St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 31ST MARCH 2021
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
09:30	1.	Employee of the Month - December 2020 - January 2021 - February 2021 - March 2021		Verbal	Assurance	Chair
09:50	2.	Patient Story		Verbal	Assurance	
10:10	3.	Apologies for Absence		Verbal	Assurance	
	4.	Declaration of Interests		Verbal	Assurance	
	5.	Minutes of the Previous Meeting held on 24th February 2021		Attached	Assurance	
		5.1	Correct Record & Matters Arising	Verbal		
		5.2	Action Log	Attached		
Performance Reports						
10:30	6.	Integrated Performance Report		NHST(21) 007	Assurance	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
BREAK						
Committee Assurance Reports						
10:50	7.	Committee Report – Executive		NHST(21) 008	Assurance	Ann Marr OBE
11:00	8.	Committee Report – Quality		NHST(21) 009	Assurance	Gill Brown
11:10	9.	Committee Report – Finance & Performance		NHST(21) 010	Assurance	Jeff Kozer
Other Board Reports						
11:20	10.	Trust Objectives 2021/22		NHST(21) 011	Decision	Ann Marr OBE

AGENDA			Paper	Purpose	Presenter
11:40	11.	CQC Registration Annual Declaration	NHST(21) 012	Assurance	Sue Redfern
11:45	12.	Mixed Sex Accommodation Annual Declaration	NHST(21) 013	Assurance	Sue Redfern
11:50	13.	2020 Staff Survey Report & Action Plan	NHST(21) 014	Assurance	Anne-Marie Stretch
12:10	14.	St Helens Cares – Memorandum of Understanding for the development of an Integrated Care Place	NHST(21) 015	Decision	Nicola Bunce
Closing Business					
12:25	15.	Effectiveness of Meeting	Verbal	Assurance	Chair
	16.	Any Other Business			
	17.	Date of Next Meeting – Wednesday 28th April 2021			

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board Briefing held on Wednesday 24th February 2021 in the Boardroom, Whiston Hospital and via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs L Knight	(LK)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mr N Khashu	(NK)	Director of Finance
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
In Attendance:	Ms S Amesu	(SA)	Insight NED Development Programme Placement *(Observer)*
	Mr B Kirton	(BK)	Chief Operating Officer, Barnsley Hospital NHS Foundation Trust *(Observer)*
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
Apologies:	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Prof R Pritchard-Jones	(RPJ)	Medical Director

1. Welcome and Introductions

1.1. RF welcomed BK, who was observing the meeting as part of his participation on the Aspiring CEO Programme.

2. Apologies for Absence

2.1. Apologies were noted as above.

3. Declaration of Interests

There were no new declarations of interest.

4. Minutes of the previous meeting held on 27th January 2021

4.1. Correct Record

4.1.1. The minutes were approved as a correct record once minute 4.5 was amended to read “and now had to be delivered *within* 12 weeks …”

4.1.2. Referring to the 'difficult decisions about care' mentioned in minute 11.1, RPJ confirmed the ethical principles were currently being discussed with other Medical Directors across Cheshire & Merseyside. RF confirmed it had also been raised at the regional Chairs' meeting.

4.2. **Action List**

There were no outstanding items on the Action Log.

5. Chief Executive's Briefing – NHST(21)001

5.1. AM presented the briefing.

5.2. COVID-19 update - the date of peak COVID bed occupancy at the Trust was on 27th January with 294 positive inpatients, representing 37% occupancy of the Trust's general and acute beds. This compared to a peak of circa 140 patients in the first wave. The highest number of critical care patients was 24 (against a baseline bed capacity of 14). In addition, several patients were transferred to other neighbouring critical care units, as part of the Cheshire & Merseyside mutual aid arrangements. The current position was that numbers had reduced to 135 positive inpatients, 6 of whom required critical care. Community prevalence of COVID remained relatively high in the surrounding area and the Trust was still admitting newly diagnosed patients each day. In order to staff the COVID cohort wards and critical care, elective activity had been suspended so that staff could be re-deployed to support the expansion of these areas.

5.3. The impact of the prolonged and extreme period of intense pressure on staff was evident and there was a tension between allowing staff some respite and moving quickly into restoration and recovery.

5.4. Restoration of elective activity – there are now very large numbers of patients whose diagnosis and treatment had been delayed as a result of the pandemic, when elective activities were suspended, and the challenge now was for trusts and systems to restore and recover this activity as quickly as possible. The proposal from the centre was that there should be system-wide ownership of recovery, to maximise the opportunity for prioritisation, transformation, mutual aid, and to reduce inequality of access. This would be managed through the Hospital Cell, whilst the Trust would take every opportunity to restore elective activity as quickly as possible.

5.5. The Trust was already working on its plans for recovery and the Hospital Cell was considering options to continue to utilise the private sector and possibly suspend 'Choose and Book'. The executive team was reviewing options to bring forward investment in additional theatre capacity to manage both the known elective backlog, the unknown backlog from reduced referrals and to assist with mutual aid across the C&M for the foreseeable future. Board members supported this concept in principle.

5.6. RC commented that it made sense to use the private sector for high-volume work, such as skin cancer, which would free hospital theatres for more complex procedures.

5.7. Vaccination programme - the initial target of the national mass vaccination programme to deliver a first dose to all people in cohorts 1-4 had been achieved. The Trust had now vaccinated 80% of frontline staff at the hospital hub and was planning to start delivery of 2nd doses in early March. Nationally the issue of whether COVID vaccination could be made mandatory for health and care staff was being considered.

5.8. Work was underway locally to encourage the remaining staff to have the vaccination, based on support and information.

5.9. NK asked if the vaccine take up amongst BAME staff was different and AMS confirmed the take up in this group was currently 73%. Promotional material was being produced to encourage the remaining BAME staff to have the vaccination.

5.10. SA asked to what extent the Trust was drilling down and understanding/ tailoring the message to the discreetly different BAME groups. AMS confirmed bespoke training, educating, and listening had been introduced and the use of role models was being considered. However, a fine balance had to be maintained to support individuals as the vaccination had not yet been mandated for staff.

5.11. Considering recent media attention, GB queried there would be sufficient supply to provide staff with their 2nd dose. AM had been assured enough vaccine had been put aside to ensure all staff could receive their 2nd dose.

5.12. The Mass Vaccination Site (MVS) at the Saints Rugby ground was currently operating under optimum capacity due to restrictions on the vaccine supply chain. SA noted the Government was providing assurances that vaccinations would be available to all members of the public by the end of July and she wondered if that assurance was misleading, given the current supply problems. AM acknowledged it would be a challenging target to achieve, for several reasons, eg delays in vaccine supply, limitations of the booking system, and cohort restrictions, however, she believed if sufficient vaccine supplies were available the target was achievable.

5.13. RF observed that the UK was much farther ahead with its vaccination programme than other parts of the work and congratulated everyone involved.

5.14. He had attended the C&M Regional Chair's meeting the previous day where David Levy had presented an interesting set of slides (which he would share with Board members) explaining the reasons why the North West had been particularly heavily hit by COVID. **ACTION: RF**

5.15. It had been noted that the Countess of Chester Hospital NHS Foundation Trust (COCH) was in the worst position of all local acute hospitals. AM explained the trust had had a long waiting list before the pandemic began, and had also had issues with validation, so there could be many referrals for Procedures of Limited Clinical Priority (PLCP), eg varicose veins, which should not have been accepted. Referrals from Wales were also not counted in their figures in the same way as English patients, so some of their denominator was missing. AM confirmed that, as an agent of the ICS, she would be involved in supporting COCH with its recovery.

5.16. Staff absence - continued to be a challenge with 12.06% total absence at the peak of the third wave on 27th January 2021. The figure had now reduced to 8.39% so the situation was easing. Most local acute trusts had seen similar levels of absenteeism.

5.17. The wellbeing of staff continued to be a high priority, with a range of interventions available to support staff in proactive and responsive ways. These ranged from the use of mobile apps, one to one and team counselling, and referral to mental health support if required. A "People Recovery Plan" was currently under development and would focus on supporting staff with the short, medium and long-term impacts of the pandemic, however it was recognised that there were really no short-term or quick solutions that could address the impact the pandemic had had on many staff, and the consequences would be felt for years to come.

5.18. Informatics update – the Digital Aspirant Programme (DAP) was making steady progress in line with or ahead of plan, despite the Wave 3 impact on the availability of clinical and operational staff.

5.19. Careflow Connect (the add-on to Careflow formerly known as Medway) continued to be deployed and team-to-team patient handover had moved away from the use of paper lists. Clinicians were now able to review and acknowledge results on a mobile device, and so far over 145,000 patient handovers had been completed using this platform.

5.20. VD queried whether Careflow Connect (CC) would improve discharge summaries performance. RC explained separate technology was used for discharges; CC allowed people to work in teams and allocated tasks. Work on discharge summaries would start later in the programme, as other work had taken priority in the last year to respond to COVID-19.

5.21. A new system called 'Combined Intelligence for Public Health Action' (CIPHA) had been partially implemented in Cheshire & Merseyside, with the following reports/tools developed: Oximetry at Home; delivery of Covid immunisations data into CIPHA; and a COVID in hospital demand prediction tool.

5.22. SA asked how value for money was demonstrated. CW confirmed a business benefit realisation team was funded as part of the Digital Aspirant Programme, and a full benefit realisation review would be undertaken and reported as part of the programme.

5.23. White Paper - the Department of Health had issued its White Paper "Integration and Innovation: working together to improve health and social care for all". The main vehicle for this would be through the establishment of 'integrated care systems' (ICS) as statutory NHS bodies that would incorporate CCG/several NHSE commissioning functions and other regulatory and performance management functions from NHSE/I. The ICS would be able to delegate functions to provider collaboratives and places. One of the issues concerning providers was the extent to which organisational sovereignty would be diminished. The White Paper did not address this but did say that NHS providers would retain their current organisational financial duties. There would also be a new duty to compel both ICS and providers to have regard to the 'system' financial objectives and to be mutually invested in achieving financial control at system level.

5.24. GB asked if this meant that CCGs would be abolished and AM confirmed that the White Paper proposed that their functions would be subsumed by the ICS from April 2022, if the legislation was passed.

5.25. VD asked whether there was value in the Trust pre-empting the changes by reviewing its own vision/strategy ahead of the establishment of the ICS and forming stronger ties with the likely candidates for greater collaboration. AM had already observed some differing behaviours amongst providers regarding proposals for collaboration in relation to Informatics and ENT services, which she hoped could now be taken forward. **ACTION: Executive Committee to consider the implications for the Trust strategy.**

5.26. RF reported that there was to be a discussion about the implication of the White Paper at the next Regional Chairs' meeting, and he would update the board following these discussions.

5.27. AM informed Board members she had recently been approached by the Chief Officer of Cheshire & Merseyside Health & Care Partnership (CMHCP), Jackie Bene, to discuss the future of Southport & Ormskirk Hospitals NHS Trust (S&O) and if the STHK Board would be prepared to "take it on". When AM had been Chief Executive at S&O several years earlier, she had agreed some principles with NHSI should such a proposal be accepted, such as access to capital to reconfigure the organisation, management support to deal with politics, not to be responsible for the Trust's revenue, and that STHK's current CQC rating of 'Outstanding' would not to be jeopardised (S&O's rating was currently 'requires improvement'). There appeared to be concerns that the existing consultation process was taking too long to produce change.

5.28. VD asked what this would mean in reality; would the Trust take S&O in its entirety or would the two hospital sites be split? AM responded that the current thinking seemed to be that the whole of S&O would initially be managed to STHK and we would oversee the development of the future clinical strategy. However, it was unclear if this was proposed as a transaction which would by-pass the existing "Shaping Care Together" programmes or if another mechanism was being considered. GB was aware of the concerns of GPs in Southport who, along with the local MP and population, wanted to retain a District General Hospital (DGH) type hospital in Southport with a full range of general acute services including an Emergency Department. AM reflected that there continued to be significant strategic advantage for the Trust and the wider system of optimising the facilities and capacity at Ormskirk Hospital, particularly in relation to restoration and recovery. However, it was also accepted that the population and service changes in Liverpool over the past five years would mean that the service model previously proposed for Southport may no longer be appropriate.

5.29. IC confirmed his support to explore the options as there were obvious benefits to making services more sustainable, however he suggested that the formation of an Integrated Care System (ICS) for Cheshire and Merseyside would change the nature of the responsibilities for S&O because the White Paper was proposing 'collective responsibility for managing collective performance.'

5.30. Board members discussed further the various risks and benefits associated with the proposal and agreed to proceed with exploratory talks, as this supported the previously agreed strategic aims of the Trust. This should be in

line with the caveats outlined by AM.

6. Integrated Performance Report (IPR) – NHST(21)002

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

6.2. Quality Indicators

6.2.1. NK presented the performance against the key quality indicators on behalf of SR.

6.2.2. There were 0 never events in January, and 3 year to date (YTD).

6.2.3. There were no cases of MRSA in Jan, and 1 YTD.

6.2.4. There were 2 C.Difficile (CDi) positive cases reported in January 2021 (1 hospital onset and 1 community onset). YTD there have been 34 cases (22 hospital onset and 12 community onset). 3 cases had been successfully appealed.

6.2.5. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2020 was 92.3%. YTD rate was 94.3%.

6.2.6. There were no grade 3 avoidable pressure ulcers reported in December, YTD 1.

6.2.7. Within community services, there were 97 reported incidents in January, one of which was STEIS reportable. The number of incidents, which had remained at this level during November and December (compared to 67 in October), was linked to the increased acuity of patients being seen by the District Nursing Service (DNS).

6.2.8. There was 1 fall resulting in severe harm in December, YTD 25.

6.2.9. VTE returns remained suspended due to COVID.

6.2.10. Year to date HSMR (April to October) for 2020/21 was 102.8.

6.2.11. NK confirmed he would review metrics that could be included in a COVID dashboard following a query from VD. **ACTION: NK**

6.3. Operational Indicators

6.3.1. RC presented the update on the operational performance.

6.3.2. The 62-day cancer standard was above the target of 85% in December 2020 at 90.2% and YTD 87.4%.

6.3.3. The 31-day cancer target was achieved in December with 97.7% performance against a target of 96% and YTD 97.4%.

6.3.4. The 2-week cancer standard was achieved in December with 94.5% in month, against a target of 93%, the YTD performance was 94.1%.

6.3.5. The A&E access time performance for all types mapped for January was 81.0%, YTD 87.1%. The Trust saw attendance levels decrease in in January compared with December 2020, with the average daily attendance being 270, down from 285 in December. Total attendances in January were 8,381.

6.3.6. GB queried whether there was any impact from the new NHS 111 First initiative. RC reported that it was still early days for the Trust as the new system had only started in November and this had coincided with the increase in COVID patients, however the numbers and types of attendances continued to be closely monitored. Other Trusts had reported seeing a small increase in attendances following the introduction of NHS111 First.

6.3.7. There were 2,775 ambulance conveyances in January 2021 and the ambulance turnaround time averaged 43 minutes against the standard of 30 minutes.

6.3.8. RF observed that when looking at operational performance figures in light of COVID, together with the number of A&E attendances and volume of ambulance conveyances, performance of the service had remained high and he thanked all involved.

6.3.9. The UTC saw 2,369 patients in December 2020, which was a reduction of 961 patients (28%) compared to the previous month. Overall, 99.9% of patients were seen and treated in 4 hours.

6.3.10. Community nursing referral numbers had further increased in December with the highest level of new referrals into the DNS since July 2020. Community matron caseloads were currently at the highest level this year and were double April 2020 levels. Referrals into the system had remained consistent in Q3 showing the strong engagement the service had with Primary Care colleagues and the continued support to patients with long-term conditions.

6.3.11. VD asked if the community nurses had sufficient capacity to respond to the increases in demand. RC assured members that quality and performance were monitored and reviewed at monthly contract meetings and that the referral levels remained within contracted levels, also capacity had been diverted as the service model was adapted to respond to COVID. VD also asked whether a Safer Staffing report existed for community services and RC confirmed there were some parameters that were monitored but there were not national standards about staffing levels such as those mandated for acute hospitals.

6.3.12. GB was aware of the success of the COVID virtual ward and wondered whether it had created a postcode lottery due to the good connections the Trust had with community services in St Helens. RC confirmed this should not be the case as the service had been commissioned across Cheshire & Merseyside so there was equality of access.

6.3.13. The average daily number of super stranded patients (length of stay of greater than 21 days) in January 2021 was 90, compared with 133 in

January 2020.

6.3.14. The 18-week referral to treatment target (RTT) was not achieved in December 2020 with 75.3% compliance against a target of 92%.

6.3.15. The COVID pandemic had had a significant impact on RTT and diagnostic performance as all routine operating, outpatient and diagnostic activity had been suspended for periods in each wave of COVID. All patients continued to be clinically triaged to ensure urgent and cancer patients remained a priority for treatment.

6.3.16. LK asked how quickly the RTT backlog could be tackled once the system plan of 15th March was approved. RC explained that recovery of the Trust's RTT performance would take a while due to the complexity of the patient cases in the backlog and, as AM had alluded to in her earlier report, these would need to be clinically prioritised across the system, rather than planning solely on the length of time they had been waiting

6.3.17. VD asked where the summary of the RTT backlog was reported so that the Non-Executive Directors had a sense of the challenge, RC confirmed this was on page 78 of the full IPR and he would be happy to answer any questions about the recovery and restoration trajectories, once approved by the Hospital Cell.

6.3.18. There were now 497 52+ week waiters.

6.4. **Financial Indicators**

6.4.1. NK presented the update on financial performance.

6.4.2. At the end of Month 10 the Trust had reported a deficit YTD position of £3.0m and deficit outturn position £12.9m. The deficit was caused by the reduced level of funding being allocated to the Trust in the second half of the year. NK reported that since this report had been produced, negotiations with NHSE/I had been on-going and additional income had been allocated, which would reduce the deficit position. £5m of the planned deficit also related to the accrual for annual leave that staff will not have been able to take during 2020/21 due to the pandemic.

6.4.3. RF thanked everyone involved for the incredible figures.

6.4.4. The agency ceiling issued by regulators for 2020/21 was £7.8m, which was a £0.2m increase on 2019/20. Year to date spend was £7.9m, which was £1.4m above the trajectory and reflected the staffing pressures during the pandemic.

6.4.5. At the end of month 10, the cash balance was £55.1m. The closing balance continued to be high due to the changes in funding arrangements related to COVID-19, where the Trust received block payments one month in advance.

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on workforce performance.

6.5.2. Overall sickness absence for January was 8.4%, which was a 2.0% increase from December. There figures reflected the rates of COVID within the local community, which had some of the highest rates infection rates in England. AMS reported the increase between December and January was all COVID-related. At the end of January, total absence was up to 12%, ie approximately 800 staff. The current position had improved and was down to 8.3%, with non-COVID sickness was back into the usual winter range of 5.5 to 6%. The Government had added also another 800,000 people nationally to the Clinically Extremely Vulnerable (CEV) list in January which also contributed to the COVID absence rates. There were now an additional 20 staff who had been instructed to shield until the end of March.

6.5.3. Appraisal compliance in January was 57.2%, which was below the target of 85% by 27.8%. Mandatory training compliance remained below the target of 85% at 76.4%. Mandatory training had been stripped back during the three waves of the pandemic, however AMS confirmed work was underway with subject matter experts to understand the likely trajectory for recovery, whilst being cognisant of the fact that staff and managers were exhausted and drained, so respect and consideration were due.

6.5.4. LK assured Board members that she had witnessed several ways in which the Trust was demonstrating it understood how staff felt, eg through the work of the Workforce Council, Charitable Funds Committee.

6.5.5. Board members noted the report.

7. Committee Report – Executive – NHST(21)003

7.1. AM presented the report and highlighted the key issues considered by the Executive Committee at meetings held during January 2021.

7.2. Annual leave – options for the carry over or payment of annual leave that staff had been unable to take during the 2020/21 leave year, because of the pandemic had been considered in light of the national guidance and a local approach had been agreed.

7.3. Pressure Ulcers Thematic Review –a review of performance for the 8 months from April to November 2020, compared with 12 months 2019/20 had shown a reduction in the number of hospital-acquired category 2 or above pressure ulcers. This was encouraging but due to the changes in reporting methodologies between years and the extraordinary circumstances of 2020/21 the Executive Committee had agreed that the baseline year for performance comparisons should be 2018/19. A final review would be undertaken on this basis in April 2021.

7.4. The committee had received weekly updates on the rate of nosocomial infections and outbreaks, which had correlated with the increases in community infection rates, although in percentage terms the trust remained the lowest in Cheshire and Merseyside.

7.5. VD asked if there was analysis of the type of transmission, eg staff to staff, patient to staff. RC confirmed that the Trust had been undertaking routine asymptomatic staff testing for a while using the lateral flow tests but was about to switch across to LAMP testing, which was more accurate. Patients were routinely tested on admission and then on day 3, day 5 and then every 5th day, using the laboratory PCR tests. Nosocomial outbreaks in the Trust were reported daily to the Gold Command meeting, where there were two or more identified nosocomial infections. All the recommended infection prevention measures were in place, such as enhanced cleaning regimes, requiring patients to wear face masks when moving away from their bed, and compliance with PPE requirements. Weekly testing of all patients and staff was undertaken on outbreak wards until 28 days after the last positive case was reported. It was acknowledged there was difficulty in policing the compliance of some patients who left the ward to meet friends and relatives at the main entrance or outside the hospital.

7.6. Safer Staffing figures – the Executive Committee had considered the findings of a review that had been undertaken, which had identified an anomaly in the reported data. The exact cause of this anomaly continued to be urgently investigated but it was apparent that the impact was to artificially increase the reported fill rate by up to 5% in some months. AM stated that the investigation had proven that something was wrong with the current reporting process, and that the board needed to be aware that there was a problem. It was hoped that the issue could be resolved, and the correct data reported from January. GB commented that she was pleased that safer staffing was being scrutinised as she found the reports that came to Quality Committee hard to understand and hoped this was an opportunity to also include more context about the numbers that were reported.

7.7. Information system for Community Services – committee had supported the case for change and the proposed strategic direction, subject to a business case being developed and inclusion in the 5-year IT capital investment plans.

7.8. Lead Employer Contracts – AM reported that the Trust had received a request from HEE North West for the Lead Employer contract to be extended for a further 12 months to September 2022, which had been agreed.

7.9. Board members noted the report.

8. Quality Briefing (Verbal)

8.1. GB presented the report, which summarised the key issues considered at the Quality Committee briefing in February.

8.2. Committee had scrutinised the quality and workforce metrics in the integrated performance report and discussed what additional information NEDs would find useful relating to COVID and in the post-COVID recovery period.

8.3. Committee had received a report regarding the Trust's clinical research, including clinical trials for COVID and GB commented on the impressive recruitment figures.

8.4. The Committee received an update from the Workforce Council and discussed the workforce strategy, the impact of COVID on staff wellbeing, including what support was in place for staff in terms of mental health and anxiety.

8.5. The Committee had received assurance in relation to learning from complaints, with updates on actions relating to the maternity deep dive review and work regarding the reporting culture in Theatres for never events.

8.6. GB reported there had been a good flow of information and healthy debate and challenge despite the shortened format of the meeting.

8.7. Chair's assurance reports were also received from the Patient Safety, Clinical Effectiveness and Patient Experience Councils.

8.8. The report was noted.

9. Finance & Performance Briefing (Verbal)

9.1. JK presented a summary of the key issues discussed at the Finance & Performance briefing.

9.2. The forecast outturn position had been reviewed and the potential reduction noted.

9.3. The plans for the 2021/22 opening budget had been reviewed, based on a number of assumptions, as the NHS planning guidance had not yet been published.

9.4. The committee was assured of the good progress on CIPs for 2021/22 with a good level of engagement with services.

9.5. Capital plans of £18.6m for 2021/22 had been reviewed but subject to change due to revision of the C&M capital allocation.

9.6. VD asked if an assessment of social value was part of the Trust procurement evaluation process, NK confirmed it was.

9.7. The report was noted.

10. Committee Report - Audit Committee – NHST(21)004

10.1. IC presented the assurance report form the Audit Committee meeting on 10th February.

10.2. There had been a progress report on the 2020/21 internal audit plan, there had been follow up reports in respect of the Consultant Job Plan and Quality Spot check audits. There had also been an update from the anti-fraud specialist. Other standing item reports included aged debt and tender and quotation waivers and losses and special payments.

10.3. The committee had reviewed the draft internal audit plan for 2021/22.

10.4. The committee had approved the appointment of Grant Thornton as the external auditor for a period of 3 years. IC noted that this had been a particularly difficult situation and commended NK on negotiating an arrangement to secure the new contract. It was noted that the contract excluded audits of the Quality Account and charitable funds where alternative arrangements would need to be made.

10.5. Board members approved the appointment of the Grant Thornton as the Trust's external auditor.

11. Charitable Funds Briefing (Verbal)

11.1. PG presented a summary of the key issues discussed at the Charitable Funds Committee in February.

11.2. Circa £120k had been received from the Captain Sir Tom Moore charity, some of which had been used for a 'Thank You – Wellbeing Week'.

11.3. Although many of the hospital charity's usual fund-raising activities had had to be put on hold due to the pandemic the charity team was still attracting donations.

11.4. RF had previously agreed to write to local businesses, and although this had been delayed because of the pandemic it was felt that now was a good time to make this contact. **ACTION: RF**

11.5. A project to encourage engagement with local schools was also going well.

11.6. RF asked for his heartfelt thanks to be passed on to the team.

11.7. Board members noted the update.

11.8. RF noted that it was a difficult time for the NED members of the Board because they were aware of how busy the Executive was, but he felt assured that the committees had continued to offer the right balance of challenge and support, in these exceptional times. He thanked the committees' chairs for managing this balance.

12. Freedom to Speak up Self-Assessment

12.1. RF presented the 2021 Freedom to Speak Up Self-Assessment for 2021.

12.2. The assessment showed that the Trust was compliant against 9 of the FTSU expectations and partially compliant in the remaining two, but with plans in place to achieve full compliance.

12.3. RF thanked Rajesh Karimbath, Assistant Director of Patient Safety, for his work on the self-assessment.

12.4. AMS added there was currently a vacancy for a FTSU Guardian for which the Trust would follow the national recruitment process, which would support

compliance with the criteria.

12.5. The Board reviewed and approved the Trust's annual Freedom to Speak Up Self-Assessment for 2021.

13. Operational Planning Guidance 2020/21 – update (verbal)

13.1. NK confirmed no planning guidance had yet been issued by NHSE/I for 2021/22, but it was hoped this was imminent. A further update would be provided at the March Board meeting.

