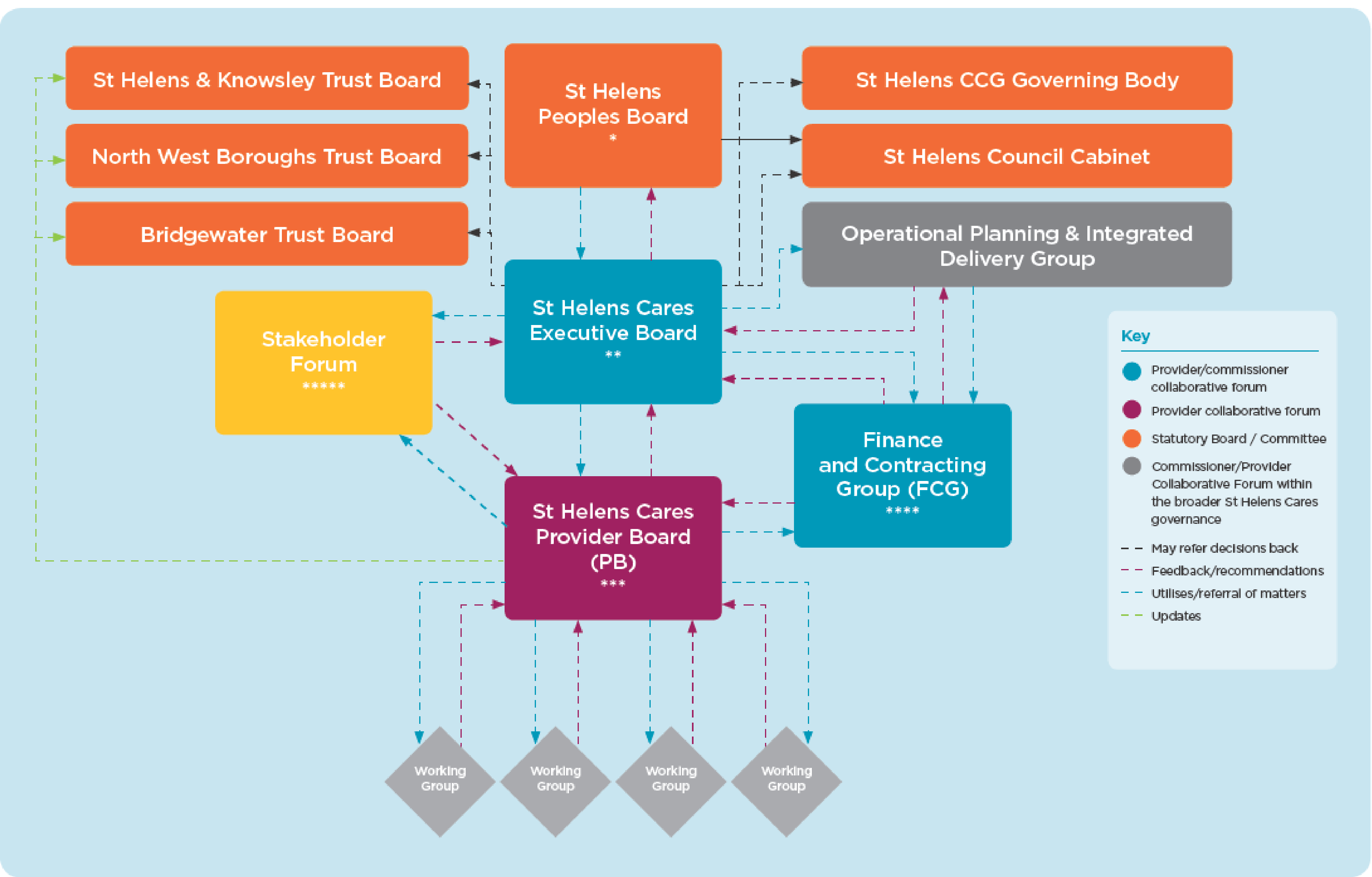
This Schedule 4 sets out the governance arrangements for St Helens Cares under this Agreement.

The diagram below summarises the governance structure which the Parties have agreed to establish and operate from the Commencement Date, to provide oversight of the development and implementation of the St Helens Cares approach and the arrangements under this Agreement.

This Schedule also contains the terms of reference for the St Helens Cares Provider Board, the St Helens Cares Finance & Contracting Group and the St Helens Cares Stakeholder Reference Forum. As at the Commencement Date, the revised St Helens Cares Executive Board terms of reference are in the process of being approved by the People's Board but will be made available by the CCG.

