St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 30th JUNE 2021
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
09:00	1.	Employee of the Month - June 2021		Verbal	Assurance	Chair
09.15	2.	Apologies for Absence		Verbal	Assurance	Chair
09.20	3.	Declaration of Interests		Verbal		
09.25	4.	Minutes of the Board Meeting held on 26th May 2021		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
09.30	5.	Integrated Performance Report		NHST(21) 034	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
Committee Assurance Reports						
10.00	6.	Committee Report – Executive		NHST(21) 035	Assurance	Ann Marr
10.15	7.	Committee Report – Quality		NHST(21) 036	Assurance	Gill Brown
10.25	8.	Committee Report – Finance & Performance		NHST(21) 037	Assurance	Jeff Kozer
10.35	9.	Audit Committee		NHST(21) 038	Assurance	Ian Clayton
10.40	10.	Charitable Funds Committee		Verbal	Assurance	Paul Growney

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<tr><td>10.55</td><td>11.</td><td>Fit and Proper Persons Annual Declaration</td><td>NHST(21) 039</td><td>Approval</td><td>Richard Fraser</td></tr>
<tr><td>11.05</td><td>12.</td><td>CNST Maternity Incentive Scheme Safety Actions 2021/22 - Declaration</td><td>NHST(21) 040</td><td>Approval</td><td>Sue Redfern</td></tr>
<tr><td>11.25</td><td>13.</td><td>Improving People Practices</td><td>NHST(21) 041</td><td>Assurance</td><td>Anne-Marie Stretch</td></tr>
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St Helens and Knowsley Teaching Hospitals
NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Public Board meeting held on Wednesday 26th May 2021 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
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Prof R Pritchard-Jones	(RPJ)	Medical Director
	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:	Michelle Corrigan	(MC)	Insight Programme Placement
	Fazilet Hadi	(FH)	Aspiring Chair Programme (Observer)
	Dr Barnabus Bagguley	(BB)	5th year medical student, Imperial College (Observer)
	Carole Slocombe	(CS)	Patient Experience Manager (item 2 only)
	Jessica Blandford	(JB)	Operational Manager (item 2 only)
	Miss K Fielding	(KF)	Executive Assistant (minute taker)

Apologies: None

1. Welcome and introductions

1.1. Welcome and introductions took place.

2. Apologies for Absence

2.1. Apologies were noted as above.

3. Declaration of Interests

There were no new declarations of interest.

4. Employee of the month

4.1. SR read out the citation for Catherine Elaine Porter, Occupational Therapist, who had been nominated for the award by Debby Glynn, Ward Manager and the team at Duffy Suite at St Helens.

4.2. Due to COVID social distancing restrictions, Elaine had been filmed receiving her award and the film will be on the Trust intranet. The Board noted the citation and congratulated Elaine.

5. Patient Story

5.1. CS presented the Patient Story. She explained that the patient was a 39 year old man living with Hodgkin's Lymphoma. He was diagnosed in July 2019 after noticing a lump above the left side of his collar bone when shaving. He commenced chemotherapy treatment in September 2019 at The Lilac Centre and had support from Macmillan Haematology Cancer Nurses throughout his journey. When asked for his feedback about the service, the patient suggested that former patients could offer support to newly diagnosed patients. They would also be happy to be considered for future patient steering group/ patient experience groups.

5.2. The Lilac Centre is planning to develop a Patient Peer Steering Group. The group will consist of people with a lived experience of cancer who can support the Lilac Centre in a number of ways including co-designing service improvements, contributing to project steering groups, ensuring literature and information is provided in a way that is optimal for patients, contributing to health and wellbeing events where appropriate and providing feedback on current services.

5.3. RF commented that a patient peer support group is an excellent idea and he knew that the wig service provided by the Lilac Centre was also very much appreciated by service users who lost their hair.

5.4. IC thought the independent rating from Macmillan was a great achievement and providing information in the right way for the individual patients demonstrated excellent personalised care. He was also pleased that psychological support was available for patients, and it was a testament to the service that this patient wants to give back by supporting other patients, after his experience at the Trust.

6. Declaration of interest

6.1. Nothing to report.

7. Minutes of the Board briefing held on 28th April 2021

7.1. **Correct Record**

7.1.1. The minutes were approved as a correct record.
7.1.2.

7.2. **Action List**

7.2.1. AM stated that neither of the outstanding actions could be progressed at the moment due to the ongoing social distancing restrictions. It was also a period of great uncertainty and change across the NHS, so it would be better to wait a few more months until there was more clarity before reviewing the Trust strategy for the new operating environment.

8. Integrated Performance Report (IPR) – NHST (21)024

8.1. 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. This was the first report for 2021/22, although there were still a few indicators which were reporting on the final months of 2020/21.

8.2. **Quality Indicators**

8.2.1. SR presented the performance against the key quality indicators.

8.2.2. There were 0 never events in April, and 0 year to date (YTD).

8.2.3. There had been 0 cases of MRSA in April, and 0 YTD.

8.2.4. There were 8 C. Difficile positive cases reported in April 2021 (5 hospital onset and 3 community onset). The annual tolerance level for the Trust had not been set for 2021/22. The final appeals in respect of C.Difficile cases from 2020/21 were being heard by the CCG in June, which would allow the final position for the previous financial year to be confirmed.

8.2.5. There were 0 falls resulting in severe harm in March, in 2020/21 there have been a total of 31. SR confirmed that a thematic review of falls was being undertaken to identify any underlying causes for the increase during 2020/21.

8.2.6. There were no hospital acquired grade 3 pressure ulcers with lapses in care in February. SR noted that a reduction in pressure ulcers had been achieved during 2020/21.

8.2.7. VTE reporting remains suspended due to COVID.

8.2.8. HSMR (April to December 2020/21) was 101.6.

It was noted that there were errors with the January HSMR figure that were currently being investigated by RPJ and the Business Intelligence Team. This appeared to be because comorbidities had not been taken into account. However, RPJ reported that the expected mortality rates had remained constant which provided assurance that this was a data and not a significant clinical issue. The IPR therefore reports the latest reliable data and will be updated once the issues with the January reported figures have been resolved.

8.2.9. AM commented that although we now have a better understanding of the cause of the problem there remains a need to correct it with the national HSMR system via NHS Digital.

8.2.10. The report was noted.

8.3. **Operational Indicators**

8.3.1. RC presented the update on operational performance.

8.3.2. Performance against the 62 day cancer standard was above the target of 85.0% in month (March 2021) at 85.9% and YTD was 86.5%.

The 31 day target was achieved in March 2021 with 97.1% performance in month against a target of 96% and YTD was 97.5%.

8.3.3. The Cancer 2 week wait rule performance was achieved in March 2021 with 96.9% in month and 94.3% year to date against a target of 93.0%.

8.3.4. RC reported on the significant increase in Emergency Department (ED) attendances in April 2021. There were 10,586 type 1 attendances and the average daily attendances had increased to 352, this had further increased to 420 average daily attendances in the first few weeks in May.

8.3.5. Accident and Emergency (A&E) 4-hour performance for April was 82.9% (all types mapped).

8.3.6. There were 2,729 ambulance conveyances in April and the average ambulance turnaround time was 29 minutes against the standard of 30 minutes.

8.3.7. The average number of super stranded patients in April was 102. Work was ongoing with partners to improve the position, as this had increased from 79 in March. RC noted the requirement to drive this down as much as possible because of the ongoing pressure on medical beds. PG asked if Social Workers were now undertaking assessments on site. RC explained that there was not a consistent approach across the three Local Authority areas, but discussions were on going and he felt they now had a better understanding of the impact on Trust staff.

8.3.8. The referral to treatment (RTT) performance in March was 70.6% against the target of 92%, and the 6-week diagnostic waiting time performance in March was 72.9% against the target of 99%. There were 1469 over 52-week waiters for elective procedures. 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.

8.3.9. RF commented that he was encouraged by the figures and the level of recovery the Trust has already achieved. He acknowledged how challenging this was and he thanked everyone for their efforts to date.

8.3.10. The report was noted.

8.4. **Financial Indicators**

8.4.1. NK presented the update on financial performance.

8.4.2. He explained that the Trust is still under negotiations with the ICS to find our final resource for the first 6 months of the year (H1). There is the expectation of the system being in a breakeven position at the end of H1 with some variability in elective work depending on system performance and being able to claim some of the additional Elective Recovery Fund (ERF). There had been no discussions yet concerning the final 6 months of the year (H2), which still meant there was significant uncertainty about the full year plan.

8.4.3. NK explained that he was assuming a Cost Improvement requirement in the region of 2.5%. NK reported good progress on Cost Improvement Plans (CIP) at the Finance & Performance Committee. RF commented that it was good to know that action was already being taken on CIP.

8.4.4. Month 1 had reported a breakeven position, in line with the Cheshire and Merseyside ICS plan.

8.4.5. There had been £0.6m expenditure on agency staff, which included agency costs for COVID and the Mass Vaccination Centre.

8.4.6. The cash balance at the end of Month 1 was £67.4m

8.4.7. VD asked in light of the pressures being experienced in ED were there plans for expansion. NK clarified that the Trust had received additional capital as part of COVID and for ambulatory care, with some schemes being completed already and the Paediatric ED and Children's Observations (CHOBs) beds scheduled to be undertaken this year.

8.4.8. RF asked NK if he was concerned about the financial regime for the rest of 2021/22. NK responded that there was a significant degree of uncertainty that remained but felt the Board should focus on doing the right things for patients to take forward the recovery plans and accept that at this stage there could be some financial risk.

8.4.9. JK asked how the performance of the different providers was being managed at ICS level to ensure that the system as a whole achieved the recovery trajectories. NK confirmed that at month 1 performance across the whole of C&M had been encouraging.

8.4.10. The report was noted.

8.5. **Workforce Indicators**

8.5.1. AMS presented the update on workforce performance and noted the context of the pandemic on the data.

8.5.2. In April overall sickness was 5.5% which is a 0.1% decrease from March. Nursing, Midwifery and HCA absence was 7.8% which is also a decrease of 0.1% since March. Now that levels of absence due to Covid have reduced the HR Advisory team are focussing on once again on reducing normal sickness levels in particular long term sickness absence. 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.

8.5.3. Appraisal compliance is below target at 53.8%. Mandatory training compliance remains below the target as 76.4%. Compliance for both has improved but continues to be impacted as a consequence of the COVID 19 when both were suspended, except for core mandatory training subjects.

8.5.4. During a recent Executive Committee Meeting, the Executive team agreed to trial an appraisal window approach. A consultation with managers showed that they felt this was achievable. The paperwork for appraisals had also been simplified and this had also received positive feedback from both staff and managers.

8.5.5. In respect of mandatory training there was an improvement, but still a long way to go to return to 85% compliance. Focus was being placed on identifying hot spots in specific services or for particular training. More training had also been made online which had proved popular with staff as completion was more flexible. However, AMS recognised that there was lots of pressure on managers to “catch up” on lots of things that were suspended during COVID-19 so it was important to be realistic about the time it would take, especially as the Trust remained very busy.

8.5.6. GB commented that she had seen the emails and was aware of all the work that was being undertaken by the HR team but agreed that there was a need to be pragmatic and recognise the recovery would take time. RF supported these comments and felt it was important that we did not place unrealistic expectations on staff.

8.5.7. RPJ commented that staff are finding it easier to complete mandatory training online but face to face training has also been stepped up with Basic Life Support (BLS) training workshops regularly being set up to engage with staff in different ways and assist in them completing essential training.

8.5.8. The report was noted.

9. Committee Report – Executive – NHST (21)025

9.1. AM presented the report and highlighted the key issues considered by the Executive Committee at the four meetings held during April 2021.

9.2. Investments approved by the committee were; the over establishment to district nurses but 4 posts to ensure the service delivers what it needs to at a time when there was increased staff absence and turnover.

9.3. Approval to recruit to two new consultant posts in the medical care group. The proposal was not new investment but combined existing funding in a different way to create two additional respiratory consultant posts. The Medical Care Group had assessed that this use of the funding would provide the greatest benefits in responding to the increased demand being experienced, with the support of all the other medical specialties.

9.4. Approved a business case to appoint a temporary additional Gastroenterology Consultant to support recovery and potentially the planned bariatric surgery service. It was noted that this investment was made at risk, as it remained unclear how additional resources would be allocated to Trusts experiencing growth in activity, under the new financial regime, however this was the right thing to do for patients where treatment outcomes could be time critical.

9.5. AM also highlighted the work that was ongoing to implement the recommendations of the Ockendon review and the bid made by the Trust for a share of the additional funding for maternity services that had been announced for 2021/22.

9.6. AM confirmed that the immediate focus for the next phase of the estate development plans was additional theatre capacity at Whiston Hospital. The options for this were currently being explored and it was hoped that a decision could be taken on whether to move forward on these plans in the next few months.

9.7. In response to a question from RF, SR explained that Parafricta booties provided heel protection for immobile patients which reduced the risk of pressure ulcers developing.

9.8. The remainder of the report was taken as read and noted by the Board.

10. Quality Committee Chair's Assurance Report – NHST (21)026

10.1. GB presented the report, which summarised the key issues considered at the Quality Committee meeting in May.

10.2. GB noted that the issues concerning the April to January HSMR figures had been flagged to the Quality Committee and the steps taken to investigate the anomaly explained. She felt it was good assurance that this had been raised with the Non-Executive Directors as soon as the issue had been identified.

10.3. The Quality Committee had reviewed and approved the Quality Account for 2020/21 and recommended it to the Board.

10.4. The committee had received a high level of assurance from the report that reviewed the Maternity Dashboard performance indicators and had noted where changes needed to be made to bring the indicators up to date.

10.5. GB also highlighted the report on the delivery of the Workforce Strategy action plan and again reflected on the amount of work needed to recover and restore following the COVID-19 pandemic.