14. Cheshire & Merseyside Health & Care Partnership (CMHCP) – Memorandum of Understanding (MoU) for the Integrated Care System (ICS) Accreditation Process – NHST(21)006

14.1. NB introduced the paper and explained that members were being asked to support the MoU for CMHCP for the next year which would allow them to progress towards being accredited to be an ICS before the proposed new legislation came into place in 2022. This MoU did not implement the changes in the White Paper but was part of the preparation for these changes.

14.2. RF provided feedback from the last C&MHCP Partnership Board where this had been discussed and reflected the MoU was not a legally, but morally binding document about co-operation and collaborative working. He also noted the intention to retain a significant role for each of the 9 places in Cheshire & Merseyside, although the details of how they would operate when CCGs were abolished were not defined.

14.3. Discussion followed regarding the drafting of the document and plans for increased council representation. IC expressed concern that the proposed reforms to the structure of the NHS could lead to funding being diverted from NHS services if there was increased political involvement and could result in a lack of autonomy, where high performers would be brought down to the average of the system.

14.4. RF noted the concerns about the proposed government legislation, but felt that the direction of travel towards system working had been in place for some time and it was important for Cheshire & Merseyside to have a properly accredited ICS, in order to move forward to the next phase. Many of the same concerns about the MoU had been raised by trust chairs from across the patch. The current proposals were a stepping-stone to move the situation forward and although there were reservations, he felt the Board should support the MoU. Board members agreed with this assessment.

14.5. Board members approved the C&M MoU.

15. Feedback from Other Meetings

15.1. IC and JK had attended an Audit and Finance forum, where the accounting issues and the problems with the market for external audit providers had been discussed.

16. Effectiveness of Meeting

16.1. BK was asked for his views of how the Board operated and if he felt it was achieving the balance between good governance and challenge in the current difficult circumstances.

16.2. BK felt there was good balance both in terms of operational issues and strategy, information, assurance, and accountability and between the NEDS and Executives. He felt the meeting was a good reflection of challenges being faced by the Trust. He found the conversation around inclusivity rich and informative.

16.3. RF thanked Bob for his comments and attendance at the Board, he felt it was important that the level of challenge was maintained without becoming confrontational.

17. Any Other Business

17.1. VD asked whether the Trust had considered recording the public element of its Board meeting and uploading it to the Trust website. NB confirmed that although some trusts were uploading recordings, there were different obligations for Foundation Trusts to hold meetings in public. Also this Board briefing format included some elements that would usually be in the closed board meeting.

18. Date of Next Meeting

18.1. The next meeting will be held on Wednesday 31st March 2021 at 09:00 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 31ST MARCH 2021

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **Deferred due to COVID-19**	NB/NK	**TBC**
36	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **Deferred due to COVID-19**	AM	**TBC**
49	24.02.21 (5.13)	RF to circulate David Levy slide presentation from recent C&M Chairs' meeting to Board members.	RF	31.03.21
50	24.02.21 (5.25)	Executive Committee to consider the implications of the establishment of the ICS for the Trust strategy.	Execs	31.03.21
51	24.02.21 (6.2.10)	NK to review metrics for COVID dashboard (no of vaccinations, etc) for inclusion in IPR. **ON CLOSED BOARD AGENDA**	NK	31.03.21
52	24.02.21 (11.4)	RF to write to local businesses to encourage local support/donations for the Trust's charity.	For Charitable Funds Committee	28.04.21

Paper No: NHST(21)007
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

The CQC rated the Trust as **outstanding** overall following its inspection in July/August 2018. The caring and well-led domains were rated as **outstanding**, with safety, responsive and effective rated as **good.**

There were no Never Events in February 2021. (YTD = 3).

There was 1 case of MRSA in February 2021. (YTD = 2).

There were 5 C.Difficile (CDI) positive cases reported in February 2021 (4 hospital onset and 1 community onset). YTD there have been 39 cases (26 hospital onset and 13 community onset). 3 further cases have been successfully appealed (1 hospital onset and 2 community onset). The annual tolerance for CDI for 2020-21 has not yet been published (the 2019-2020 limit is being used in the absence of publication of the 2020-21 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2021 was 87.0%. YTD rate is 92.6%.

There were no grade 3 hospital acquired pressure ulcers with lapses in care in December 2020. (YTD = 1). Reducing the number of Trust-acquired pressure ulcers with lapses in care, including category 2, is a priority for this year.

Reported incidents within community services remain at levels consistent with the last two months. In total 92 were reported.

During the month of January 2021 there were 2 falls resulting in severe harm. (YTD severe harm falls = 27)

Performance for VTE assessment for February 2020 was 95.70% against a target of 95%. VTE returns for March to January 2021 have been suspended.

YTD HSMR (April to November) for 2020-21 is 101.9

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 20/21 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: 31st March 2021

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (January 2021) at 85.1%. YTD 87.1%. Performance in December 2020 was 90.2%. The 31 day target was achieved in January 2021 with 97.9% performance in month against a target of 96%, YTD 97.4%. Performance in December 2020 was 97.7%. The 2 week rule target was not achieved in January with 92.2% in month and 93.3% YTD against a target of 93.0%. Performance in December 2020 was 94.5%. The situation with regard to patients not wanting to attend for appointments is continuing to improve and we are seeing an increase in the numbers of referrals and patients receiving treatment.

Accident and Emergency Type 1 performance for February 2021 was 75.1% and YTD 78.4%. Type 1 Performance in January 2021 was 68.1%. The all type mapped STHK Trust footprint performance for February 2021 was 85.6% and YTD 86.9%**.** The Trust saw average daily attendance levels increase in February 21 compared with January 21, with the average daily attendance of 277 up from 270 in January . Total attendances for February 2021 were 7783, January 2021 were 8381. For December 2020 it was 8,843, November 8,458, October 8,645, September 9,219 compared with 9,524 in August, 9,374 in July, 8,764 in June, 7,815 in May 2020 and 5,548 in April 2020.

Total ambulance turnaround time was achieved in February 2021 with 27 mins on average. (Standard is 30 minutes). Arrival to handover time was 14 minutes which includes on average 6-7 mins time for crews to notify ED of their arrival on site (standard is 15 minutes). There were 2553 ambulances conveyed in February (busiest Trust in C+M/GM) compared with 2775 in January 2021, 2750 in December, and 2,486 ambulance conveyances in November.

The UTC saw 3,045 patients in January 2021, which is an increase of 676 patients (28%) compared to the previous month. Overall 99.9% of patients were seen and treated in 4 hours.

Community district nursing referrals have shown a 6% reduction in January from December, which is consistent with usual seasonal variation and relates to a reduction in referrals received from acute care. The total number of patients on the District Nursing caseload has increased marginally to 1247 in January, from 1220 in December. Community matron caseloads are also increasing (December 133- January 145), with referral numbers in line with previous months.

The average daily number of super stranded patients in February 2021 was 86 compared with 125 in February 2020. This remains below the target of 92 @ end of March 2020. (90 was the average in January 2021, 72 in December 2020, 89 in November, 69 in October, 62 in September, 61 in August, 60 in July 2020 and 70 in June 2020). Work is ongoing with all system partners to maintain the current position.

The 18 week referral to treatment target (RTT) was not achieved in February 2021 with 70.6% compliance and YTD 70.6% (Target 92%). Performance in January 2021 was 72.8%. There were (1124) 52+ week waiters. The 6 week diagnostic target was not achieved in February 21 with 70.1% compliance. (Target 99%). Performance in January 2021 was 65.3%. **NB Elective programme closed down in Wave 1 with only urgent and 2ww patients being managed during March, April and May. Due to the impact of Covid in January 2021 , only cancer cases, some urgent cases and limited routine cases have been undertaken.**

The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. We have now restarted activity in all areas, albeit at reduced capacity compared with pre-covid due to social distancing and infection control measures. All patients have been and continue to be clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

At the March 2020 Board the Trust agreed to a plan of £0.3m deficit excluding the Financial Recovery Fund (FRF). This allowed the Trust to access £0.3m of FRF assuming the planned deficit is achieved.

Following the COVID-19 crisis the financial regime for 2020/21 was put on hold and a system introduced to ensure all Trusts remained in financial balance for six months from April to September 2020. From October this changed to a system-wide funding envelope with a block payment allocated to the Trust by Cheshire and Merseyside Health Care Partnership. A revised forecast was submitted on 22nd October to NHSI and C&M HCP.

Surplus/Deficit - At the end of month 11 the Trust has reported a deficit YTD position of £0.2m and deficit outturn position of £8.1m.

The Trusts deficit is being driven by the reduced resources allocated in the second half of the year by the Health & Care Partnership (HCP) and NHSE/I.

The agency ceiling issued by regulators for 2020/21 is £7.8m which was a £0.2m increase on 2019/20. The year to date spend is £8.8m which is £1.4m above the agency cap and slightly above the previous years spend.
The requirement for CIP is currently on hold under the block payment arrangement.

At the end of month 11, the cash balance was £74.3m. This high closing balance continues to be high due to changes in funding arrangements related to COVID-19 where the Trust receives block payments one month in advance. The Trust is also receiving lead employer payments in advance of invoices which is increasing the Trust cash position.

Human Resources

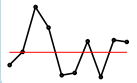
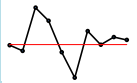
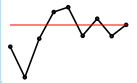
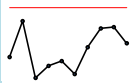
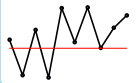
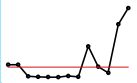
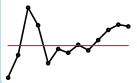
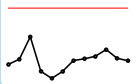
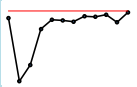
In February overall sickness was 7.7% which is a 0.7% decrease from January. Front line Nursing, Midwifery and HCA's was 12.2% which was the same as in January . Front line Nursing and Midwifery was 10.2 % which was an increase of 0.3%. These figures are a reflection of the rates of Covid within the local community which have been some of the highest in England. These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension or staff on special leave e.g. due to childcare.
Appraisal compliance is below target by 29.5%. Mandatory training compliance remains below the target by 9.3%. Compliance for both continues to be impacted as a consequence of the second spike in COVID 19 including high sickness, isolation, special leave absences and other service demands.

The following key applies to the Integrated Performance Report:

▲ = 2020-21 Contract Indicator
▲£ = 2020-21 Contract Indicator with financial penalty
● = 2020-21 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Feb-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Feb-21	4.2%	3.2%	No Target	2.4%		Spike in three waves of covid are reflected in the variation. HSMR continues to be challenging in the pandemic due to disease groups needing three years worth of data.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits despite the second and third waves of COVID. Independent consideration of our COVID mortality is currently showing it to be in line with expected rates. By way of context, HSMR for NW England is 107.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Oct-20	1.07		1.00						
Mortality: HSMR (HED)	Q	▲	Nov-20	105.7	101.9	100.0	101.6					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Nov-20	106.2	107.0	100.0	101.2					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Oct-20	100.0	100.2	100.0	97.4		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Low readmission was likely a reflection of the upswing in COVID cases and has now returned to well within expected limits.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Nov-20	92.3	90.5	100.0	91.9		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. Increased discharges in recent months with improved integrations with system partners. Superstranded patients reduced considerably.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Nov-20	112.7	107.4	100.0	100.3					
% Medical Outliers	F&P	T	Feb-21	6.8%	1.7%	1.0%	1.0%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Feb-21	73.1%	59.3%	52.5%	39.3%		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	▲	Jan-21	74.9%	75.0%	90.0%	72.3%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. Specific wards have been identified and new processes developed to support improvement. OP attendance letters - As a result of COVID many appointments had to be moved or replaced with telephone appointments. Not all appointments were conducted at the expected time and a brief disconnect in generating letters occurred. This has been addressed and we continue to support clinicians with our novel processes.		Specific wards have been identified with poor performance and staff are being supported to complete discharge in a timely manner. All CDs and ward managers receive weekly updates of performance. The most challenged area in the Trust has a new SOP in place to track all patients to get discharges completed. The most challenged area in SDECC is the subject of a deep dive to review current process. This has oversight of clinicians from MCG and ED.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Jan-21	94.2%	89.2%	95.0%	84.9%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jan-21	96.9%	96.8%	95.0%	94.9%					

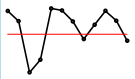
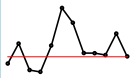
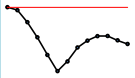
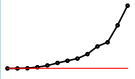
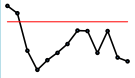
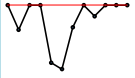
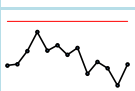
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q3	85.9%	88.9%	83.0%	89.3%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement of required 80% of patients have spent 90% of their stay in the stroke unit	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲£	Feb-21	0	3	0	1			Quality and patient safety	RCA undertaken and actions in place to mitigate chances of recurrence. Local actions and monitoring procedures in place.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20	98.5%		98.9%	98.7%		Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Feb-21	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Consistent good performance is supported by the EPMA platform.	RPJ
Number of hospital acquired MRSA	Q F&P	▲£	Feb-21	1	2	0	1		There was 1 case of MRSA in February 2021.	Quality and patient safety	The annual tolerance for CDI for 2020-21 has not yet been published. The 2019-2020 trajectory is being used in the absence of publication of the 2020-21 objectives.	SR
Number of hospital onset and community onset C Diff	Q F&P	▲£	Feb-21	5	39	48	42		There were 5 positive C Diff sample in February 2021. YTD there have been 42 cases, with 3 cases successfully appealed, leaving 39 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Feb-21	4	27	No Target	25		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Dec-20	0	1	No Contract target	1		No category 3 or 4 pressure ulcers in December 2020.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April.	SR
Number of falls resulting in severe harm or death	Q	▲	Jan-21	2	27	No Contract target	13		2 falls resulting in severe harm in January 2021 . The incident was reported from Ward 1A and Duffy suite.	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Feb-20			95.0%	95.54%		**March 20 to February 21 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA. Performance remained above target.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. A spike of thrombotic events during the height of COVID reflects the nature of the disease and performance has now improved. Despite second wave, we have understood the risk in patients and minimised events. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Sep-20	3	29	No Target	26					
To achieve and maintain CQC registration	Q		Feb-21	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-21	87.0%	92.6%	No Target	95.6%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Feb-21	9	43	No Target	8					

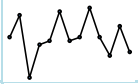
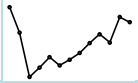
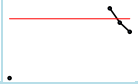
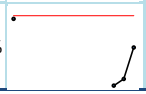
Feb-21

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲£	Jan-21	92.2%	93.9%	93.0%	91.0%		Cancer targets, unusually 2 week not achieved this month in part impacted by Covid crisis, staff absence and elongated patient process. 31 and 62 day performance achieved.	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity 2. Capacity/demand review on going at speciality level 3. Trust continues to utilise Imaging capacity via temp CT facility at St Helens Hospital 4. Trust commenced Rapid Diagnostic Service early 2020 5.Cancer surgical Hub at St Helens to recommence 6. ESCH plans reignited	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲£	Jan-21	97.9%	97.4%	96.0%	97.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jan-21	85.1%	87.1%	85.0%	86.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-21	70.6%	70.6%	92.0%	90.3%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled.	COVID restrictions had stopped elective programme and therefore the ability to achieve RTT is not possible.	RTT continues to be monitored and patients tracked. Long waiters tracked and discussed in depth at weekly PTL meetings. activity recommenced but at reduced rate due to social distancing requirements, PPE, patient willingness to attend and this has begun to be impacted upon as Covid activity increases again. urgents, cancers and long waiters remain the priority patients for surgery at Whiston	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-21	70.1%	66.9%	99.0%	99.7%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-21	1,124	1,124	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Feb-21	0.2%	0.4%	0.8%	0.7%		All routine elective work was cancelled until COVID restrictions lifted and this impacted adversely on the 28 day re-list target	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲£	Jan-21	100.0%	96.0%	100.0%	98.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲£	Mar-20	0		0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Feb-21	75.1%	78.4%	95.0%	69.8%		Accident and Emergency Type 1 performance for February 2021 was 75.1% and YTD 78.4%. Type 1 Performance in January 2021 was 68.1%. The all type mapped STHK Trust footprint performance for February 2021 was 85.6% and YTD 86.9%. The Trust saw average daily attendance levels increase in February 21 compared with January 21, with the average daily attendance of 277 up from 270 in January . Total attendances for February 2021 were 7783, January 2021 were 8381. For December 2020 it was 8,843, November 8,458, October 8,645, September 9,219 compared with 9,524 in August, 9,374 in July, 8,764 in June, 7,815 in May 2020 and 5,548 in April 2020. Total ambulance turnaround time was achieved in February 2021 with 27 mins on average. (Standard is 30 minutes). Arrival to handover time was 14 minutes which includes on average 6-7 mins time for crews to notify ED of their arrival on site (standard is 15 minutes). There were 2553 ambulances conveyed in February (busiest Trust in C+M/GM) compared with 2775 in January 2021, 2750 in December, and 2,486 ambulance conveyances in November.	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 COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Feb-21	85.6%	86.9%	95.0%	83.9%					
A&E: 12 hour trolley waits	F&P	▲	Feb-21	0	0	0	0					

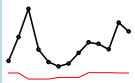
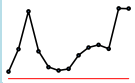
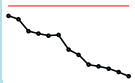
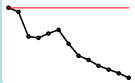
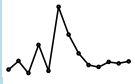
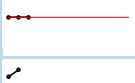
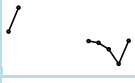
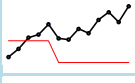
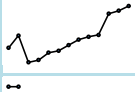
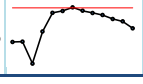
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Feb-20	0		0	2		**March 20 to February 21 submissions suspended.** MSA breach occurred on ICU due to delay in stepping level 1 patients down for 24 hours (involved 2 patients only) as Trust was at full capacity and patients in ED waiting beds. All actions taken to try prevent this.	Patient Experience	All patients waiting step down are highlighted at bed meeting x 3 daily and an escalation plan is in place to prevent this reoccurring where possible.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Feb-21	16	214	No Target	319		% new (Stage 1) complaints resolved within agreed timescales continues to remain above the 90% target year to date.	Patient experience	The Complaints Team continue to focus on increasing response times with active monitoring of any delays and provision of support as necessary. Complainants made aware of the significant delays that will be experienced in receiving responses going forward due to current operational pressures, with continued focus on achieving the target of 90%. The impact of the second/third waves of the pandemic in being able to meet the 90% target was evident in December/January and performance will be closely monitored and addressed to reduce the risk of a further decline.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Feb-21	11	195	No Target	310					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Feb-21	100.0%	93.3%	No Target	92.9%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20	24		No Target	21		**March 20 to February 21 submissions suspended.** In February 2020, the average number of DTOCS (patients delayed over 72 hours) was 24.		COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity/reduce delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Feb-21	307	256		333					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Feb-21	86	71		126					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-21	89.3%	89.9%	90.0%	86.5%		FFT submissions recommenced from January 2021, with recommendation rates above target for inpatients and maternity delivery suite and postnatal community year-to-date. ED, antenatal, postnatal and outpatients are slightly below target.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team as a valuable mechanism for receiving up-to-date patient feedback. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. There has been an increase in posters being displayed . At least two members of staff have been identified in each area to take responsibility for production of the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides are available for each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-21	94.9%	95.8%	90.0%	95.6%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-21	100.0%	89.3%	98.1%	98.8%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-21	100.0%	100.0%	98.1%	97.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-21	92.3%	92.3%	95.1%	96.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-21	N/A	100.0%	98.6%	99.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-21	94.6%	94.3%	95.0%	94.6%					

Feb-21

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Feb-21	7.7%	6.7%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.3%		In February overall sickness was 7.7 % which is a 0.7% decrease from January. Front line Nursing, Midwifery and HCA's was 12.2% which remained the same as the previous month. N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include, covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension, or special leave.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team review COVID and non COVID absences daily to ensure staff eligible for swabbing are referred to HWWB. Additional health and well being support is provided to help staff with stress, anxiety and depression caused by the impact of COVID19. This includes ongoing support to staff anxious about working in a covid environment including daily on site mental health support staff in ICU and ED.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Feb-21	12.2%	8.7%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Feb-21	55.5%	55.5%	85.0%	79.4%		Appraisal compliance in February is below target by 29.5%. Mandatory training compliance remains below the target by 9.3%. and continues to be impacted as a consequence of the second spike in COVID 19 including high sickness, isolation, special leave absences and other service demands.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance continues to be impacted by COVID 19 with both decreasing in month and remaining below target. The requirement to complete Appraisals and Mandatory training was resumed in July with flexible electronic options available for both to support remote completion and to enable improved compliance. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area and is monitored monthly through Quality Committee.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Feb-21	75.7%	75.7%	85.0%	84.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			No Contract Target			**Further submissions suspended by NHSE/NHSI until further notice.**	Staff engagement, recruitment and retention.	The Q3 survey in the form of the Annual Staff Survey closed on the 30th November, with results expected to be published in March.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Feb-21	0.9%		No Target	10.1%		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 62-67)												
UORR - Overall Rating	F&P UOR	T	Feb-21	suspended	suspended	3.0	3.0			Delivery of Control Total	The 2021 financial plan has been put on hold and a system introduced where Trusts will breakeven for the first six months of 2020/21.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Feb-21	suspended	suspended	-	16,152					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Feb-21	(199)	(199)	-	3,900					
Cash balances - Number of days to cover operating expenses	F&P	T	Feb-21	23	23	2	7					
Capital spend £ YTD (000's)	F&P	T	Feb-21	19,600	19,600	26,700	10,293					
Financial forecast outturn & performance against plan	F&P	T	Feb-21	(8,060)	(8,060)	-	3,900					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Feb-21	90.7%	90.7%	95.0%	87.9%					

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	2020-21 YTD	2020-21 Target	FOT	2019-20	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%	94.6%	100.0%	86.7%	76.5%	100.0%	100.0%	45.5%	77.8%	100.0%	100.0%	96.3%	90.0%	85.0%		92.7%		
	Total > 62 days		0.0	0.0	1.0	0.0	1.0	2.0	0.0	0.0	3.0	3.0	0.0	0.0	0.5	9.5			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Lower GI	% Within 62 days	▲£	50.0%	100.0%	82.6%	76.0%	85.7%	76.5%	100.0%	75.0%	83.3%	90.0%	80.0%	89.5%	78.9%	82.5%	85.0%		83.2%		
	Total > 62 days		2.0	0.0	2.0	3.0	1.0	2.0	0.0	1.0	1.0	1.0	2.0	1.0	2.0	14.0			13.0		
	Total > 104 days		0.0	0.0	1.0	1.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	3.0			2.0		
Upper GI	% Within 62 days	▲£	100.0%	100.0%	80.0%	60.0%	80.0%	60.0%	100.0%	100.0%	100.0%	66.7%	100.0%	83.3%	100.0%	84.8%	85.0%		90.5%		
	Total > 62 days		0.0	0.0	1.0	2.0	0.5	2.0	0.0	0.0	0.0	1.5	0.0	1.0	0.0	7.0			6.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	2.5			1.0		
Urological	% Within 62 days	▲£	86.4%	69.2%	79.3%	74.2%	66.7%	100.0%	100.0%	90.0%	95.7%	87.0%	77.1%	86.7%	80.0%	84.6%	85.0%		85.5%		
	Total > 62 days		1.5	6.0	3.0	4.0	2.0	0.0	0.0	1.0	0.5	1.5	4.0	2.0	2.5	17.5			25.0		
	Total > 104 days		1.0	1.0	0.0	1.0	2.0	0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	5.5			5.5		
Head & Neck	% Within 62 days	▲£		25.0%	20.0%	100.0%	0.0%	100.0%	100.0%	66.7%	0.0%	20.0%	100.0%	0.0%	33.3%	47.8%	85.0%		29.3%		
	Total > 62 days			1.5	2.0	0.0	0.0	0.0	0.0	0.5	1.5	2.0	0.0	1.0	1.0	6.0			20.5		
	Total > 104 days			0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			4.0		
Sarcoma	% Within 62 days	▲£					100.0%				100.0%	100.0%	0.0%		100.0%	77.8%	85.0%		66.7%		
	Total > 62 days						0.0				0.0	0.0	1.0		0.0	1.0			2.0		
	Total > 104 days						0.0				0.0	0.0	0.0		0.0	0.0			0.0		
Gynaecological	% Within 62 days	▲£	80.0%	66.7%	100.0%	100.0%	40.0%	100.0%	100.0%	100.0%	66.7%	69.2%	69.2%	0.0%	55.0%	66.3%	85.0%		69.1%		
	Total > 62 days		1.0	2.0	0.0	0.0	3.0	0.0	0.0	0.0	1.0	2.0	2.0	1.0	4.5	13.5			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	2.0			1.5		
Lung	% Within 62 days	▲£	100.0%	71.4%	75.0%	69.2%	86.1%	100.0%	88.9%	60.0%	100.0%	100.0%	81.8%	71.4%	100.0%	85.1%	85.0%		85.0%		RC
	Total > 62 days		0.0	1.0	1.0	2.0	5.0	0.0	1.0	2.0	0.0	0.0	1.0	2.0	0.0	13.0			10.5		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0			2.5		
Haematological	% Within 62 days	▲£	80.0%	100.0%	100.0%	50.0%	66.7%	100.0%	66.7%	80.0%	100.0%	100.0%		100.0%	50.0%	78.3%	85.0%		86.7%		
	Total > 62 days		1.0	0.0	0.0	1.0	0.5	0.0	1.0	1.0	0.0	0.0		0.0	3.0	6.5			7.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0		0.0	0.0	1.0			1.0		
Skin	% Within 62 days	▲£	78.4%	93.9%	95.2%	91.2%	100.0%	92.5%	97.4%	100.0%	89.5%	92.2%	93.8%	100.0%	96.8%	94.7%	85.0%		92.0%		
	Total > 62 days		5.5	1.5	1.5	2.5	0.0	1.5	1.0	0.0	4.0	3.0	2.0	0.0	1.0	15.0			26.5		
	Total > 104 days		1.5	1.5	1.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.5			9.5		
Unknown	% Within 62 days	▲£	0.0%						100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	93.3%	85.0%		69.2%		
	Total > 62 days		0.5						0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.5			2.0		
	Total > 104 days		0.0						0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.5		
All Tumour Sites	% Within 62 days	▲£	85.2%	83.4%	88.0%	82.0%	81.6%	87.5%	96.0%	92.7%	85.8%	85.8%	85.4%	90.2%	85.1%	87.1%	85.0%		86.2%		
	Total > 62 days		11.5	12.0	11.5	14.5	13.0	7.5	3.0	5.5	11.0	14.0	12.5	8.0	14.5	103.5			141.0		
	Total > 104 days		2.5	2.5	3.5	2.0	2.0	3.5	0.0	4.0	0.5	1.5	2.0	0.0	1.0	16.5			27.5		
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%	85.0%		80.0%		
	Total > 31 days									0.0		0.0		0.0	0.0	0.0			0.0		
	Total > 104 days									0.0		0.0		0.0	0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲£															85.0%		100.0%		
	Total > 31 days																		0.0		
	Total > 104 days																		0.0		
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)008
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during February 2021. There were four Executive Committee meetings held during this period. The Executive Committee approved: • Upper Gastrointestinal Cancer Nursing Workforce Business Case • Gastroenterology Consultant Business Care • Community Services Electronic Patient Record Business Case • Five-Year IT Investment Proposals • Supporting Trainee Nurse Associates Business Case At every meeting, the Executive Committee received updates from Gold Command on the COVID-19 pandemic and its impact on the Trust. The Committee also considered regular assurance reports covering; Risk Management Council and Corporate Risk Register, mandatory training and appraisal performance, safer staffing, and the integrated performance report.
Trust objectives met or risks addressed: All 2020/21 Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 31st March 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in February 2021.