© Hill Dickinson LLP 2019

St Helens Cares Phase 1 - Provider System Lead Arrangements governance structure



© Hill Dickinson LLP 2019

St Helens Cares Provider Board Terms of Reference	
Version	**1.0**
Implementation Date	**1st February 2019**
Review Date	**31st January 2020**
Approved By	
Approval Date	

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**

DRAFT

1. Purpose

The purpose of the St Helens Cares Provider Board ("Provider Board") is to develop the collaborative approach of the provider organisations that are parties to the St Helens Cares Collaboration Agreement with the aim of delivering key objectives of the St Helens People's Board, to improve the health of the St Helens population.

The Provider Board will work within existing contractual frameworks to improve collaboration and the opportunities for integration of services where this will improve the health outcomes for patients and service users.

The priorities and work plan for the Provider Board will be agreed with St Helens Cares Executive Board, based on the strategic direction for the St Helens borough agreed by the St Helens People's Board.

2. Chair

The Provider Board will be chaired by St Helens and Knowsley Teaching Hospitals NHS Trust, as the Provider System Lead.

3. Membership

The Provider Board will include membership from the provider organisations that are party to the St Helens Cares Collaboration Agreement. Where additional provider organisations become parties to the St Helens Cares Collaboration Agreement, they will also become members of the Provider Board and these Terms of Reference will be kept under review accordingly.

The current membership of the Provider Board as at the date of these Terms of Reference is as follows:

(i) NHS Organisations (Community and Secondary Care Services):
   a. St Helens and Knowsley Teaching Hospitals NHS Trust
   b. North West Boroughs Healthcare NHS Foundation Trust
   c. Bridgewater Community Healthcare NHS Foundation Trust

(ii) St Helens Council:
   a. St Helens Council Social Care Services

Together, these are the "member provider organisations."

Each of the member provider organisations will be represented by up to three designated officers (in addition to the Chair and administrative support in the case of St Helens and Knowsley Teaching Hospitals NHS Trust) who may attend each Provider Board meeting.

The Director of Integration for St Helens Cares will also be a member of the Provider Board.

Organisations may nominate their designated officers as they wish, taking into account that:

- All organisations should aim for consistency of their nominated attendees at meetings (although the attendance of fully briefed deputies is permitted); and

DRAFT

- Designated officers (or their fully briefed deputies) will be expected to attend a minimum of 4 meetings per year.

One representative from each of the following organisations shall also be in attendance at Provider Board meetings:

- St Helens Primary Care Networks
- TORUS Housing

One representative from the Voluntary/Third Sector organisations in St Helens shall also be in attendance at Provider Board meetings.

Other attendees (including but not limited to commissioners) may be requested to attend, observe and/or participate in discussions at Provider Board meetings, as agreed between the member provider organisations from time to time.

4. Quorum

A quorum will be at least 1 representative from each of the member provider organisations (excluding the Chair and administrative support in the case of St Helens and Knowsley Teaching Hospitals NHS Trust).

5. Functions

The Provider Board is not a decision making body, although it will be instrumental in developing proposals and recommendations by consensus which shall be presented to the St Helens Cares Executive Board from time to time.

As a forum for promoting and supporting effective collaborative working between providers and service integration across the individual organisational contracts where this will improve service quality, outcomes or efficiencies, the functions of the Provider Board are to (by consensus):

- Develop proposals for changes to the delivery of health and care services in St Helens for the key priority areas identified by the St Helens Cares Executive Board that will improve quality, outcomes and/ or sustainability of health services in the borough;

- Establish and agree the remit of working groups (which may be time limited) to review key priority areas agreed by the St Helens Cares Executive Board and/or to produce specific improvement proposals;[1]

- Review and sense check any proposals made by a working group established by the Provider Board, to enable presentation of a collective provider view by the Provider Board to the St Helens Cares Executive Board and, as appropriate, to commissioners for decisions on service change;

[1]The initial key priority areas for 2018/19 / 2019/20 been agreed as: Frailty; Respiratory; Children's Mental Health; and Community Mental Health (Crisis Support).

DRAFT

- Oversee the implementation of any service changes within the borough in respect of the key priority areas identified by the St Helens Cares Executive Board and provide feedback and reports on progress, impact and evaluation to the St Helens Cares Executive Board and, as appropriate, for onward communication to individual organisations' Boards;

- Develop proposals for system wide outcome measures and mechanises for reporting collectively on the performance of providers working in the St Helens Cares system;

- To identify and evaluate risk in relation to the NHS providers operating within St Helens Cares and for any proposed pathway changes in respect of the key priority areas identified by the St Helens Cares Executive Board; and

- Develop collective mitigation plans to manage risks identified

.

The Provider Board may establish working groups to support its agreed functions; these can include co-opting members from other organisations/stakeholders and other external bodies in an advisory role.