10.6. The results of the 2020/21 committee effectiveness review had been noted.

10.7. IC commented that he joined as an observer as his background is non-clinical. This had been a real learning opportunity, and he had been assured by the level scrutiny and challenge concerning complex issues.

10.8. The report was noted.

11. Finance & Performance Committee Chair's Assurance Report – NHST (21)027

11.1. JK presented a summary of the key issues discussed at the Finance & Performance Committee meeting in May.

Committee had received the month 1 financial reports and received an update on the continuing negotiations to agree the H1 financial envelope.

11.2. RF commented that he was assured by the detailed work undertaken by the Finance and Performance Committee and the finance team to maintain the Trusts financial performance in the current period of change.

11.3. The report was noted.

12. Aggregated Incidents, Complaints and Claims Report, September 2020 to March 2021 – NHST (21)028

12.1. SR presented the report, noting that the report reflected the impact of the 2nd and 3rd waves of COVID-19 experienced by the Trust.

12.2. There had been 27 incidents reported to StEIS between September and March, of which 12 related to falls. A review was being undertaken to establish if these were linked to the impact of the pandemic, for example staff needing to put on PPE before they attended at patient.

12.3. LK asked about the possible reintroduction of patient visiting. She done the maternity safety walk around with the Maternity Matron and witnessed the processes in place such as lateral flow testing. She felt there would be a significant resourcing and staffing burden to rolling out these arrangements across all the wards. SR explained that limited visiting had already been re-introduced for long stay patients in the adult wards, and this was supported by a group of liaison staff who organised the visits and provided updates to patient's relatives. This was an additional COVID expenditure that had been approved by the Executive Committee. The limited re-introduction of visiting undoubtedly had benefits for patients but also increased the risks of infection and so would be reviewed in light of changing population infection rates and government guidance.

12.4. In relation to inquests, SR explained that if the Trust was named as an “interested party” it had been directly involved in providing the care to the patients and if it was a 3rd party the involvement was indirect, and the Trust may not be aware of the case.

12.5. RF asked if the difficulties with communication during the pandemic could have led to more complaints about clinical treatment. AM felt this could have been the case especially where a single relative had been identified as the point of contact, but nevertheless the onus is on the Trust to provide the information patients and relatives need to understand treatment decisions. This had been reflected in the Trust objectives for 2021/22 as a focus for improvement.

12.6. The report was noted.

13. 2020/21 Quality Account – NHST (21)029

13.1. SR presented the 2020/21 Quality Account to the Board, which was taken as read.

13.2. The deadline for publication of the Quality Account this year has now been confirmed as 30th June 2021.

13.3. SR thanked Anne Rosbotham-Williams, Deputy Director of Governance for her work coordinating the content of the Quality Account, which had been particularly challenging this year because of the impact of the pandemic, which had resulted in some activities and targets being suspended.

13.4. The draft Quality Account had been reviewed in depth by the Executive Committee and the Quality Committee. The Quality Committee had recommended approval.

13.5. SR confirmed that she had consulted with HealthWatch and had received positive feedback on the document. The Quality Account was also being formally presented to the CCCGs on 3rd June and their feedback would also be incorporated into the published version.

13.6. GB felt the priorities for 2021/22 were clearly set out and progress in achieving them would be monitored by the Quality Committee. She also felt it was extremely important to have a historical record of 2020/21 and suggested that links to the Trust videos recording the impact of COVID-19 should also be accessible to the public.

13.7. RF also wished to record the Boards thanks for the work of the volunteers who had continued to support us during the pandemic and improving the patient experience.

13.8. The 2020/21 Quality Account was approved.

14. Board and Committee Effectiveness Review – NHST (21)030

14.1. NB presented the report which resulted from the Board and committee effectiveness review of 2020/21. She confirmed that the detailed findings of each review had been shared with the committee chair and a summary of the recommendations would also be made to the audit committee.

14.2. The conclusion of the review was that the Board and its committees remained effective and fit for purpose and minor changes to the Terms of Reference (ToR) of each was recommended for approval.

14.3. NB highlighted that the review had highlighted the range and complexity of issues currently under the remit of the Quality Committee and there was a proposal to establish a separate Strategic Workforce Committee.

14.4. The Board approved the proposal to create a separate Strategic Workforce Committee and asked AMS and NB to develop draft ToR and an annual work plan for consideration by the Board in July, with the consequent changes to the Quality Committee ToR and annual work plan. **ACTION: AMS and NB**

14.5. VD requested that the Trust objectives be aligned to each committee. NB confirmed that the governance route for each objective was already included as part of the Trust objectives but she could further enhance this by aligning to each committees work plan.

14.6. The updated ToR for the Board and its committees were approved.

15. Appointment and role of the Wellbeing Guardian – NHST(21)031

15.1. AMS gave a short presentation which set out the requirement for and role of the Workforce Guardian.

15.2. The cost of poor mental health in the NHS workforce had been estimated at circa £2k per employee per year. The rates of stress related staff absence were increasing, even before the impact of the COVID-19 pandemic. It was therefore imperative for the NHS to try and support staff with Mental Health and other health issues.

The role of the Wellbeing Guardian was to promote a culture of wellbeing where organisational activities support the holistic health and wellbeing of its people.

15.3. LK had been nominated as the Wellbeing Guardian for the Trust and the Board was asked to ratify her in this role.

15.4. LK reported that this is a developing role in the NHS and she had joined the North West Wellbeing Guardian steering group the previous week and noted this was mainly a Non-Executive role. The purpose of the steering group was to ensure consistency in the development of the role across all organisations and facilitate benchmarking and sharing of good practice.

15.5. VD asked what support is there now for staff who have witnessed traumatic events, acknowledging that such events can happen at any time and have not only occurred during the pandemic. AMS explained that the Trust works hard to provide as much support as necessary and the Health, Work and Wellbeing (HWWB) team provide group de-brief sessions as well as individual support which includes low level counselling up to specialist psychology and psychiatry support where needed.

15.6. VD asked if there were any national metrics to measure the effectiveness of wellbeing activities. AMS stated that at the present time a self-assessment approach was being used. The Trust has completed the self-assessment tool and from this an action plan. This work would hopefully lead to the development of core standards in the future.

15.7. RPJ commented that he is so pleased to see these developments particularly after the past year. AMS explained that the Trust already scores highly in the staff survey for health and wellbeing, which demonstrated that staff at the Trust are aware of the support that they can access.

15.8. GB asked how the NHS will support junior Doctors who move between Trusts for their training placements. AMS felt this is one of the major benefits of the lead employer model which gives continuity for the employer and trainees, so that issues can be followed through wherever the trainee is working.

15.9. The board approved LK as the Trust's first Wellbeing Guardian.

16. Effectiveness of Meeting

16.1. BB thanked the Board for allowing him to observe the meeting. He felt it had been well chaired and interesting to see how the issues from other committees have been brought up to the Board. The challenges from the NED members had been effective and he had witnessed the shared values and open culture of the Board. BB felt this was key in improving patient care. He thanked the Trust for accommodating his last minutes student elective placement and stated that he had found it very informative.

AL said he has had cause to visit the Trust recently and had been impressed by the attitude of the staff right from the consultants to the volunteers, which he felt was exceptional given the pressures that everyone in the NHS had faced in recent months.

16.2. FH echoed the comments of BB and AL. she was struck by the deep dive into the mortality ratio and how seriously data is taken. The Board were always looking for improvement and it is good to keep focusing on how to make an excellent Trust even better.

16.3. MW had enjoyed the meeting and echoed the comments of the other observers. He is pleased to see the UTC numbers in St Helens going up and exceeding pre-pandemic levels. He had also noted the issue around social workers face to face on the wards which he will take back to the Governing Body and ask that this resumes as soon as possible. The meeting has a good balance of being formal but easy to contribute to.

17. Any Other Business

17.1. None to report

18. Date of Next Meeting

18.1. Wednesday 30th June 2021 at 0900

Chairman: ……………………………………………………………………………………

Date: ……………………………………………………………………………………

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(21)034
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 May 2021. (YTD = 0).

There were no cases of MRSA in May 2021. (YTD = 0).

There were 5 C.Difficile (CDI) positive cases reported in May 2021 (3 hospital onset and 2 community onset). YTD there have been 13 cases (8 hospital onset and 5 community onset). The annual tolerance for CDI for 2021-22 has not yet been published (the 2019-20 limit is being used in the absence of publication of the 2021-22 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May 2021 was 94.6%. 2021-22 YTD rate is 92.6%.

The number of incidents, reported within St Helens community services in April , has increased (98 in March compared to 133 in April). 106 of these (79.7%) were related to skin damage.

During the month of April 2021 there was 1 fall resulting in severe harm. (YTD severe harm falls = 1)

There were no grade 3 hospital acquired pressure ulcers with lapses in care in March 2021. (YTD 2020-21 = 1). Reducing the number of Trust-acquired pressure ulcers with lapses in care, including category 2, was a priority for the year.

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

YTD HSMR (April to February) for 2020-21 is 96.1

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 21/22 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 30th June 2021

Operational Performance
Performance against the 62 day cancer standard was above the target of 85.0% in month (April 2021) at 86.1%. YTD 86.1%. Performance in March 2021 was 86.4%. The 31 day target was achieved in April 2021 with 99.1% performance in month against a target of 96%, YTD 99.1%. Performance in March 2021 was 97.2%. The 2 week rule target was not achieved in April 2021 with 86.5% in month and 86.5% YTD against a target of 93.0%. Performance in March 2021 was 96.9%. The situation with regard to patients not wanting to attend for appointments is continuing to improve and we are seeing further increases in the numbers of referrals and patients receiving treatment.

Accident and Emergency Type 1 performance for May 2021 was 63.8% and YTD 66.3%. The all type mapped STHK Trust footprint performance for May 21 was 80.7% and YTD 81.7%**.** The Trust saw average daily attendance levels significantly increase in May 21 compared with April 21 , with the average daily attendance of 362, up from 352 in April and 325 in March. Total attendances for May 2021 was 11,525, which is our busiest month on record. Prior to this, it was October 19, with 10,627

Total ambulance turnaround time was achieved in May 2021 with 30 mins on average. There were 2,888 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2729 in March 21

The UTC saw 4874 patents in April 2021; which is an increase of 12% (528) compared to the previous month. Overall 99% of patients were seen and treated in 4 hours.

St Helens community nursing referral numbers have shown a slight increase in March from April (609 from previous month of 590). The service is undertaking regular caseload reviews, to ensure all appropriate discharges are undertaken to support effective use of the available capacity. St Helens community matron caseloads have risen (171 in April compared with 150 in March) as a result of the increased demand within the community (66 new referrals in April compared to 34 in March).

The average daily number of super stranded patients in May 2021 was 89 compared with 102 in April 2020 (79 was the average in March 21, 86 in February 21, 90 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 April 2021 with 71.0% compliance and YTD 71.0% (Target 92%). Performance in March 2021 was 70.6%. There were (1345) 52+ week waiters. The 6 week diagnostic target was not achieved in May 21 with 75.2% compliance. (Target 99%). Performance in April 2021 was 69.8%.

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
Planning and funding arrangements have been confirmed for the first six months of the 2021/22 financial year. The Trust financial plan, triangulated across activity, workforce and budget, has therefore been finalised for Months 1 to 6 only (referred to as 'H1'). The Trust plan is for £247m of income and expenditure giving a breakeven position overall.
A full financial settlement for October to March (M7-12) will be agreed once there is greater certainty around the circumstances facing the NHS in the second half of the year.

Surplus/Deficit - At the end of Month 2 the Trust has reported a YTD breakeven position in line with the Cheshire & Merseyside system plan for H1 as outlined above.

Agency - The year to date spend is £1.3m, including agency costs incurred in relation to COVID (£0.05m) and Mass Vaccination (£0.2m).

Cash - At the end of M2, the cash balance was £57.1m. The cash balance continues to be high due to advanced receipt of income in 2020/21.

Human Resources
In May overall sickness was 5.7% which is a 0.2% increase from April. Front line Nursing, Midwifery and HCA's was 8.4% which is an increase of 0.6% since April . Front line Nursing and Midwifery was 6.8 % which was an increase of 0.7% since April. The HR Advisory team have been working with HWWB focussing on supporting members of staff who are currently absent with Anxiety, Stress and Depression and intervening at an earlier stage with referrals to talking therapies and supporting them to return to work. The HR Advisory team have also been working with members of staff whose absence is now classed as long term (anything over 20 working days) undertaking welfare meetings and providing support to get them back into work. 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. Appraisal compliance is below target at 49.6%. Mandatory training compliance remains below the target at 75.1%. Compliance for both has fallen slightly in month in part due to the availability of staff and as expected following the introduction of the new appraisal window process.