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

All meetings included a standard agenda item to consider the COVID-19 pandemic or restoration and recovery, COVID-19 specific expenditure requests and issues escalated from the operational gold command meetings.

2. 4th February 2021

2.1 Internal Medicine Training (IMT) Posts

The Medical Director introduced a presentation detailing the pressures on the medical workforce from the introduction of new IMT arrangements for junior doctors and the implications for service provision. The principal change to the training programme was the requirement for additional supervision, which had implications for on call rotas and therefore the number of doctors needed to populate a compliant rota. Committee discussed the allocation of junior doctor placements to trusts across Cheshire and Merseyside and the historical preferential allocation of posts to the larger university teaching hospital. The consequence of this was that the financial burden of increasing doctor numbers to achieve compliance with the new training requirements from August 2021, would fall to the less specialist hospitals. This was inequitable and it was agreed that the Medical Director should discuss the situation with the Dean.

The Medical Care Group had reviewed the staffing gaps that would be created when the IMT programme started and had considered potential options for covering these gaps and maintaining services, all of which had significant financial implications. It was agreed that equity in the allocation of training posts across trusts should be the priority, so that the financial burden of implementing the new training requirements was shared by all trusts. Following discussions with Health Education England (HEE) a further paper would be presented outlining next steps.

2.2 Upper Gastrointestinal Cancer Workforce Business Case

The Director of Operations and Performance introduced the business case which sought to increase nurse staffing in the service to ensure that patients could be tracked and supported throughout their treatment journey, with the holistic care that was required. Funding contributions had been made by the Cheshire and Merseyside Cancer Alliance and Macmillan Cancer Support. The number of patients accessing the service had also increased significantly. Funding for 3 additional nurses and a cancer support worker was approved.

2.3 Trust Board Agenda - February

The Director of Corporate Services presented the draft Trust Board agenda for February. Committee discussed the current national escalation status and operational demands in light of the continued pressures from COVID. It was proposed that the Board and Committee meetings should continue as briefings for February. The core papers that needed to be discussed by the Board to maintain high standards for corporate governance were agreed.

2.4 COVID-19 Issues

The Director of Nursing, Midwifery and Governance presented the latest nosocomial infection rate (NCI) information. To 4th February from 1st September 2020 the overall NCI rate was now 8.9% and the weekly NCI rate was 11.3%, which had reduced from the previous week. There were 18 active outbreaks.

The Director of Integration reported that although community infection rates remained high, they had now started to fall. Knowsley (1st), St Helens (4th) and Halton (11th) continued to have some of the highest infection rates of all boroughs in England. Hospital bed occupancy and admission rates had also started to plateau, which was welcome news.

It was reported that 73% of eligible cohorts of the population had now been vaccinated in St Helens. Plans to increase the take up of the vaccine offer by the local population, working with St Helens CCG, were discussed.

2.5 Community Midwifery Service

The Director of Nursing, Midwifery and Governance reported that Halton CCG had served notice to Bridgewater Community NHSFT for the Community Midwifery service contract. A process to ensure service continuity and a smooth transition to a new provider(s) would commence in the near future.

3. 11th February 2021

3.1 Gastroenterology Consultant Business Care

The Director of Operations and Performance introduced the business case for a 10th Gastroenterology Consultant. Demand for the service had increased by 43% in the last four years and this is predicted to continue. New services had been introduced, e.g. Pill Cam and the creation of a 6th endoscopy room at St Helens Hospital. The service had also been selected to be a new site for colonoscopy as part of the Cheshire and Merseyside bowel screening programme. There was flexibility in the existing service budget so only a small additional investment was required to fund the new post. The business case was approved.

3.2 Risk Management Council (RMC) Chair's Assurance Report

The Director of Corporate Services presented the Chair's assurance report from the virtual RMC meeting on 9th February. The capacity of staff to monitor and review risks

during this period of extreme operation pressures was noted. No new risks had been escalated to the corporate risk register.

3.3 Monitoring of staff testing positive for COVID-19 following vaccination

The Director of Nursing, Midwifery and Governance reported that in line with Public Health England guidance, the Trust had introduced a reporting system for any members of staff who tested positive for COVID-19 after receiving the first dose of vaccine, to feed into the national surveillance programme. To date this had been very small numbers, and all had tested positive within 10 days of receiving the vaccine.

3.4 COVID-19 Mortality Review

The Medical Director reported on work that had been initiated to compare mortality rates in the 1st and 3rd waves of the virus. In both cases the Trust mortality rates had been within expected levels compared to national benchmarks. Improvements in care as knowledge of the disease had increased, and differences in the age groups of admitted patients, also impacted on a reduced mortality rate in wave 3. Further benchmarking with local hospitals was also being undertaken.

3.5 Patchwork Business Case – Benefits Realisation Report

The Deputy CEO/Director of Human Resources introduced the paper which provided an interim benefits realisation from the investment made in June 2020. The patchwork system allowed doctors to book bank shifts via an app. Although the full implementation had been disrupted by the pandemic the benefits already included a 6% increase in fill rate for bank shifts and an increase of 182 doctors registered with the Trust staff bank. It was also reported that the doctors found the system easier to use. A full benefits realisation review would be undertaken in the summer when the system had been in place for 12 months.

3.6 St Helens Integrated Care Partnership (ICP) Collaboration Agreement

The Director of Integration presented the draft collaboration agreement and explained that the aim was for all partners to have endorsed this by the end of March 2021. The Collaboration Agreement had been updated to reflect the organisational changes due to take place in 2021, e.g. the North West Boroughs and Mersey Care merger, and also prepare for the next stage in the development of Integrated Care structures for the NHS, ahead of the proposed legislation that was planned to come into effect from April 2022. It was noted that the concept of a lead provider was no longer part of the proposed agreement. It was recognised that there was likely to be national guidance on the role of ICPs in the new NHS structure, which may change the requirements again, but it remained important to confirm the Trust's commitment to taking forward the vision of St Helens Cares. It was agreed that the ICP Collaboration Agreement would be presented to the Trust Board in March for approval.

3.8 Integrated Performance Report (IPR) – January

The Director of Finance and Information presented the IPR for review.

3.9 COVID-19 Issues

The Director of Nursing, Midwifery and Governance reported that the cumulative nosocomial infection rate from 1st September to 11th February was now 9.5%. 18 patient outbreaks remained active but there had been no new outbreaks reported in the previous week. Outbreaks are closed 28 days after the last positive case is detected.

The most recent information demonstrated continued decreases in COVID-19 infections rates in the local population, although the rate in St Helens was still the 4th highest in the country. Although hospital admission rates had started to fall, there was still pressure on ICU capacity and the Trust had sought mutual aid via the Critical Care Network, from other units in Cheshire and Merseyside. One of the COVID cohort wards had now been de-escalated and this process would continue as patient numbers reduced.

The Trust had been allocated 32 military personnel to work at Whiston Hospital initially for a period of 4 weeks. This was very welcome, and it had been agreed they would support the facilities management functions, e.g. portering and also work with the family liaison and discharge coordination teams. A full induction and training programme had been arranged.

4. 18th February 2021

4.1 Community Services Electronic Patient Record (EPR) Business Case

The Director of Informatics presented the business case to implement a community services EPR. Following the award of national technology funding, the capital costs of the investment had been secured. This investment would enable the community services to move away from the legacy systems inherited from the previous service providers and support alignment with the systems used in primary care. An options appraisal had been undertaken on four community systems and a preferred supplier identified. The revenue costs were an increase on the current payments made for services, however the benefits of interoperability and access to electronic information also had to be considered. The cost negotiations were also ongoing and there were further opportunities to reduce revenue costs. It was agreed that the revenue cost risks could be mitigated with planned service developments and the business case was approved.

4.2 COVID Issues

The Medical Director reported that the nosocomial infection rate remained at 9.5%. There were now 17 active ward outbreaks. There was continued concern that regionally the reporting focused on outbreaks rather than the overall nosocomial infection rates, and that not all trusts appeared to be reporting outbreaks in the same way. These concerns had been raised with the regional infection prevention and control team and reporting practices were being audited.

The Cheshire and Merseyside public health data showed that community infection rates and hospital admissions continued to fall, and notably the infection rates in the over 80

age group had fallen significantly, which was likely to be as a result of this group receiving the first dose of vaccine.

COVID expenditure requests extending medical cover arrangements to the end of March were approved.

Following the introduction of the new risk algorithm, additional staff had been identified by their GP as needing to shield. To date this was only a small number of additional staff who had been added to the list of clinically extremely vulnerable people.

5. 25th February 2021

5.1 Mandatory Training and Appraisals

The Deputy CEO/Director of HR presented the performance figures for January, which reflected the suspension of all but core mandatory training, and the formal appraisal meetings. It was agreed that as operational pressures lifted all services would be supported to develop realistic recovery plans.

5.2 Five-Year IT Investment Proposals

The Director of Informatics presented an updated version of the 5-year IT investment strategy that had been amended to account for the Community EPR and reflected the revised priorities for the Digital Aspirant Programme maturity ambition post COVID-19. The revenue and capital costs were outlined, although it was recognised these were subject to funding allocations. The Committee approved year 1 of the plan, and confirmed support in principle for years 2 – 5, subject to the annual funding allocations.

5.2 Safer Staffing

The Deputy CEO/Director of HR introduced the report which provided an update on the work of the task and finish group that was reviewing the safer staffing data. The report also introduced a new format for the monthly reporting of the nurse safer staffing figures that would be used in the future. Although progress had been made, it was clear that there was not a single cause of the anomalies and there remained further issues that needed to be investigated to conclude the review and ensure the reported figures were accurate. The revised format of the report was welcomed as it was easier to understand, however it was agreed that a full audit trail needed to be provided between the previous reported figures and the revised methodology that would be adopted going forward.

5.3 Supporting Trainee Nurse Associates Business Case

The Deputy CEO/Director of HR introduced the report which sought approval to invest £107k funding allocated by Health Education England to enhancing the clinical and professional development support for Trainee Nurse Associates and Nurse Apprenticeships. The experience of the previous year had highlighted the need for dedicated support to ensure these individuals reached their potential and the roles were accepted in the workplace. Although the allocated funding was currently non-recurrent, it was agreed that this was an important investment to support the future nursing workforce

and further bids for external funding could be made if the new posts were successful. The case was approved.

5.4 COVID Issues

The nosocomial infection rate was now 9.4% and there were 19 ward outbreaks that remained active.

COVID expenditure requests were approved in relation to extending the ICU Consultant resident rota for a further month if necessary, and extending the additional junior doctor cover for nights until the end of March, or until the Medical Care Group fully contracted back into its normal bed base.

Community infection rates continued to reduce but were still 140 per 100k population locally, which was as high as in the 2nd wave.

The Director of Operations and Performance reported that the COVID Gold Command meetings had now been de-escalated to 3 times a week, instead of daily.

5.5 Restoration and Recovery

The Director of Operations and Performance reported that the North West NHSE/I team were now modelling recovery trajectories based on the backlog of elective patients whose care had been suspended during the surges in COVID infections. It had been calculated that the region would need to undertake circa 2.5% more activity compared to the 2019/20 baseline in order to restore waiting times to pre-COVID levels. Trusts had been asked to submit recovery trajectories by 15th March for the North West to make a case to receive funding from the £1.6b national recovery fund. Committee discussed the challenges for the Trust and agreed that access to additional theatre capacity would be critical to achieving the recovery trajectory and also offering mutual aid across Cheshire and Merseyside.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)009

Title of paper: Committee Report – Quality Committee

Purpose: To summarise March's Quality Committee and escalate any areas of concern

Agenda items discussed

Matters arising and action log
The action log was updated; noting the actions taken to revise Junior Doctor rotas during the pandemic to ensure appropriate and safe levels of cover. The increasing number of CAMHS referrals from the Trust has been raised with NHSE/I and a review of CAMHS capacity in the North West has been commissioned. The planned review of the IPR will now be undertaken in 2021/22 and the Dr Foster organisation has been selected to advice on best practice in presenting the KPI information. The full review is expected to take 6 – 9 months and NEDs will be engaged in the development of the new IPR. In April the committee will receive a report on the incidents related to the skin cancer pathway and the actions that have been put in place as a result.

Integrated Performance Report (IPR)
Committee members reviewed the information contained in the IPR noting particularly the level of falls resulting in severe harm in 2020/21 compared to 2019/20 and the increase in SUIs compared to 2019/20. A deep dive review of 2020/21 SUIs in was requested for the April meeting.

Quality Governance Review
The Committee were pleased to note the progress made to date in reviewing the quality governance structure. This included a review of the Quality Committee Terms of Reference (ToR), and the annual work plan, which would be recommended to the Board as part of the annual Board effectiveness review. The updated ToRs for the Patient Safety Council were also reviewed and a few point of clarification were needed before these could be approved.

Quality assurance report from Community Services
A presentation was provided to give an overview of the quality governance processes that had now been embedded in to the management arrangements of the Primary Care and Community Services Care Group, to create a robust framework and consistency of approach across all the services now managed by the Trust. The Committee noted the challenges faced by these services during the pandemic and recognised the importance to welcoming all the community nursing staff to the Trust, when they transferred in April 2020 and their role during the pandemic.

Patient Safety Council (PSC) Assurance Report – March 2021
The Committee noted the PSC report which included details of the Q3 serious incidents, including those reported to StEIS. Committee was assured that an allegation of abuse had been fully investigated both internally and by the Police and no evidence was found to substantiate the claim. The PSC had also received reports on CAS alerts, Sepsis screening and the results a neutropenic sepsis audit.

Maternity Staffing for Safety (Q1 and Q2)
The Committee received two reports that provided assurance that the staffing levels met the recommendations for safe staffing levels in Maternity services. For both quarters the staffing had met the birth rate plus standards and all staffing incidents "red flag events" had been investigated. In the Q2 report the increase in red flag incidents was noted, as staffing pressures due to sickness and COVID related absences, had increased. It was noted that none of the red flag incidents had resulted in patient harm. It was noted that a new baseline Birth Rate Plus staffing review was being undertaken across Cheshire and Merseyside to take account of service developments, such as continuity of carer and patient acuity. Committee recognised the pressures that had been faced by the Maternity Services during the pandemic and the challenges of meeting the personalisation and choice targets e.g. the increase in home births.

Maternity – Perinatal Maternity Reviews
Committee received 3 quarterly reports covering April – December 2020, which detailed the reviews using the Perinatal Mortality Review Tool (PMRT) that had been reported to MBRRACE-UK in each quarter and the reviews completed, with the lessons learnt and actions taken. It was noted that the impact of coronavirus on perinatal mortality was not yet fully understood but was being monitored nationally. The steps taken to improve the electronic recording and real time updating of risk assessments of pregnant women was also highlighted. These reports also reflected the pressures faced by Maternity Services during the pandemic. A further deep dive report will be presented to Quality Committee in April.

Patient Experience Council (PEC) Chair's Report March 2021
A summary of the meeting was provided highlighting the positive comments posted on the NHS website and an update regarding the Volunteer Service who are active in supportive roles across the Trust. The Committee commended the volunteers for the hard work undertaken during the pandemic and especially over the Christmas period.

Clinical Effectiveness Council Chair's Report – March 2021
A summary of the meeting highlighted that the Council had received a number of catch up reports, following meetings that had been cancelled due to the pandemic and noted that there were still a number that had been deferred. The NICE Q2 and Q3 report highlighted the actions being taken to ensure the Trust was compliant with the circa 130 pieces of new guidance that had been received with only 8 items outstanding.

Issues for escalation to the Board
There were no specific issues to be escalated to the Trust Board but the actions being taken to catch up on the issues deferred during the last 2 months is to be noted.

Corporate objectives met or risks addressed: Care, safety, pathways, communication, system

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff, regulators and commissioners

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

Presenting officer: Gill Brown, Non-Executive Director and Chair of Committee

Date of meeting: 31st March 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)010

Title of paper: Committee Report – Finance & Performance

Purpose: To update Board members on key issues discussed at the Finance & Performance Committee meeting on 25th March 2021

Summary:

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
P Growney – NED
AM Stretch – Deputy Chief Exec & Director of HR
N Khashu – Director of Finance & Information
R Pritchard Jones – Medical Director
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
A Bassi – Divisional Medical Director
J McCabe – Divisional Medical Director
G Lawrence – Deputy Director of Finance & Information

Agenda Items
For Assurance

A) Integrated Performance Report

- Performance on RTT and the rise in 52-week waits was discussed, and the committee was updated on workstreams being led locally and regionally by the respective directors. It was agreed that this would be a long recovery and additional capacity would be required to return to pre-pandemic levels of performance.
- Cancer performance was highlighted and continues to be strong overall with concerns regarding some sub-specialities.
- The committee noted that there was 1 case of MRSA in February and 5 C-Diff cases.
- The committee also noted the increases in activity through the UEC and A&E as these have started to increase.

B) Finance Report Month 11

- The Trust is currently forecasting an £8.1m deficit, this has improved by £4.8m since the previous month because of the Trust receiving additional income. £4m has been received for non-NHS income that could not be delivered because of the pandemic and £0.8m for the costs of testing.
- The committee discussed the annual leave accrual and were informed that the Trust will receive £4.4m in March to offset this cost. This will improve the forecast outturn again in March from the current £8.1m deficit to £3.7m deficit.
- The Trust had a cash balance of £74m at the end of February. The committee discussed the advanced payments the Trust have been receiving during March. The committee agreed that the Trust should continue to accept advance payments whenever possible as this strengthens the liquidity of the Trust going into the next financial year.
- Capital was discussed and the committee were pleased that the capital resource would be utilised in year as this is not always the case in other organisations.

For Approval

A) Interim Expenditure budgets for 2021/22

- The committee discussed the interim expenditure budgets for 2021/22.
- It was noted that no national guidance had yet been published but it was important that the Trust had expenditure budgets to work with for the new financial year. It was agreed that these interim expenditure budgets would be updated at future meetings when guidance is released.
- The committee discussed the bridge from the agreed budgets of 20/21 and noted that these did not include any costs for recovering the Elective programme or the continued management of COVID.
- The committee discussed the proposed capital plan and noted the outstanding funding element of the plan and that this would either be funded by agreed surpluses or additional borrowing. The committee also noted that the capital envelope for Cheshire & Merseyside was over-subscribed and that this will potentially affect the proposed capital plan.
- The committee approved the interim expenditure budgets and agreed to recommend them to the Board.

For Information

A) Month 11 2020/21 Financial Performance

- It was noted that outpatient activity had continued during wave 3 and this was testament to the Trust in ensuring it continued this service for its patients.

B) CIP Planning 2021/22

- The Committee noted the progress made on CIP for 21/22
- The Committee were assured on the number of schemes and that there were 25% more than this time last year. It was also noted that the schemes would need to be reviewed once planning guidance is released.

C) Briefing Papers accepted from

- Procurement Steering Council
- Capital Steering Council

Risks noted/Items to be raised at Board

- To approve the interim expenditure budgets for 2021/22

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: 31st March 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)011

Title of paper: Trust Objectives 2021/22

Purpose: To review the progress made against the 2020/21 Trust Objectives, including those to be rolled forward to 2021/22 as a result of the COVID-19 pandemic and to approve the Trust Objectives for 2021/22.

Summary:

The Board agreed objectives for 2020/21 in March 2020 and these were then reviewed and updated in June 2020, following the first wave of the pandemic. However this review did not anticipate the impact of the 2nd and 3rd waves of COVID-19, when business as usual activities were suspended and all available resources diverted in to supporting the response to the emergency situation, in line with national directions. In some cases national NHS targets were also suspended or not set for the year and in others the impact of COVID on other organisations and businesses has limited the progress that could be delivered.

As a result many of the planned objectives for 2020/21 have not been fully achieved, but the Trust has delivered many other changes and developments as part of its response to the pandemic. The Trust Board has previously recognised the importance of acknowledging these extraordinary achievements that reflected the changed priorities of the Trust and the whole NHS, during this period.

The 2020/21 objectives (Appendix 1) have therefore been reviewed and categorised as follows;

2020/21 Assessment Key	Colour
Achieved	
Partially Achieved	
Partially Achieved and roll forward to 2021/22	
Not achieved or not achievable due to COVID	
Not achieved or achievable due to COVID and carry forward to 2021/22	

On this basis it is proposed that a number of objectives from 2020/21 are rolled forward to 2021/22 and these are supplemented with new objectives focusing on safety, recovery and preparing for system change in response to the recent White Paper, that support the delivery of the Trusts vision for “Five Star Patient Care”.

The delivery of the Trust Objectives for 2021/22 assumes that there are no further significant waves of COVID-19 that necessitate a full emergency escalation response.

The proposed objectives for 2021/22 (Appendix 2) have been categorised as;

2021/22 Key	Colour
Objective rolled over from 2020/21	
Updated objective for 2021/22	
New objective for 2021/22	

The Trust Objectives for the year will form the core of each director's personal objectives, and will be publicised across the organisation and launched at the start of the year conference.

There will be a mid-year review of progress that will come to Board in November 2021.

Corporate objectives met or risks addressed: Five star patient care

Financial implications: None arising directly from this report

Stakeholders: Non-Executive Directors, staff, patients, regulators, partners

Recommendation(s): The Trust Board;

1. Notes the achievement or roll over of the 2020/21 Trust Objectives
2. Approves the Trust Objectives for 2021/22

Presenting officer: Ann Marr, Chief Executive

Date of meeting: 31st March 2021

Appendix 1

Review of 2020/21 Trust Objectives

Initial 2020/21 Trust Objectives were reviewed and revised in June 2020 to reflect the impact of the first wave of the COVID-19 Pandemic, they were not adjusted to reflect the impact of wave 2 (October and November 2020) and wave 3 (January to March 2021) which also resulted in the suspension of elective activity and BAU across the organisation to mobilise the required emergency response.

Achieved		Partially Achieved		Partially Achieved and roll forward to 2021/22		Not achieved or not achievable due to COVID		Not achieved or achievable due to COVID and carry forward to 2021/22	

Objective	Lead Director	Measurement	Governance Route	Status
Extraordinary Collective Objective 1 Achieve restoration, resetting and recovery of Trust services following COVID-19, across all clinical and corporate departments	Executive Team	• Restore maximum capacity of clinical services, achievable with social distancing and compliance with Infection Prevention Control guidance • Ensure that patients requiring urgent care and treatment are identified and prioritised • Support staff as they continue to cope with the consequences of COVID-19 • Reduce the backlog of outstanding work were services or activities have been suspended or staff re-deployed	Trust Board	Partially achieved between waves of COVID and to be rolled over into 2021/22
Extraordinary Collective Objective 2 Embed the clinical, technological and process innovations achieved during COVID-19 into the future business as usual of the Trust	Executive Team	• Review the clinical and corporate changes that have been introduced during the COVID-19 major incident and assess the benefits • Wherever possible secure an ongoing return for the additional investments made during the COVID-19 and restoration periods • Work with stakeholders to ensure the changes that have improved patient care, become embedded in normal practice	Trust Board	Partially achieved – To be rolled over to 2021/22
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				

Objective	Lead Director	Measurement	Governance Route	Status
1.1 Continue to increase the range of services provided 7 days a week	MD	• Achieve the national targets for 90% of patients across all the 7-day services metrics by 2021, in particularly improve performance in 2019/20 against the targets for: ➢ 90% of patients to receive a senior clinical review each day ➢ 90% of patients to be assessed by a Consultant within 14 hours of admission	Quality Committee	The national audit and monitoring process was suspended due to COVID and confirmation received that it will not be re-started.
1.2 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of AKI and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee	Partially achieved. Quality Account priorities to be rolled over to 2021/22
1.3 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	DoOp	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Quality Committee	Partially achieved. Quality Account priorities to be rolled over to 2021/22
1.4. Increase capacity at Whiston		• Complete the scheme to create 60 additional beds on the Whiston		Bevan Court opened in

Objective	Lead Director	Measurement	Governance Route	Status
Hospital and improve clinical adjacencies at the Trust to optimise patient flow	DoOp/ DoCS	Hospital site • Progress the capital schemes planned for 2020/21 that will expand the emergency department and Paediatric assessment area and progress the ambulatory and Same Day Emergency Care (SDEC) redesign. • Continue to review care pathways to reduce variation and duplication	Trust Board	August 2020 Discharge lounge scheme to be completed early April. Alternative proposals for SDEC and clinical adjacencies developed
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Continue to learn lessons and change practice by improved measuring of the outcomes for our patients	MD	• Use available date to identify where care for patients can be improved, allowing targeted projects to make long lasting changes to practice. • Reduce AKI by 20% • Reduce hospital acquired pneumonia by 10% • Use lessons learnt from incidents, complaints and claims to improve practice and reduce similar incidents in the future	Quality Committee	Partially achieved. Roll over to 2021/22
2.2 Reduce avoidable harm by preventing pressure ulcers (QA)	DoN	• Quarterly audit to confirm compliance with Trust policy in the identification of patients at risk of developing pressure ulcers and in the provision of appropriate equipment to support prevention • 10% reduction in category 2 pressure ulcer incidents with possible lapses in care from 2019-20 baseline	Quality Committee	Achieved
2.3 Reduction in hospital acquired blood stream infections (C-Diff and E-Coli)	DoN	• Achieve or improve upon the Trust incidence levels set by NHSE/I • Fully implement the C-Diff action plan • Share lessons from RCA's	Quality Committee	No levels set by NHSE/I for 2020/21 so have measured against 2019/20 for C-Diff, and other outcomes measures suspended due to