The Provider Board will consult and seek the views of the St Helens Cares Stakeholder Reference Forum to inform its proposals to the St Helens Cares Executive Board.

The Provider Board may consult and seek the views of the St Helens Cares Finance and Contracting Group as it sees fit in relation to financial and contractual implications of proposals and recommendations under discussion by the Provider Board.

6. Authority/Reporting

The Provider Board is established by the member provider organisations, each of which remains a sovereign organisation, to enable the further development of collaborative working between those organisations and to achieve the objectives of the St Helens Cares Peoples Board to improve the health of the population in the St Helens Borough.

The Provider Board is not a separate legal entity, and as such is unable to take decisions separately from its constituent members or bind any one of them; nor can one provider organisation 'overrule' the other on any matter.

The Provider Board will operate as a place for discussion of issues with the aim of reaching consensus to make recommendations and proposals to the St Helens Cares Executive Board, in with the ultimate aim of development of a system lead approach for St Helens.

To that end:

- a report from the Provider Board will be a standing item on every meeting agenda for the Executive Board; and

- In addition, each of the member provider organisations will ensure that their designated officer:

  - Is appointed to attend and represent their organisation on the Provider Board with such authority as is agreed to be necessary in order for the Provider Board to

DRAFT

function effectively in discharging its responsibilities as set out in these terms of reference which is, to the extent necessary, recognised in an organisation’s respective scheme of delegation (or similar);

- Has equivalent delegated authority to the designated officers of all other member provider organisations comprising the Provider Board; and

- Understand the status of the Provider Board and the limits of their responsibilities and authority.

Where necessary, proposals and recommendations presented to the Executive Board by the Provider Board may subsequently be presented to individual organisations for proposals/decisions to be taken and/or implemented.

7. Frequency of Meetings

The Provider Board will meet at least 6 times a year and a schedule of dates for the following 12 months will be agreed between and disseminated amongst the member provider organisations at the beginning of each financial year.

Meetings may be held by telephone or video conference. Members may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference.

The Chair may call extraordinary meetings of the Provider Board at his or her discretion, subject to providing at least 5 working days’ notice to Provider Board members**.**

8. Administration

The Provider Board will be administered by St Helens and Knowsley Teaching Hospitals NHS Trust.

The annual work plan and meeting agendas will be approved by the Chair.

Agenda items and supporting papers must be notified 7 working days in advance of each meeting to the Chair. All member provider organisations may suggest agenda items. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair.

Agendas and supporting papers will be circulated at least 3 working days before each meeting of the Provider Board.

The meetings can consider items of any other business at the discretion of the Chair however papers should not normally be tabled.

Draft minutes of meetings will be sent to members of the Provider Board within 14 days of each meeting. Approval of the minutes of the previous meeting of the Provider Board will be a specific item on each meeting agenda. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Minutes shall be circulated to the Executive Board and otherwise in accordance with members’ wishes.

DRAFT

9. Review

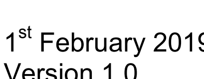
The terms of reference and effectiveness of the Provider Board will be reviewed by the Executive Board annually or more frequently if required.

10. Conduct

All members are required to notify the Chair of any actual, potential or perceived conflict of interest in advance of the meeting to enable appropriate management arrangements to be put in place. All members are required to uphold the Nolan Principles and all other relevant NHS or St Helens Council Code of Conduct requirements which are applicable to them.

It is expected that members act in the spirit of co-production and collaboration in line with the key principles and ethos of St Helens Cares.

DRAFT



St Helens Cares Finance and Contracting Group Terms of Reference	
Version	**1.0**
Implementation Date	**1st February 2019**
Review Date	**31st January 2020**
Approved By	**St Helens Cares Executive Board**
Approval Date	

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**

DRAFT

1. Purpose

The purpose of the Finance & Contracting Group (FCG) is to assist the St Helens Cares Executive Board to achieve the objectives of the St Helens People's Board to improve the health of the St Helens population in a sustainable manner. The FCG will provide such support through exploring the financial, contractual and activity related elements of existing and potential future models of care across the St Helens Borough footprint. The FCG shall use the expertise of its members to identify opportunities for improvements and greater collaboration to enable integration of services where this will improve the health outcomes for patients and service users and support the challenge of managing cost and demand.

2. Chair

The FCG will be chaired by the Chief Finance Officer of St Helens CCG.

3. Membership

The FCG will include membership from:

- CFO - St Helens CCG (Chair)
- Director of Finance - St Helens & Knowsley Teaching Hospitals NHS Trust
- Director of Finance - North West Boroughs Healthcare NHS Foundation Trust
- Director of Finance - Bridgewater Community Healthcare NHS Foundation Trust
- Senior Finance Officer - St Helens Council (Vice Chair)
- Director of Integration – St Helens Cares

Members can nominate a deputy with appropriate authority as necessary.