The following key applies to the Integrated Performance Report:

▲ = 2021-22 Contract Indicator

▲£ = 2021-22 Contract Indicator with financial penalty

● = 2021-22 CQUIN indicator

T = Trust internal target

UOR = Use of Resources

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	May-21	2.3%	2.2%	No Target	3.1%		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. We continue to independently benchmark the COVID performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Nov-20	1.09		1.00						
Mortality: HSMR (HED)	Q	▲	Feb-21	91.6		100.0	96.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Feb-21	104.3		100.0	103.0					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jan-21	103.1		100.0	99.8		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	A spike in readmissions reflects COVID third wave but remains within expected range and is improving.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Feb-21	85.4		100.0	92.8		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,	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Feb-21	101.1		100.0	109.2					
% Medical Outliers	F&P	T	May-21	1.2%	1.1%	1.0%	1.6%		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	May-21	34.3%	37.5%	52.5%	58.8%		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 although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Apr-21	74.5%	74.5%	90.0%	74.8%		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 - a recent deterioration is recovering.		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 daily updates of performance. The most challenged area in SDECC is moving discharges to the Medway system to support rapid, detailed discharges. This is ready fro go-live with SOP, training and audit in place.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Apr-21	82.4%	82.4%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Apr-21	96.8%	96.8%	95.0%	96.8%					

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	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	▲	Q4	93.7%		83.0%	90.4%		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	▲ £	May-21	0	0	0	3		No never events reported in May 2021	Quality and patient safety	Investigation into previously reported incidents completed 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			98.9%			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	May-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	▲ £	May-21	0	0	0	2		There were no cases of MRSA in May 2021. YTD = 0.	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	▲ £	May-21	5	13	48	40		There were 5 positive C Diff sample in May 2021. YTD there have been 13 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		May-21	7	9	No Target	29		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Mar-21	0		No Contract target	1		No hospital acquired category 3 or 4 pressure ulcers with lapses in care in March 2021.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April 20.	SR
Number of falls resulting in severe harm or death	Q	▲	Apr-21	1	1	No Contract target	31		1 fall resulting in severe harm in April 2021 (reported from ward 5B).	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%			**March 20 to May 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 and third wave, we have understood the risk in patients and minimised events. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway. A new spike reflects third COVID wave. All guidance is in place.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Feb-21	12		No Target	69					
To achieve and maintain CQC registration	Q		May-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	May-21	94.6%	92.6%	No Target	92.2%		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	May-21	3	8	No Target	49					

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St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	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	▲ £	Apr-21	86.5%	86.5%	93.0%	94.3%		There has been a significant increase in 2WW referrals that are currently being managed within capacity. It is too soon to determine if this trend is the new normal or a result of catch up in the system.	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	▲ £	Apr-21	99.1%	99.1%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Apr-21	86.1%	86.1%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Apr-21	71.0%	71.0%	92.0%	70.6%		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. Recovery plans are in place.	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 with application of P- codes effectively implemented. Application of D-codes is on target for delivery.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	May-21	75.2%	72.5%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Apr-21	1,345	1,345	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	May-21	0.7%	0.7%	0.8%	0.4%		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	▲ £	Apr-21	100.0%	100.0%	100.0%	97.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0						
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	May-21	63.8%	66.3%	95.0%	78.0%		Accident and Emergency Type 1 performance for May 2021 was 63.8% and YTD 66.3%. The all type mapped STHK Trust footprint performance for May 21 was 80.7% and YTD 81.7%. The Trust saw average daily attendance levels significantly increase in May 21 compared with April 21 , with the average daily attendance of 362, up from 352 in April and 325 in March. Total attendances for May 2021 was 11,525, which is our busiest month on record. Prior to this, it was October 19, with 10,627 Total ambulance turnaround time was achieved in May 2021 with 30 mins on average. There were 2,888 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2729 in March 21.	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. The continued absence of face to face assessments from social workers is causing some delays.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	May-21	80.7%	81.7%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	May-21	0	0	0	0					

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-20			0			**March 20 to May 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	May-21	30	47	No Target	242		% new (Stage 1) complaints resolved within agreed timescales dipped below the 90% target in April and May.	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, with performance improving in February and March, but dipping in April and May. This is being closely monitored to bring it back above target.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	May-21	18	36	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	May-21	77.8%	77.8%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to May 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. The absence of face to face assessments from social workers is causing some delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	May-21	288	298		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	May-21	89	96		72					
Friends and Family Test: % recommended - A&E	Q	▲	May-21	80.5%	82.8%	90.0%	88.4%		FFT submissions recommenced from January 2021, with recommendation rates above target in month for inpatients and postnatal community, but below target for ED, Antenatal, Delivery Suite, Postnatal Ward and Outpatients.	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	▲	May-21	96.4%	96.0%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		May-21	85.7%	90.0%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	May-21	94.9%	96.1%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		May-21	91.7%	94.7%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		May-21	100.0%	100.0%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	May-21	94.2%	94.0%	95.0%	94.2%					

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St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	May-21	5.7%	5.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In May overall sickness was 5.7% which is a 0.2% increase from April. Front line Nursing, Midwifery and HCA's was 8.4% which was an increase of 0.6% since April. 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.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team undertake a review of sickness absence daily to try an analyse the hotspots and manage long term sickness with support from HWWB with interventions and welfare meetings.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	May-21	8.4%	8.1%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	May-21	49.6%	49.6%	85.0%	51.3%		Appraisal compliance in May has reduced following implementation of the 'window' approach and is below target at 49.6%. Mandatory training compliance has also reduced and is below the target at 75.1%. Both continue 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	May-21	75.1%	75.1%	85.0%	75.7%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			No Contract Target			**NHSE/NHSI to resume from Q2 (July)**	Staff engagement, recruitment and retention.	NHSE/I to introduce new Quarterly staff survey to replace suspended Staff FFT commencing July 2021.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	May-21	1.3%		No Target	12.9%		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	May-21	Discontinued	Discontinued	N/A				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	May-21	1,274	1,274	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	May-21	-	-	-						
Cash balances - Number of days to cover operating expenses	F&P	T	May-21	29	29	10						
Capital spend £ YTD (000's)	F&P	T	May-21	1,400	1,400	17,600						
Financial forecast outturn & performance against plan	F&P	T	May-21	-	-	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	May-21	83.5%	83.5%	95.0%						

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

Cancer 62 day wait from urgent GP referral to first treatment by tumour site

Tumour site	Measure		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Breast	% Within 62 days	▲ £	100.0%	88.2%	76.5%	100.0%	100.0%	38.5%	77.8%
	Total > 62 days		0.0	1.0	2.0	0.0	0.0	4.0	3.0
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lower GI	% Within 62 days	▲ £	73.9%	83.3%	76.5%	100.0%	75.0%	85.7%	90.0%
	Total > 62 days		3.0	1.0	2.0	0.0	1.0	1.0	1.0
	Total > 104 days		1.0	0.0	1.0	0.0	1.0	0.0	0.0
Upper GI	% Within 62 days	▲ £	60.0%	80.0%	66.7%	100.0%	100.0%	100.0%	80.0%
	Total > 62 days		2.0	0.5	2.0	0.0	0.0	0.0	1.5
	Total > 104 days		0.0	0.0	2.0	0.0	0.0	0.0	0.5
Urological	% Within 62 days	▲ £	74.2%	71.4%	100.0%	100.0%	90.9%	95.7%	88.0%
	Total > 62 days		4.0	2.0	0.0	0.0	1.0	0.5	1.5
	Total > 104 days		1.0	2.0	0.0	0.0	1.0	0.5	0.0
Head & Neck	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	50.0%	0.0%	20.0%
	Total > 62 days		0.0	0.0	0.0	0.0	1.0	1.5	2.0
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sarcoma	% Within 62 days	▲ £		100.0%				100.0%	100.0%
	Total > 62 days			0.0				0.0	0.0
	Total > 104 days			0.0				0.0	0.0
Gynaecological	% Within 62 days	▲ £	100.0%	33.3%	100.0%	100.0%	100.0%	66.7%	73.3%
	Total > 62 days		0.0	3.0	0.0	0.0	0.0	1.0	2.0
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lung	% Within 62 days	▲ £	69.2%	100.0%	100.0%	88.9%	60.0%	100.0%	86.7%
	Total > 62 days		2.0	0.0	0.0	1.0	2.0	0.0	1.0
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.0
Haematological	% Within 62 days	▲ £	40.0%	66.7%	100.0%	66.7%	80.0%	100.0%	100.0%
	Total > 62 days		1.5	0.5	0.0	1.0	1.0	0.0	0.0
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.0
Skin	% Within 62 days	▲ £	91.4%	86.8%	92.5%	97.5%	100.0%	92.1%	92.4%
	Total > 62 days		2.5	5.0	1.5	1.0	0.0	3.0	3.0
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	1.0
Unknown	% Within 62 days	▲ £				100.0%	100.0%	100.0%	100.0%
	Total > 62 days					0.0	0.0	0.0	0.0
	Total > 104 days					0.0	0.0	0.0	0.0
All Tumour Sites	% Within 62 days	▲ £	81.4%	81.9%	87.7%	96.1%	92.3%	86.2%	85.8%
	Total > 62 days		15.0	13.0	7.5	3.0	6.0	11.0	15.0
	Total > 104 days		2.0	2.0	3.5	0.0	4.0	0.5	1.5

Tumour site	Measure	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	2021-22 YTD	2021-22 Target	FOT	2020-21	Trend	Exec Lead
Breast	% Within 62 days	100.0%	100.0%	96.3%	100.0%	97.4%	100.0%	100.0%	85.0%		91.1%		RC
	Total > 62 days	0.0	0.0	0.5	0.0	0.5	0.0	0.0			11.0		
	Total > 104 days	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Lower GI	% Within 62 days	80.0%	82.6%	78.9%	58.6%	87.5%	61.1%	61.1%	85.0%		78.7%		
	Total > 62 days	2.0	2.0	2.0	6.0	1.0	3.5	3.5			22.0		
	Total > 104 days	0.0	0.0	0.0	2.0	1.0	0.0	0.0			6.0		
Upper GI	% Within 62 days	81.8%	83.3%	100.0%	100.0%	66.7%	100.0%	100.0%	85.0%		83.1%		
	Total > 62 days	1.0	1.0	0.0	0.0	3.5	0.0	0.0			11.5		
	Total > 104 days	1.0	0.0	0.0	0.0	0.5	0.0	0.0			4.0		
Urological	% Within 62 days	79.5%	88.2%	82.8%	92.3%	79.2%	80.0%	80.0%	85.0%		85.6%		
	Total > 62 days	4.0	2.0	2.5	1.0	2.5	2.0	2.0			21.0		
	Total > 104 days	1.0	0.0	0.0	0.0	0.5	0.0	0.0			6.0		
Head & Neck	% Within 62 days	100.0%	0.0%	33.3%	57.1%	50.0%	0.0%	0.0%	85.0%		51.4%		
	Total > 62 days	0.0	1.0	1.0	1.5	1.0	1.0	1.0			9.0		
	Total > 104 days	0.0	0.0	0.0	0.0	0.0	1.0	1.0			0.0		
Sarcoma	% Within 62 days	0.0%	100.0%	100.0%	100.0%		100.0%	100.0%	85.0%		83.3%		
	Total > 62 days	1.0	0.0	0.0	0.0		0.0	0.0			1.0		
	Total > 104 days	0.0	0.0	0.0	0.0		0.0	0.0			0.0		
Gynaecological	% Within 62 days	69.2%	66.7%	55.0%	60.0%	57.1%	83.3%	83.3%	85.0%		66.3%		
	Total > 62 days	2.0	1.0	4.5	1.0	3.0	0.5	0.5			17.5		
	Total > 104 days	1.0	0.0	1.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	81.8%	75.0%	100.0%	80.0%	100.0%	100.0%	100.0%	85.0%		83.9%		
	Total > 62 days	1.0	2.0	0.0	1.0	0.0	0.0	0.0			10.0		
	Total > 104 days	0.0	0.0	0.0	0.0	0.0	0.0	0.0			1.0		
Haematological	% Within 62 days		100.0%	50.0%		75.0%	57.1%	57.1%	85.0%		77.9%		
	Total > 62 days		0.0	3.0		1.0	3.0	3.0			8.0		
	Total > 104 days		0.0	0.0		0.0	1.0	1.0			1.0		
Skin	% Within 62 days	93.9%	100.0%	96.8%	86.0%	94.6%	92.9%	92.9%	85.0%		93.6%		
	Total > 62 days	2.0	0.0	1.0	4.0	2.5	2.5	2.5			25.5		
	Total > 104 days	0.0	0.0	0.0	1.0	0.5	0.0	0.0			3.0		
Unknown	% Within 62 days	66.7%	100.0%	100.0%	100.0%	80.0%			85.0%		92.3%		
	Total > 62 days	0.5	0.0	0.0	0.0	0.5					1.0		
	Total > 104 days	0.0	0.0	0.0	0.0	0.5					0.5		
All Tumour Sites	% Within 62 days	85.2%	90.4%	85.3%	82.0%	86.4%	86.1%	86.1%	85.0%		86.7%		
	Total > 62 days	13.5	9.0	14.5	14.5	15.5	12.5	12.5			137.5		
	Total > 104 days	3.0	0.0	1.0	3.0	3.0	2.0	2.0			23.5		

Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)

Tumour site	Measure		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Testicular	% Within 31 days	▲ £					100.0%		100.0%
	Total > 31 days						0.0		0.0
	Total > 104 days						0.0		0.0
Acute Leukaemia	% Within 31 days	▲ £							
	Total > 31 days								
	Total > 104 days								
Children's	% Within 31 days	▲ £							
	Total > 31 days								
	Total > 104 days								

Tumour site	Measure	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	2021-22 YTD	2021-22 Target	FOT	2020-21	Trend	Exec Lead
Testicular	% Within 31 days		100.0%	100.0%	100.0%	100.0%			85.0%		100.0%		RC
	Total > 31 days		0.0	0.0	0.0	0.0					0.0		
	Total > 104 days		0.0	0.0	0.0	0.0					0.0		
Acute Leukaemia	% Within 31 days								85.0%				
	Total > 31 days												
	Total > 104 days												
Children's	% Within 31 days								85.0%				
	Total > 31 days												
	Total > 104 days												

Trust Board

Paper No: NHST(21)035
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 May 2021. There were four Executive Committee meetings held during this period. There were no new investment decisions made in May. At every meeting the Executive Committee discussed 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 compliance, safer staffing and the integrated performance report.
Trust objectives met or risks addressed: All Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 30th June 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in May 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, and COVID-19 specific expenditure requests. The frequency of the operational Gold Command meetings was reduced in May, as the number of COVID-19 patients admitted to the Trust continued to reduce.