Objective	Lead Director	Measurement	Governance Route	Status
		• Audit compliance with Trust guidance for the timeliness of testing		COVID
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)	DoOp	• Ensure sufficient and appropriate information is provided to all patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information • Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards.at weekends • Implementation of standardised patient equipment ordering process for aides required at home	Quality Committee	National Patient surveys did not take place. Project suspended due to COVID roll forward to 2021/22
3.2 Integrate and transform the community health services that will be directly provided by the Trust from April 2020 and continue to improve end to end pathways of care	DoOp	• Assimilate the new the Community Nursing and Paediatric services that are transferring to the Trust and make staff feel welcome • Optimise the delivery of integrated care pathways across primary, community and secondary care working with primary care networks to provide care closer to home and avoid unnecessary hospital admissions • Improve patient experience scores and feedback related to discharge	Quality Committee	Achieved
3.3 Transformation of Urgent Treatment Centre (UTC) to maximise	DoOp	• Attendance rate at UTC and associated 4-hour performance	Finance and	COVID-19 changed ED and UTC

Objective	Lead Director	Measurement	Governance Route	Status
capacity, throughput and patient experience		• Reduced rate of A&E attendances and hospital admissions • Reduced deflection rate from UTC to A&E • Implementation of condition specific pathways • Improve patient satisfaction and experience ratings	Performance Committee	attendance patterns and hospital admission rates. NHS111 First implemented. Roll forward to 2021/22
3.4 Review Trust Acute medical care pathways to ensure optimal configuration	DoOp	Agree the optimal configuration of services to; • Reduced number of patient ward moves • Reduced number of FCEs • Implement direct to specialty pathways • Improve patient satisfaction and experience ratings	Executive Committee	Configuration of all Trust inpatient beds impacted by COVID Roll forward to 2021/22
3.5 Increase the opportunities for patients to enter research studies and increase the number of clinical trials that the Trust participates in.	MD	• Increase recruitment to research studies by 20% • Open more trials across both commercial and portfolio studies	Quality Committee	Achieved
3.6 Continue to redesign outpatient pathways through transformation and modernisation	DoI/DoOp	• Continued roll-out of Telehealth across identified specialties • Optimisation of current systems to continue the reduction in DNAs • Reduction in complaints from patients due to late or over-running clinics • Reduced travelling time and costs for clinicians using the technology to provide outreach services	Executive Committee	Telehealth now used by 50 specialities. Social distancing and IPC measures have a significant impact on the delivery of outpatient services and has accelerated move to telehealth and video consultations

Objective	Lead Director	Measurement	Governance Route	Status
		• Extra clinical capacity that can now be invested back into patient care in the acute setting or scheduling more clinics • Reduced car parking congestion		Will be part of the restoration and recovery plans in 2021/22
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Increase the proportion of patients who report that they have received an appropriate amount of information about their care (QA)	DoN	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	Quality Committee	All national patient surveys were suspended during 2020/21
4.2 Implementation of an automated switchboard system that improves the experience for the public/patient by introducing automatic call routing to the desired ward/department whilst reducing call wait times.	DoI	• Achieve a target of 95% phone calls answered and routed through to the appropriate department • Reduce average call answering time to 20 seconds	Executive Committee	Achieved – in February 2021 96.2% of calls answered with an average queue time of 20 seconds
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Digitise more of the paper based medical record e.g. observation charts, nursing assessments and care plans, AHP assessments and care plans and inpatient clinical narrative	DoI	• Reduce the amount of paper in Nursing documentation produced as part of the paper based medical record by 25% • Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need access • Improve e- observation to facilitate early identification of deterioration leading to earlier intervention Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care	Executive Committee	Partially achieved. DAP programme re-prioritised to support COVID pandemic response Elements to be carried forward to 2021/22

Objective	Lead Director	Measurement	Governance Route	Status
5.2 Reduce PC login times making it faster for staff to log on to systems to access the right patient information quickly and easily	DoI	• Reduce the time to log on to a PC by at least 30% • Benchmark login times over a period in Q2 of 2020/2021 (Windows 10) compared to a period in Q4 of 2019/2020 (Windows 7).	Executive Committee	Achieved
5.3 Implementation an integrated bed management and discharge planning system to allow Clinicians to see patient status “at a glance” and improve the accuracy of information on patient flow, to support admission and discharge decisions by the Site Management teams	DoI/DoOp	• Reduced the time taken to admit patients to wards from A&E • Increase the % of patients discharged before midday. • Support the reduction in bed occupancy to 92% • Reduce the number of medical patients who have to outlie in surgical beds • Help support reduction in length of stay • Improve access to patient information for Clinicians, to enable more effective prioritisation	Executive Committee	Partially achieved / suspended or delayed due to COVID Roll forward to 2020/21
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				

Objective	Lead Director	Measurement	Governance Route	Status
6.1 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Maintain all efforts to recruit 80 additional permanent new nurses, 50 further nurses 20 medical and dental posts are recruited via international recruitment programmes • Create more opportunities for staff to retire and return, transfer between wards for job enrichment, or adopt flexible approaches to working • Reduce staff turnover rates and improve labour stability rates • Comply with NICE guidance and the NHS People Plan in the extended range of support services available to improve the health, well-being, and resilience of our staff • Increase the % of the apprenticeship levy that is allocated • Recruitment of 24 trainee nursing associates (TNA) and develop new posts and appropriate specialist training routes for 4 Advanced Care Practitioners and 10 Physician Associates • Enhance the provision of development opportunities to support talent management and retention	Trust Board	Some elements achieved or enhanced due to COVID-19. Roll over to 2021/22 accepting suspension of apprenticeships and TNA courses will take some time to re-start and will impact on pipeline
6.2 Continue to respond to feedback from staff to improve appraisals to support staff to deliver high quality patient care.	DoHR	• Engage with staff about what a quality appraisal looks like • Improve the staff survey results for the quality of appraisals for all staff • Provide targeted training for managers on appraisal skills	Quality Committee	The national staff survey had a different focus in 2020/21 to reflect the pandemic. And appraisals suspended for much of the year. New appraisal process launched, but many training activities suspended.

Objective	Lead Director	Measurement	Governance Route	Status
				Roll forward to 2021/22
6.3. Improve the compliance delivery and ease of access of mandatory training for all staff	DoHR	• Undertake a review of how mandatory training is currently delivered • Engage staff and managers in new ways of delivery • Explore innovative and engaging delivery methods by learning from the best in class	Trust Board	Partially achieved. Mandatory training suspended due to COVID, but has prompted innovation in delivery methods. Roll forward to 2021/22
6.4 Continue to listen to our staff to ensure we remain an employer of choice	DoHR	• NHS Staff Survey Action Plan monitoring • WRES & WDES Action Plan monitoring	Executive Committee	Partially achieved some actions will be rolled forward to 2021/22 action plan
6.5 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimum design of the workforce and the right number and skill mix of staff	DoHR	• Implement e-rostering to 100% of all staff remaining staff to include non-clinical and corporates services staff • Restart the specialist nursing-job planning project with the aim of having 50% with refreshed job descriptions that reflect to needs of the service • Restart the Activity Manager project for theatres and all surgical specialities by during Q3 2020 with the aim of completion by Q3 2021 • Deliver the benefits realisation plan for “Better eRostering” for Medical Staff, Nursing & AHP’s by September 2021 • Produce reports from the Roster perform, Activity Manager and Safe Care systems to demonstrate safe levels of staffing based on the acuity of patients	Executive Committee	Projects had to be suspended to re-direct resources to support COVID-19 response Re-start in 2021/22

Objective	Lead Director	Measurement	Governance Route	Status
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including any new measures • 62-day cancer treatment standard • Diagnostic tests completed within 6 weeks • Ambulance handover times	Finance and Performance Committee	The 18-week target has been suspended due to COVID -19, and introduction of the new emergency access standards delayed. Cancer target achieved Recovery and restoration trajectories to recover constitutional standards to be a focus for 2021/22
7.2 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g. GiRFT and Model Hospital to ensure that all services meet best practice standards	DoOp	• Continued participation in national programme of GiRFT reviews and delivery of the resulting action plans • Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery	Finance and Performance Committee	National GiRFT programme has been suspended, with no known date to recommence. Monitoring of previous action plans will continue. Roll forward to 2021/22

Objective	Lead Director	Measurement	Governance Route	Status
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaborative corporate services	DoF	• Membership of the Collaboration at Scale Board and leadership of the Finance, HR Services, Legal, Risk and Governance work streams.	Finance and Performance Committee	All CaS activities have been suspended during 2020/21 due to COVID-19
8.2 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Plan to achieve break even income and expenditure position subject to NHSE/I financial framework and confirmation • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.	Finance and Performance Committee Audit Committee	Achieved as far as possible within the emergency COVID financial regime
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve system success	DoCS	• Meet statutory responsibilities • Within these work in partnership across the Cheshire and Merseyside HCP to achieve the goals of the NHS LTP for collaboration and integration	Trust Board	Continued to meet statutory responsibilities and regulatory requirements that remained in place during COVID-19
9.2 Working with health and care system partners to develop plans to implement the ambitions of the NHS Long Term Plan for the local population	DoT/DoInt	• Launch the St Helens Place Based Plan 2020-24 • Development a 'Place' Dashboard to measure the delivery of the plan and demonstrate the impact of integrated care • Support the Primary Care Networks to deliver the Primary Care Network (PCN) Service Specifications	Trust Board	Hospital and out of hospital "cell" structures in place and progress with integrated care and collaboration.
9.3 Provide leadership and direction as part of the C&M HCP to achieve clinically and financially sustainable acute services.	DoInt	• Develop areas for collaboration that bring benefits for patients and partner organisations • Leadership of the Acute Sustainability Programme	Trust Board	

Appendix 2

2021/22 Proposed Objectives

Objective rolled over from 2020/21		Updated objective for 2021/22		New objective for 2021/22	

Objective	Lead Director	Measurement	Governance Route	Category
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Use lessons learnt from incidents, complaints and claims to improve practice and reduce similar incidents in the future	Quality Committee	Rolled over from 2020/21
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	DoOp	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring • Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Quality Committee	Rolled over from 2020/21

Objective	Lead Director	Measurement	Governance Route	Category
1.3. Increase capacity at Whiston Hospital and improve clinical adjacencies at the Trust to optimise patient flow	DoOp/ DoCS	• Continue to progress the strategic site development plans for the Trust and the capital schemes that are planned for 2021/22 to improve patient facilities and increase capacity; ▪ Paediatric Emergency Department and Children's Observation Ward ▪ Theatre capacity ▪ Same Day Emergency Care and optimisation of clinical adjacencies/pathways	Trust Board	Updated
1.4 Review and improve the management, monitoring and tracking of patients on waiting lists to ensure a consistent approach by all elective specialties, learning lessons from previous incidents.	DoOp	• Number of Datix incidents related to issues with waiting list management • Embed learning from harm reviews • Adequate Business Intelligence (BI) reporting to flag priority patients • Standardisation of patient pathway management across all specialties • Implementation of end to end automated patient tracking	Quality Committee	New
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Continue to learn lessons and change practice by improved measuring of the outcomes for our patients	MD	• Use available date to identify where care for patients can be improved, allowing targeted projects to make long lasting changes to practice. • Reduce hospital acquired AKI by 20% • Reduce hospital acquired pneumonia by 10%	Quality Committee	Rolled over from 2020/21

Objective	Lead Director	Measurement	Governance Route	Category
		• Reduced rates of AKI and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data		
2.2 Reduce avoidable harm by preventing falls (QA)	DoN	• To reduce the number of avoidable falls per 1000 bed days from 9.2 to 7.2 or less • All patients will have a documented falls risk assessment within 6 hours of admission and this is review at least every 72 hours or change in the patient's condition • To audit that all preventative actions are implemented following falls risk assessments	Quality Committee	New
2.3 Evaluate best practice and develop proposals for improving the Trust wide safety culture/methodology	DoN	• Involve and engage staff across the organisation to co-design a Trust-wide "Safe and Sound" Quality Improvement Methodology • Develop a business case to support implementation of preferred methodology • Develop a "Safe and Sound" work programme and celebrate achievements	Quality Committee	New
2.4 Implement the recommendations of the Ockenden Report in to the safety of Maternity Services	DoN	• To monitor the delivery of the Ockenden report implementation plan • To meet the requirements of the 51% for continuity of carer target by March 2022	Quality Committee	New
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)	DoOp	• Ensure sufficient and appropriate information is provided to all patients on discharge	Quality Committee	Rolled forward from 2020/21

Objective	Lead Director	Measurement	Governance Route	Category
		• Improve Inpatient Survey satisfaction rates for receiving discharge information • Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards.at weekends		
3.2 Transformation of Urgent Treatment Centre (UTC) to maximise capacity, throughput and patient experience	DoOp	• Attendance rate at UTC and associated 4-hour performance • Reduced rate of A&E attendances and hospital admissions • Reduced deflection rate from UTC to A&E • Implementation of condition specific pathways • Improve patient satisfaction and experience ratings	Finance and Performance Committee	Rolled forward from 2020/21
3.3 Review Trust Acute medical care pathways to ensure optimal configuration	DoOp	Agree the optimal configuration of services to; • Reduced number of patient ward moves • Reduced number of FCEs • Implement direct to specialty pathways • Improve patient satisfaction and experience ratings	Executive Committee	Rolled forward from 2020/21
3.4 Continue to redesign outpatient pathways through transformation and modernisation	DoI/DoOp	• Continued roll-out of Telehealth across identified specialties	Executive Committee	Rolled forward from 2020/21

Objective	Lead Director	Measurement	Governance Route	Category
		• Optimisation of current systems to continue the reduction in DNAs • Reduction in complaints from patients due to late or over-running clinics • Reduced travelling time and costs for clinicians using the technology to provide outreach services • Extra clinical capacity that can now be invested back into patient care in the acute setting or scheduling more clinics • Reduced car parking congestion		
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Increase the proportion of patients who report that they have received an appropriate amount of information about their care (QA)	DoN	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information compared to last published surveys in 2019	Quality Committee	Rolled forward from 2020/21
4.2 Introduction of new Trust Website to improve access to information about the Trusts services	DoHR	• Develop and launch the new Trust website • Monitor the impact and record and report access metrics e.g. number of clicks to required information	Executive Committee	New
4.3 Ensure patients relatives are kept appropriately informed, whilst COVID-19 visiting restrictions remain in place	DoN	• Nominated relatives to receive an update on the patient's condition and care plan at least every 48 hours • Reduction in the number of concerns received about communication with relatives	Quality Committee	New

Objective	Lead Director	Measurement	Governance Route	Category
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Further develop the use of electronic patient information to replace paper based medical records e.g. observation charts, nursing assessments and care plans, AHP assessments and inpatient clinical narrative	DoI	• Reduce the amount of paper in Nursing documentation produced as part of the paper based medical record by 25% • Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need to access • Improve e- observation to facilitate early identification of deterioration leading to earlier intervention • Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care	Executive Committee	Rolled forward from 2020/21
5.2 Implementation an integrated bed management and discharge planning system to allow Clinicians to see patient status "at a glance" and improve the accuracy of information on patient flow, to support admission and discharge decisions by the Site Management teams	DoI/DoOp	• Reduced the time taken to admit patients to wards from A&E • Increase the % of patients discharged before midday. • Support the reduction in bed occupancy to 92% • Reduce the number of medical patients who have to outlie in surgical beds • Help support reduction in length of stay • Improve access to patient information for Clinicians, to enable more effective prioritisation	Executive Committee	Rolled forward from 2020/21
5.3 Continue to develop the Trust's digital maturity	DoI	• Deliver the agreed Digital Aspirant Programme objectives for 2021/22 • Continue to host and develop the CIPHA system and shared care record on behalf of the Cheshire and Merseyside ICS		New

Objective	Lead Director	Measurement	Governance Route	Category
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				
6.1 Enhance health and wellbeing support and services for staff	DoHR	• Comply with NICE guidance and the NHS People Plan in the extended range of support services available to improve the health, well-being, and resilience of our staff , including supporting staff who have been impacted by the COVID-19 pandemic	Quality Committee	New
6.2 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Maintain all efforts to recruit 80 additional permanent new nurses, 50 further nurses and 20 medical and dental posts are recruited via international recruitment programmes • Create more opportunities for staff to retire and return, transfer between wards for job enrichment, or adopt flexible approaches to working • Improve labour stability rates and reduce staff turnover rates in targeted areas • Increase the % of the apprenticeship levy that is allocated • Recruitment of 24 trainee nursing associates (TNA) and develop new posts and appropriate specialist training routes for 4 Advanced Care Practitioners and 10 Physician Associates • Enhance the provision of development opportunities to support talent management and retention	Quality Committee	Rolled forward from 2020/21
6.3 Continue to respond to feedback from staff to improve appraisals to support staff to deliver high quality patient care.	DoHR	• Embed the new Trust appraisals process and evaluate the impact • Survey staff satisfaction with the quality of appraisals • Provide targeted training for managers on appraisal skills	Quality Committee	Updated

Objective	Lead Director	Measurement	Governance Route	Category
6.4. Improve the compliance delivery and ease of access of mandatory training for all staff	DoHR	• Fully implement the review of how mandatory training is delivered, including the innovations in training that were used during COVID-19 • Engage staff and managers in new ways of delivery	Quality Committee	Updated
6.5 Continue to listen to our staff to ensure we remain an employer of choice	DoHR	• NHS Staff Survey Action Plan monitoring • WRES & WDES Action Plan monitoring • A refreshed Equality, Diversity and Inclusion Strategy and development plan	Executive Committee	Rolled forward from 2020/21
6.6 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimum design of the workforce and the right number and skill mix of staff	DoHR	• Implement e-rostering to 100% of all staff remaining staff to include non-clinical and corporates services staff • Restart the specialist nursing-job planning project with the aim of having 50% with refreshed job descriptions that reflect to needs of the service • Deliver the benefits realisation plan for "Better eRostering" for Medical Staff, Nursing & AHP's • Produce reports from the 'Roster Perform' and Safe Care systems to demonstrate safe levels of staffing based on the acuity of patients	Executive Committee	Rolled forward from 2020/21
7. OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Resume and restore corporate activities to business as usual standards following COVID-19, across all services	Executive Team	• Restore maximum possible capacity of clinical services, achievable with social distancing and compliance with Infection Prevention Control guidance • Ensure that patients requiring urgent care and treatment are identified and prioritised	Trust Board	Rolled over from 2020/21

Objective	Lead Director	Measurement	Governance Route	Category
		• Support staff as they continue to cope with the consequences of COVID-19 • Reduce the backlog of outstanding work were services or activities have been suspended or staff re-deployed		
7.2 Achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including any new measures • 62-day cancer treatment standard • Diagnostic tests completed within 6 weeks • Ambulance handover times • Achieve the Trust level recovery trajectory for elective activity, as agreed with the Cheshire and Merseyside Hospital Cell	Finance and Performance Committee	Updated
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g. GiRFT and Model Hospital to ensure that all services meet best practice standards	DoOp	• Continued participation in national programme of GiRFT reviews and delivery of the resulting action plans, when the national programme re-starts • Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery	Finance and Performance Committee	Rolled over from 2020/21
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Embed the clinical, technological and process innovations achieved during COVID-19 into the future business as usual of the Trust	Executive Team	• Review the clinical and corporate changes that have been introduced during the COVID-19 major incident and assess the benefits • Wherever possible secure an ongoing return for the additional investments made during the COVID-19 and restoration periods	Trust Board	Rolled over from 2020/21

Objective	Lead Director	Measurement	Governance Route	Category
		• Work with stakeholders to ensure the changes that have improved patient care, become embedded in normal practice		
8.2 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaborative corporate services	DoF	• Take forward the agreed collaborative projects for corporate functions, when the C&M Collaboration at Scale work stream resumes • Until corporate collaboration as scale resumes, to drive other opportunities in support services such as clinical support services (pathology & radiology)	Finance and Performance Committee	Updated
8.3 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2021/22 agreed under the new NHS financial regime. • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.	Finance and Performance Committee Audit Committee	Updated
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve system success	DoCS	• Meet statutory and regulatory responsibilities • Prepare for the system changes which will be introduced by the NHS White Paper, including the changing responsibilities of the Cheshire and Merseyside Integrated Care System and shaping the development of effective Place structures.	Trust Board	Updated
9.2 Working with health and care system partners to develop and implement Place based Integrated Care Partnerships to improve the health of the local population	DoInt	• Support our local boroughs to establish Integrated Care Partnerships (ICPs) • Establish a programme delivery infrastructure for St Helens ICP including a dashboard of key performance and health improvement indicators • Support Primary Care Networks (PCNs) to deliver the primary care	Trust Board	Updated

Objective	Lead Director	Measurement	Governance Route	Category
		service specifications and become central to locality delivery		
9.3 Provide leadership and direction as part of the C&M ICS to achieve clinically and financially sustainable acute services.	DoInt	• Develop areas for collaboration that bring benefits for patients and partner organisations • Support the development of effective Provider Collaboratives that enhance collaboration and integration with other providers	Trust Board	Updated

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)012

Title of paper: Care Quality Commission (CQC) compliance & registration

Purpose: This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to provide assurance to the Board.

Summary:

The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The latest Trust inspection took place in July/August 2018 and covered the following areas:

- Use of resources
- Surgery
- Urgent and emergency care
- Maternity
- Community services
- Marshalls Cross Primary Care Service
- Well-led domain

The final report was published on 20th March 2019 and the overall Trust rating was outstanding.

The report identified three breaches of the CQC regulations in relation to Marshalls Cross Medical Centre. Actions have previously been taken to address the three issues internally, which have been assessed by Mersey Internal Audit Agency and found to be compliant.

During 2020-21 the CQC implemented a transitional regulatory approach to monitoring, which included a review of the Trust's Infection Prevention Board Assurance Framework in July 2020. This confirmed that the board was assured that the Trust had effective infection prevention and control measures in place. In addition, a review of compliance with a selection of key lines of enquiry for the large vaccination centre at St Helens Rugby Ground was completed in March via a monitoring call. There were no issues highlighted during the call, however, written feedback has not yet been received.

Appendix 1 provides an updated summary of compliance against each of the relevant standards.

Corporate objectives met or risks addressed: Care, safety and communication

Financial implications: The CQC charges all providers an annual registration fee to cover its regulatory activities based on a % of the patient care income from the most recent annual accounts:
2019-20 fee = £238,394
2020-21 fee = £249,293
2021-22 fee estimated as £281,838

Stakeholders: Trust Board, patients, carers, staff, regulators, including the CQC & commissioners

Recommendation(s): For the Trust Board to review the information provided to confirm compliance with the fundamental standards and on-going CQC registration requirements and to determine if further information or evidence is required.

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

Date of meeting: 31st March 2021

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 12th March 2021
	Full assurance in place in STHK
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Remuneration	DoHR		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard, which is applied to all new appointments and renewed annually. All records available for review by CQC if required.
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive	DoNMG		Director of Nursing, Midwifery and Governance is the Accountable Person registered with the CQC. Director of Nursing registered with the CQC as responsible officer and confirmed in the latest certificate received dated 02/12/2019.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	Quality	DoNMG		See information below for compliance
1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	Quality	DoNMG		All patients are assessed on admission/commence on caseload and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, promotion of John's Campaign to support carers who wish to stay with patients/carer beds (which has remained in place during the pandemic as a valid exemption to the visiting restrictions) hearing loops & communication aids. In outpatients, double, early and late appointments are used along with desensitising visits to clinics. Specialities have developed their own pathway supporting people with additional needs and include imaging, endoscopy and pre-operative assessment. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. Mental Capacity Act included in mandatory training with compliance achieved year-to-date. Up-to-date Consent Policy in place and available on the Trust's intranet with consent training provided. This is currently being updated following appointment of new clinical lead for consent. Compliance with nursing care indicators is regularly audited and reported to each ward and the Patient Experience Council. The Trust received an overall rating of outstanding for the caring domain, with examples of compliance sited in the CQC inspection report, including the fact there were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were met appropriately and promptly. The CQC observed positive interactions when staff were seeking consent. Positive comments continue to be received via NHS website and Friends and Family Test feedback.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, including when sleeping, toileting and conversing.	Safe, **Caring,** Responsive	Quality	DoNMG		The Trust's values include respectful and considerate and these are reiterated at interview, on induction and during appraisals. Values based recruitment is in place for all staff. Privacy and dignity is assessed as part of the CQC inspection, external PLACE assessments (which were paused during the pandemic) and internal audits (which have continued in 2020-21). Trust rated best nationally in latest PLACE assessment for third year running (2019). 2019 inpatient survey results state 90% patients' privacy maintained definitely and 9% to some extent. Privacy and dignity consistently scores highly in the Nursing Care Indicators. Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. Provision of Single Sex Accommodation Policy in place, which requires any breaches to be reported via the Datix system. Annual mixed sex declaration submitted to the Board each March with no breaches reported in 2020-21, two breaches reported in 2019-20 for step down patients in Critical Care and none for over two years prior to this.
3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe,** Responsive	Quality	MD		Up-to-date Consent Policy in place and patients are consented using standard Trust forms for all procedures. Annual consent audit undertaken as part of the clinical audit programme which is reported to the Clinical Effectiveness Council. CQC observed positive interactions when staff were seeking consent. Consent training provided. Any incidents where consent issues are identified, including through claims and complaints, are investigated and actions taken to deliver improvements.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	Quality; Workforce Council; Executive	DoHR, DoNMG, DoCS,		H&S risk assessments in place and outlined in H&S Policy & supporting documents. Work place inspections reported to Health and Safety Committee which reports to Workforce Council and programme of environmental checks in place, with actions taken to address any issues identified. All staff were risk assessed as part of the pandemic response, with appropriate redeployment put in place depending on the outcome of the risk assessment. Staff reported positively on the availability of personal protective equipment during the pandemic and Health and Safety Executive review in December 2020 found no cause for concern. Relevant checks against job description/person specification undertaken as part of recruitment process for all staff. Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. Missed doses of medication are recorded in electronic prescribing and medicines administration (ePMA). Pharmacy undertake audits of missed doses and medicines security, providing feedback to individual wards for improvement. Improvements noted in the latest medicines security audits reported to the Quality Committee. Programme of medical device maintenance in place. Compliance with infection prevention is regularly audited and root cause analysis undertaken on any serious incidents, including CDiff/MRSA cases. One MRSA bacteraemia reported year to date in 2020-21 and CDiff cases remain below threshold set in 2019-20. In relation to Marshalls Cross Medical Centre actions were taken to strengthen the processes for the following, which have been reviewed by MIAA and confirmed as completed: • Follow up of uncollected prescriptions • Monitoring of NICE guidelines • Managing patients on high risk medicines • Undertaking risk assessments