In addition, the following individuals have a standing invitation at all FCG meetings:

- Deputy CFO - St Helens CCG
- Deputy Director of Finance - St Helens & Knowsley Teaching Hospitals NHS Trust
- Deputy Director of Finance - North West Boroughs Healthcare NHS Foundation Trust
- Deputy Director of Finance - Bridgewater Community Healthcare NHS Foundation Trust
- Financial Representative of St Helens MBC - Integrated Peoples Service

Other attendees (including but not limited to commissioners, such as the Assistant Director of Contracting & Procurement at St Helens CCG) may be requested to attend, observe and/or participate in discussions at FCG meetings, as agreed by the FCG from time to time and in line with agenda items to be discussed.

4. Quorum

A quorum will be at least 4 members of the FCG.

5. Functions

The FCG is not a decision making body, although it will be instrumental in developing proposals and recommendations by consensus which shall be presented to the Executive Board from time to time.

DRAFT

As a forum for promoting and supporting effective collaborative working between providers and service integration where this will improve service quality, outcomes or efficiencies, the functions of the FCG are to (by consensus) provide advice and recommendations to the St Helens Cares Executive Board:

- With respect to the development of future integrated models of care and the associated financial and contracting aspects of such models;

- As to how any proposed Integrated Care Provider (ICP)[1] Contract could underpin integration between services, with reference to the differences from existing NHS contracts and how any ICP would fit into the broader commissioning system;

- To identify and evaluate financial risk in relation to the NHS providers operating within St Helens Cares and for the proposed pathway changes, including any mechanisms for distributing risk share financial gains that may be available and recommendations as to collective mitigation plans to manage risks identified that may be available;

- Develop and provide financial modelling information at the request of the Operational Planning & Integrated Delivery Group in relation to the broader St Helens Cares transformational priorities set by the St Helens Cares Executive Board.

The FCG may also advise and make recommendations to the Provider Board upon the Provider Board's request in relation to financial and contractual implications of proposals and recommendations under discussion by the Provider Board, before the Provider Board puts any such proposals or recommendations to the Executive Board.

6. Authority/Reporting

The FCG is established by its member organisations, each of which remains a sovereign organisation, to enable the further development of collaborative working between those organisations and to achieve the objectives of the St Helens Cares People's Board.

The FCG is not a separate legal entity, and as such is unable to take decisions separately from its constituent members or bind any one of them; nor can one member of the FCG 'overrule' the other on any matter.

The FCG will operate as a place for discussion of financial issues with the aim of reaching consensus on recommendations and proposals to the St Helens Cares Executive Board, in line with the functions as outlined in section 5 above.
To that end, a report from the FCG will be a standing item on every meeting agenda for the Executive Board (and, where necessary, proposals and recommendations presented to the Executive Board by the FCG may subsequently be presented to individual organisations for proposals/decisions to be taken and/or implemented).

[1] NHS England has defined an ICP as '…a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services, which enters into an ICP contract with the commissioner(s) of those services. The ICP (which is sometimes referred to as a multispecialty provider or integrated services provider in different parts of the country) would be a 'lead' provider organisation, and so would be contractually responsible for delivering integrated services for local people.'

7. Frequency of Meetings

The FCG shall meet on a monthly basis.

Meetings may be held by telephone or video conference. Members may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference.

The Chair may call extraordinary meetings of the FCG at his or her discretion, subject to providing at least 10 working days' notice to FCG members.

The Chair must call an extraordinary meeting of the FCG upon written request from at least two member organisations within no more than 15 working days and no less than 10 working days' notice to FCG members.

8. Administration

The FCG will be administered by an appropriate Secretary from St Helens CCG.

Agenda items and supporting papers must be notified 7 working days in advance of each meeting to the Chair. All members may suggest agenda items. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair.

Agendas and reports shall be distributed to members 5 working days in advance of each meeting date.

The meetings can consider items of any other business at the discretion of the Chair however papers should not normally be tabled.

Draft minutes of meetings will be sent to members of the FCG within 14 days of each meeting. Approval of the minutes of the previous meeting of the FCG will be a specific item on each meeting agenda. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. A Key Issues Report will be provided to the St Helens Cares Executive Board. Minutes shall be made available to the Executive Board and otherwise in accordance with members' wishes.

9. Review

The terms of reference and effectiveness of the FCG will be reviewed by the Executive Board annually or more frequently if required.

10. Conduct

All members are required to notify the FCG Chair of any actual, potential or perceived conflict of interest in advance of the meeting; to enable appropriate management arrangements to be put in place. All members are required to uphold the Nolan Principles and all other relevant NHS or St Helens Council Code of Conduct requirements which are applicable to them.