2. 6th May 2021

2.1 Perfect Ward – Quality Assurance

The Director of Nursing, Midwifery and Governance presented the implementation plan for the new approach to ward quality assurance. Many of the standard ward audits had been suspended during COVID-19 and this represented an opportunity to relaunch these activities. The perfect ward "app" enabled real time updates to ward level quality indicators. The implementation aimed to reduce the management and administrative time needed to collect and report the quality indicators information and the benefits of being able to have a live dashboard that would feed into QCAT and quality ward rounds, when they were able to resume. It was acknowledged that full implementation would take several months and therefore a benefits realisation report was requested in six months.

2.2 Deteriorating Patient Project

The Medical Director reported that the project team had now been able to rearrange the planned away day and the output would be a plan for how specialist teams could collaborate to improve care for the sickest patients, outside of Intensive Care. Significant data had been gathered from different sources to inform the discussions. The outcome and proposals would be reported back to the Executive and Quality committees.

2.3 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agenda for May.

2.4 COVID-19 Issues

An extension of the temporary additional procurement support staff to assist with the stock management and distribution of PPE was approved.

Additional weekend consultant cardiology sessions during May were approved to help reduce the backlog of urgent patients.

2.5 Maternity Key Performance Indicators (KPI) Review

The Director of Nursing, Midwifery and Governance introduced a review of the maternity dashboard and reported KPIs. It was acknowledged that the national parameters and guidance in relation to some of the indicators had changed and the Maternity Dashboard needed to be updated to reflect these. However this had been delayed due to COVID-19 but all the KPIs would be reviewed and adjusted accordingly in 2021/22. Changes in national policy guidance also impacted on some indicators and national benchmarking data presented in the report provided assurance that the Trust's services continued to perform well. It was agreed that the Trust should adopt the standard KPIs from the North West maternity dashboard that was being developed and maternity reporting should be refreshed as part of the planned IPR review.

3. 13th May 2021

3.1 Risk Management Council and Corporate Risk Register Report

The Director of Corporate Services presented the chair's assurance report from the Risk Management Council. There were 615 risks on the Trust risk register of which 18 had been rated as high risks and escalated to the corporate risk register, including 3 new approved high risks in the previous month. The council had received assurance reports from the Claims Governance Group and the Information Governance Group.

3.2 2020/21 Quality Account

The Director of Nursing, Midwifery and Governance presented the draft Quality Account. The national deadline for publication had been confirmed as 30th June, despite the impact of COVID-19. The Trust's internal auditors were undertaking a review of the data to provide independent assurance. Consultation with commissioners and stakeholders was being undertaken over the coming weeks and their comments would be included in the final published version. Committee also reviewed the proposed quality improvement objectives for 2021/22. The Quality Account was due to be presented at Quality Committee and then Trust Board for approval.

3.3 Appraisal Window Proposal

The Deputy CEO/Director of HR presented the proposal to move to a 4 month appraisal window as part of the renewed focus on appraisals to recover the 85% compliance target, post pandemic. This approach had been successful in other organisations and allowed for closer alignment with the Trust objectives. Committee approved the proposal for those staff whose appraisal was not linked to their incremental date for pay progression.

3.4 Patient Pathway Programme Report

The Director of Operations and Performance presented the monthly progress report. Good progress was being made with the individual patient reviews and there were no further cases that required ongoing investigation or reporting to StEIS. The best options to create an (electronic) patient flag (so that patients on the cancer pathways could be easily identified and tracked), had been discussed with the Director of Informatics, the

Chief Clinical Information Officer and system suppliers. Clinic configuration changes were being tested in several specialities over the coming month.

3.5 Community Diagnostic Hub

The Director of Finance and Information reported that the Trust had submitted a bid for St Helens Hospital to be a community diagnostic hub as part of the Cheshire and Merseyside restoration and recovery plans.

4. 20th May 2021

4.1 Breast Surgery Service Business Case

The Director of Operations and Performance introduced a paper which proposed the creation of a new substantive consultant post, following some changes to other positions in the department, including a retirement. The available funded sessions were split between breast and general surgery. It was also proposed to create temporary additional sessions to support waiting list reduction. The committee reflected that despite continuing increases in referrals and high performance against the cancer targets, the new NHS financial regime created a risk; however it was hoped that this temporary expansion of capacity would qualify for an Elective Recovery Fund (ERF) allocation. The case was approved.

4.2 Safer Staffing – Month 1

The Director of Nursing, Midwifery and Governance presented the safer staffing report for April (month 1). The overall registered nurse/midwife fill rate had been 90.7% and the HCA fill rate 104%. Committee discussed the format of the report and suggested changes that would provide greater assurance and explanation of the actions taken on the wards where staffing had been below planned levels.

4.3 Electric Vehicle (EV) Charging Points - Implementation

The Director of Corporate Services presented the paper. As part of the Trust's commitment to achieving "Net Zero" carbon emissions, a grant had been obtained to install EV charging points. Although this work had been delayed because of COVID-19 the charging points had now been installed and the committee was asked to approve the implementation plan and operational policy. The charging points had been installed across the Trust premises in locations where the electrical infrastructure could support them and they would form part of the national network. The committee agreed the operational principles to optimise the availability of the charging points for all potential users. It was agreed that the charging points would become operational in June, following the installation of appropriate signage and communication of the operational policy to staff.

4.4 Hospital Standard Mortality Ratio (HSMR)

The Medical Director briefed the committee on his investigation into the unexpected increase reported in the April – January HSMR figure. It was confirmed that this was an error and the crude mortality rates had not changed in the latest reported month, but there appeared to be a problem with the system including coded comorbidities.

Investigations continued but the report provided assurance that there had not in fact been an unexplained sudden increase in mortality.

4.5 COVID -19 Issues

For the first time in several months the Trust had no COVID-19 positive inpatients. Pre-operative swabbing was discussed as patients could now access lateral flow tests themselves. It was noted that some patients continued to refuse to be tested and therefore had to be treated as though they were infected. It was agreed to seek legal advice on this issue. It was agreed that with the appropriate individual risk assessments in place volunteers could resume ward visits, whilst community infection rates remained low. The visiting pilot for long stay patients who did not meet the other exemption criteria had commenced and was proving successful.

5. 27th May 2021

5.1 Command Centre Feasibility - Update

The Director of Finance and Information introduced the presentation which provided an update on the development of a potential command centre for the Trust. Work in this phase had focused on optimising the utilisation of the current radiology equipment by improved scheduling. Another work stream was scenario planning and modelling based on real time data which was already being used to help plan the restoration and recovery trajectories. The team were also looking at how the available data could be used to support cancer pathway coordination and tracking. Opportunities to use the same approach for Community Diagnostic Hubs were being explored. The potential for this technology to support optimal workforce deployment and equipment utilisation was noted. The programme remained exploratory with a formal proposal and business case to be developed in the coming months.

5.2 Safer Staffing Paper Review

The Director of Nursing, Midwifery and Governance provided a progress report on the work that was being undertaken with the support of HR and Finance colleagues to interrogate the Allocate system and improve the presentation of safer staffing information and levels of assurance.

5.3 Foetal Monitoring and Surveillance Training

The Director of Nursing, Midwifery and Governance presented the report which recommended the Trust move to physiological cardiotocography (CTG) interactive training in the maternity service. This is in line with the latest national guidance and research had demonstrated this training was more effective and reduced errors in CTG interpretation. There were no cost implications to this change and the proposal was agreed.

5.4 Agile Working

The Deputy CEO/Director of HR introduced a paper which explored some of the drivers and considerations for moving to a more formal policy of agile working for certain staff groups. During the pandemic all staff who were able to, were instructed to work from

home, under government guidance. As a result of this experience, 9 out of 10 employers were now adopting agile working policies for their office based staff, and the majority of NHS organisations were also looking to formalise flexible practices and expand agile working, where this was feasible. Issues such as organisational culture would need to be carefully considered so that staff continued to feel a sense of belonging to the Trust. It was agreed that a project group should be established to evaluate agile working and develop future options.

5.5 Business case pipeline

The Director of Finance and Information presented the updated and prioritised list of service developments that were being proposed by Care Groups. The list continued to exceed the available resources. The difficulties of funding such developments under the current block contract arrangements were acknowledged.

5.6 Improving People Practices

The Deputy CEO/Director of HR briefed the committee on the work that had been undertaken on the Trust disciplinary policy following the letter from Dido Harding in May 2019. The Trust had now undertaken extensive engagement on how the Trust policy could be improved to make the process more compassionate and considerate of the health and wellbeing of the staff involved in the process. The new policy is now subject to formal consultation and then will need to be approved by the Trust Board, to meet the NHSE/I requirements.

5.7 COVID-19 Issues

An extension to the funding for free TV for patients was agreed, whilst normal visiting remained suspended.

ENDS

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Trust Board

Paper No: NHST(21)036
Report: Quality Committee Chair's Assurance Report – June 2021
Date of Committee Meeting: 22nd June 2021
Reporting to: Trust Board

1. Matters Discussed

Ian Clayton, Non-Executive Director in attendance to observe the meeting.

2. Action Log

- It was reported that the safety culture questionnaire in Theatres had been reopened to ensure wider representation of views from all staff groups.
- Further work has taken place to improve performance figures in sending electronic discharge summaries from the Emergency Department/Same Day Emergency Care (SDEC).
- Training is to be rolled out, followed by a re-audit, on the recording of urgent blood results telephoned through to wards.

3. Quality Performance - Integrated Performance Report (IPR)

- The Committee reviewed the quality and performance metrics, noting that there had been no never events, category 3 or 4 pressure ulcers or MRSA bacteraemia year to date, however there had been 13 C difficile infections year to date, with root cause analysis being undertaken. The final year position for 2020-21 was confirmed as being 28 Trust-attributable cases, significantly less than the previous year's 40.
- It was noted that the technical error relating to HSMR had been resolved and the correct figure was reported as 96.1 (to February 2020-21).
- The Committee discussed the decrease in Genito-Urinary Medicine (GUM) activity, noting that 100% referrals had a telephone appointment within 48 hours, but that face-to-face follow ups were taking longer to see. An update is to be provided at July's meeting.
- The Committee noted the increase in two week rule referrals, particularly in breast and the work ongoing to improve achievement of the target.
- The continued increase in urgent and emergency care attendances was noted.
- The Committee received assurance that contact was maintained with patients on waiting lists, including information provided to GPs on the length of time patients would need to wait for routine appointments.
- Assurance was also provided on the work being undertaken with system partners to reduce the number of super-stranded patients.
- Ongoing demand for community and acute services and the impact this was having on staff was highlighted and the work undertaken with partners to ensure effective communications when transferring patients to other services.

4. IPR Refresh Progress Report

The Committee received a presentation on progress in refreshing the IPR, including

plans to hold engagement sessions with stakeholders, including Board members.

5. Monitoring of annual objectives aligned to the Quality Committee

The Committee received a report outlining how assurance would be provided in the delivery of the objectives and the reporting routes for each of those aligned to the Quality Committee.

6. Patient Experience Council Assurance Report

The impact of the pandemic on performance in providing complaint responses within the agreed timeframes was noted as this had declined to 72.2% in April against a target of 90%. In addition, the increased number of PALS contacts was noted and the development of a business case for additional resources in response to this. The reinstatement of the bleep holder daily walk-about was highlighted as a positive step to reduce complaints within Maternity Services. The high number of positive postings on the NHS website from patients and the positive feedback to Healthwatch Halton and Knowsley were also noted. The Council's Terms of Reference were approved.

7. Patient Engagement Strategy annual progress report

The report detailed the actions being taken to deliver the Patient Engagement Strategy. It was noted that the Strategy would be refreshed this year to reflect the innovations achieved during the pandemic in maintaining patient engagement. It was noted that the majority of actions had been implemented, but that it had not been possible to complete the relatives' survey by the original deadline. The Committee noted the wide range of engagement activity, including use of social media.

8. Patient Safety Council (PSC) Chair's Assurance Report

The report summarised the items reviewed at the last meeting, including reports on StEIS incidents, falls, serious incident action plans, incident reporting for Q4, decontamination, medicines safety, manual handling (Q3&4), Surgical Care Group patient safety, sepsis, infection prevention and the trial use of Omnicell as a Controlled Drug registry. The Committee was pleased to note the reducing trend in patient falls, particularly those resulting in severe harm and the ongoing achievement of the previous sepsis CQuIN targets. The improvement plan for sepsis training and care group involvement in promoting patient safety ward to Board were also highlighted.

9. Deteriorating Patient Project Presentation

The Committee received a presentation on the work being undertaken in relation to deteriorating patients and the outcome of the initial scoping workshop held in May 2021 in taking this forward. This included reviewing the working arrangements for a number of teams across the Trust, including MET, sepsis, acute kidney injury and resuscitation, to deliver patient-centred care with improved integrated and collaborative working. The Committee sought assurance that any changes that could be delivered in the short-term would be in place as soon as possible and momentum maintained for what was noted to be a large-scale and long-term project.

10. Q4 Perinatal Mortality Review Tool (PMRT) Update

The report noted that there had been one case eligible for PMRT review and a 72 hour review was completed to identify immediate learning in quarter 4. In addition, three PMRT reviews were undertaken on previous cases, with action plans in place where learning has been identified. The Committee received confirmation that relevant organisations are involved and informed where learning is identified for their trust in StHK-led reviews and vice versa, that where there is learning for StHK in

other organisation's reviews that this is shared with the Trust, which is supported by the effective links with other trusts.

11. Q4 Maternity Staffing for Safety

The report demonstrated compliance with national requirements and Birthrate Plus® recommendations for safer staffing with a ratio of clinical midwives employed to births of 1:27 compared to the recommended ratio of 1:28. It was noted that there had been staffing challenges during the pandemic and recently, both internally and in neighbouring trusts, due to maternity-leave, sickness absence and COVID-related absence. Daily staffing meetings are undertaken, with the use of bank and agency staff where possible to increase staffing numbers. The Committee noted that there will be a full review of the staffing establishment in the next few weeks.