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	Quality, Workforce Council	DoNMG, DoHR		The Trust has a zero tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's values and ACE behavioural standards. Each clinical area has a Safeguarding file with key information to ensure all suspicions are reported appropriately. Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, ie those working with children and young people and those in decision-making roles respectively. Compliance with training reported to the Quality Committee. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training, with increase in referrals maintained in 2020-21. The Trust provides training in conflict resolution. CQC inspection report highlighted that the relevant policies and procedures were in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care.
6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	Quality	DoNMG		Nutrition and hydration screening tools in place (MUST) and relevant patients have food charts. There is a red tray and red jug system in place for patients who require additional support with eating and drinking. All general wards are required to operate protected mealtimes, which will be reviewed and relaunched in 2021-22. Patients are regularly assessed to note any changes in nutrition and hydration status. Trust rolled out the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance in 2015 which is now included in the electronic risk assessments. Improved compliance in the recording of MUST scores and implementation of relevant care plans has been noted. In addition, electronic fluid balance charts to support appropriate recording of hydration are now in place and moved to Careflow vitals in March 2021, which will further aid compliance due to reduction in need to use different systems/devices. An action plan to continue to improve hydration is in place. The volunteer service had increased the number of trained dining companions to further support patients during meal times, which will be reintroduced in 2021-22 following suspension due to volunteers not attending wards in the pandemic.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	Quality	DoCS		The Trust was rated best acute Trust for Patient Led Assessments of the Care Environment (PLACE) programme in 2017, 2018 and 2019 (the latest inspection). The Trust achieved 100% for; • cleanliness • condition, appearance and maintenance of the hospital buildings A comprehensive internal environmental audit is undertaken to maintain these exceptionally high standards. Workplace inspections and COSHH risk assessments in place. Waste Management Policy in place with regular awareness raising and training provided for staff. Security service provided 24 hours per day and Lone Worker Policy in place.
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	Quality	DoNMG		Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of PALS. Improvements to the management of complaints remain ongoing, with effective system in place via Datix for recording and monitoring each complaint. Themes and actions taken identified and reported to Patient Experience Council, the Quality Committee and the Board, to support Trust-wide lessons learned. Mersey Internal Audit Agency provided a significant assurance rating on the process for learning lessons from complaints and incidents in 2020-21.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
9	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	**Well-led,** Responsive	Board	CEO		An annual Board effectiveness review is undertaken, including a review of the Board Committees and the outcomes are considered by the whole Board. Progress in delivering the Trust's objectives is reported to the Board annually and these are then refreshed for the next year. The Board and its committees review key performance indicators via the integrated performance report (IPR) monthly, identifying areas where compliance could be improved to target actions appropriately. MIAA review the governance arrangements within the Trust, including compliance with the CQC processes. External Audit review the annual governance statement. The Trust complies with the NHS Publication scheme, with an internal team briefing system in place to ensure staff are aware of the results of external reviews. Ward accreditation scheme in place (Quality Care Assessment Tool – QCAT) that is aligned to CQC standards, which will be relaunched in 2021-22 following temporary suspension due to the pandemic. CQC noted that there was effective staff engagement in the development of the Trust's vision and values, which were widely understood across the organisation. The comprehensive ward to Board review of each clinical area through the annual Quality Ward Round will be relaunched in 2021-22. In relation to Marshalls Cross Medical Centre actions were taken to put in place; • Audit programmes to monitor quality and identify areas for improvement • Undertake risk assessments

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce Council	DoHR		Comprehensive workforce strategy in place supported by Recruitment and Retention Strategy, including targeting workforce hotspots and proactive international recruitment for both medical and nursing staff. The Trust has an ongoing collaboration with Masaryk University, Brno, Czech Republic to recruit newly qualified doctors who trained using the English syllabus. There is an active recruitment programme for the nursing and midwifery workforce, on-going throughout the year. The Trust continues to explore all possible opportunities to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals: • On-boarding and retention of new and existing staff including flexible working, self-rostering, itchy feet discussions, career clinics, assigning a buddy, welcome packs/information, retire and return initiatives, internal transfer scheme • An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, locally and internationally • Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and ODP apprenticeships • Implementation of the new nursing associate role with first cohort completing their training and second cohort now underway • Implementing the Trust's Preceptorship Plus and Foundations in Clinical Leadership, alongside a nursing leadership development programme • Implemented e-rostering, e-job planning and activity manager for allied health professionals to ensure the most effective rostering and planning of work There is a comprehensive workforce performance dashboard, which enables detailed monitoring/oversight. A safer staffing report is presented every month to the Quality Committee, with detailed staffing review reported to the Board twice yearly including nurse establishment and patient acuity. In relation to Marshalls Cross Medical Centre action was taken to ensure sufficient numbers of suitably qualified, competent, skilled and experienced people to provide formal clinical leadership, including increased GP lead sessions.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
11	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	**Well-led**	Workforce Council	DoHR		Effective procedures in place for pre-employment and on-going revalidation of relevant staff. The Trust has range of HR policies and procedures in place. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties. MIAA review recruitment as part of ongoing audit cycle to provide external assurance on compliance with policy and procedure.
No FS maps to this regulation	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying and harassment is tackled in relation to duty of candour.	**Safe**	Quality Committee	DoNMG		Electronic reporting system, Datix, includes mandatory field to confirm compliance with Duty of Candour Compliance included in serious incident Board report Training is provided to staff within the following training programmes: • Trust's induction. • Mandatory training • Root cause analysis training There are a number of routes for raising concerns across the Trust, including speak in confidence electronic system launched in 2016-17 as a route for staff to report concerns anonymously. Assistant Director of Patient Safety appointed as Freedom to Speak Up Guardian, with 4 additional guardians to ensure staff have wide access. CQC confirmed in their inspection report that the Trust has good systems in place to fulfil its obligations in relation to the Duty of Candour Regulations.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	**Responsive,** Well-led	Executive	DoCS		Ratings available on internet with links to the full reports using the CQC widget. Full list of clinics and sites where services provided collated for staff to display ratings in individual clinics.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)13
Title of paper: Elimination of Mixed Sex Accommodation - Declaration
Purpose: To provide assurance to the Trust Board that the Trust has complied with the national guidance to eliminate mixed sex accommodation.
Summary: All trusts are required to make an annual declaration confirming compliance with the guidance in relation to elimination of mixed sex accommodation and the provision of appropriate single-sex facilities. Failure to comply with the guidance could result in significant financial penalties for breach of contractual standards, unless it would be in the overall best interests of the patient or is their personal choice. The annual declaration must be published on the Trust website. No breaches were declared in 2020-21and the Trust continues to implement the Provision of Same Sex Accommodation Policy in order to prevent any breaches.
Corporate objectives met or risks addressed: Safe and effective care
Financial implications: Financial penalties can apply if breaches occur
Stakeholders: All staff and external partners
Recommendation(s): The Board approves the declaration in relation to the elimination of mixed sex accommodation
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 31st March 2021

Eliminating Mixed Sex Accommodation Declaration

1. Background

1.1 In November 2010, the Chief Nursing Officer (CNO) and Deputy NHS Chief Executive wrote to all NHS Trusts. The letter (PL/CNO/2010/3) set out the expectations that all NHS organisations 'are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, or their personal choice'. The CNO letter included detailed guidance on what was meant by 'overall best interests', including situations, for example, when a patient is admitted in a life threatening emergency.

1.2 This was followed by another letter from the Chief Nursing Officer and Deputy NHS Chief Executive in February 2011 (Gateway ref 15552) setting out expectations regarding annual declarations of compliance.

1.3 Further guidance, ‘Delivering same-sex accommodation’ was issued by NHS England and NHS Improvement in September 2019 which provided clarification about what constitutes a breach.

1.4 Trust Boards are required to declare compliance annually and if they are not able to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance.

2. Declaration of Compliance

2.1 The Trust Board of St Helens and Knowsley Teaching Hospitals NHS Trust confirms that mixed sex accommodation has been virtually eliminated within all its hospitals, except where it is in the overall best interest of the patient, or reflects their personal choice.

2.2 We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen by exception based on clinical need, for example, where patients need specialist equipment such as in critical care areas.

2.3 Sleeping accommodation does not include areas where patients have not been admitted, such as cubicles in the Emergency Department or assessment areas.

2.4 If our care should fall short of the required standard, the Trust will report it. St Helens and Knowsley Teaching Hospitals NHS Trust have assurance mechanisms in place to monitor compliance, the management structure to manage any breaches and the desire to ensure we are communicating to patients and the public that we are continuing to meet our commitment to providing same-sex accommodation.

3. Data collection and performance

3.1 There were no reportable breaches in 2020-21.

4. Current Situation

4.1 Gender mixing only occurs within critical care units and the emergency department. This is in line with the overall best interests criteria stated by the CNO.

4.2 All adult in-patient wards are either single sex, or where they are mixed sex, areas within the ward are designated as male or female, with separate designated toilets and bathrooms. Where admissions and transfers may potentially cause a mixed sex breach ward teams are able to move patients to prevent this.

4.3 Children, young people and their parents will be asked at time of admission if they wish to be cared for with others of a similar age in a single sex bay or in a single room. This preference is used to determine where to place a child or young person in our children's wards.

4.4 Any changes proposed to the ward environment include a risk assessment to ensure that the requirements for single sex accommodation can continue to be met.

4.5 The Trust's Provision of Same Sex Accommodation Policy was updated in 2020 and is available for staff on the Trust's intranet.

5. Patient experience

5.1 Year-to-date there has been one concern raised regarding privacy and dignity, however, this related to coronary care, where it is permissible to provide high dependency care for level 2 and 3 patients in a mixed sex area, including coronary care units.

6. Recommendation

6.1 The Trust Board is asked to approve the declaration and for it to be published on Trust website and submitted to NHS England.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)014
Title of paper: 2020 Staff Survey Report and Action Plan
Purpose: To provide the Trust Board with an overview of the outcomes of the Staff Survey for 2020 and recommended actions
Summary: Under the current reporting scheme, the Trust has recorded the best score nationally for 3 of the 10 themes and second best nationally for a further 5 themes. The five year look back has revealed notable results including: best national score for 'quality of care' since 2016 and for 'staff engagement' since 2016. Areas highlighted as requiring further investigation and which will form the basis of the 2021-2022 action plan, include responses to questions relating to Staff Health & Wellbeing and Staff Motivation.
Corporate objectives met or risks addressed: Developing Organisational Culture and supporting our workforce, Safety, Communication
Financial implications: No new financial requirements from this paper
Stakeholders: Staff, Staff Side colleagues, Service users, Line Managers, CCG, CQC.
Recommendation(s): Members are asked to note the outcomes and accept for progression into a detailed milestone plan with interventions to address the areas of concern.
Presenting officer: Anne-Marie Stretch, Director of HR & Deputy CEO
Date of meeting: 31st March 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

2020 NHS Staff Survey Report

1. INTRODUCTION

During October and November 2020, 280 NHS organisations in England took part in the NHS Staff Survey. Full-time and part-time staff directly employed by an NHS organisation, were invited to participate, with over 595,270 responses received. A return rate of 47%. The data generated is used for the purposes of the Care Quality Commission (CQC) monitoring assessments and by other NHS bodies such as the Department of Health.

At St Helens and Knowsley Teaching Hospitals NHS Trust (STHK/ the Trust) a sample group of 1250 staff were invited to take part in the survey, which was administered on our behalf by Quality Health (QH). The sample was generated at random, determined by the total number of staff employed on a national sliding scale and included those on maternity leave.

Postal questionnaires were distributed to staff by hand through the Trusts' network of Staff Survey Champions. Staff could respond either by post, using a pre-paid envelope provided by QH, or on line using the web link included in the invite letter. Two reminders were sent; a first reminder letter, and a further mailing which included a repeat full questionnaire.

The results were published nationally on 11th March 2021.

Detailed results are available on the Trust Intranet Staff Survey pages, with a breakdown of the responses to each question available from the following site: http://www.nhsstaffsurveyresults.com/

2. QUESTIONNAIRE CONTENT

It is important to note that this year saw some significant changes to the questionnaire content driven by the COVID pandemic. The questions and theme relating to 'Your personal development' was replaced with a section on 'The Covid-19 pandemic,' focusing staff experience of working through this period.

Results are reported both as individual question responses and as 10 'Themes' which for 2020 are:

- Equality, diversity & inclusion
- Health & wellbeing
- Immediate managers
- Morale
- Quality of care
- Safe environment - bullying & harassment
- Safe environment - Violence
- Safety culture
- Staff engagement
- Team working

The themes are scored on a 0 to 10 point scale, a higher score indicating a better result. The list of questions feeding into each theme is presented in Appendix 1. There are also a number of questions which are reported independently.

In addition to the themes, question-level data is presented in the updated benchmark reports for all questions included in the core questionnaire. The question-level results are reported as percentages.

The additional Covid questions included 2 free text questions:

- Q21a. Thinking about your experience of working through the Covid-19 pandemic, what lessons should be learned from this time? (what lessons should be learned)

- Q21b. What worked well during Covid-19 and should be continued? (what went well)

The Survey Coordination Centre is working with text analytics specialists to process the free text data received in response these questions and the release date is yet to be confirmed. Once we have received this analysis, any resultant actions will be linked into the action plan.

3. RESPONSE RATE

3.1 STHK

510 completed questionnaires were returned from the initial sample of 1250. A response rate of **41%** (510 usable responses from a final sample of 1244). A slight reduction since last year.

3.2 National

The average national response rate for Acute and Acute & Community Trusts in England was 45%, with the highest being 55%. Overall response rates saw a marginal decrease since 2019.

3.3 Respondent Demographics

The 510 respondents comprised the following groups:

Gender	%
Male	16.6
Female	81.6
Prefer to self-describe	0.2
Prefer not to say	1.6

Age	%
66+	2
51-65	36.1
41-50	25.2
31-40	20.6
21-30	15.9
16-20	0.2

Ethnicity	%
White	91.1
Mixed/Multiple-ethnic background	0.2
Asian/Asian British	7.2
Black/African/Caribbean /Black British	0.8
Other ethnic groups	0.4

Sexual orientation	%
Heterosexual or straight	93.8
Gay or lesbian	2.4
Bisexual	0.2
Other	0.2
Prefer not to say	3.4

Religion	%
No religion	26.9
Christian	65.3
Buddhist	0.2
Hindu	1.8
Muslim	1.8
Sikh	0.2
Other	0.8
Prefer not to say	2.9

Physical or mental health conditions	%
Yes	21.5
No	78.5

Occupational Group	%
AHP, Scientist, Technical	10.2
Medical & Dental	6.9
Nurses & Midwives	26
Healthcare Assistants	9.3
Wider Healthcare Team	35
General Management	2.4
Admin and Clerical	18.5
Central Functions /Corporate Services	7.5
Maintenance /Ancillary	4.5
Scientific and Technical/Healthcare Scientists	12.2
Public Health	0.6
Other occupational group	1.6

4.0 RESULTS

To support benchmarking of performance, the results for all organisations are presented within one of the 10 national benchmarking groups below.

- Acute and Acute & Community
- Acute Specialist
- Mental Health & Learning Disability & Mental Health Learning Disability & Community
- Community
- Ambulance
- CCG
- CSU's
- Social enterprises-mental Health
- Social enterprises-Community
- Community Surgical Services

Each group comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. It should be noted that the Trusts benchmarking group was amended in 2020 in incorporate organisations that were previously in the benchmarking groups:

- Acute
- Acute & Community trusts.

This has increased the number of organisations in the Trust benchmarking group from 85 in 2019, to 125 in 2020.

4.1 Themes

Performance of the Trust against its benchmark group for all 10 themes is shown below.
Of the 10, the Trust holds the **best score nationally** for 4 themes and second best nationally for a further 4 themes.

Theme	Score (where measured)						2020 STHK National position
	2015	2016	2017	2018	2019	2020	
Quality of Care	8.1	8.2	7.9	8.1	8.1	8.1	1/125
Staff Engagement	7.3	7.4	7.4	7.6	7.5	7.6	1/125
Immediate Managers	7	7.0	7.0	7.2	7.2	7.3	1/125
Safe Environment – Bullying & Harassment	8.4	8.5	8.3	8.5	8.5	8.5	1/125
Team Working	6.7	7.0	6.9	7	7.1	7.0	2/125
Morale	N/A	N/A	N/A	6.7	6.7	6.7	2/125
Equality, Diversity & Inclusion	9.4	9.4	9.4	9.6	9.3	9.4	2/125
Safety Culture	7	7	7	7.2	7.1	7.2	2/125
Health & Wellbeing	6.6	6.8	6.6	6.5	6.5	6.7	3/125
Safe Environment – Violence	9.3	9.3	9.3	9.4	9.5	9.5	3/125

5 theme scores saw an increase from the 2019, 4 themes remained unchanged and only 'Team Working, saw a decreased by 0.1 and is in line with the national best score which decrease by 0.2% from 2019. The national view on this is that due to movement of staff to deliver care during covid individuals are not working within their normal' teams and so has had a negative impact on responses to questions in this theme.

4.2 Overall Staff Engagement

Staff Engagement is calculated as an average from the scores of the following three sub-sections:

- Advocacy (staff recommendation of the Trust as a place to work or receive treatment);
- Motivation (staff motivation at work);
- Involvement (staff ability to contribute towards improvement at work).

The most notable contributory responses to this overall indicator of staff engagement is staff members 'feeling enthusiastic about their job' (79.7%), for which the Trust returned the best scores nationally for 2020 and an increase of 1.4% since 2019

	2020
Best	79.7%
STHK	79.7%
Average	73.1%
Worst	68.0%

90.4% of staff agreed that care of patients/service users is the organisation's top priority, only 0.3% below the best national score and an increase of 3.3 from 2019

I am able to make improvements happen in my area of work saw an increase of 2.6 since 2019.

I look forward to going to work has seen an increase of positive responses by 2.2% from 2019 and *time passes quickly when I'm working* has seen a significant increase of 4.2

There are frequent opportunities for me to show initiative in my role and I am able to make suggestions to improve the work of my team / department' saw a slight decrease in positive responses compared to 2019, the average NHS score and best score also saw a decrease when compared to 2019.

4.2 Other notable questions linking in with Theme scores

Q3c '*I am able to do my job to a standard I am personally pleased with'*, although there was a slight decrease from 2019 the Trust retained the best national score held since 2018

	2018	2019	2020
Best	90.9%	90.5%	88.9%
STHK	90.9%	90.5%	88.9%
Average	79.3%	80.0%	80.6%
Worst	69.4%	69.4%	71.7%

Q4e '*I am able to meet all the conflicting demands on my time at work'*. We have seen a 3% increase since 2019 and have retained the best national score since 2018

	2018	2019	2020
Best	59.4%	59.2%	62.2%
STHK	59.4%	59.2%	62.2%
Average	45.1%	46.7%	47.6%
Worst	36.1%	36.2%	38.4%

Q5c '*The support I get from my work colleagues'* This year we saw a decrease of 1.9% since 2019 which is line with the national average score also decreasing. However the trust achieved the best national score of 88.2%

	2020
Best	88.2%
STHK	88.2%
Average	80.7%
Worst	75.2%

Q5g '*My level of pay'.* Trust's score has improved by 6.2% since 2017, receiving the best national score for 2020.

	2020
Best	46.0%
STHK	46.0%
Average	36.1%
Worst	27.8%

Q7a '*I am satisfied with the quality of care I give to patients / service users'*
After obtaining the best national results in 2018, 2019 saw a decrease of 1.6% in staff stating they Agree or Strongly Agree. Following work carried out in 2019/2020, 2020 saw a significant increase of 4.2% and attain the best 2020 national score.

	2018	2019	2020
Best	89.5%	90.3%	91.6%
STHK	89.5%	87.4%	91.6%
Average	80.2%	80.8%	82.0%
Worst	72.2%	68.2%	73.2%

***Q7c** 'I am able to deliver the care I aspire to'.* Following a decrease in the national score in 2017**,** work has gone into retaining the best national score since 2018 with an increase of 2.4% from 2019.

	2016	2017	2018	2019	2020
Best	80.6%	79.0%	81.0%	80.4%	82.7%
STHK	80.6%	76.7%	81.0%	80.4%	82.7%
Average	69.4%	67.2%	67.1%	68.4%	70.0%
Worst	56.1%	57.9%	58.2%	55.7%	57.5%

Q8b 'My immediate manager can be counted on to help me with a difficult task at work' 2020 has seen an increase of 2.9 since 2019 and an increase of 5.5% since 2018 achieving the national best score of 79.3%

	2020
Best	79.3%
STHK	79.3%
Average	70.0%
Worst	61.4%

Q8e *'My immediate manager is supportive in a personal crisis'.* Measures put in place throughout 2020 have resulted in the Trust obtaining best score nationally in 2020 with an increase of 1.6% since 2019 and an increase of 4.3 since 2017

	2020
Best	82.9%
STHK	82.9%
Average	75.1%
Worst	68.5%

11b 'In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?' Measures put in place following the 2018 result have resulted in the Trust retaining the best score nationally since 2019.

	2019	2020
Worst	36.2%	37.4%
Your org	21.5%	18.7%
Average	28.8%	28.8%
Best	21.5%	18.7%

15b 'In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?' The Trust scored the best score for 2020 and a 2% decrease of yes Answers since 2019

	2020
Worst	16.1%
Your org	4.0%
Average	7.9%
Best	4.0%

Q13c '*In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?'* 2020 saw a 0.7% decrease since 2019. The score of 12.2% is a national best score.

	2020
Worst	26.3%
Your org	12.2%
Average	19.8%
Best	12.2%

Q16b '*My organisation encourages us to report errors, near misses or incidents'.* Measures put in place following last year's results have resulted in the Trust obtaining best score nationally in 2020 with an increase of 3% since 2019.

	2020
Best	93.0%
STHK	93.0%
Average	88.2%
Worst	81.2%

Q16c '*When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again'*. Measures put in place following last year's results have resulted in the Trust obtaining best score nationally in 2020 with a significant increase of 5.9% since 2019.

	2020
Best	84.2%
STHK	84.2%
Average	72.7%
Worst	60.3%

4.3 Whilst the majority of responses are very positive, there are some areas for which the results are not as we would wish. Areas of note are:

4.3.1 Health, well-being and safety at work

On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours? (% of staff working additional unpaid hours) The Trusts

score of 49.5 was 4.7 higher than the NHS Best score however lower than the NHS average score. This question has seen an increase of 2.1% since 2019 which in contrast to the national average score which saw a decrease of 0.5%.
Data analysis has identified some areas where the score is significantly worse than the trusts score. These areas are corporate services, Allied Health professionals, Health Scientist nursing and Midwifery and medical and Dental

The trust scores for 'Feeling pressure to come to work despite not feeling well enough to perform your duties' has reduced by 8.8% since 2019, this is in line with the NHS average score which reduced by 10.1% Although this result is a significant increase its worth considering that those that selected a yes response, 21.8% felt the pressure came from Managers 16.1% felt the pressure came from colleagues and 92.5% felt that they put themselves under pressure.
When Analysing this data the areas which reported the highest yes answers was Medirest, particularly from Managers, Surgical care Group and medical & Dental who both reported feeling pressure from colleagues.

Furthermore staff who reported as having a LTC or illness reported feeling pressure to come to work from managers was 9.2% higher than those without a LTC

4.3.2 Safe Environment

The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? 13d (% of staff saying they, or a colleague, reported it). The Trust score was 1.2% higher than the NHS average score but 7.6% below the NHS best score. This score also saw a drop of 2.8% compared to the Trusts scores in 2019. The areas returning the lowest scores were Alex Park, BME, Medical and Dental and Allied health professionals

In the last 12 months, how many times have you personally experienced physical violence at work from patients/services users their relatives or other members of the public (12a) (% of staff saying they experienced at least one incident of violence) The Trusts score of 12.4 was 1.8% lower than the NHS average score but 6.1% higher than the NHS Best score. However the score has decrease by 2.7 since 2019. Areas returning a high score in this area are Community services and Medical Care group, more specifically Nursing and Midwifery and additional Clinical Services.

'The last time you experienced physical violence at work, did you or a colleague report it?' 12d (% of staff saying they, or a colleague, reported it) The Trust score of 77.0% was 9.5% above the national average but 6.8 below the NHS best score. The score saw a slight decrease of 0.5% which was in keeping with the national average score which also decreased by 0.2%. The areas returning the lowest scores were Corporate Services, medical care group and Surgical Care.
It is worth considering that the question **'***My organisation encourages us to report errors, near misses or incidents and When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again'* received *a* national Best score with a score of 93%. This area require some further exploration from the SME's.

The Trust score for '*If a friend or relative needed treatment would be happy with the standard of care provided by this organisation*' 18d (% of staff selecting 'Agree'/'Strongly Agree) as decreased by 0.2% since 2018 and is now 4.5% lower than the best national score. Although this is 12.9% above the average there are some areas which are significantly lower than the Trust score. These areas are Medirest, BME, Medical & Dental and Allied health professionals.

The score for 'Staff often thinking about leaving the organisation' (Q19a) is only 4.1% higher than the best national score at 21.0%, however this has increased since 2018 when the Trust had the best national score (19.1%). Particularly as part of the covid recovery, retention of staff

is a priority for the organisation and so actions exist in the plan (Appendix 3) to understand the reasons behind the scores and take restorative action.

Medirest Scores were low across a number of the themes, so will need some further investigation and possible action by the relevant SMEs.

Although the Immediate manager's theme score was a national best score, further analysis of the results, indicates that Clinical support services and Medical care group showed a significantly lower score than the rest of the Trust. This will be explored further by the SME's for these areas.

5.0 CONCLUSIONS AND RECOMMENDATIONS

The Trust has worked hard over the last 12 months in the delivery of the 2020-21 staff survey action plan and to engage with, support and develop its workforce and would like to recognise the progress made in what continues to be an extremely challenging operational environment.
Following the successful implementation of the 2020-2021 survey action plan, the Trust now has best national score recorded for the question 'When errors, near misses or incidents are reported, my organisation takes action' to ensure that they do not happen again' as well as 'staff experiencing musculoskeletal problems (MSK) as a result of work activities', with the Trust's score continuing to improve.

Although 'The Quality of Appraisals' did not feature in the 2020 staff Survey, work is continuing to improve this part of the service and it will continue to form part of the action plan.
Our staff continue to be our most vital resource and we will use the results from the Survey to continuously improve staff experience and service to our patients.

Appendix 3 details the suggested action points based on those areas where the Trust has responded less favourably when compared to similar organisations. The headline areas recommended for the Board to keep under close review throughout the year are highlighted below and progress will be monitored monthly as part of the combined workforce report through the Workforce Council. Whilst some of the areas of focus are consistent with those from the previous survey results, it should be recognised that progress has been made with the Trust improving its position across a wide range of measures and maintaining its excellent performance when compared to 'like' organisations.