It is expected that members act in the spirit of co-production and collaboration in line with the key principles and ethos of St Helens Cares.

DRAFT

St Helens Cares Stakeholder Reference Forum Terms of Reference	
Version	**1.0**
Implementation Date	**1st February 2019**
Review Date	**31st January 2020**
Approved By	
Approval Date	

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**

DRAFT

1. Purpose

We are changing the way that healthcare and social care services are organised in St Helens. Moving forward, clinicians, managers and planners will work together and will engage with patients/service users, the public and staff to develop plans for a better healthcare and social care system for St Helens' residents.

We aim to ensure that this local system of care will be organised in the most effective way to provide safe, effective, person centred and sustainable care to meet the current and future needs of our population. This will also support the vision of the St Helens People's Board which is *improving people's lives together, by tackling the challenge of cost and demand*.

The local care system, St Helens Cares, will be developed through locality working. This will see a core team of multidisciplinary health care and social care clinical and managerial staff from across St Helens working collaboratively. They will work in partnership with our local hospital providers, the ambulance service, local police and fire services, community and voluntary services, the local housing trust and education providers. They will engage with the full range of people[1] in an open, transparent and accessible way and use their feedback to support the implementation of the transformational St Helens Cares Clinical & Support Strategy.

The Stakeholder Reference Forum (SRF) is established to build and sustain meaningful engagement with people across all communities within St Helens, enabling them to have a voice in improving their health and in shaping services as part of St Helens Cares. As such, the SRF will play a key role in providing feedback to the St Helens Cares Provider Board and the St Helens Cares Executive Board, as well as other governance groups within St Helens Cares, on proposals for service change.

This Forum will be made up of patients, service users and carers, and representatives from groups and organisations that represent them or that have an interest in this area. They will offer their perspectives on how St Helens Cares can inform and engage with people on its programmes of work.

We firmly believe that to be properly engaged, people must feel included and valued. Our Stakeholder Reference Forum will promote a culture where inclusiveness is our baseline not an initiative. We will be diverse in age, gender identity, race, sexual orientation, physical or mental ability, ethnicity, and perspective and we will create an environment where everyone, from any background, can participate fully in our work.

To this end, the aims of this Forum will be to:

- Act as a sounding board for testing early plans, and information materials;
- Share insights to influence / inform areas requiring redesign;
- Offer perspectives on how individual work programmes can engage more widely with people;
- Advise on the development of information for wider public use; and
- Strengthen and play a significant role in wider public communication.

[1] The word "people" should be interpreted to refer to healthcare and social care service users, patients, staff, members of the public, carers, volunteers, and the voluntary organisations which represent them.

DRAFT

For the avoidance of doubt, this Forum does not supersede any individual organisation's legal duties to undertake public and patient involvement as may be required, although it can be used as one option to discharge and support such involvement duties as appropriate.

2. Chair

The SRF will be chaired by the St Helens CCG Governing Body Lay Member with responsibility for Patient & Public Involvement.

3. Membership

Participation in the SRF is completely voluntary. Members can decide to leave at any time. It is envisaged that there will be core members and those whose attendance will vary, dependent on the subject under discussion by the SRF.

Core Members:

Mark Weights	NHS St Helens CCG Governing Body Lay Member for Patient and Public Involvement
Councillor Representative	St Helens Council, St Helens Cares portfolio lead
Representative	Halton & St Helens Council for Voluntary Services
Provider representative	Voluntary Services
Representative x 4	Locality Patient Practice Groups (PPGs)
Representative	Torus Housing Residents Forum
Jayne Parkinson-Loftus	Healthwatch
Representative	Carers Forum
Representative	Faith Forum
Representative	St Helens Borough Council Public Health Department
Paul Steele (Facilitator)	NHS St Helens CCG Engagement & Involvement Lead

Other Members to be invited to join the SRF (as required – to be determined by SRF Chair):

These may include: officers, representatives from provider organisations or patient groups who may be co-opted onto the SRF dependent on the work programmes under scrutiny at any time.

All members are expected to comply with the Code of Conduct for SRF Members at all times. The Chair may, in his or her absolute discretion, remove a member from the SRF if the Chair reasonably considers that SRF member has failed to do so without good cause.

4. Functions

Individual Teams leading specific transformational work programmes as part of St Helens Cares will engage with the SRF and will ensure that:

- Information is provided in advance of meetings;
- Information provided is clear and accessible;
- The venues chosen for meetings are fully accessible;
- The teams encourage open discussion on matters arising;

DRAFT

- The teams listen to and respond to points raised by SRF members – and if that is not possible at the meeting, it is answered as soon as possible thereafter;
- Meetings run to the agreed timings; and
- Individual support and assistance is provided as requested.