12. Saving Babies Lives

The report provided an update on compliance with CNST safety standard 6: saving babies lives care bundle. Audits demonstrated compliance with 4 of the 5 standards, as well as the additional requirement for the CNST incentive scheme. The one standard not achieved related to the percentage of women receiving a full course of antenatal steroids within 7 days of birth, which only achieved 20%. An action plan is in place to achieve the required 85%.

13. Continuity of Carer Action Plan

An updated action plan was presented, noting the requirement to provide all women with continuity of carer by March 2023, which will be delivered by teams of 6-8 midwives based in the community.

14. STHK Maternity Services Summary of maternal and neonatal safety

In line with the Ockenden Report, Maternity Services presented a safety dashboard, based on the NHSEI template to provide assurance of the actions being taken to provide a safe service. This will be further developed going forward.

15. Clinical Effectiveness Council Assurance Report

The report noted the presentation received by the Diabetes and Endocrinology Department and the work that they are doing to reduce the number of prescribing errors. The report highlighted the increased number of patients being treated with fractured neck of femur, highlighting the negative impact of the pandemic, including loss of dedicated ward, reduced theatre capacity and increased mortality rates. The dedicated ward has now been reopened, with additional work being undertaken to increase theatre capacity through the use of nerve blocks rather than general anaesthetic where possible. It was noted however that the team were performing above the national average in a number of areas, including prompt orthogeriatric review.

The Committee noted the positive feedback given to Critical Care via Intensive Care National Audit and Research Centre (ICNARC) relating to research recruitment and good outcomes.

16. Research Development and Innovation Annual Report 2020/2021

The Committee were pleased to note the outstanding work undertaken by the research team across the Trust in delivering high quality research projects for both COVID-related studies and in reopening studies paused due to the pandemic. The Trust was the top recruiter to a number of studies and achieved well over target for SIREN and RECOVERY studies. The contribution of staff across the Trust in supporting this was noted.

The quality of research and subsequent publications were also highlighted, with the potential to consider establishing a dedicated clinical research facility noted.

17. Workforce Council Report

The report was noted, which included a summary of the items discussed at the meeting including strategic resourcing, equality, diversity & inclusion, Workforce Strategy and MIAA audit of management of overtime.

18. Freedom to speak out update quarter 3 and 4

The Committee received the report highlighting the number of concerns raised and the improved Freedom to Speak Up index score from 81.9% in 2019 to 82.3% in 2020, above the national average of 79.2%.

19. Any Other Business

The Chair highlighted the positive assurance report received from Mersey Internal Audit Agency in relation to the production of the annual Quality Account.

Matters for escalation:

Committee noted the following:

- Extremely positive work being undertaken in relation to research across the Trust, both for COVID and other studies.
- Evidence of compliance with CNST Maternity Incentive Scheme to be presented to the Board for approval.

Recommendation(s): To note the report

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

Date of Meeting: 30th June 2021

TRUST BOARD

Paper No: NHST(21)037
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 24th June 2021

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
P Growney – NED
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
R Pritchard Jones – Medical Director
N Khashu – Director of Finance & Information
G Lawrence – Deputy Director of Finance & Information
A Matson – Assistant Director of Finance – Financial Management
L Knight – Associate NED
C Dawn - Assistant Director of Operations – Clinical Support Services

Agenda Items

For Assurance

A) Integrated Performance Report

- Target 62 day and 31 day performance was met in April, at 86.1% and 99.1% respectively.
- Target 2 week wait cancer performance was not achieved in April, with delivery of 86.5% against a target of 93% due to the ongoing impact of the pandemic.
- Urgent care attendances have increased in May, with Accident & Emergency Type 1 performance at 63.8%. Improvement plans covering the full urgent care pathway are in progress and will be shared with the Committee once approved.
- The ambulance turnaround time target was achieved in May.
- Sickness has increased slightly in May, with an overall Trust increase of 0.2% since April. Front line Nursing, Midwifery and HCA sickness has increased by 0.7%. There have been increases in both COVID-19 related sickness and staff needing to self-isolate without testing positive.
- The committee is assured that plans are in progress to address underachievement of appraisal and mandatory training compliance.

B) Finance Report Month 2

- The Trust is reporting a breakeven position for Month 2, in line with system planning. This includes expenditure of £87.3m year to date.
- The Month 2 year to date position includes £5.5m Elective Recovery Fund (ERF) income, based on activity performance during April and May.
- Schemes are fully identified to meet the Trust's H1 CIP target of £3.8m.
- System CIP also assumes a £3.3m contribution from Elective Recovery Fund income; however, this is a non-recurrent for H1 only.
- As at Month 2, the Trust had a cash balance of £57.1m.
- The Trust has a total 2021/22 capital plan of £17.7m.

C) Cancer Performance – Head & Neck and Gynaecology
- The committee reviewed the performance on both specialities with comparisons to the C&M overall position and other local Trusts.
- The committee were assured of the measures put in place and the work the Trust was doing to support patients on this pathway.
- The committee noted the challenges within the wider system and that there needs to be a continued focus across the health economy to support overall performance.

For Approval

N/A

For Information

A) Clinical Support CIP Presentation
- The committee were encouraged by the progress made by the caregroup in delivering and identifying the CIP during H1
- It was noted that a high proportion of the schemes were expenditure reductions that was encouraging.

CIP Council report – Update noted by committee
Capital Council report – Update noted by committee

Risks noted/items to be raised at Board

N/A

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 24th June 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)038

Committee Report – Audit

Purpose: To feed back to members matters arising from the Audit Committee – 21 June 2021.

Summary

For Assurance

External Audit

- **Audit Progress Report –** Grant Thornton UK LLP (GT) verbally updated the Committee, which was introduced to the Trust's new Audit Manager. Planning and interim work is underway in line with the Trust's extended timetable.

Internal Audit

- **Progress Report** – MIAA outlined delivery to date of the 2021-22 internal audit plan, including two finalised reports [*substantial assurance*] and a review, providing assurance in the absence of external audit procedures, over the compilation of the Trust's Quality Account 2020-21.

Other

- **COVID-19 Cost Reimbursement Review** – Deloitte's findings in relation to COVID-related expenditures to M6, as reported to NHSEI, were received for assurance.

Anti-fraud

- **Anti-fraud Progress Report** – the Report was discussed and accepted.
- **Counter Fraud Functional Standard Return (CFFSR) Baseline Assessment 2020-21** – the assessment was green overall. The Committee noted the *planned actions* in amber areas.

Standing Items

- **Audit Log** – the Trust's internal summary of progress in implementing MIAA recommendations was discussed and accepted.
- **Aged Debt –** the Trust's 'over 90 day' debt total has remained low, as at 31 May, at £5.6m.
- **Tender and Quotation Waivers –** the Head of Procurement's assurance paper was noted.

For Information

Internal Audit

- **Internal Audit Charter –** the Charter provided an update on the internal auditor function's purpose, authority and responsibility.

Other

- **Annual Meeting Effectiveness Review 2020/21** – the review was noted, and in particular, Committee attendance was noted as satisfactory.

Standing Items

- **Losses and Special Payments –** report was discussed and accepted.

Risks noted / items to be raised at Board

None.

Corporate objectives met or risks addressed: Contributes to the Trust's governance arrangements.

Financial implications: None as a direct consequence of this paper.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): For the Board to note.

Presenting officer: Ian Clayton, NED and Chair of the Audit Committee.

Date of meeting: 30 June 2021

TRUST BOARD

Paper No: NHST(20)039
Title of paper: Fit and Proper Persons Regulations – Annual Declaration
Purpose: To provide assurance to the Trust Board that the Trust has met the requirements of the Care Quality Commission (CQC) Fit and Proper Persons Regulations (Regulation 5).
Summary: The Fit and Proper Persons Regulations (FPPR) have been in place since 2014, with additional guidance being issued by the CQC in January 2018. The Trust has a robust FPPR Policy that is reviewed annually. The regulations require that all providers of NHS services; "*are able to show evidence that appropriate systems and processes are in place to ensure that all new and existing directors are, and continue to be, fit and that no appointments meet any of the unfitness criteria*" In additional to undertaking checks on new Directors as part of the recruitment process, the Trust has also put in place a process whereby every Director makes an annual declaration of their fitness to be a Director. In addition annual checks are undertaken by the Human Resources Department, to ensure that no new information has come to light that could affect the Directors "fitness" for the role. The Chairman reviews the declarations and the results of the checks and provides assurance to the Board that the organisation continues to meet the requirements of CQC regulation 5. Appendix 1 – Fit and Proper Persons Regulations Annual Declaration 2021.
Trust objectives met or risks addressed: The Trust is compliant with all the CQC regulations and can maintain registration.
Financial implications: None arising directly from this report.
Stakeholders: Members of the public, Patients, Staff, Commissioners, Regulators
Recommendation(s): That the annual declaration be noted
Presenting officer: Richard Fraser, Chairman
Date of meeting: 30th June 2021

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Annual Fit and Proper Person Requirement 2021

The table below certifies that the appropriate checks by the HR department and self-declarations have been completed for all Board Directors and that these have been reviewed by the Chairman who has confirmed that, based on the evidence presented, all Directors meet the requirements.

The Trust is also in the process of undertaking 3 yearly DBS checks for all Board members.

Board Member	Position	F&PPR Checks Completed	F&PPR Self-Declaration Reviewed	Meets Requirements /Comments
Richard Fraser	Chairman	09/06/21	11/06/21	✓ *
Val Davies	Non-Executive Director	28/05/21	23/06/21	✓
Jeff Kozer	Non-Executive Director	03/06/21	23/06/21	✓
Paul Growney	Non-Executive Director	03/06/21	23/06/21	✓
Gill Brown	Non-Executive Director	04/06/21	23/06/21	✓
Ian Clayton	Non-Executive Director	03/06/21	23/06/21	✓
Lisa Knight	Non-Executive Director	28/05/21	23/06/21	✓
Ann Marr	Chief Executive	03/06/21	23/06/21	✓
Anne-Marie Stretch	Deputy Chief Executive/Director of HR	28/05/21	23/06/21	✓
Rowan Pritchard-Jones	Medical Director	28/05/21	23/06/21	✓
Sue Redfern	Director of Nursing, Midwifery and Governance	03/06/21	23/06/21	✓
Nik Khashu	Director of Finance and Information	03/06/21	23/06/21	✓
Rob Cooper	Director of Operations and Performance	09/06/21	23/06/21	✓
Christine Walters	Director of Informatics	28/05/21	23/06/21	✓
Nicola Bunce	Director of Corporate Services	28/05/21	23/06/21	✓
Tiffany Hemming	Director of Transformation (Seconded to East of England NHSE/I)	23/06/21	23/06/21	✓

*Reviewed by the Deputy Chair

Chairman's Signature:

Date: 23/06/2020
ENDS

Trust Board

Paper No: NHST(21)040

Title of paper:

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 3 (2020/2021) Trust Board declaration.

Purpose: To provide assurance the Trust has met the 10 CNST Maternity safety actions for 2020/21 to qualify for the Maternity Incentive Scheme discount.

Summary:

NHS Resolution's (NHSR) CNST Maternity Incentive Scheme recognises Trusts that deliver safer maternity care. This is in the form of a discounted CNST premium for Trusts that can evidence they have achieved the prescribed safety actions each year. The Trust Board is required to make a declaration that it is satisfied that achievement of the 10 safety actions can be evidenced.

To be eligible for the CNST discount under the scheme, Trusts must submit their completed Board declaration to NHS Resolutions by 15th July 2021.

2020/21 was year three of the Maternity Incentive Scheme. The scheme evolves each year to incorporate key learning, so that safety continues to improve. This year the scheme has also incorporated emerging themes identified through the COVID-19 pandemic.

The 2020/21 scheme was relaunched in October 2020 but has been revised in January and March 2021.

Trusts that can demonstrate they have achieved all of the 10 safety actions will recover the element of their contribution to the CNST maternity incentive fund and can also receive a share of any unallocated funds.

This report provides confirmation that the Maternity Service has achieved all 10 safety actions in line with guidance provided by NHSR. A summary of the action, the criteria for achievement and the evidence that supports the assessment is provided (Appendix 1).

A review of all evidence relating the 10 safety actions has been undertaken on 7th June 2021 and 24th June 2021 by the Director of Nursing, Midwifery and Governance/Executive Maternity Safety Champion. This was also presented to the Executive Committee on 10th June 2021 to provide assurance that the evidence supports the 2020/21 declaration.

Corporate objectives met or risks addressed: Safety, service improvement and learning

Financial implications: Yes, 10% discount on the CNST maternity premium for 2020/21

Stakeholders: Patients, Regulators,

Recommendation(s): To Trust Board are requested to approve: 1. The Neonatal workforce action plan 2. The CNST declaration of achievement of the 2020/21 Maternity Incentive scheme safety actions.
Paper presented by Sue Redfern, Director of Nursing, Midwifery and Governance
Date: 30th June 2021

Appendix 1

CNST Maternity Incentive Scheme Trust Board declaration.

1. Introduction

The Maternity Safety Strategy has set out the Department of Health's target of halving the rates of stillbirths, neonatal and maternal deaths, and brain injuries associated with delivery, by 2025. The first milestone in the process of achieving that target was an expectation of a 20% reduction by 2020.

In order to incentivise improvement in the delivery of best practice and safer care, NHS Resolution have made a 10% (at least) reduction in the CNST maternity contributions of Trusts who are able to demonstrate compliance with the annually agreed safety actions developed by the National Maternity Champions.