6.0 PUBLICISING THE RESULTS

Results will be presented to staff and managers by Quality Health on 30th March 2021 via MS Teams. It is important that staff see the benefits of participating in this survey and are aware both of the outcomes from the Staff Survey and the resultant actions. In support of this, with the support of the Media and Communications team, the results of the staff survey will be publicised through all available channels including:

- Display presentations in appropriate locations on St Helens & Whiston Hospital sites.
- The management and full reports to be uploaded and available on the Intranet.
- Copies to Clinical Governance teams and to Divisional and Departmental Heads.
- Summary of findings at Team Brief.
- Summary with links to full report on Global emails.
- Copies to the local Staff Side representatives.
- Circulation to the Valuing Our People Steering Group.
- Publication in News 'n Views.
- Circulation of 'You said/We did' communications.
- STHK Staff Engagement App

Reporting to staff on the outcomes of the survey, and telling staff what has been done about key issues arising from it is a major help in maximising response rates at the next survey and significantly improves the credibility of the process.

7.0 ACTION REQUIRED BY THE BOARD

The Trust Board are asked to note the content of this report and to approve and support the recommendations. Actions to address the limited areas of concern will be incorporated into the Staff Survey Action Plan for 2021-2022, monitored by the Workforce Council and Quality Committee as part of the Board Governance Assurance Framework.

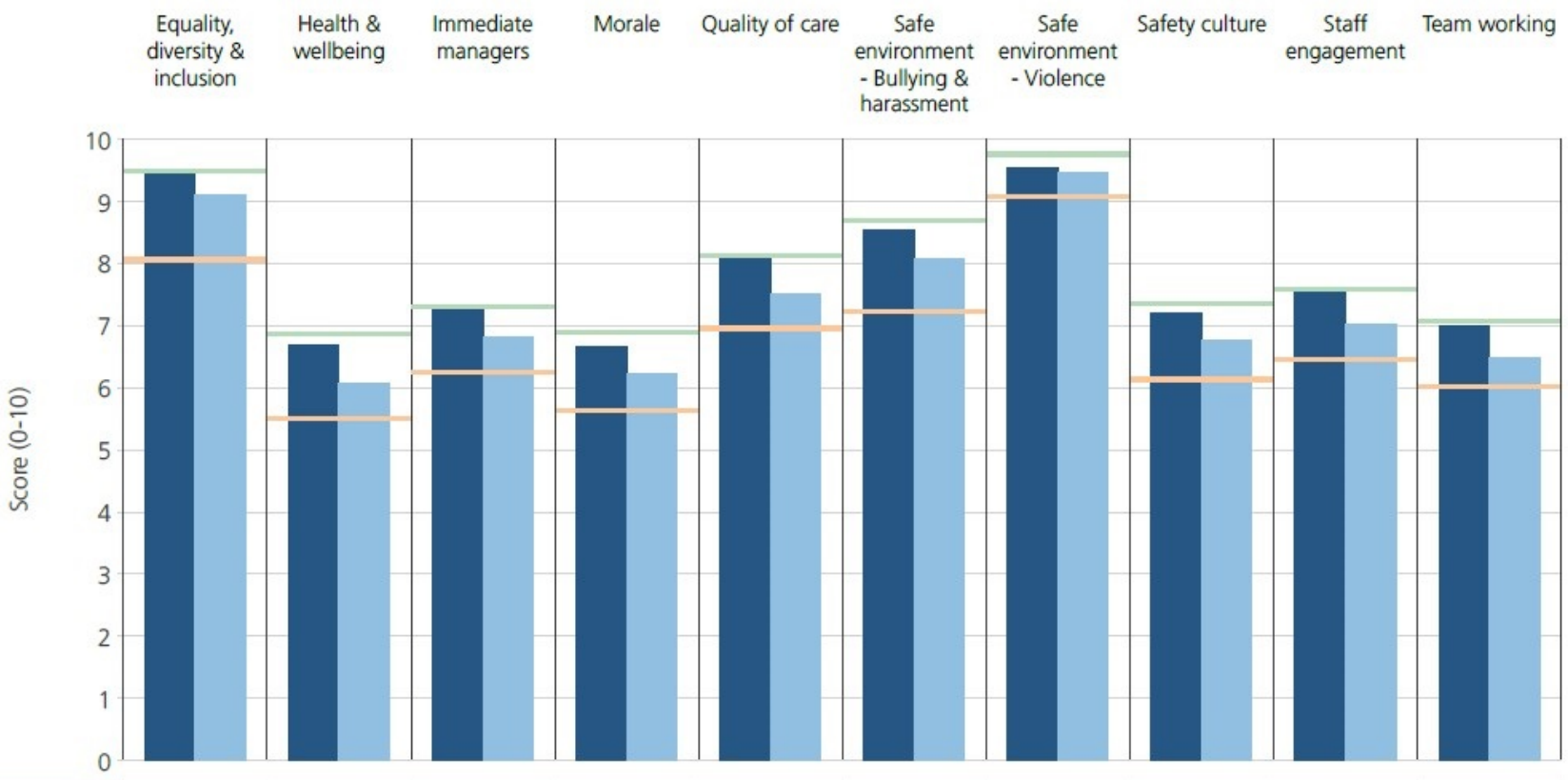
APPENDIX 1 – Questions feeding into the 10 themes

Theme	Questions	%		
		StHK	Best	Av.
1. Equality, diversity & inclusion	"Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?"	93.2	94.3	84.9
	"In the last 12 months have you personally experienced discrimination at work from any of the following? Patients/ service users, their relatives or other members of the public"	5.0*	1.9	6.2
	"In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/ team leader or other colleagues"	4.0*	4.0	7.9
	"Has your employer made adequate adjustment(s) to enable you to carry out your work?"	84.9	89.7	75.6
2. Health & wellbeing	"How satisfied are you with the opportunities for flexible working patterns?"	55.7	64.9	55.5
	"Does your organisation take positive action on health and well-being?"	44.4**	51.1	31.7
	"In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?"	18.7*	18.7	28.8
	"During the last 12 months have you felt unwell as a result of work-related stress?"	37.9*	32.6	44.1
	"In the last three months have you ever come to work despite not feeling well enough to perform your duties?"	41.8*	38.3	46.6
3. Immediate managers	"How satisfied are you with each of the following aspects of your job? The support I get from my immediate manager."	77.2	77.6	69.1
	"My immediate manager gives me clear feedback on my work."	67.9	70.3	60.6
	"My immediate manager asks for my opinion before making decisions that affect my work."	57.9	63.6	54.5
	"My immediate manager takes a positive interest in my health and well-being."	73.8	76.9	69.2
	"My immediate manager values my work."	79.3	79.5	71.8
4. Morale	"I am involved in deciding on changes introduced that affect my work area / team / department."	54.8	57.3	50.3
	"I receive the respect I deserve from my colleagues at work."	82.1	82.1	70.4
	"I have unrealistic time pressures."	32.3	33.8	24.4
	"I have a choice in deciding how to do my work."	54.7	62.6	54.3
	"Relationships at work are strained."	55.5	55.5	45.5
	"My immediate manager encourages me at work."	75.2	77.3	69.2
	"I often think about leaving this organisation."	21.0	16.9	26.7
	"I will probably look for a job at a new organisation in the next 12 months."	14.3	11.2	18.7
	"As soon as I can find another job, I will leave this organisation."	11.0	7.5	13.2
5. Quality of care	"I am satisfied with the quality of care I give to patients / service users."	91.6	91.6	82.0
	"I feel that my role makes a difference to patients / service users"	91.4	93.4	89.7
	"I am able to deliver the care I aspire to"	82.7	82.7	70.0
7. Safe environment - Bullying & harassment	"In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public"	22.0*	18.0	26.0
	"In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers"	9.1*	6.2	12.6
	"In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues"	12.2*	12.2	19.8
8. Safe environment – Violence	"In the last 12 months how many times have you personally experienced physical violence at work from...? Patients/ service users, their relatives or other members of the public"	12.4*	6.3	14.2
	"In the last 12 months how many times have you personally experienced physical violence at work from...? Managers	0.4*	0.0	0.5

Theme	Questions	%		
		StHK	Best	Av.
	"In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues"	0.8*	0.1	1.4
9. Safety culture	"My organisation treats staff who are involved in an error, near miss or incident fairly."	66.7	71.1	61.4
	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again."	84.2	84.2	72.7
	"We are given feedback about changes made in response to reported errors, near misses and incidents."	71.5	72.6	61.9
	"I would feel secure raising concerns about unsafe clinical practice."	73.2	77.6	71.8
	"I am confident that my organisation would address my concern."	67.1	74.2	59.1
	"My organisation acts on concerns raised by patients / service users."	86.0	86.9	74.0
10. Staff engagement	"I look forward to going to work."	63.7	67.8	58.5
	"I am enthusiastic about my job."	79.7	79.7	73.1
	"Time passes quickly when I am working."	79.9	81.1	76.0
	"There are frequent opportunities for me to show initiative in my role."	77.4	78.1	71.9
	"I am able to make suggestions to improve the work of my team / department."	74.4	81.7	73.0
	"I am able to make improvements happen in my area of work."	60.8	63.5	55.4
	"Care of patients / service users is my organisation's top priority."	90.4	90.7	79.4
	"I would recommend my organisation as a place to work."	78.5	84.0	91.7
	"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."	87.2	91.7	74.3
11. Team working	"The team I work in has a set of shared objectives."	80.6	81.2	71.6
	"The team I work in often meet to discuss the team's effectiveness."	62.9	67.2	56.7

* the lower the score the better
** 'yes, definitely' answers only

APPENDIX 2 – National benchmarking of theme results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
STHK	9.4	6.7	7.3	6.7	8.1	8.5	9.5	7.2	7.6	7.0
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0

APPENDIX 3 – Staff Survey 2020 recommended actions

Theme	Theme questions with lower than expected scores	Directorates with scores requiring further investigation	Responsible Officers	Recommended Actions	Expected Completion
Equality, Diversity & Inclusion	• In the last 12 months have you personally experienced discrimination at work from patients/services users, their relatives or other member of the public/managers? • On what grounds have you experienced discrimination? - Ethnic background • Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age?	Medical Care Group	Victoria Reynolds - ED&I Lead Leanne Williams –HRBP Diane Stafford – ADO	Results and available detailed breakdown provided to Victoria Reynolds -ED&I Lead. (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Community Services	Victoria Reynolds - ED&I Lead Joanne Pickstock –HRBP Mike Roscoe – ADO		
		Medirest	Victoria Reynolds - ED&I Lead Diana Lewis – HRBP Dyan Clegg – ADO		
Health & Wellbeing	• On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours? • In the last three months have you ever come to work despite not feeling well enough to perform your duties?	Surgical Care Group	Adam Hodkinson – Head of Operations HWWB Yvonne Malkin – HRBP Phil Nee – ADO	Results and available detailed breakdown provided to Adam Hodkinson –Head of Operations HWWB (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Medirest	Adam Hodkinson – Head of Operations HWWB Diana Lewis – HRBP Dyan Clegg – ADO		
		Corporate Services	Adam Hodkinson –Head of Operations HWWB Diana Lewis – HRBP Claire Scrafton - ADO Gareth Lawrence – ADO		
Immediate Managers	• The support I get from my immediate manager? • My immediate manager gives me clear feedback on my work • My immediate manager asks for my opinion before making decisions that affect my work • My immediate manager takes a positive interest in my health and well-being • My immediate manager values my work	Clinical Support Services	Adam Rudduck - ADOD Diana Lewis – HRBP Caroline Dawn – ADO	Results and available detailed breakdown provided to Adam Rudduck - ADOD (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Medirest	Adam Rudduck - ADOD Diana Lewis – HRBP Dyan Clegg – ADO		
		Medical Care Group	Adam Rudduck - ADOD Leanne Williams – HRBP Diane Stafford – ADO		

Morale	• I have unrealistic time pressures • Relationships at work are strained • I often think about leaving this organisation	Clinical Support Services	Adam Rudduck - ADOD Diana Lewis – HRB Caroline Dawn – ADO	Results and available detailed breakdown provided to Adam Rudduck - ADOD (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Medirest	Adam Rudduck - ADOD Diana Lewis – HRBP Dyan Clegg – ADO		
		Medical Care Group	Adam Rudduck – ADOD Leanne Williams – HRBP Diane Stafford – ADO		
Quality of Care	• If a friend or relative needed treatment would be happy with the standard of care provided by this organisation'	Corporate Services	Adam Rudduck – ADOD Diana Lewis – HRBP Claire Scrafton - ADO Gareth Lawrence - ADO	Results and available detailed breakdown provided to Adam Rudduck – ADOD. (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
Safe Environment – Bullying & Harassment	• In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public? • The last time you experienced physical violence at work, did you or a colleague report it? • The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	Surgical Care Group	Chris Stanley – Non–clinical Risk Yvonne Malkin – HRBP Phil Nee – ADO	Results and available detailed breakdown provided to Chris Stanley – Non–clinical Risk. (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Medical Care Group	Chris Stanley – Non–clinical Risk Leanne Williams – HRBP Diane Stafford – ADO		
		Community Services	Chris Stanley – Non-clinical Risk Joanne Pickstock – HRBP Mike Roscoe – ADO		
Safety Culture	• My organisation treats staff who are involved in an error, near miss or incident fairly • We are given feedback about changes made in response to reported errors, near misses and incidents	Surgical Care Group	Rajesh Karimbath – AD Patient Safety Yvonne Malkin – HRB Phil Nee – ADO	Results and available detailed breakdown provided to Rajesh Karimbath – AD Patient Safety (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Community Services	Rajesh Karimbath – AD Patient Safety Joanne Pickstock – HRBP Mike Roscoe – ADO		
Staff Engagement	• I look forward to going to work • There are frequent opportunities for me to show initiative in my role • I am able to make suggestions to improve the work of my team/department	Medical Care Group	Adam Rudduck – ADOD Leanne Williams – HRBP Diane Stafford – ADO	Results and available detailed breakdown provided to Adam Rudduck - ADOD. (SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is	**19th May 2021**
		Medirest	Adam Rudduck – ADOD Diana Lewis – HRBP Dyan Clegg – ADO		

	• I am able to make improvements happen in my area of work	Community Services	Adam Rudduck - ADOD Joanne Pickstock – HRBP Mike Roscoe – ADO	necessary and provide a detailed action plan for monitoring through Workforce Council.	
Team Working	• The team I work in has a set of shared objectives • The team I work in often meets to discuss the team's effectiveness	Corporate Services	Adam Rudduck - ADOD Diana Lewis – HRBP Claire Scrafton - ADO Gareth Lawrence - ADO	Results and available detailed breakdown provided to Adam Rudduck - ADOD.(SME). SME to work with ADO, Directorate Managers and HRBP to determine if further action is necessary and provide a detailed action plan for monitoring through Workforce Council.	**19th May 2021**
		Medirest	Adam Rudduck - ADOD Diana Lewis – HRBP Dyan Clegg – ADO		

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)015

Title of paper: St Helens Cares Integrated Care Partnership Collaboration Agreement

Purpose: For the Trust Board to review and approve the St Helens Cares Integrated Care Partnership (ICP) Collaboration Agreement

Summary:

This paper provides an update on the proposed arrangements for the next phase of development of the place-based approach to integrated health and care in St Helens, known as St Helens Cares (referred to in this paper and in the draft Collaboration Agreement as the St Helens Cares Integrated Care Partnership ("St Helens ICP")).

The ICP will be underpinned by a revised governance structure and a refreshed Collaboration Agreement between St Helens CCG, St Helens Council, St Helens & Knowsley Teaching Hospitals NHS Trust, North West Boroughs Healthcare NHS Foundation Trust, Torus, Primary Care Network (PCN) representatives and Voluntary Community and Social Enterprise (VCSE).

The development of an ICP approach is in line with the policy direction set by NHS England/Improvement in respect of the development of Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP) by April 2022, and also reflects the approach being taken at a Cheshire & Merseyside Health & Care Partnership level in terms of its own development as an ICS comprising nine ICPs (of which St Helens is one). The recent White Paper – Integration and Innovation confirms the Government's intent.

The arrangements build on the existing collaboration agreement between the local authority and NHS partners for St Helens Cares (documented in the previous Memorandum of Understanding (MOU)) and broaden the partnership to formally include other key partners such as Torus, VCSE, and PCNs. The arrangements are intended to further develop the place-based integrated working between the partners for the benefit of the St Helens population.

The draft Collaboration Agreement sets out a revised governance framework for the St Helens ICP, including an ICP Board drawn from all partner organisations and to be chaired by a lay chair, which will report into the St Helens People's Board.

In drawing up the revised arrangements, the Partners have agreed three key priority areas on which the Partners will place particular focus as a collaborative, over a 5-year period, with initial outcomes to be achieved set for the 2021/22 (acknowledging the current challenges posed to the health and care system by the Covid-19 pandemic). The Partners have also refreshed the objectives and principles underpinning their collaboration as documented in the revised agreement, taking into account the latest policy direction.

The following documents are attached to this paper for consideration by the Board:

i. Diagram of proposed revised governance arrangements
ii. Draft Terms of Reference for:
    a. St Helens ICP Board (formerly the St Helens Cares Executive Board)
    b. St Helens ICP Programme Delivery Group
    c. St Helens ICP System Resources Group
iii. Draft amended Terms of Reference for the St Helens Stakeholder Reference Forum
iv. Draft Collaboration Agreement (based on the existing MOU)
v. Summary slide setting out the Priorities for the ICP and agreed target outcomes for the next 5 years, as well as the initial 12 months from April 2021.

Since 2018, St Helens Cares has developed into a strong and effective place-based partnership for St Helens. The Partners agree that they are now in a position to take the next steps to develop their collaboration further through an integrated care partnership for St Helens. The draft collaboration agreement recognises the progress to date of St Helens Cares and sets out a revised governance framework for the St Helens ICP (including terms of reference).

The agreement represents a further step towards developing an ICP for St Helens, in line with the ICS approach and focuses on the Key Priority Areas which shall initially be (i) Mental Wellbeing; (ii) Tackling Obesity; and (iii) Resilient Communities, subject to any changes agreed by the Partners. The Partners will collaborate to achieve certain outcomes in relation to the Key Priority Areas as set out in the attached summary slide (attachment v).

This phase of development will take place over the next 12 months to 31 March 2022, with the initial term of the Agreement expiring on 31 March 2023 (subject to extension). An annual review process will be built in, and it is acknowledged by all Partners that 2021/22 will be a transitional year in view of the structural changes to NHS commissioning that are anticipated in April 2022.

The governance structure has been refreshed as part of the development of the St Helens ICP. In addition to the St Helens People's Board and the Stakeholder Reference Forum which will continue to play key roles, the governance structure for the St Helens ICP will be as follows:

- **The St Helens ICP Board** which will replace the St Helens Cares Executive Board. The St Helens ICP Board will report to the People's Board and ultimately be accountable to Partner organisation boards. The ICP Board will provide strategic and collective leadership to identify transformational priorities for the ICP and monitor the delivery of the key priority areas, whilst overseeing the ICP arrangements under the Agreement.

- **A Programme Delivery Group** which will be responsible for delivering the Outcomes in respect of the Key Priority Areas and developing proposals for changes to the delivery of the health and care services to support delivery of the Outcomes. The Programme Delivery Group will report to the St Helens ICP Board and will be able to establish working groups with representation from clinicians and others to focus on the Key Priority Areas (initially). This Group broadly replaces the **Provider Board** – embracing commissioners and providers. STHK no longer has the title of **Lead Provider** (although in practical terms will remain so for St Helens), as from April 2022 the majority of Acute contracts will be held by the Cheshire and Merseyside ICS.

- **A System Resources Group** which will be responsible for providing strategic oversight of the collective resources of the Partners within the St Helens ICP. The System Resources Group will develop proposals as to the future financial and resources model for the ICP and make recommendations and report to the St Helens ICP Board. The System Resources Group will identify opportunities to shift / release resources to ensure that the St Helens £ and the collective resources of the ICP are used effectively to achieve the outcomes in the Key Priority Areas, providing input to the Programme Delivery Group in respect of resource considerations.

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 Stakeholder Reference Forum have been revised to reflect these developments. The draft amended terms of reference are included within the papers for reference.

The collaboration agreement is not legally binding but sets out the commitment and intent of all the partners. The changes from the previous Agreement to the one proposed is minimal, save for the removal of the plans to have a "Lead Provider" and the signatories have been broadened to include more partners. The Lead Provider element was a concept developed ahead of legislative powers and in more recent times the focus has moved to the establishment of provider collaboratives, mutual aid, and recovery of backlogs, block contracts and system control totals.

It should also be noted that the White Paper does not include any specific proposals about the development of ICPs, however the C&M ICS has a desire to implement ICPs for each place. The form, functions, and level of delegation from the ICS to ICPs is still to be confirmed and so this collaboration agreement will be subject to change.

Corporate objectives met or risks addressed: Work with partner organisations to deliver plans for more integrated care

Financial implications: None as a direct result of this paper

Stakeholders: All partners in St Helens Cares and Cheshire and Merseyside ICS.

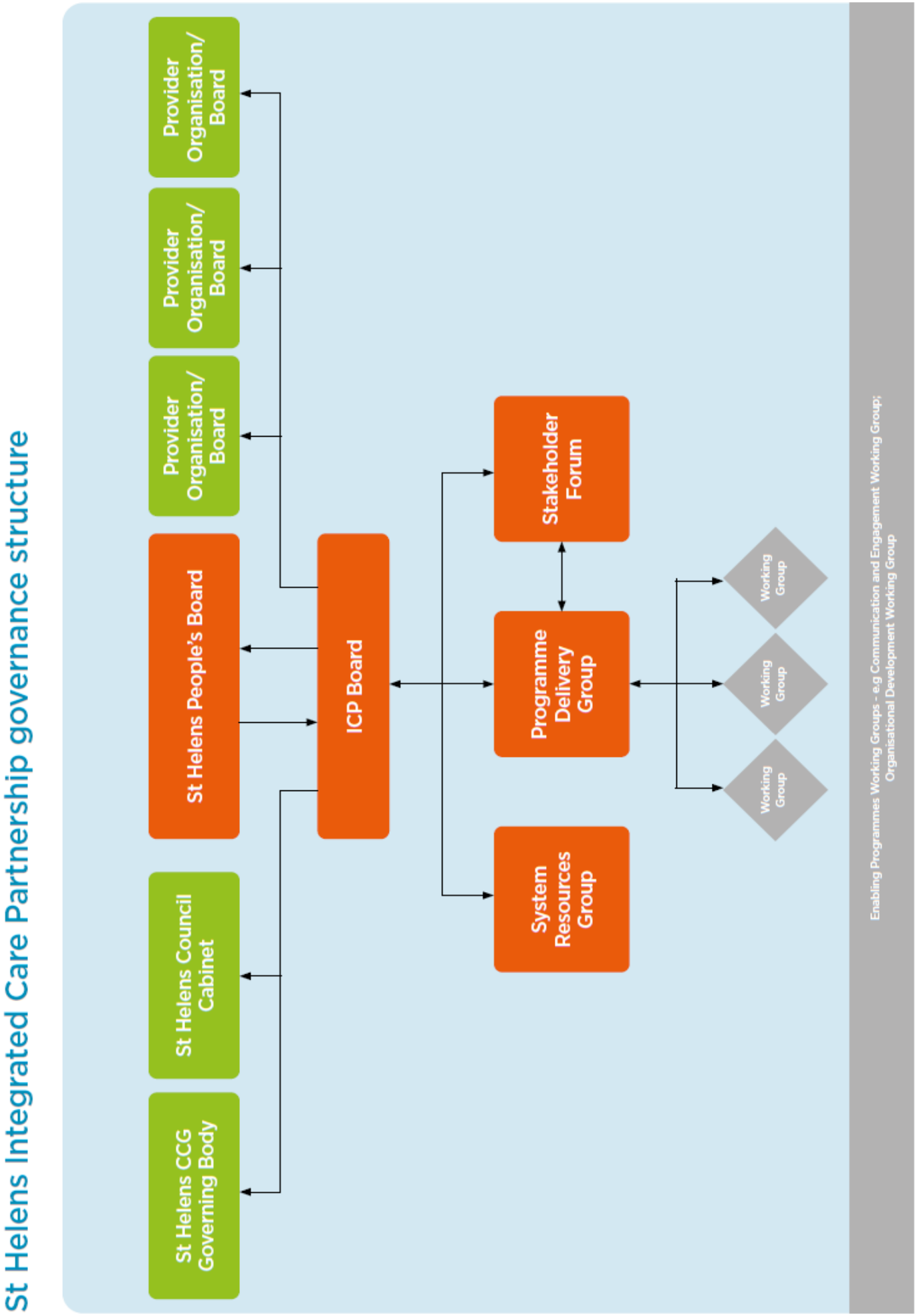
Recommendation(s): The Trust Board is asked to:

1. Note and endorse the progress made to date in establishing the St Helens ICP;
2. Note the proposed framework for the governance of the St Helens ICP and the proposed Terms of Reference for the governance groups;
3. Approve the collaboration agreement.

Presenting officer: Nicola Bunce, Director of Corporate Services

Date of meeting: 31st March 2021

Doc i: Diagram of proposed revised governance arrangements



ST HELENS CARES INTEGRATED CARE PARTNERSHIP BOARD Terms of Reference	
Version	**1.0**
Implementation Date	**[TBC]**
Review Date	**[TBC]**
Approved By	**The People's Board**
Approval Date	**[TBC]**

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

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 Integrated Care Partnership Board.

The purpose of the St Helens Cares Integrated Care Partnership (**ICP**) Board is to provide strategic oversight and management of the St Helens ICP model of delivery to achieve the objectives of the St Helens People's Board in line with the ICP Plan to improve the health and wellbeing of the St Helens population. This supports the vision for St Helens which is *improving people's lives in St Helens together.*

The ICP Board will work within existing contractual frameworks and the existing Section 75 Agreement between the CCG and the Local Authority to transform the way in which health and care services are delivered and services are integrated.

The priorities and work plan for the ICP Board will be set out in the ICP Plan and aligned with the strategic direction for the St Helens borough agreed by the St Helens People's Board.

2. Chair

The ICP Board will be chaired by a Lay Chair.

3. Membership

The ICP Board will include executive members from the Local Authority, CCG, secondary and primary care providers, and Torus and a nominated representative from the People's Board.

The membership of the ICP Board is as follows:

Nominated Representative (Role/Title)	Organisation	Status
Lay Chair	N/A - Independent	Chair
Executive Director for Integrated Health and Care	St Helens CCG & St Helens Council	Member
[TBC]	St Helens & Knowsley Teaching Hospitals NHS Trust	Member
[TBC]	North West Boroughs NHS Foundation Trust	Member
[Clinical Director]	[Primary Care Network]	Member
[Clinical Director]	[Primary Care Network]	Member
[Clinical Director]	[Primary Care Network]	Member
[Clinical Director]	[Primary Care Network]	Member
[TBC]	Torus Group (representing Housing Organisations in St Helens)	Member
[TBC]	[VCS]	?
Director of Communities	St Helens Council	Member
[Care Provider Representative]	[TBC]	Member

[Public Health Provider Rep]	[TBC]	Member
Director of Children's Services	St Helens Council	Member
Cllr Portfolio Holder (with responsibility for integration)	St Helens Council	Member
Chair of the Stakeholder Reference Forum	N/A	Member
Chair of System Resources Group	N/A	Member
Representative of St Helens Place Board	St Helens Council	Member

Other attendees may be requested to attend, observe and/or participate in discussions at ICP Board meetings, as agreed by the members, from time to time.