In response, through the SRF, members are asked to contribute to the work and development of St Helens Cares by providing feedback and comments in light of their individual personal qualities, experience and insight.

In doing so, members are asked to:

- Use their experience and knowledge to offer thoughts and ideas;
- Actively contribute to discussion whilst always respecting the contribution of others;
- Be courteous to each other at all times and allow each other to speak;
- Prepare for and attend meetings and keep to agreed timings; and
- Comply with the Code of Conduct for SRF Members appended to these Terms of Reference.

5. Authority/Reporting

The work of the SRF will be shared with the St Helens Cares Executive Board[2] through a report prepared following each SRF meeting to the Executive Board.

The Executive Board will report periodically on the work of the SRF to the People's Board, St Helens Clinical Commissioning Group Governing Body or St Helens Borough Council Cabinet, as the Executive Board deems appropriate.

6. Frequency of meetings

Meetings of the SRF will be held every six weeks. A schedule of meeting dates for the SRF for the following 12 months will be prepared by the Chair and disseminated amongst all members at the beginning of each financial year.

The Chair may call extraordinary meetings of the SRF at his or her discretion, subject to providing at least 10 working days' notice to SRF members**.**

In addition, further public and patient involvement and engagement events may take place across St Helens as the commissioners and providers in St Helens decide are necessary and appropriate. Such events will be publicised by those organisations individually, including, where possible, notifying SRF members through the SRF Chair.

7. Administration

The SRF will be administered by the St Helens CCG Engagement Lead.

[2] The St Helens Cares Executive Board is the group responsible for ensuring effective arrangements are in place to secure public involvement in the planning, development and consideration of proposals for changes to health and care services

DRAFT

Notes of meetings and reports produced by the SRF shall be made available via the St Helens Cares website. [3]

8. Review

The terms of reference and effectiveness of the SRF will be reviewed by the Executive Board annually or more frequently if required.

9. Conduct

In addition to the obligation to comply with the Code of Conduct for SRF Members, all members of the SRF are required to notify the Chair of any actual, potential or perceived conflict of interest in advance of the meeting to enable appropriate management arrangements to be put in place. All members are required to uphold the Nolan Principles and all other relevant NHS or St Helens Council Code of Conduct requirements which are applicable to them.

It is expected that members act in the spirit of co-production and collaboration in line with the key principles and ethos of St Helens Cares.

DRAFT

[3] This website will host a virtual discussion forum for SRF members and other invited guests to enable on-going discussion on specific topics to enhance the quality of the formal meetings.

Additional Information and Code of Conduct for SRF Members

The aim of this activity is to bring a patient, service user, carer focus or public perspective to the St Helens Cares (SHC) public engagement process.

Who can attend the SRF Meetings?
Patient and service user representatives, carers and representatives from groups and organisations that represent them have been invited to participate in this discreet group. Participation is by invite only; however to ensure a transparent process details, information and a note of each meeting will be made available. We will also invite extensive participation at future public events and provide other means and opportunities for people to provide feedback.

What does the SRF do?
The function of the SRF is to assist and advise those working on St Helens Cares Programmes with how it informs and engages with people. The SRF will use their collective experience and knowledge to develop approaches that support the SHC Teams in wider public engagement. The SRF will act as a means for wider communication and with prior permission some participant's details might be used in public facing information materials.

Why would you participate on the SRF?
As a representative of patients, service users and carers, or someone from a group or organisation that represents them, you have insight into the questions and concerns other people might have and can pose these on their behalf. You can use this insight to help shape the early ideas around planning future service delivery and how the SHC work programmes present information and communicates these plans with the wider public.

DRAFT

Stakeholder Reference Forum

Code of Conduct

The SRF operates under the principle of mutual respect and all participants agree to:

- be open warm and friendly; and
- have a non-judgmental attitude.

In order to make best use of people's time and expertise, we ask that all those attending agree to:

- give apologies ahead of time if unable to attend or take part;
- study information sent in good time before meetings and be prepared to contribute to discussions and other work during the meeting;
- respect the authority of the chair or staff member leading the meeting;
- maintain focus and relevance to matters being discussed during meetings;
- be mindful of the time available in meetings, and use the opportunity to contribute by raising issues with the chair, facilitator or SHC Team between meetings;
- engage in debate and decision-making in meetings according to any agreed procedure, maintaining a respectful attitude for the opinion and of others;
- maintain confidentiality about any meetings held in private;

You should only act as a SRF representative with the prior knowledge and approval of the Chair or programme team. This applies to discussions in a public forum, private or informal discussion or discussions conducted using social media.