The Maternity Service has reviewed its compliance against the CNST Maternity Incentive Scheme standards for 2020/21 and confirms compliance against all safety actions as listed within this report.

The detailed evidence submissions were reviewed by the Director of Nursing, Midwifery and Governance, Executive Maternity Safety Champion on 7th June and 24th June 2021; who confirmed that the evidence requirements for each Safety Action have been met.

2. Summary of safety actions

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

The Maternity Service has embedded the PMRT tool into their governance arrangements; this process has been in place since January 2018.

In line with the required standard:

- Measure: All perinatal deaths meeting the criteria from 11th January 2021 are notified to MBRRACE-UK within seven working days and the surveillance information completed within four months of the death.
- Evidence: All eligible cases in 2020/21 (four) were reported to MBRRACE-UK within the required timeframe - (100% Achieved)

- Measure: Baby deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). 95% of reviews for baby deaths between 20th December 2019 and 15th March 2021 have been started before 15th July 2021.
- Evidence: Sixteen cases met the criteria and are eligible and active on MBRRACE-UK. (100% Achieved)

- Measure: At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, from Friday 20th December 2019 to Monday 15th March 2021 have been reviewed using the PMRT, by a multidisciplinary review team. Each review has been completed to the point

that at least a PMRT draft report has been generated by the tool before 15th July 2021.

- Evidence: Sixteen cases have been identified as eligible. Twelve of the sixteen cases have had an MDT review and a draft report completed (75% Achieved against target of 50%).

- Measure: For 95% of all deaths of babies who were born and died in the Trust from Friday 20th December 2019, the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by the Trust staff and the baby died.
- Evidence: Contact with the families continued during the COVID-19 pandemic. The maternity bereavement leads proactively supported families and debrief meetings were conducted where appropriate. There are sixteen cases eligible and all of the parents have been notified by letter that a PMRT review will take place with an opportunity to raise questions about their care (100% Achieved)

- Measure: Have you submitted quarterly reports to Trust Board from 1 October 2020 onwards?
- Evidence: Quarterly PMRT reports have been submitted to the Board via the Quality Committee from 1st October 2020. The quarterly PMRT reports are discussed at the Trust's Maternity Safety Champions monthly meeting (100% Achieved)
- The Baseline Summary report in response to the National MBRRACE report released in December 2020 has been approved by the Executive team, the internal governance processes and shared wider with the LMS

- Measure: Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?
- Evidence: All the quarterly reports have discussed with the Trust maternity safety champion and have been discussed the maternity champions safety meeting (100% Achieved)

This demonstrates compliance with all aspects of this standard.

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Confirmation has been received from NHS Digital (NHSX) confirming that the Trust have achieved compliance with this standard, this was confirmed based on the submission in January 2021 relating to December 2020 data which included all the required information. in the following tables:

This demonstrates compliance with all aspects of this standard.

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units (ATAIN) programme?

Measure: Commissioner Returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing Transitional Care.

Evidence: Neonatal Critical Care Minimum Data Set data is submitted monthly as part of the SUS process for submitting hospital episode data to NHS Digital for the commissioning data set (CDS). The Operational Delivery Network (ODN)have access to this through Badgernet Neonatal.

The neonatal team input all transitional care data in the Badgernet system. To date there have been no requests to submit additional information to the ODN – this has been confirmed by the ODN Director (100% Achieved)

Measure: An action plan to address local findings from Avoiding Term Admissions into Neonatal units (ATAIN) reviews, including those identified through the COVID-19 period above has been agreed with the maternity and neonatal safety champions and Board level champion.

Evidence: A review of term admissions to the NNU (SCBU) during the COVID-19 period was undertaken to identify the impact of:

a) Closures or reduced capacity of TC
b) Changes to parental access – there were no changes made
c) Staff redeployment – no staff redeployment during this time
d) Changes to postnatal visits leading to increase in admission including those for jaundice, weight loss and poor feeding.

(100% Achieved)

Measure: Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions. The ATAIN report has been submitted to Maternity Governance, Quality Committee and is proactively reviewed and included on the agenda and minutes of the Maternity Champions meeting.

Evidence: The ATAIN Action Plan has been submitted through the internal governance processes for oversight is regular agenda item at the Maternity Safety Champion meeting. A Newsletter during Q4 was developed and circulated. (100% Achieved)

This demonstrates compliance with all aspects of this standard.

Safety action 4**:** Can you demonstrate an effective system of clinical workforce planning to the required standard?

Measure: Anaesthetic Medical Workforce

Evidence: During 2020/21 the Trust met all the applicable Anaesthesia Clinical Services Accreditation (ACSA) standards.

Measure: Neonatal Medical Workforce - The Neonatal Unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

Evidence: Tier 1 - Required standard for a Local Neonatal Unit (STHK designation) is an immediately available resident T1 practitioner dedicated to providing emergency care for the neonatal service 24/7.

STHK do not currently meet this standard as there is a gap in the rota (after midnight) when there is no dedicated T1 doctor on the unit. STHK need 1.0 WTE T1 doctor to become fully compliant (with an increase in the rota from 1:11 to 1:12). There is a vacant T1 Paediatric Trust Grade post which is currently out to advert when the post is filled the Trust will be fully compliant.

Evidence: Tier 2 - Required standard for LNU is an immediately available resident T2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit, e.g. 09.00-22.00, 7 days a week.

STHK do not currently meet this standard. There is a gap of 25 hrs per week where there is no dedicated T2 cover from 1700-2200hrs Mon-Fri. To meet the standard, therefore an action plan is in place so that this can be achieved over the next two years. The Neonatal workforce paper was presented Executive Committee on 10th June 2021, which approved the action plan to achieve compliance. With the approved action plan in place this indicator can be reported as achieved.

Measure: Neonatal Nursing Workforce: Implementing the recommendations of the Neonatal Critical Care Transformation review:

Evidence: The Trust has completed the required neonatal nursing workforce staffing tool. This identified that whilst STHK meets the service specification for budgeted total nursing workforce, there is a need to undertake a skill mix review to address the variances noted, e.g. a shortage of nurses Qualified in Speciality (QiS) and an over-establishment of non-qualified nursing staff.

The Trust has an ongoing action plan in place and commitment to work with the ODN to achieve the recommendations as soon as possible. Therefore, this indicator can be recorded as achieved. (Appendix 2)

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Evidence: A systematic, evidence-based process is used to calculate midwifery staffing establishment based on the Birthrate Plus methodology from a baseline set in 2016 (when the review was undertaken by Birthrate Plus). Monthly Birthrate Plus calculations (in line with the guidance) are undertaken by the Finance Department and Head of Midwifery to provide a midwife to birth calculation. The Trust is currently at 1:27.2, which is within the recommended level of 1:28. A full external Birthrate Plus review is currently in progress to reflect new guidance and establish an up to date baseline.

The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

All women in active labour receive one-to-one midwifery care.

Midwifery staffing reports have been presented to Quality Committee quarterly, they include red flags on safer care including compliance with the requirement for a supervisory coordinator, one to one care in labour and any other incidents related to staffing. The service also provides regular progress report on the implementation of Continuity of Carer. (100% Achieved)

This demonstrates compliance with all aspects of this standard.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Evidence: Quarterly reports have been submitted to Quality Committee to demonstrate compliance with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.

In Q4 a gap analysis was undertaken against SBLCBv2, this indicated that implementation of all the elements of SBL has been achieved.

CO monitoring was nationally paused due to COVID-19. This has now recommenced, and the Trust is 100% compliant.

This demonstrates compliance with all aspects of this standard.

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to co-produce local maternity services?

Evidence: The Maternity Service has various methods of obtaining service user feedback including FFT, Facebook pages which reach 7,372 followers. Maternity Matron quality visits, continuity of carer team, breast feeding support group and labour ward forum. Feedback from these methods is discussed and improvements actioned via our monthly senior Midwifery Improvement Forum (MIF) and Multidisciplinary team (MDT) debriefs with families.

Participation in the annual CQC Maternity Survey (suspended in 2020 due to COVID-19).

Terms of reference have been agreed for a Maternity Voice Partnership (MVP: a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.). Regular feedback sessions and Maternity Voice Partnership meetings are ongoing. We have user representation in labour ward forum meetings and the MVP will be attending the Maternity Champions meetings.

The MVP participated in the recent Head of Midwifery interview has regular updates with DONM&G. Remuneration for the chair & other services user members of the committee has been obtained to demonstrate compliance with this criterion (via CCG).

BAME action plan is in place.

This demonstrates compliance with all aspects of this standard.

Safety action 8:

Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of Maternity Incentive Scheme year three in December 2019?

Measure:

a) COVID-19 specific e-learning training has been made available to the multi-professional team members
b) Teams required to be involved in immediate resuscitation of the newborn and Management of the deteriorating newborn infant have attended your in-house neonatal resuscitation training or newborn Life Support (NLS) course since the launch of MIS year three in December 2019
c) There is a commitment by the Trust Board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.

Changes have been made so that e-learning training content delivered remotely or digitally could be included with a 90% threshold for compliance.

Evidence: This is monitored through the maternity, neonatal and anaesthetics governance structure, with oversight by the Maternity Champions group.

Prompt Training compliance is above 90% for all teams

Staff group	Attendance Compliance
Obstetric Consultants	94.1%
All other Obstetric Doctors	97.61%
Midwives	93.41%
Neonates	90.56%
Anaesthetic staff	96%
Theatre staff	92.85%

This demonstrates compliance with all aspects of this standard.

Safety action 9: Can you demonstrate that the Trust Safety Champions (obstetric, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?

Measures:

a) A pathway has been developed to formalise how safety intelligence from floor to Board which is shared through LMS & Maternity and Neonatal Special interest Group (MatNeo SiG).
b) Board level safety champions undertaking feedback session every other month for Maternity and neonatal staff to raise concerns relating to safety issues.

c) Demonstrate progress with actioning named concerns that are visible to staff.

Evidence: A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the Local Maternity System (LMS) and Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) Patient Safety Networks.

Board level safety champions undertake feedback sessions every month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback, we can demonstrate that progress with actioning concerns is visible to staff. "You said We did" posters are in place and actions are monitored via the Maternity Champions meeting

Board level safety champions and the Quality Committee have reviewed our continuity of carer action plan in the light of COVID-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service continues to work towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups we serve.

Together with the frontline safety champions, the Board safety champion has reviewed local outcomes in relation to:

1. Maternal and neonatal KPIs
2. The MBRRACE-UKSARS-Covid-19
3. The letter regarding targeted perinatal support for Black, Asian and minority ethnic groups and have undertaken a review of the recommendations to ensure compliance.

The Maternity Safety Board Level Champion (DONM&G) undertakes twice weekly walkabouts in conjunction with Maternity Safety Champions and is undertaking listening events with the Assistant Director of Operations to obtain staff views. This is documented in a template developed to capture the detail of those events and is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas:

- Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to COVID-19 safety concerns.
- The Patient Safety Networks of which each Trust will be a member
- Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with
- The Patient Safety Network clinical leaders' group where Trust staff are members

Lisa Knight is the Trust's Non-Executive Director Maternity Safety Board Level Champion.

This demonstrates compliance with all aspects of this standard

Safety action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/2020 births only) reported to NHS Resolutions Early Notification (EN) scheme?

Evidence: The Trust can demonstrate 100% compliance with Safety action 10.

There were 8 eligible cases for reporting to the EN Scheme at STHK from April 2019 to March 2020 and 100% (8) of cases have been reported to the EN scheme.

There have been 5 eligible cases in the period October 2020 to March 2021 at STHK maternity services. In 100% (5) of cases the family have received information on the role of HSIB and the EN Scheme.

100% (5) of cases have all complied with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

All eligible cases are reported to HSIB and findings for the reviews are shared quarterly with the clinical teams and reported in the closed Trust Board StEIS report

HSIB quarterly shared learning updates have been cascaded.

This demonstrates compliance with all aspects of this standard.

Conclusion

The Maternity and Neonatal Services were able to meet the requirements to declare that all 10 of the 2020/21 safety actions have been achieved.

Where the standard (relating to the neonatal workforce) was not fully achieved an action plan is in place, which has been reviewed and accepted by the Executive Committee and now requires Trust Board ratification to meet the standard of evidence.