4. Quorum

A quorum will be at least [50%] of the membership (to include one PCN representative, one St Helens Council representative), and the chair. This excludes those in attendance and administrative support.

5. Functions

The ICP 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 ICP Board will be responsible for:

- Providing strategic and collective leadership to identify the transformational priorities for the ICP, in line with the strategic direction set by the People's Board
- Providing direction for the development of an integrated local care system
- Promoting and encouraging commitment to agreed principles and objectives of the ICP amongst all partner organisations
- Overseeing delivery of agreed schemes and priorities
- Design and implementation of effective governance arrangements for the ICP
- Designing the organisational development strategy and action plan for the ICP, including system leadership capacity and capability of the ICP workforce, and monitoring delivery
- Approving proposals for system wide outcome measures and mechanisms for reporting collectively on the performance of providers working in the ICP;
- Evaluating risk in relation to system change proposals for the ICP and ensuring mitigation plans are robust.
- Receiving and scrutinising reports and recommendations from the Programme Delivery Group and System Resources Group.
- Approving the communications and engagement strategy and action plan for the ICP and monitoring delivery.
- Overseeing the transition from commissioner-led model to an Integrated Care Partnership model led by collaboration between commissioners and providers.

- Overseeing systems and infrastructure workstreams on behalf of the ICP (e.g. enablers such as digital, estates, workforce) and monitor progress.

The ICP Board may 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 ICP Board will receive and consider recommendations and proposals from the Programme Delivery Group and the System Resources Group in the course of fulfilling its functions.

The ICP Board will seek the views of the Stakeholder Reference Forum to inform its proposals.

The ICP Board will seek the views of the System Resources Group in relation to financial and contractual implications of proposals and recommendations under discussion.

6. Authority/Reporting

The ICP Board is established by the People's Board to achieve the objectives of the St Helens People's Board to develop a sustainable Health and Social Care system.

The ICP 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 ICP 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 the ICP.

The ICP Board will have following sub groups:

- Programme Delivery Group
- System Resources Group
- Stakeholder Reference Forum.

A report from each of the above sub groups will be a standing item on every meeting agenda for the ICP Board.

Each of the member organisations of the ICP Board will ensure that their designated officer:

- Is appointed to attend and represent their organisation on the ICP Board with such authority as is agreed to be necessary in order for the ICP 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 ICP Board (as confirmed in writing and agreed between the member organisations); and
- Understand the status of the ICP Board and the limits of their responsibilities and authority.

The ICP Board will provide regular reports to the People's Board.

The ICP Board will keep the Cheshire & Mersey Health and Care Partnership informed of developments of the local care system

7. Frequency of Meetings

The ICP 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 ICP Board at his or her discretion, subject to providing at least 5 working days' notice to members**.**

8. Administration

The ICP Board will be administered by Integrated Health & Care Services secretariat.

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 ICP 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 ICP Board within 14 days of each meeting. Approval of the minutes of the previous meeting of the ICP 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 ICP 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 ICP 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.

St Helens Cares Integrated Care Partnership
Programme Delivery Group
Terms of Reference

1. Purpose

The purpose of the St Helens Cares Programme Delivery Group ("Programme Delivery Group") is to develop the collaborative approach of the commissioner and provider organisations that are parties to the St Helens ICP 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 Programme Delivery Group 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 Programme Delivery Group will be agreed with St Helens ICP Board, based on the strategic direction for the St Helens borough agreed by the St Helens People's Board.

2. Chair

The Programme Delivery Group will be chaired by the Executive Director for Integrated Health and Care.

3. Membership

The Programme Delivery Group will include membership from both commissioner and provider organisations that are party to the St Helens Cares ICP Collaboration Agreement. Where additional commissioner and provider organisations become parties to the St Helens ICP Collaboration Agreement, they will also become members of the Programme Delivery Group and these Terms of Reference will be kept under review accordingly.

The current membership of the Programme Delivery Group as at the date of these Terms of Reference is as follows:

Nominated Representative (Role/Title)	Organisation	Status
Executive Director for Integrated Health and Care	St Helens CCG & St Helens Council	Chair
[Clinical Director/Business Manager]	[Primary Care Network]	Member

[Clinical Director/Business Manager]	[Primary Care Network]	Member
[Clinical Director/Business Manager]	[Primary Care Network]	Member
[Clinical Director/Business Manager]	[Primary Care Network]	Member
Director of Public Health	St Helens Council	Member
Director of Adult Social Services	St Helens Council	Member
Assistant Director of Operations	St Helens and Knowsley Teaching Hospitals NHS Trust	Member
[TBC]	North West Boroughs Healthcare NHS Foundation Trust	Member
Director of Commissioning	St Helens CCG and St Helens Council	Member
Director of Quality	St Helens CCG and St Helens Council	Member
[TBC]	Torus	Member
[TBC]	VCS provider	Member
[TBC]	Representative from Stakeholder Reference Forum	Attendee
[Senior Responsible Officer for Resilient Communities Working Group]	[TBC]	
[Senior Responsible Officer for Mental Wellbeing Working Group]	[TBC]	
[Senior Responsible Officer for Tackling Obesity Working Group]	[TBC]	

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
- Designated officers (or their fully briefed deputies) will be expected to attend a minimum of [4 meetings per year].

Other attendees (including but not limited to commissioners) may be requested to attend, observe and/or participate in discussions at Programme Delivery Group meetings, as agreed between the Programme Delivery Group members from time to time.

4. Quorum

A quorum will be at least 50% of the membership and must include the SRO or nominated representative from each of the priority working groups [(excluding the Chair)].

5. Functions

The Programme Delivery Group is not a decision making body, although it will be instrumental in developing proposals and recommendations by consensus which shall be presented to the ICP Board from time to time.

As a forum for promoting and supporting effective collaborative working between the members of the ICP and service integration across the individual organisational contracts where this will improve service quality, outcomes or efficiencies, the functions of the Programme Delivery Group are to (by consensus):

- Deliver the ICP Plan, monitor achievement of outcomes and report on progress to the ICP Board;
- Ensure programmes are delivered through locality working and that Primary Care Networks are involved in each programme;
- Develop proposals for changes to the delivery of health and care services in St Helens for the key priority areas identified by the ICP Board that will improve quality, outcomes and/ or sustainability of health services;
- Establish and agree the remit of working groups (which may be time limited) to review key priority areas agreed by the ICP Board and/or to produce specific improvement proposals;[1]
- Prioritise and coordinate the work programmes to deliver the ICP Plan and priorities;
- Resource the delivery of the ICP Plan;
- Oversee the implementation of any service changes within the borough in respect of the key priority areas identified by the ICP Board and provide feedback and reports on progress, impact and evaluation to the ICP Board and, as appropriate, for onward communication to individual organisations' Boards;
- Develop proposals for system wide outcome measures and mechanisms for reporting collectively on the performance of ICP performance;
- Develop business cases for transformational change developments.

The Programme Delivery Group 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 Programme Delivery Group will consult and seek the views of the Stakeholder Reference Forum to inform its proposals to the ICP Board.

The Programme Delivery Group may consult and seek the views of the System Resources Group as it sees fit in relation to financial, resource and contractual implications of proposals and recommendations under discussion by the Programme Delivery Group.

6. Authority/Reporting

The Programme Delivery Group 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 ICP Board to improve the health of the population in the St Helens Borough.

[1]The initial key priority areas for the ICP have been agreed as: Mental Wellbeing; and Tackling Obesity and Resilient Communities.

The Programme Delivery Group 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 Programme Delivery Group will operate as a place for discussion of issues with the aim of reaching consensus to make recommendations and proposals to the ICP Board, in with the ultimate aim of development of the ICP.

To that end:

- a report from the Programme Delivery Group will be a standing item on every meeting agenda for the ICP Board; and
- In addition, each of the Programme Delivery Group members will ensure that their designated officer:
    - Is appointed to attend and represent their organisation on the Programme Delivery Group with such authority as is agreed to be necessary in order for the Programme Delivery Group 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 provider organisations comprising the Programme Delivery Group; and
    - Understand the status of the Programme Delivery Group and the limits of their responsibilities and authority.

Where necessary, proposals and recommendations presented to the ICP Board by the Programme Delivery Group may subsequently be presented to individual organisations for proposals/decisions to be taken and/or implemented.

7. Frequency of Meetings

The Programme Delivery Group 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 Programme Delivery Group at his or her discretion, subject to providing at least 5 working days' notice to Programme Delivery Group members**.**

8. Administration

The Programme Delivery Group will be administered by an 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 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 Programme Delivery Group.

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 Programme Delivery Group within 14 days of each meeting. Approval of the minutes of the previous meeting of the Programme Delivery Group 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 ICP Board and otherwise in accordance with members' wishes.

9. Review

The terms of reference and effectiveness of the Programme Delivery Group will be reviewed by the ICP 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 ICP.

St Helens Cares Integrated Care Partnership
System Resources Group
Terms of Reference

1. Purpose

The purpose of the System Resources Group (SRG) is to assist the St Helens ICP 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 SRG will provide strategic oversight of the collective resources of the partner organisations in the St Helens Cares Integrated Care Partnership (ICP). The SRG will develop a strategic approach to ICP resources including finance, workforce, estates and other infrastructure (including technology) throughout the ICP and provide advice to the ICP Board to support effective and efficient system decision making.

2. Chair

The SRG will be chaired by the Chief Finance Officer of St Helens CCG.

3. Membership

The membership of the SRG will be as follows:

Nominated Representative (Role/Title)	Organisation	Status
Chief Finance Officer	St Helens CCG	Chair
Director of Finance	St Helens & Knowsley Teaching Hospitals NHS Trust	Member
Director of Finance	North West Boroughs Healthcare NHS Foundation Trust	Member
Director of Finance	Torus Housing	Member
Senior Finance Officer	St Helens Council	Member
[Clinical Director/Business Manager]	[Primary Care Network]	Member
[Clinical Director/Business Manager]	[Primary Care Network]	Member
[Clinical Director/Business Manager]	[Primary Care Network]	Member
[Clinical Director/Business Manager]	[Primary Care Network]	Member
Public Health Consultant	[TBC]	Member
Strategic Estates Group Representative	[TBC]	Member
[Business Intelligence/Performance Representative]	[TBC]	Member

Members can nominate a deputy with appropriate authority as necessary.

In addition, representative(s) from the following services will have a standing invitation at SRG meetings in line with the annual work plan:

- IT
- Workforce

Other attendees may be requested to attend, observe and/or participate in discussions at SRG meetings, as agreed by the SRG 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 SRG], excluding the Chair.

5. Functions

The SRG is not a decision making body, although it will be instrumental in developing proposals and recommendations by consensus which shall be presented to the ICP Board from time to time.

As a forum for promoting and supporting effective collaborative working between Partners where this will improve service quality, outcomes or efficiencies, the functions of the SRG are to:

- Identify, evaluate and report on financial and other resource risk across the ICP, including monitoring the system performance dashboard, and recommending any mitigating actions required;
- Identify opportunities to shift / release resources to ensure the St Helens £ and resources of the ICP are used effectively to further the ICP Plan, using population health intelligence and horizon scanning;
- Develop and provide financial and other resource modelling information for the St Helens £ at the request of the ICP Board in relation to the broader ICP priorities;
- Feed into decisions to be made by the ICP Board which have a material impact on the resources of the ICP or any Partners;
- Provide assurance to the ICP Board on system sustainability and report on organisational sustainability;
- Establish the financial framework and principles against which proposals for service change within the ICP are developed;
- Advise on the development of mechanisms for risk/gain share amongst ICP partners.

The SRG may also advise and make recommendations to the Programme Delivery Group upon request in relation to resource and contractual implications of proposals and recommendations under discussion by the Programme Delivery Group, before the Provider Board puts any such proposals or recommendations to the ICP Board.

6. Authority/Reporting

The SRG 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 SRG 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 SRG 'overrule' the other on any matter.

The SRG will operate as a place for discussion of financial issues with the aim of reaching consensus on recommendations and proposals to the ICP Board, in line with the functions as outlined in section 5 above.

To that end, a report from the SRG will be a standing item on every meeting agenda for the ICP Board (and, where necessary, proposals and recommendations presented to the ICP Board by the SRG may subsequently be presented to individual organisations for proposals/decisions to be taken and/or implemented).

7. Frequency of Meetings

The SRG 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 SRG at his or her discretion, subject to providing at least 10 working days' notice to SRG members.

The Chair must call an extraordinary meeting of the SRG 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 SRG members.

8. Administration

The SRG will be administered by secretariat of 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 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 SRG within 14 days of each meeting. Approval of the minutes of the previous meeting of the SRG 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 ICP Board. Minutes shall be made available to the ICP Board and otherwise in accordance with members' wishes.

9. Review

The terms of reference and effectiveness of the SRG will be reviewed by the ICP Board annually or more frequently if required.

10. Conduct

All members are required to notify the SRG 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.

ST HELENS CARES

St Helens Integrated Care Partnership Stakeholder Reference Forum: Terms of Reference

1. Purpose

We are changing the way that health and 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 health and 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 ICP which is *improving people's lives in St Helens together.*

The St Helens ICP 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.

The Stakeholder Reference Forum (SRF) is established to build and sustain meaningful engagement with people across all communities within St Helens including those with lived experience, enabling them to have a voice in improving their health and in shaping services as part of St Helens ICP. As such, the SRF will play a key role in providing feedback to the Programme Delivery Group and the ICP Board on proposals for service change, and co-production.

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 the ICP 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 SRF 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.

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:

Nominated Representative (Role/Title)	Organisation	Status
Lay Member with responsibility for Patient & Public Involvement	St Helens CCG	Chair
Public Governor Rep	North West Boroughs Healthcare NHS Foundation Trust	Member
[TBC]	Willbrook Hospital	Member
[TBC]	VCA	Member
[TBC]	Saints Rugby Club	Member
[TBC]	St Helens Mind	Member
[TBC]	Deafness Resource Centre	Member
[TBC]	Children & Young Peoples Council	Member
[TBC]	Age UK MM	Member
[Employer Representative]	Co-op Distribution Centre	Member
[TBC]	Pilkington Family Trust	Member
[TBC]	St Helens Council, St Helens Cares portfolio lead	Member
[TBC]	Halton & St Helens Council for Voluntary Services	Member
[TBC]	Voluntary Services	Member
[TBC]	Locality Patient Practice Groups (PPGs)	Member
[TBC]	Locality Patient Practice Groups	Member

	(PPGs)	
[TBC]	Locality Patient Practice Groups (PPGs)	Member
[TBC]	Locality Patient Practice Groups (PPGs)	Member
Chair	St Helens Maternity Voices Partnership	Member
[TBC]	Torus Housing Residents Forum	Member
[TBC] [Jayne Parkinson-Loftus]	Healthwatch	Member
[TBC]	Carers Forum	Member
[TBC]	Faith Forum	Member
[TBC]	St Helens Borough Council Public Health Department	Member
Engagement & Involvement Lead	NHS St Helens CCG	Member
[Headteacher]	[Headteacher Network?]	[Member]

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 the ICP will engage with the SRF and will ensure that:

- Information is provided in advance of meetings;
- Information provided is clear and accessible;
- The venues/virtual platform chosen for meetings are fully accessible;
- The teams encourage open discussion on matters arising;
- 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 the ICP 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.

5. Authority/Reporting

The work of the SRF will be shared with the ICP Board[1] through a report prepared following each SRF meeting to the ICP Board.

The ICP 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 ICP 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].

Notes of meetings and reports produced by the SRF shall be made available via the St Helens ICP website. [2]

8. Review

The terms of reference and effectiveness of the SRF will be reviewed by the ICP Board annually or more frequently if required.

9. Conduct

[1] The ICP 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.
[2] 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.

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 Code of Conduct requirements.

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 ICP.

Doc iv Draft Collaboration Agreement (based on existing MOU)

ST HELENS CARES ICP COLLABORATION AGREEMENT

[INSERT LOGOS WHEN PARTIES ARE SETTLED]

DATE **2021**

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. TORUS

6. [PRIMARY CARE PARTNERS]

7. HALTON AND ST HELENS VOLUNTARY AND COMMUNITY ACTION

Commented [EV1]: Torus legal name to be confirmed

Commented [EV2]: Primary Care sign up to be determined

COLLABORATION AGREEMENT FOR

ST HELENS CARES INTEGRATED CARE PARTNERSHIP

HD Draft v4 03/03/21

ST HELENS CARES ICP COLLABORATION AGREEMENT

Contents

ST HELENS CARES ICP COLLABORATION AGREEMENT

Overarching Note – Collaboration Agreement for St Helens Cares Integrated Care Partnership (ICP)

This Agreement provides an overarching framework for the place-based approach to integrated health and care in St Helens, known as the St Helens Cares ICP. The arrangements set out build on the previous collaboration agreement between NHS and local authority partner organisations in St Helens. They are intended to broaden the partnership to include key partners such as Torus, primary care and voluntary sector partners and further develop the established place-based integrated working between the partners for the benefit of the St Helens population.

This Agreement sets out the Partners' approach to the St Helens Cares ICP model. This Agreement will cover the agreed Priority Areas which shall be the key focus of the St Helens Cares ICP for 2021/22 and beyond subject to changes agreed between the Partners.

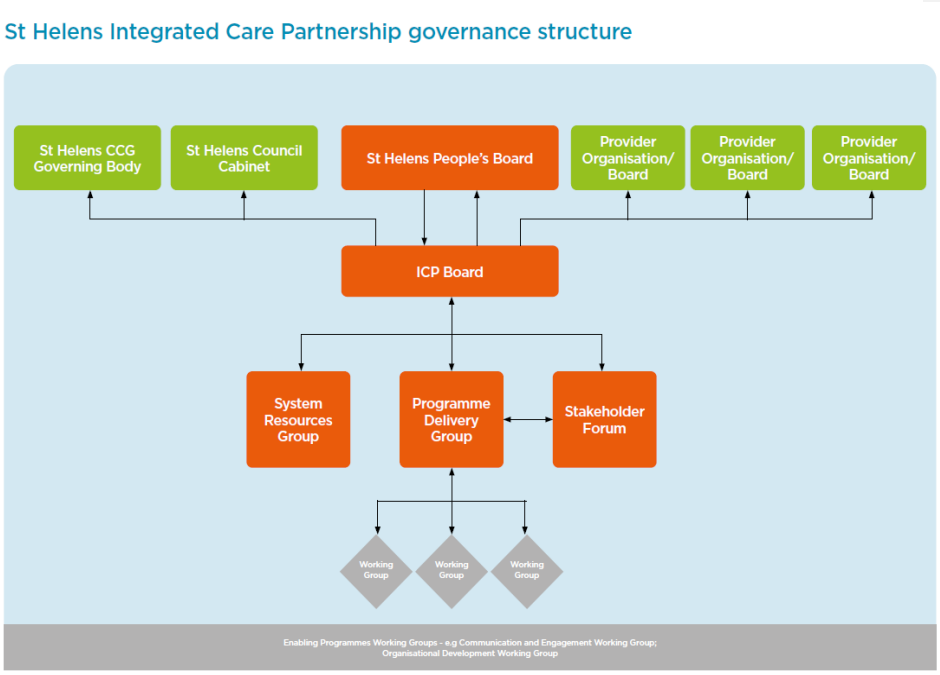
This Agreement is based on a Memorandum of Understanding approach and provides an overarching arrangement. It is designed to work alongside existing contracts and arrangements for the delivery of care, support and community services via the provider organisations to the extent such services are within the scope of the Agreement. As at the Commencement Date, 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 Partners will work together under the governance framework set out in this Agreement to develop the St Helens Cares ICP approach to ultimately, over time, include requirements in relation to outcomes, risk/gain share, financial and contract management and regulatory requirements. The Partners intend to work towards documenting such arrangements as may be agreed in a formal legally binding agreement for April 2022, in line with the policy direction set by NHSE/I in respect of the development of place-based partnerships.

Schedule 4 includes a diagram illustrating the governance arrangements for St Helens Cares ICP as at the Commencement Date. The approach that the Partners are working towards through this Agreement is illustrated in Figure 1 below. The Partners will review progress made and the terms of this Agreement at six monthly intervals from the Commencement Date and may agree to vary the Agreement to reflect developments.

ST HELENS CARES ICP COLLABORATION AGREEMENT

FIGURE 1



ST HELENS CARES ICP COLLABORATION AGREEMENT

DATE: 2021

This Collaboration Agreement (the **Agreement**) is made between:

1. **NHS ST HELENS CLINICAL COMMISSIONING GROUP** of Forster House, Waterside, St Helens WA9 1UB (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. **TORUS** [INSERT DETAILS] ("**Torus**");

6. **[Primary Care Network Partner(s)]** [INSERT DETAILS] ("**Primary Care**") and

7. **HALTON AND ST HELENS VOLUNTARY AND COMMUNITY ACTION** of St Maries, Lugsdale Road, Widnes WA8 6DB (Registered Charity No. 1106001 and Company Limited by Guarantee No. 2539153) ("**VCA**"),

together referred to in this Agreement as the "**Partners**".

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, Torus, Primary Care, VCA 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 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".* The NHS Long Term Plan, published in January 2019, provided a vision of health and care joined up locally around population needs.

b) The engagement document published by NHS England / Improvement (NHSEI) in November 2020 builds on the NHS Long Term Plan vision and sets out the key components of an integrated care system. One of these components is "*strong and*

Commented [EV3]: Full name and details to be confirmed

Commented [EV4]: Parties to be confirmed.

effective place-based partnerships" in local places between the NHS, local government and key local partners. The Partners recognise that as at the Commencement Date, the policy direction is such that a formal place-based partnership is likely to be required to be in place in St Helens by April 2022. This will require the Partners to keep this Agreement under review throughout 2021/22 in order to prepare for the transition for the ICP Board and the arrangements established under this Agreement to a more formal, legally binding, footing, with potential for a 'place leader' within St Helens as set out in the November 2020 engagement document.

c) St Helens Cares has operated under a collaboration agreement since 2019 and has developed into a strong and effective place-based partnership for St Helens. This Agreement sets out the next steps to further develop relationships through an Integrated Care Partnership ("**ICP**") for St Helens.

d) This Agreement sets out the values, principles and shared ambition of the Partners in supporting work towards the transformation and better integration of health and care services for the people of St Helens through the St Helens Cares ICP. The Partner organisations under this Agreement include Torus, Primary Care and VCA, recognising both the vital role of wider cross-sector partners and the central role Primary Care will play in moving towards a population health management approach for St Helens.

e) The Partners will particularly focus on agreed priority areas in which to work towards the achievement of specific outcomes over the term of this Agreement as set out in Schedule 2. Further priority areas may be identified by the Partners during the term of this Agreement or changes agreed between the Partners to the existing priority areas as required to further the collaborative work of the Partners for the benefit of the St Helens population.

f) 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. The Providers (including the Council in its provider role) are together providers of social care, NHS funded healthcare services, housing, community and support services to the population of St Helens.

g) The Parties acknowledge that the delivery and development of the ICP will rely on both Commissioners and Providers working collaboratively rather than separately to plan financially sustainable methods of delivering services in furtherance of the priority areas.

h) The Parties acknowledge that the Council has a dual role within the ICP 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.

i) This Agreement sets out the ICP 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.

j) This Agreement is intended to work alongside:
   a. the Services Contracts; and
   b. 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 Partner 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 Partners have agreed to work together to develop the ICP 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 Partners have agreed.

2.3 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners agree that save as provided in Clause 2.4 below this Agreement shall not be legally binding. The Partners each enter into this Agreement intending to honour all of their respective obligations.

2.4 This Clause 2.4, 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 of this Agreement and shall give rise to legally binding commitments between the Partners.

2.5 Each of the Providers (excluding Torus and VCA) 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.

2.6 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 Partners in writing.

3. ACTIONS TO BE TAKEN ON OR POST THE COMMENCEMENT DATE

Each Partner 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 Partners agree in writing that the term of the Agreement shall be extended for a further term to be agreed between the Partners (the "**Extended Term**").

SECTION A: VISION, OBJECTIVES AND PRINCIPLES

5. VISION

5.1 The overarching vision for the St Helens ICP is as follows:

"One Place, One System, One Ambition: Improving people's lives in St Helens, together"

6. OBJECTIVES FOR THE ICP

6.1 The Objectives agreed by the Partners for the ICP are intended to deliver sustainable, effective and efficient health and care, support and community services to improve the lives of people in St Helens through collaborative working. The Partners have agreed to work together and to perform their duties under this Agreement in order to achieve the following Objectives:

6.1.1 to develop an Outcomes framework for the Priority Areas and an implementation plan in respect of these Outcomes (the **ICP Plan**);

6.1.2 to consider lessons learned by the Partners during the Covid-19 pandemic and build upon the collaborative working arrangements developed during this period;

6.1.3 to develop population health management systems and intelligence which use health, social and economic population measures to ensure high quality health, care, support, and community services which improve health and wellbeing and reduce health inequalities across St Helens;

6.1.4 to establish and operate collaborative governance arrangements in respect of the ICP and, initially, the Priority Areas;

6.1.5 to support and develop Primary Care Networks as collaboratives of primary care providers, as well as support and develop PCNs' role in broader collaborative working with other partners within neighbourhoods and the wider ICP;

6.1.6 to work together to undertake the agreed enabling programmes of work as set out in Schedule 3 (*Areas for Development*), recognising that such programmes are key to achieving these Objectives and the Outcomes; and

6.1.7 to develop a strong research and development culture in the ICP, with Primary Care taking a leading role.

6.2 The Partners acknowledge that they will have to make decisions together in order for the ICP to work effectively. The Partners 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. In doing so, the Partners will ensure that the impact of changes in one part of the health and care system in St Helens on other parts are understood, taken into account and mitigated wherever possible.

6.3 The Partners acknowledge that STHK, NWB and Torus 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.

7. PRINCIPLES FOR THE ICP

7.1 The Principles underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners.

7.2 The Partners 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 Priority Areas (together with the Council as a Provider) under this Agreement in conjunction with the CCG and Council (as a Commissioner).