We ask that representatives from groups or organisations remain mindful of them, but to also positively contribute to meetings as an individual member of the SRF as past, current or future user of the healthcare and social care services we provide.

Those found to be in breach of the SRF code of conduct will be asked not to participate in the SRF.

DRAFT

SCHEDULE 5

Dispute Resolution Procedure

1. Avoiding and Solving Disputes

1.1 The Parties commit to working cooperatively to identify and resolve issues to the Parties' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Parties will look to collaborate and resolve differences under Clause 7 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Parties believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the St Helens Cares arrangements set out in this Agreement.

1.3 The Parties shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of St Helens Cares (each a '**Dispute**') when it arises.

1.4 In the first instance the relevant Parties' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Parties. If the Dispute cannot be resolved by the relevant Parties' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Parties, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for St Helens basis in accordance with this Agreement so as to seek to reach a unanimous decision.

1.5 The Parties agree that the senior officers may, on a Best for St Helens basis, determine whatever action it believes is necessary including the following:

1.5.1 If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and

1.5.2 The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;

© Hill Dickinson LLP 2019

(iii) regulate his or her own procedure;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Parties in Dispute equally.

1.5.3 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 5 and only after such further consideration again fails to resolve the Dispute, the Parties may agree to:

(i) terminate this Agreement in accordance with Clause 14.1.1; or

(ii) agree that the Dispute need not be resolved.

Appendix 2

ST HELENS CARES EXECUTIVE BOARD Terms of Reference	
Version	**3.0**
Implementation Date	**1st February 2019**
Review Date	**31st January 2020**
Approved By	**The People's Board**
Approval Date	

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**
07.01.19	**3**	Membership updated to increase provider representation and integrated director role.	
	5	Function to include provider system lead arrangements	
	6	Authority/reporting to include reports from sub groups Clarity on level of authority	
	9	Added role of People's Board in approving any changes to ToR	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**
	ToRs to be re-drafted to align with Provider system lead arrangements	SHC Executive Board

1. Purpose

St Helens People's Board provides the overall strategic direction in accordance with its remit set out under section 195 of the Health & Social Care Act 2012 to encourage those who arrange for the provision of health or social care services to work in an integrated way. The People's Board has delegated the function of overseeing the local care system to this multi-agency group, established as the St Helens Cares Executive Board.

The purpose of the St Helens Cares (SHC) Executive Board is to provide strategic oversight and management of the St Helens Cares model of delivery to achieve the objectives of the St Helens People's Board to improve the health and wellbeing of the St Helens population. This supports the vision for St Helens which is *improving people's lives together, by tackling the challenge of cost and demand.*

The SHC Executive Board will work within existing contractual frameworks to transform the way in which health and care services are delivered and services are integrated.

The priorities and work plan for the SHC Executive Board will be based on the strategic direction for the St Helens borough agreed by the St Helens People's Board.

2. Chair

The SHC Executive Board will be chaired by Joint LA/CCG Executive post, the Strategic Director of People's Services/ Clinical Accountable Officer.

3. Membership

The SHC Executive Board will include executive members from the Local Authority, CCG, secondary and primary care providers, and a nominated representative from the People's Board.

The current membership of the SHC Executive Board is as follows:

Position	Nominated Representative	Organisation	Status
Strategic Director People's Services/Clinical Accountable Officer	Sarah O'Brien	St Helens Council & NHS St Helens Clinical Commissioning Group	Member / Chair
Deputy Strategic Director People's Services / Deputy Accountable Officer CCG	Rachel Cleal	St Helens Council & NHS St Helens Clinical Commissioning Group	Member
Two Executives from the main NHS Providers in the Borough (one of which to be the Chair Provider Board)	Ann Marr (Chair Provider Board)	St Helens and Knowsley Teaching Hospitals NHS Trust	Member
	tbc	North West Boroughs NHS Foundation Trust	Member
Representative of a Primary Care Provider operating in the Borough selected by agreement of the GP networks	tbc		Member
Member nominated by the St Helens People's Board	Gillian Healy	Torus Group	Member
Senior Finance Officer from	Cath Fogarty	St Helens Council	Member

the CCG or Council *			
Director of Integration, St Helens Cares	Wayne Longshaw	St Helens and Knowsley Teaching Hospitals NHS Trust	In attendance
Representative of SHC Communications & Engagement	Angela Delea	NHS St Helens Clinical Commissioning Group	In attendance

* this position will also represent the views of the SHC Finance & Contracting Group

Other attendees may be requested to attend, observe and/or participate in discussions at SHC Executive Board meetings, as agreed by the members, from time to time.