The Trust Board declaration needs to be made by 15th July 2021; the Trust Board are requested to approve the declaration (

ENDS

Appendix 2 - Neonatal workforce action plan

St Helens and Knowsley Teaching Hospitals NHS Trust

Paediatric Department – Neonatal Unit

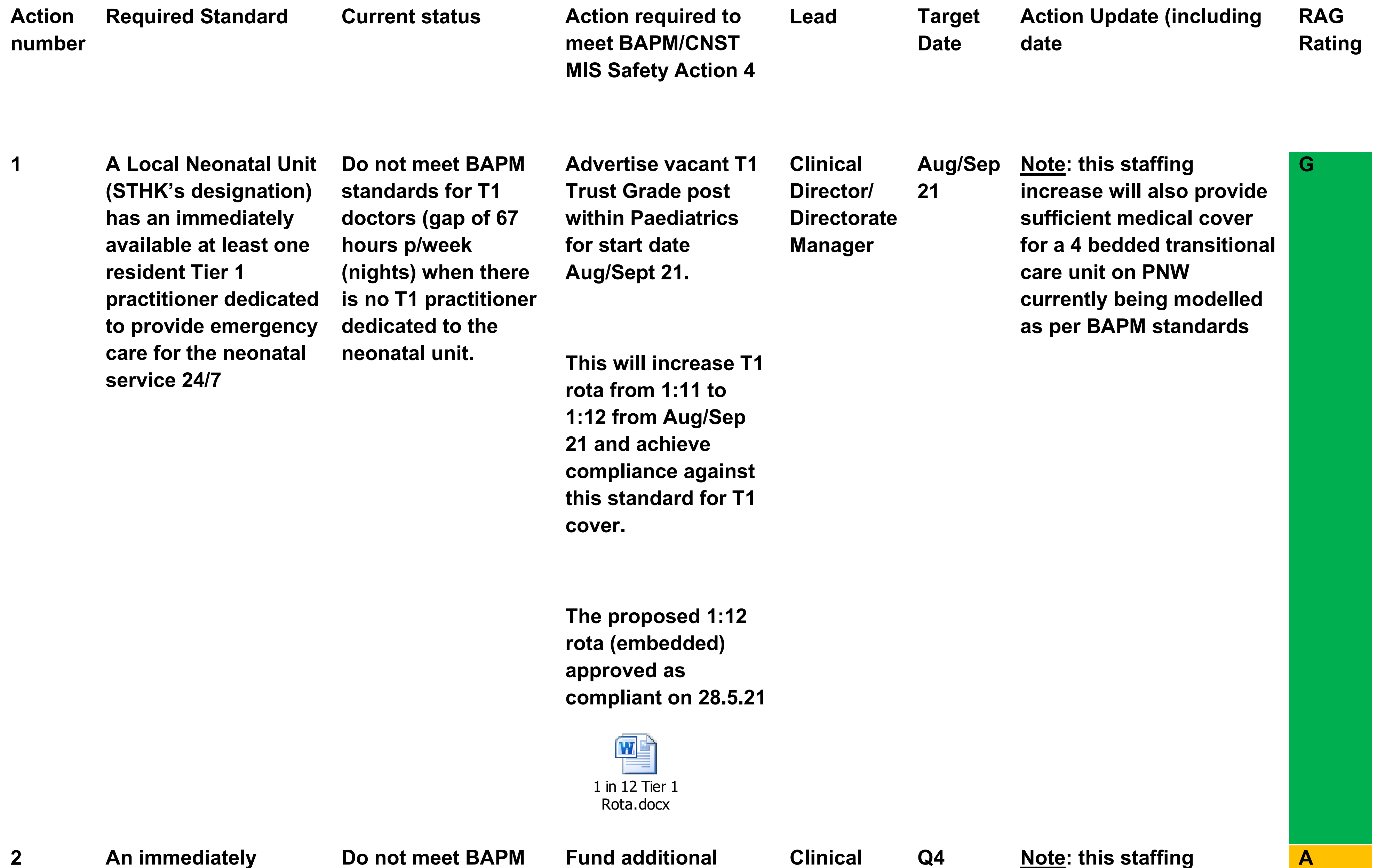
CNST MIS Safety Action 4

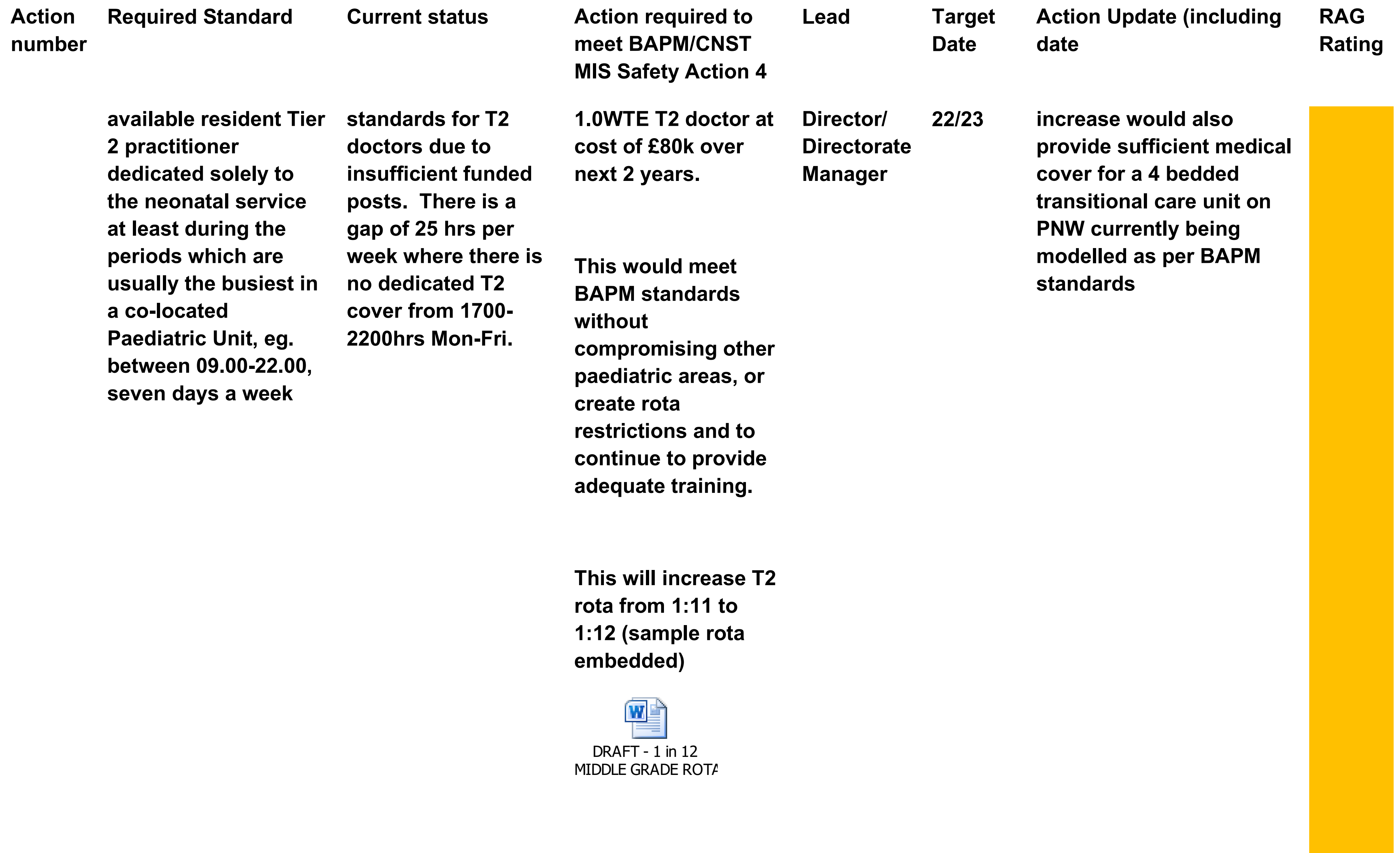
KEY TO STATUS RAG RATING			
(red)	Risk to completion	(amber)	Work On-going
(green)	Action on Track	(blue)	Completed action

Action number	Required Standard	Current status	Action required to meet BAPM/CNST MIS Safety Action 4	Lead	Target Date	Action Update (including date	RAG Rating

Neonatal Medical Workforce Standard

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level. To include: Do you meet the BAPM national standards of junior medical staffing depending on unit designation? If no, please submit a Trust board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.

Action number	Required Standard	Current status	Action required to meet BAPM/CNST MIS Safety Action 4	Lead	Target Date	Action Update (including date	RAG Rating
1	A Local Neonatal Unit (STHK's designation) has an immediately available at least one resident Tier 1 practitioner dedicated to provide emergency care for the neonatal service 24/7	Do not meet BAPM standards for T1 doctors (gap of 67 hours p/week (nights) when there is no T1 practitioner dedicated to the neonatal unit.	Advertise vacant T1 Trust Grade post within Paediatrics for start date Aug/Sept 21. This will increase T1 rota from 1:11 to 1:12 from Aug/Sep 21 and achieve compliance against this standard for T1 cover. The proposed 1:12 rota (embedded) approved as compliant on 28.5.21  1 in 12 Tier 1 Rota.docx	Clinical Director/ Directorate Manager	Aug/Sep 21	<u>Note</u>: this staffing increase will also provide sufficient medical cover for a 4 bedded transitional care unit on PNW currently being modelled as per BAPM standards	G
2	An immediately	Do not meet BAPM	Fund additional	Clinical	Q4	<u>Note</u>: this staffing	A

Action number	Required Standard	Current status	Action required to meet BAPM/CNST MIS Safety Action 4	Lead	Target Date	Action Update (including date	RAG Rating
	available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit, eg. between 09.00-22.00, seven days a week	standards for T2 doctors due to insufficient funded posts. There is a gap of 25 hrs per week where there is no dedicated T2 cover from 1700-2200hrs Mon-Fri.	1.0WTE T2 doctor at cost of £80k over next 2 years. This would meet BAPM standards without compromising other paediatric areas, or create rota restrictions and to continue to provide adequate training. This will increase T2 rota from 1:11 to 1:12 (sample rota embedded)  DRAFT - 1 in 12 MIDDLE GRADE ROTA	Director/ Directorate Manager	22/23	increase would also provide sufficient medical cover for a 4 bedded transitional care unit on PNW currently being modelled as per BAPM standards	

Neonatal Nursing Workforce Standard

The neonatal unit performs a workforce calculation* using the Neonatal Clinical Reference Group recommended Neonatal Nursing Workforce Staffing tool. Units that do not meet the service specification requirement for nursing workforce should have an action plan developed to meet the recommendations, signed off by their Trust Board (with a copy submitted to RCN and the North West Neonatal ODN). *This supersedes the Dinning Tool initially required for CNST Action Plan 4.

To achieve National Neonatal Nursing Standards: NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010)

Action No.	Actions identified	Lead	Timescale	Action Update / Notes	RAG Rating
1	Undertake review of neonatal workforce using the Neonatal Nursing Workforce Staffing Tool (NNWST) to identify compliance against service specification and BAPM recommendations and share with NWNODN	Paed Matron	Mar 21	Completed Tool identified that whilst STHK meets the requirement for total budgeted nursing workforce (1.28WTE over), there is a need to undertake a skill mix review as the Tool identified a shortfall in registered nurses (1.25 WTE) & QIS nurses (1.97 WTE) and an over-establishment of non-registered staff (2.53 WTE) that are required to meet activity (based on avg 80% occupancy) Since submission of data 1.0 WTE Band 2 nurse has successfully completed Nurse Associate Programme and is now a Band 4 Registered Nurse Associate.	B

Action No.	Actions identified	Lead	Timescale	Action Update / Notes	RAG Rating
2	Ensure organisational awareness of staffing position/challenges (Trust Board, Service & Finance Leads)	DM/ Paed Matron	May 21	Completed	B
3	Ensure Neonatal Safety Champion is aware of ongoing challenges/risks due nurse skill mix variances	Paed Matron	May 21	Completed	B
4	Share Nurse staffing information with NWNODN & RCN	Paed Matron	June 21		G
5	Work with ODN Workforce & Education Strategy Lead (once appointed) to review roles and develop workforce strategy to: 1. Address the skill mix variance (1.97 WTE shortage of QIS nurses and 0.72 WTE over-establishment of non-QIS nursing staff)	Paed Matron / DM	Ongoing	1. Phased plan for current B5 non-QIS staff to achieve QIS within next 2-3 years. Since submission of data: • 0.91 WTE Band 5 has successfully completed QIS • Current Band 5 vacancy 1.15 WTE is out to advert for QIS only (generated from leaver who was non-QIS). Recognising that there is a shortfall nationally of registered nurses with QIS. • 1.0 WTE is due to commence QIS in September 2021	G

Action No.	Actions identified	Lead	Timescale	Action Update / Notes	RAG Rating
	2. Address the 2.53 WTE over-establishment of non-registered staff			• **0.69 WTE Band 5 has completed the Neonatal Induction Course (which is the initial part of the pathway towards QIS) and will progress to completing QIS in the next 12-18 months** • **2.0 WTE Band 5 have been recruited who have completed the Neonatal Induction Course and will progress to complete QIS in the next 12-18 months** **2. Plan to address 2.53 WTE over-establishment of non-registered staff as follows:** • **4.32 WTE non-registered staff required to meet activity** • **5.17 WTE non-registered staff currently in post (3.37 WTE Band 4 and 1.8 WTE Band 2)** • **1.6 WTE Band 2 current vacancy funding will be utilised to address shortfall of 1.25 WTE Band 5 registered staff (per point 3 below)** • **Leavers/reduction in hours of Band 4 and below will not be replaced (0.53 WTE**	

Action No.	Actions identified	Lead	Timescale	Action Update / Notes	RAG Rating
	3. Address the 1.25 WTE shortfall of registered staff 4. 1.8 WTE Band 2 providing direct care -			is a R&R) • Band 5 and above are included in NCCR calculations Band 4 NA's not included as registered staff 3. Plan to address shortfall of 1.25 WTE registered staff • Explore conversion of 1.6 WTE Band 2 into Band 5 hours to partly fund 1.25 WTE shortfall in registered staff • Costings from Finance indicate an additional £6k is required to fund remainder of the 1.25 WTE Band 5 shortfall after 1.6 WTE Band 2 monies are utilised 4. Plan to address current band 2 workforce providing direct care: • Explore development of current 1.8 WTE Band 2 into Band 3 or Band 4 via TNA programme/competency framework • Liaise with Finance regarding additional funding required to convert to Band 3 or	

Action No.	Actions identified	Lead	Timescale	Action Update / Notes	RAG Rating
	STHK has been identified as an outlier for this **NB: Whilst not noted as a gap in the NWWT, National standards recommend there is a full time non-clinical nurse lead. Current 1.0 WTE Band 7 Ward Manager is 0.5 WTE clinical. Consideration needs to be given for this post to become 1.0 WTE non-clinical which will also allow time to lead on initiatives such as Transitional Care and other Quality roles.**			**Band 4** • **Costings from Finance indicate an additional £5k us required to convert B2s to B3 and £8.5k to convert B2s to B4.** **Further review required to explore current Ward Manager working 1.0 WTE in non-clinical role in accordance with NWN ODN future workforce plans:** • **Costings from Finance indicate funding for 0.5 WTE Band 6 is c£30k.**	
6	**4.7 WTE Band 6 quality roles have been identified as being required for STHK based on activity. Currently 0.6WTE are undertaken by current workforce.** **Therefore current Band 6 gap of 4.1 WTE in**	**Paed Matron / DM**	**Ongoing**	**Recently qualified ANNP undertaking consolidation year could potentially undertake some aspects of quality role in future**	**G**