7.3 The Principles are that the Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will:

7.3.1 take decisions solely in terms of the patient/resident's best interest and not that of self or organisation;

7.3.2 not place themselves under any financial or other obligation to outside individuals/organisations;

7.3.3 in carrying out public business, make choices on merit when awarding contracts and making appointments;

7.3.4 be accountable for their decisions and actions to the public and submit themselves to appropriate scrutiny;

7.3.5 be as open as possible about all the decisions and actions that they take and give reasons for their decisions;

7.3.6 have a duty to declare any private interests relating to their public duties;

7.3.7 promote and support these principles by leadership and example;

7.3.8 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;

7.3.9 achieve continuous, measurable and measured improvement in Outcomes. Agree improvements which are specific, challenging, add value and eliminate waste; and

7.3.10 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**").

7.4 The Partners acknowledge that:

7.4.1 STHK, NWB and Torus also provide services in areas outside of St Helens; and

7.4.2 the Council has wider responsibilities in addition to health and social care functions,

which they each may need to take into account when seeking to act in accordance with the Principles.

8. PROBLEM RESOLUTION AND ESCALATION

8.1 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 6 and 7 above and which:

8.1.1 seeks solutions without apportioning blame;

8.1.2 is based on mutually beneficial outcomes;

8.1.3 treats Providers and the Commissioners as equal Partners in the dispute resolution process; and

8.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

8.2 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to the Objectives, Principles or any matter in this Agreement and is appropriate for resolution between the Commissioners and the Providers such Partner shall notify the other Partners and the Partners 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.

8.3 Any Dispute arising between the Partners which is not resolved under Clause 8.2 above will be resolved in accordance with Schedule 5 (*Dispute Resolution Procedure*).

8.4 If any Partner 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 Partner will liaise with the other Partners as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE SYSTEM

9. RESERVED MATTERS

9.1 The Partners 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 9.2 for their respective determination as they see fit in accordance with Clause 9.3.

9.2 Each of the Commissioners shall be free to determine the following Reserved Matters:

9.2.1 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

9.2.2 any matter upon which they may be required engage with the public (including by way of public consultation) or in relation to which they may be required to respond to or liaise with a local Healthwatch organisation.

9.3 The Partners agree that:

9.3.1 the Reserved Matters are limited to the express terms of Clause 9.2 above; and

9.3.2 the ICP Board may not make a final recommendation on any of the matters set out in Clause 9.2 above, which are reserved for determination by either Commissioner respectively.

9.4 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 or failing to act in accordance with any relevant guidance, the relevant

Commissioner will first consult with the ICP Board in respect of their proposed determination of a Reserved Matter in line with the Objectives and the Principles.

10. TRANSPARENCY

10.1 Subject to complying with the Law, the Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and deliver the Outcomes for the Priority Areas.

10.2 The Partners have responsibilities to comply with Law (including Competition Law). The Partners 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 ICP Board and the Programme Delivery Group will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

10.2.1 it is essential;

10.2.2 it is not exchanged more widely than necessary;

10.2.3 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

10.2.4 it may not be used other than to achieve the Objectives in accordance with the Principles.

10.3 Subject to compliance with Clause 10.2 above, the Partners will ensure that they provide the System Resources Group (SRG) with financial cost resourcing, activity or other information as may be reasonably required so that the SRG can assure the ICP Board that the Objectives in respect of the development of outcomes and payment systems are being met.

10.4 The Commissioners will make sure that the Programme Delivery Group (PDG) and the SRG 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 Partners do not breach Competition Law.

10.5 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the ICP 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 the ICP, other than as a result of a breach of this Agreement, does not preclude the CCG and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations.

10.6 Notwithstanding Clause 10.5 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.

11. OBLIGATIONS AND ROLES OF THE PARTNERS

Commissioners' obligations and role

11.1 Each Commissioner will:

11.1.1 help to establish an environment that encourages collaboration between the Providers where permissible;

11.1.2 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;

11.1.3 support the Providers in developing links to other relevant services;

11.1.4 comply with their statutory duties;

11.1.5 seek to commission the services within the Priority Areas in an integrated, effective and streamlined way to meet the Objectives; and

11.1.6 work collaboratively with the Providers to develop the ICP approach for the Priority Areas in accordance with Schedule 2 (*Priority Areas*).

Providers' obligations and role

11.2 Each Provider will:

11.2.1 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;

11.2.2 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 Priority Areas and so as to achieve continuity in the provision of services within the 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

11.2.3 through high performance and collaboration, unlock and generate enhanced innovation and better outcomes and value for the Population in line with the Objectives.

11.3 Each Provider acknowledges and confirms that:

11.3.1 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;

11.3.2 it will be separately and solely liable to the CCG or the Council (as applicable) under its own Services Contracts;

11.3.3 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

11.3.4 it will work collaboratively with the Commissioners and the other Providers to develop the ICP approach for the Priority Areas in accordance with Schedule 2 (*Priority Areas*).

SECTION C: GOVERNANCE ARRANGEMENTS

12. ICP GOVERNANCE

12.1 The Partners must communicate with each other and all relevant staff in a clear, direct and timely manner. In addition to the Partners' own Boards / Cabinet / Governing Body, which shall remain accountable for the exercise of each of the Partners' respective functions, the governance structure for the ICP will comprise:

12.1.1 the Health and Wellbeing Board for St Helens (known as the "People's Board");

12.1.2 the Integrated Care Partnership Board (ICP Board);

12.1.3 the Programme Delivery Group (PDG);

12.1.4 the System Resources Group (SRG); and

12.1.5 the St Helens Cares Stakeholder Reference Forum (SRF).

12.2 The diagram in Schedule 4 (*Governance*) sets out the governance structure and the links between the various groups in more detail.

St Helens People's Board

12.3 The St Helens 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 ICP Board as to the development of the ICP under this Agreement and progress against the Outcomes and the areas for development set out in Schedule 3.

Integrated Care Partnership Board (ICP Board)

12.4 The ICP Board reports to the People's Board and is the group responsible for:

12.4.1 providing strategic and collective leadership to identify the transformational priorities for the ICP, in line with the strategic direction set by the People's Board;

12.4.2 overseeing the ICP arrangements under this Agreement;

12.4.3 reporting to the People's Board on progress against the Objectives; and

12.4.4 liaising where appropriate with:

(a) the Health Overview & Scrutiny Committee for St Helens;

(b) national stakeholders (including NHS England and NHS Improvement); and

(c) the Cheshire and Merseyside Health & Care Partnership,

to communicate the views of the ICP on matters relating to integrated care in St Helens.

12.5 The ICP Board will act in accordance with its terms of reference set out in Part 1 of Schedule 4 (*Governance*) and will be responsible for:

12.5.1 promoting and encouraging commitment to the Principles and Objectives amongst all the Partners;

12.5.2 ensuring alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the Population;

12.5.3 approving proposals for system wide outcome measures and reporting mechanisms;

12.5.4 overseeing systems and infrastructure workstreams (e.g. enablers for the ICP such as digital, estates, workforce) and monitoring progress;

12.5.5 in undertaking its role, considering recommendations from the PDG and the SRG in respect of the development and operation of the ICP, the delivery of the Objectives and the development of the Priority Areas; and

12.5.6 discharging the functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.5.

Programme Delivery Group (PDG)

12.6 The PDG is the group responsible for delivering the ICP Plan in respect of the Priority Areas and developing proposals for changes to the delivery of health and care services to support the delivery of the Outcomes. The PDG will report to the ICP Board, acting in accordance with its terms of reference set out in Part 2 of Schedule 4 (*Governance*) and will:

12.6.1 monitor and report on the achievement of the Outcomes and report on progress to the ICP Board;

12.6.2 ensure programmes in respect of the Priority Areas are delivered through locality working and that Primary Care Networks are involved in each programme;

12.6.3 make recommendations to the ICP Board in relation to changes to the Priority Areas in respect of Service User pathways / services;

12.6.4 resource the delivery of the ICP Plan;

12.6.5 establish and agree the remit of working groups (which will be time limited) to review the Priority Areas agreed by the ICP Board and/or to produce specific improvement proposals;

12.6.6 seek and reflect the views of the Stakeholder Reference Forum in drawing up recommendations to the ICP Board;

12.6.7 make recommendations to the ICP Board as to the addition of new Partners to the arrangements under this Agreement, including new providers of services in the Priority Areas; and

12.6.8 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.6.

System Resources Group (SRG)

12.7 The SRG is the group responsible for providing strategic oversight of the collective resources of the Partners in St Helens. The SRG will report to the ICP Board, acting in accordance with its terms of reference set out in Schedule 4 (*Governance*) Part 3 and will:

12.7.1 develop proposals as to future financial and resource models for the ICP for recommendation to the ICP Board;

12.7.2 identify opportunities to shift / release resources to ensure that the St Helens £ and the collective resources of the ICP are used effectively to achieve the Outcomes in the Priority Areas;

12.7.3 provide input on an ad hoc basis to the PDG in respect of resources considerations related to proposals being worked up by the PDG; and

12.7.4 discharge the other functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.7.

St Helens Stakeholder Reference Forum (SRF)

12.8 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 ICP. The SRF will act in accordance with its terms of reference set out in Schedule 4 (Governance) Part 4 and will provide views and feedback to the ICP Board and the PDG in respect of the development of the ICP and proposals to integrate care in respect of the Priority Areas developed by the PDG. The SRF also has a broader role to consider transformational priorities identified by the ICP Board.

12.9 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Partners (and their representatives) present at the ICP Board, the PDG and the SRG are able to represent their nominating organisations to enable effective and timely recommendations to be made in relation to the Priority Areas.

12.10 Each Partner must ensure that its appointed members of the ICP Board, the PDG and /or the SRG (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 6 (*Objectives*) and Clause 7 (*Principles*).

13. CONFLICTS OF INTEREST

13.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

13.2 The Partners will:

13.2.1 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 ICP Board, the PDG or the SRG immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any

person employed or retained by them for or in connection with the performance of this Agreement;

13.2.2 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 Partners) before they participate in any decision in respect of that matter; and

13.2.3 use best endeavours to ensure that their representatives on the ICP Board, PDG and/or the SRG also comply with the requirements of this Clause 13 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

14. PAYMENTS

14.1 The Partners will continue to be paid in accordance with the mechanism set out in their respective Services Contracts.

14.2 The Partners have not agreed as at the Commencement Date to share risk or reward. 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 Partners and incorporated into this Agreement in accordance with Clause 18.

SECTION E: GENERAL PROVISIONS

15. EXCLUSION AND TERMINATION

15.1 A Partner may be excluded from this Agreement on notice from the Commissioners (acting in consensus) in the event of:

15.1.1 the termination of their Services Contract; or

15.1.2 an event of Insolvency affecting them.

15.2 A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives.

15.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or a persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (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 Partner.

15.4 The ICP Board may resolve to terminate this Agreement in whole where:

15.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

15.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

15.5 Where a Provider is excluded from this Agreement, or withdraws from it, the excluded or withdrawing (as relevant) Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

16. INTRODUCING NEW PROVIDERS

Additional parties may become parties to this Agreement on such terms as the Partners 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.

17. LIABILITY

The Partners' 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.

18. 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 Partners.

19. CONFIDENTIALITY AND FOIA

19.1 Each Partner shall keep confidential all Confidential Information that it receives from the other Partners except to extent such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this Agreement.

19.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

19.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 19 (*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.

19.4 Nothing in this Clause 19 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

19.5 The Partners 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 Partner is able to comply with their statutory obligations.

19.6 Each Partner will hold harmless each other and will indemnify and keep indemnified each of the other Partners, in full and on demand, against all Claims (and related costs, charges and reasonable legal expenses) which the other Partners 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 Partners for any direct, indirect, incidental or consequential or other loss or damage of whatsoever kind, arising from any breach by such a Partner to this Agreement of the obligations under this Clause 19 (*Confidentiality and FOIA*) or otherwise.

20. INTELLECTUAL PROPERTY

20.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Partner grants each of the other Partners 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 Partner's obligations under this Agreement.

20.2 If any Partner creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations and the development and delivery of the arrangements under this Agreement.

21. GENERAL

21.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner

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.

21.2 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.

21.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

21.4 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 Partner has executed at least one counterpart.

21.5 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 Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

21.6 A person who is not a Partner 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.

Signed by [insert]

.....

for and on behalf of **NHS ST HELENS CLINICAL COMMISSIONING GROUP**

[ ]

ST HELENS CARES ICP COLLABORATION AGREEMENT

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 **[TORUS]** [ ]

Commented [EV5]: Full name to be confirmed

Signed by [insert] .....

for and on behalf of **[PRIMARY CARE PARTNER(S)]** [ ]

Commented [EV6]: Contracting entities to be confirmed.

Signed by [insert] .....

for and on behalf of **HALTON AND ST HELENS VOLUNTARY AND COMMUNITY ACTION** [ ]

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 Vision, 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 Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner 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 Partner, 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	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its

Information	entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business 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 Partners 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 8 (*Problem Resolution and Escalation*).
Extended Term	has the meaning set out in Clause 4.2.
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.
ICP Board	the St Helens Integrated Care Partnership Board, the terms of reference of which are set out in Schedule 4 Part 1.
ICP Plan	the St Helens ICP Plan, to be developed during the Initial Term based on the summary ICP Plan set out in Schedule 2 (*Priority Areas*).
Initial Term	the period from and including the Commencement Date until the second anniversary of the Commencement Date.
Insolvency	(as may be applicable to each Partner) a Partner 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 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.
Priority Area	one of the priority areas set out in Schedule 2 (*Priority Areas*) as may be amended or added to by agreement of the Partners from time to time.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) 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 the ICP set out in Clause 6.1.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Outcomes	the outcomes for the Priority Areas set out in Schedule 2 (*Priority Areas*), which are to be further developed during the term of this Agreement.
People's Board	has the meaning set out in Clause 12.1.1.
Population	the population of St Helens covered by each of the Commissioners.
Principles	the principles for the ICP set out in Clause 7.3.
Programme Delivery Group or PDG	the Programme Delivery Group, the terms of reference of which are set out in Part 2 of Schedule 4 (*Governance*).
Reserved Matter	has the meaning set out in Clause 9.2.

Section 75 Agreement	the agreement relating to 2021/22 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 (other than Torus or VCA) 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 ICP Stakeholder Reference Forum, the terms of reference of which are set out in Part 4 of Schedule 4 (*Governance*).
System Resources Group or SRG	the System Resources Group, the terms of reference of which are set out in Part 3 of Schedule 4 (*Governance*).

SCHEDULE 2

Priority Areas

The Partners have identified the initial Priority Areas during the Initial Term (as may be agreed and amended from time to time) as:

Priority	**Description**	**Outcomes for 2021/22**
Mental Wellbeing	Our residents will achieve and maintain a sense of wellbeing. They will be supported when needed to maintain confidence, hope and resilience throughout their life.	Working to reverse Health Inequalities exacerbated by the pandemic by moving the key measures towards the 2019/2020 baseline.
Tackling Obesity	We will support our residents to invest in their health. Encouraging people to maintain a healthy weight through wholesome food and an active lifestyle.	Working to reverse Health Inequalities exacerbated by the pandemic by moving the key measures towards the 2019/2020 baseline.
Resilient Communities	Building resilient communities based around our localities and primary care networks which will support people living independently, reduce neglect and eliminate social isolation.	A fully multiagency locality model implemented with appropriate infrastructure and governance arrangements in all Networks.

Summary ICP Plan

The Partners have developed the following summary ICP Plan (as may be amended from time to time by agreement of the Partners) in order to achieve the above Outcomes and which also sets out the intended Outcomes in respect of the Priority Areas across a five year period to April 2026:

ICP Summary Plan 01022021.pptx

SCHEDULE 3

Areas for Development

1. The Partners will work together, through the governance structures set out in this Agreement, to take forward agreed 'enabling' programmes of work which are acknowledged to be key to the delivery of the Outcomes for the Priority Areas. The Partners may agree to establish working groups during the Initial Term to take forward such programmes of work.

2. As at the Commencement Date, the Partners have agreed to establish working groups to take forward the following enabling programmes:

(a) a communications and engagement framework for the ICP; and

(b) an organisational development framework for the ICP.

3. The Partners will continue to work together to develop their shared business intelligence function and the St Helens Shared Care Record to further support the delivery of the Objectives and the Outcomes.

4. The Partners will also, during the Initial Term, undertake joint work to establish the principles and milestones for the development of a framework for a potential risk / reward sharing or other financial arrangements between the Partners in respect of the Priority Areas and future Priority Areas (if any).

SCHEDULE 4

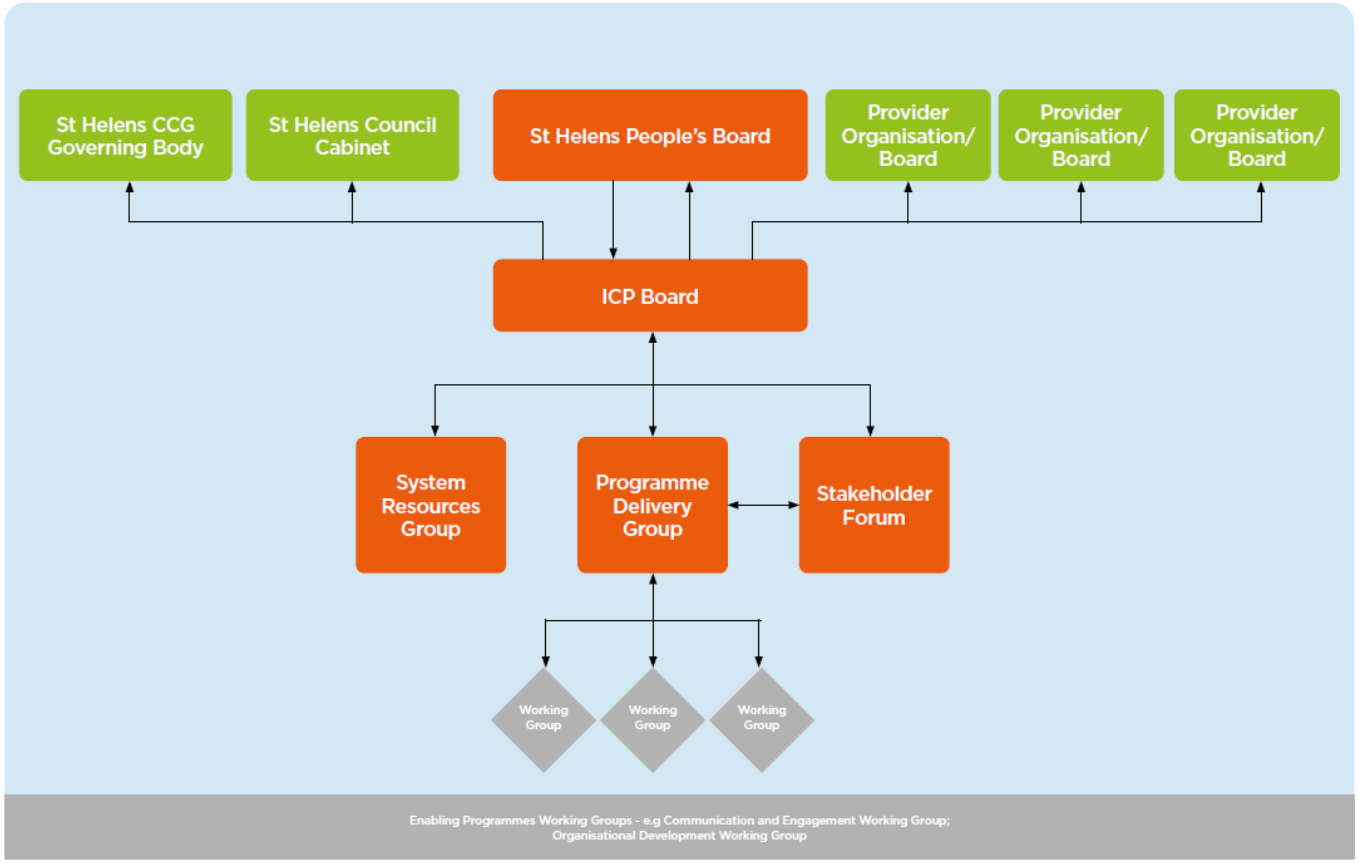
Governance

This Schedule 4 sets out the governance arrangements for the ICP under this Agreement.

The diagram below summarises the governance structure which the Partners have agreed to establish and operate from the Commencement Date, to provide oversight of the development and implementation of the ICP approach and the arrangements under this Agreement.

This Schedule also contains the draft terms of reference for the ICP Board, the Programme Delivery Group, the System Resources Group and the St Helens Stakeholder Reference Forum. The Partners will agree the final form of the terms of reference for each of these groups as soon as possible following the Commencement Date and attach the agreed forms to this Schedule 4.

St Helens Integrated Care Partnership governance structure



Part 1 – Integrated Care Partnership Board - Terms of Reference

ICP Board TORs 010221.docx

Part 2 – Programme Delivery Group – Terms of Reference

PDG TORs
010221.docx

Part 3 – System Resources Group - Terms of Reference

SRG TORs
010221.docx

Part 4 – Stakeholder Reference Forum – Terms of Reference

SRF TORs
010221.docx

SCHEDULE 5

Dispute Resolution Procedure

1. Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 8 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners 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 ICP arrangements set out in this Agreement.

1.3 The Partners 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 the ICP (each a '**Dispute**') when it arises.

1.4 In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, 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 Partners 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;

(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 Partners 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 Partners may agree to:

(i) terminate this Agreement in accordance with Clause 15.1.1; or

(ii) agree that the Dispute need not be resolved.

Doc v: ICP priorities/outcomes …

St Helens Integrated Care Partnership Breakthrough Priorities

Vision	One Place, One System, One Ambition: Improving people's lives in St Helens together		
Priorities	**Mental Wellbeing**	**Tackling Obesity**	**Resilient Communities**
Description	Our residents will achieve and maintain a sense of wellbeing . They will be supported when needed to maintain confidence, hope and resilience throughout their life.	We will support our residents to invest in their health. Encouraging people to maintain a healthy weight through wholesome food and an active lifestyle.	Building resilient communities based around our localities and primary care networks which will support people living independently, reduce neglect and eliminate social isolation.
What will breakthrough success look like? **Goals in Bold** supported by key measures	**By 2026, we will** **A. Support people who are a harm** 1. Reduce the Emergency Admissions for intentional self harm to below the NW Ave. 2. Reduce the suicide rate to below NW Ave. **B. Reduce Alcohol dependency in the Borough** 3. Halve the Admission episodes for alcohol specific conditions – under 18s to below the NW average 4. Reduce Alcohol Specific hospital admissions to below the NW average **C. Improve personal wellbeing in the Borough** 5. Improvements in personal wellbeing to be the best in the Liverpool City Region.	**By 2026, we will:** 1. Reduce the prevalence of obese children (4-5) to below the NW average 2. Reduce the prevalence of obese children - Year 6 to below the NW average 3. Reduce the percentage of adults classified as overweight/obese to below the NW average **B. Encourage residents to lead a more active lifestyle** 4. Premature deaths (<75) reduce by 10% from Cardiovascular disease, Cancer , Respiratory disease **C. Improve Borough Healthy Life Expectancy** 5. Increase Healthy Life Expectancy by 2 years	**By 2026, we will:** **A. Supporting people to live independently** 1. To be the best borough in Merseyside for older people who are still at home 91 days after discharge from hospital 2. Improve by 20%, the proportion of adults with learning disabilities in employment 3. Reducing our delayed transfer of care from hospital becoming the best borough in Merseyside 4. Reducing injuries (65+) due to falls by 25% **B. Reduce social isolation and loneliness** - Measures to be determined. **C. Embed multi-sector/disciplinary team working in our four localities/networks**
Priorities to Sept 2022	**Working to reverse Health Inequalities exacerbated by the pandemic by moving the key measures towards the 2019/20 baseline.**	**Working to reverse Health Inequalities exacerbated by the pandemic by moving the key measures towards the 2019/20 baseline.**	**A fully established multiagency locality model implemented with appropriate infrastructure and governance arrangements in all Networks**

Doc ii (c) Draft TOR for ICP System Resources Group

St Helens Integrated Care Partnership Breakthrough Priorities Scorecard

SRO	Locality Director Mersey Care*	Director of Public*	Director of Primary Care*
Priorities	**Mental Wellbeing** By 2026, we will A. Support people who are at risk of self-harm B. B. Reduce Alcohol dependency in the Borough C. Improve personal wellbeing in the Borough	**Tackling Obesity** By 2026, we will: A. Support healthy eating choices in the Borough B. B. Encourage residents to lead a more active lifestyle C. C. Improve Borough Healthy Life Expectancy	**Resilient Communities** By 2026, we will: A. Supporting people to live independently B. Reduce social isolation and loneliness C. Embed multi-sector/disciplinary team

Scorecard Measures

Key Measures**	Baseline	Target 2026/7
1. Reduce Emergency Admissions for intentional self harm to below the NW Average.	**433.4** /100,000	**246** /100,000
2. Reduce the suicide rate to below NW Average.	**13.9** /100,000	**10.5** /100,000
3. Halve Admission episodes for alcohol specific conditions – under 18s	**100.2** /100,000	**45.9** /100,000
4. Reduce Alcohol related hospital admissions to below the NW average	**883** /100,000	**742** /100,000
5. Improvements in personal wellbeing:	Scores out of 10	Scores out of 10
Anxiety	**2.9**	**2.7**
Happiness	**7.5**	**7.7**
Life Satisfaction	**7.7**	**7.9**
Feeling Worthwhile	**7.8**	**8.0**

Key Measures**	Baseline	Target 2026/7
1. Reduce the prevalence of obese children (4-5) to below the NW average	**11.6%**	**10.4%**
2. Reduce the prevalence of obese children - Year 6 to below the NW average	**23%**	**21.0%**
3. Reduce the percentage of adults classified as overweight/obese to below the NW average	**69.2%**	**64.8%**
4. Increase Healthy Life Expectancy by 2 years	**59** years	**61** years
5. Premature deaths (<75) reduce to below NW:	per 100,000	per 100,000
All causes	**405**	**382**
Cardiovascular Disease	**92.1**	**86**
Cancer	**138.2**	**132**
Respiratory Disease	tbc	tbc

Key Measures**	Baseline	Target 2026/7
1. To be the best borough in Merseyside for older people who are still at home 91 days after discharge from hospital (ASC-17)	**90.6%**	**94%**
2. Improve by 20%, the proportion of adults with learning disabilities in employment (ASC-12)	**7.4%**	**8.9%**
3. Reducing our delayed transfer of care from hospital becoming the best borough in Merseyside (ASC -20a)	**219** days/100k	**180** days/100k
4. Reducing injuries (65+) due to falls by 25%	tbc	tbc
5. Reduce social isolation and loneliness	tbc	tbc
6. Embed multi-sector/disciplinary team working in our four localities/networks	Localities defined, PCNs in place	Seamless integrated services locally

* SROs are placeholders and are subject to change

**Key measures are subject to change once programme leads have established areas of intervention, some measures are to be confirmed (tbc)