4. Quorum

A quorum will be at least 50% of the membership and the chair. This excludes those in attendance and administrative support.

5. Functions

The SHC Executive Board is not a decision making body, although it will be instrumental in developing proposals and recommendations by consensus which shall be presented to the statutory boards of the partner organisations.

The SHC Executive Board will be responsible for:

- Identifying the transformational priorities for St Helens Cares
- Development of an integrated local care system
- Overseeing delivery of agreed schemes and priorities
- Establishment of provider system lead arrangements, including determining services to be included in such arrangements
- Design and implementation of effective governance arrangements for St Helens Cares
- Developing the system leadership capacity and capability of the St Helens Cares workforce
- Developing proposals for system wide outcome measures and mechanisms for reporting collectively on the performance of providers working in the St Helens Cares system;
- Evaluating risk in relation to system change proposals for St Helens Cares and ensuring mitigation plans are robust.

The SHC Executive Board will establish sub groups to support its agreed functions; this can include co-opting members from other organisations/stakeholders and other external bodies in an advisory role. The SHC Executive Board will receive and consider recommendations and proposals from the St Helens Cares Provider Board in the course of fulfilling its functions.

The SHC Executive Board may seek the views of the St Helens Cares Stakeholder Reference Forum to inform its proposals.

The SHC Executive Board will seek the views of the St Helens Cares Finance and Contracting Group in relation to financial and contractual implications of proposals and recommendations under discussion.

6. Authority/Reporting

The SHC Executive Board is established by the People's Board to achieve the objective of the St Helens People's Board to develop a sustainable Health and Social Care system.

The SHC Executive Board is not a separate legal entity, and as such is unable to take decisions separately from its constituent members or bind any one of them; nor can one organisation 'overrule' the other on any matter.

The SHC Executive Board will operate as a place for discussion of issues with the aim of reaching consensus to make recommendations and proposals to the statutory Boards of partner organisations and to the People's Board, with the ultimate aim of developing an integrated local care system for St Helens.

The SHC Executive Board will have following sub groups:

- The Provider Board
- The Finance & Contracting Group
- Operational Planning and Integrated Delivery Group
- Stakeholder Reference Forum

A report from each of the above sub groups will be a standing item on every meeting agenda for the SHC Executive Board.

Each of the member organisations of the SHC Executive Board will ensure that their designated officer:

- Is appointed to attend and represent their organisation on the SHC Executive Board with such authority as is agreed to be necessary in order for the SHC Executive Board to function effectively in discharging its responsibilities as set out in these terms of reference which is, to the extent necessary, recognised in an organisation's respective scheme of delegation (or similar);
- Has equivalent delegated authority to the designated officers of all other member organisations comprising the SHC Executive Board (as confirmed in writing and agreed between the member organisations); and
- Understand the status of the SHC Executive Board and the limits of their responsibilities and authority.

The SHC Executive Board will provide regular reports to the People's Board.

The SHC Executive Board will keep the Cheshire & Mersey Health and Care Partnership informed of developments of the local care system

7. Frequency of Meetings

The SHC Executive Board will meet at least 6 times a year and a schedule of dates for the following 12 months will be agreed between and disseminated at the beginning of each financial year.

Meetings may be held by telephone or video conference. Members may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference.

The Chair may call extraordinary meetings of the SHC Executive Board at his or her discretion, subject to providing at least 5 working days' notice to members**.**

8. Administration

The SHC Executive Board will be administered by St Helens Cares Integrated PMO.

The annual work plan and meeting agendas will be approved by the Chair.

Agenda items and supporting papers must be notified 7 working days in advance of each meeting to the Chair. All members may suggest agenda items. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair.

Agendas and supporting papers will be circulated at least 3 working days before each meeting of the SHC Executive Board.

The meetings can consider items of any other business at the discretion of the Chair however papers should not normally be tabled.

Draft minutes of meetings will be sent to members of the SHC Executive Board within 14 days of each meeting. Approval of the minutes of the previous meeting of the SHC Executive Board will be a specific item on each meeting agenda. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Minutes will be made available to each of the partners' boards on request.

All members of the SHC Executive Board are responsible for reporting on key issues from the meetings and communicating decisions within their respective organisations.

9. Review

The terms of reference and effectiveness of the SHC Executive Board will be reviewed by the St Helens Cares People's Board annually or more frequently if required.

10. Conduct

All members are required to notify the Chair of any actual, potential or perceived conflict of interest in advance of the meeting to enable appropriate management arrangements to be put in place. All members are required to uphold the Nolan Principles and all other relevant NHS or St Helens Council Code of Conduct requirements which are applicable to them.

It is expected that members act in the spirit of co-production and collaboration in line with the key principles and ethos of St Helens Cares.