Action No.	Actions identified	Lead	Timescale	Action Update / Notes	RAG Rating
	order to undertake quality roles identified by the ODN • **1.0 WTE Breastfeeding Lead** • **0.3 WTE Developmental Care Lead** • **0.5 WTE Family Support and Education Lead** • **0.3 WTE Emotional and Psychological Support Lead** • **1.0 WTE Governance Lead** • **0.8 Education and Training Lead** • **0.5 WTE Discharge Co-ordinator** • **0.3 Infection Control Lead**				

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 31.87, of which 22.31 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	29.59	23.80	28.31	1.28	-4.51
Total reg nurses	22.74	19.83	23.99	-1.25	-4.16
Total QIS	14.82	15.73	16.79	-1.97	-1.06
Total non-QIS	7.92	4.10	7.20	0.72	-3.10
Total non-reg	6.85	3.97	4.32	2.53	-0.35
Reg nurses as % nursing staff	76.9%	83.3%	84.7%		
QIS as % reg nurses	65.2%	79.3%	70.0%		

Appendix 3

Maternity incentive scheme - Board declaration Form

Trust name	**St Helens and Knowsley Teaching Hospitals NHS Trust**
Trust code	**T213**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes	Yes	-	You have met the action as well as submitting an action plan, please check
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**1**		**You have a validation on 1 safety action. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.**
Total sum requested			-	

Sign-off process:

Electronic signature

For and on behalf of the board of St Helens and Knowsley Teaching Hospitals NHS Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of St Helens and Knowsley Teaching Hospitals NHS Trust

For and on behalf of the board of	St Helens and Knowsley Teaching Hospitals NHS Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature	
For and on behalf of the board of	St Helens and Knowsley Teaching Hospitals NHS Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature	
For and on behalf of the board of	St Helens and Knowsley Teaching Hospitals NHS Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature	
For and on behalf of the board of	St Helens and Knowsley Teaching Hospitals NHS Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board

Name:	
Position:	
Date:	

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q4 Clinical workforce planning	**To be met by**	Q4 2022/23
Work to meet action	*Action plan in place to meet Bapen standards for Neonatal junior doctor and nursing workforce*		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes
Action plan owner	*Clinical Director and Directorate Manager Neonatal care*		
Lead executive director	*Director of Nursing, Midwifery and Goveranace*		
Amount requested from the incentive fund, if required	-		
Reason for not meeting action	*staffing gaps in medical workforce and skill mix review in nursing workforce being addressed by workforce action plan*		
Rationale	*Actions set out in the Plan will achieve BAPM standards for medical workforce within the next 2 years and the actions set out for nursing workforce, requiring a skill mix review will be met within the next 12 months (meeting the standards set out under the Neonatal Nursing Workforce Staffing tool).*		
Benefits	*Optimal neonatal care with requisite staffing levels, in full compliance with BAPM standards*		
Risk assessment	*Risks of not achieving this action are that there will not be immediately available medical staff on the neonatal unit for non urgent issues and without a nursing staff skill review, there is a risk of there being inadequately trained nurses (eg none QiS) at times, thus providing sub optimal care to babies on the unit*		

If you do not request any funds please enter 0

	How?	**Who?**	**When?**
Monitoring	Action Plan owners to provide quartely updates to Lead Executive Director and Neonatal ODN	Clinical Director and Directorate Manager, Neonatal Care & Lead Executive Director	Quarterly from Oct 21.

St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST BOARD

Paper No: NHST(21)041

Subject: Learning lessons to improve our people practices – Disciplinary policy review.

Purpose:

This paper provides assurance to the Trust Board of the actions taken as a result of the letter sent to provider chief executives and chairs on the 24th May 2019 from Baroness Dido Harding, Chair, NHS England and NHS Improvement.

The letter reported a case at an NHS Trust in London where a member of staff who had been the subject of an investigation and disciplinary procedure had taken his own life. An independent investigation followed which highlighted many shortcomings in the case. Subsequently a national Advisory Group was established which determined that sadly the case management in this instance was not untypical of other staff experiences in Trusts.

The NHSE/I letter urged Trusts to learn lessons from the Advisory Group work to improve NHS people practices with regard to disciplinary processes and made several recommendations. Furthermore the letter built on NHSE/I guidance and the NHS People Plan encouraging organisations to develop a more compassionate and just culture.

This paper details how the Trust has responded.

Summary:

The outcome of the local review resulted in the following changes to internal processes and the revision of the Trust's disciplinary policy:

- Engagement symposiums with managers and staff colleagues to review the disciplinary policy against national recommendations to inform the development of the new policy.
- Increased early intervention to support the health and wellbeing of those staff taking part in investigations
- The implementation of the Just and Learning Culture approach to case management
- The introduction of the 72 hour pause process prior to a decision as to whether a case is to progress to a formal process or be handled informally.
- Challenging potential suspension decisions where it is safe for staff to remain in work while investigations take place to support wellbeing and any long term effects of being involved in a disciplinary process
- Alternative actions to disciplinary action being considered where reflection and learning is more appropriate than a disciplinary sanction
- Ensure that a wellbeing assessment of the employee's mental health and wellbeing has taken place prior to any potential dismissal to include any pertinent personal/domestic mitigating circumstances

In addition the review recommends the following:

• Consider where complex cases could be more effectively investigated by external resources where there is insufficient management capacity to conduct a timely investigation and develop a business case for this proposal. • Investigation and case management training to be commissioned for delivery to managers by the Trust's solicitors.
Corporate Objective met or risk addressed: Developing organisational culture and supporting our workforce
Financial Implications: To be confirmed following scoping of resources required to implement the new policy and provide training to managers
Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues
Recommendation(s): The Trust Board is asked to note the Trust's response to the national review and approve the Board level oversight proposed.
Presenting Director: Anne-Marie Stretch, Deputy CEO/ Director of HR
Trust Board: 30th June 2021

Learning Lessons to Improve our People Practices

1.0 Purpose

This paper is to update the Trust's Board with the progress made on improving people practices as a result of the letter sent to provider chief executives and chairs on the 24th May 2019 from Baroness Dido Harding, Chair, NHS England and NHS Improvement. The letter outlined why Trusts need to learn lessons to improve our people practices, which built upon other NHSI guidance regarding Trusts developing a more compassionate and just culture, and the NHS People Plan. A number of recommendations were made and this paper shows the Trusts response and actions to date.

2.0 Background

The independent investigation into the tragic case of suicide of an NHS employee at a NHS Trust, who had been the subject of a disciplinary process resulting in dismissal, highlighted several key themes, among these were:

- poor framing of concerns and allegations;
- inconsistency in the fair and effective application of local policies and procedures;
- lack of adherence to best practice guidance;
- variation in the quality of investigations;
- shortcomings in the management of conflicts of interest;
- insufficient consideration and support of the health and wellbeing of individuals; and,
- an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The national Advisory Group established to review the case and other NHS disciplinary processes made a series of recommendations, many of which have been used as the basis for the provision of additional guidance to provider organisations. The purpose in issuing this guidance was to encourage all those involved in disciplinary processes, and in particular boards and HR teams, to reflect on its contents and recommendations. Boards were further asked to review and assess their respective procedures and processes relating to the management of investigatory and disciplinary matters against the guidance, and to make any adjustments required to bring their organisation in line with best practice.

In January 2021 Prerana Issar, NHS Chief People Officer wrote to Directors of HR acknowledging the importance of promoting good practice in the management and conduct of local investigations and disciplinary procedures and reminding Trusts that the recommendations for improvement from the Advisory Group were provided to ensure that the learning is used to best effect in informing positive changes across the NHS. A key learning point is that there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centered approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view is echoed in the NHS People Plan looking at tackling the disciplinary gap and support through Health Work and Wellbeing is high on its agenda.

3.0 Recommendations from the national reviews and the Trust response

Following Dido Harding's letter in May 2019, a Trust action plan was developed and has been extended into 2021/22 as national guidance about the delivery of the NHS People plan has evolved to include new 2021/22 deliverables.

The key additions to the action plan are with regards to the Board oversight of the review of Trust Disciplinary policies, training for all management roles and appropriate resources to ensure the completion of timely disciplinary processes with increased staff support through compassionate leadership. This includes an equality impact assessment to ensure that throughout the process staff with protected characteristics or health conditions are afforded appropriate reasonable adjustments which will also support achievement of the WRES and WDES action plans.

The table below shows the recommendations from the national reviews (including the NHS People Plan) and the Trust response to date.

Recommendations from the national reviews	Trust response
Adhering to best practice: a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice. b) Ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure (this may require the sourcing of independent external advice and expertise)	Introduction of the revised Disciplinary Policy that embraces the ethos of a "Just and learning culture" and ACAS Disciplinary and Grievance guidelines which is seen as best practice throughout the NHS and beyond. The new policy focusses on the trained internal investigation officer who is independent from all parties involved in the incident. A business case has been developed to secure funding for training. External investigators can be utilised if appropriate.
Applying a rigorous decision-making methodology: Consistent with the application of "just culture" principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.	The new policy introduces several informal stages before formal management action is invoked. • Stage 1 is the 72 hour pause after an adverse incident or failure to adhere to acceptable behaviors. During this 72 hour pause the manager will triage the case. • If informal action is to be taken then it is either an expectations meeting, facilitated conversation, or no further action. • If formal action is to be taken then an investigation begins. Once the investigation has been completed then 3 options are still available • No further action, • Fast-track where both parties agree to a

	remedy or the final choice of formal disciplinary action. The Employment Relations Scrutiny Panel, chaired by a NED will review the application of formal procedures.
Ensuring people are fully trained and competent to carry out their role: Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training.	The new policy specifically states the training requirements of all employees involved in the Disciplinary process. In order to achieve this commitment a business case has been developed for funding to provide training to investigators, case managers and panel members via face to face and on line training and podcasts.
Assigning sufficient resources: Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures.	The new policy provides guidance on the process and all documentation. Managers of the investigators and case managers are asked to support their team members in providing them with enough time to carry out the processes. The Employee Relations Scrutiny panel will monitor the timeliness of cases via the disciplinary procedure and take action if cases are taking too long.
Decisions relating to the implementation of the suspensions/exclusions: Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort this is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/ exclusion of any individual should be subject to appropriate senior-level oversight and sanction.	The new disciplinary policy states that permission to exclude or suspend should be sought from a Band 8b or above. The policy is quite specific about when an employee should be suspended and it is an exception. An employee who is suspended will be offered support through HWWB and be assigned a Pastoral support (Buddy) . The Employee Relations Scrutiny Panel will monitor the circumstances and length of an exclusion. The Trust Board will continue to receive information on cases involving exclusions.
Safeguarding people's health and wellbeing: a) Concern for the health and wellbeing of people involved in investigation and disciplinary procedures should be paramount and continually assessed. b) A communication plan should be established with people who are the subject of an investigation or	Throughout the new policy the introduction of support for the individual going through the process is paramount which includes: • Referral to the HWWB team • Being assigned a Case Manager independent from the process. • Being assigned Pastoral Support (Buddy) once the 72 hour pause has

disciplinary procedure, with the plan forming part of the associated terms of reference. c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a "never event" which therefore is the subject of an immediate independent investigation which will be commissioned and received by the Board.	been completed and it is decided that a formal sanction is appropriate. Each formal case has a Terms of Reference created once a formal investigation commences. Any employee who goes through a formal disciplinary procedure and suffers any harm whether physical or mental is recorded as a never event and reported to the Non-Executive Director responsible for overseeing the process and reporting to the board.
Annual review of all disciplinary procedures formally discussed and minuted at public Trust Board:	All Disciplinary procedures are formally discussed with the Non-Executive Director (NED) responsible for overseeing the process on a bi-monthly basis at the Employee Relations Scrutiny Panel. The NED will provide a report to the Board. In addition an annual review via the designated NED will be provided to the Trust Board.
Board-level oversight: Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at Board level.	The Employee Relations Scrutiny Panel report to the designated NED for reporting to the board. The panel provide information for the Board Report through the analyses of data provided by HR such as: • The number of employees going through the process. • The background of cases • Information on the protected characteristics of the employees involved The scrutiny panel and NED will in turn highlight any concerns and actions required.
Training to support the implementation of the new Disciplinary Policy: Improvement plan is under development following a training needs analysis to identify those managers who need to be trained in the various roles as identified in the disciplinary policy. This will include refresher training in employment law, equality, diversity and inclusion and how to implement the revised disciplinary policy.	The new Disciplinary Policy specifically states the training requirements of each role involved in the process. A business case has been developed for training resources.

4.0 Trust disciplinary policy review and summary of changes

In reviewing the Trust disciplinary policy, engagement symposiums took place with managers, HR team representatives and staff side colleagues to ensure the recommendations from the national guidance were actioned. A legal view of the revised policy has also taken place to ensure that it is fit for purpose and meets ACAS Code of Practice. A summary of the changes to the disciplinary policy are as follows:

4.1 The language used in the policy is more inclusive and utilises the recommendations from Dido Harding that it should be fair and open and embrace the Just and Learning culture. The link to the Trust's ACE behavioural standards has been strengthened through the use of changes in wording from Misconduct and Gross Misconduct to Failure to adopt Acceptable Behaviours and Adverse Incidents, and instead of using Warnings we now use Letters of Concern.

4.2 The Introduction of Key Principles that the Trust will adhere to when dealing with an employee going through the Disciplinary procedure with the emphasis being on restorative outcomes.

The key principles of the new policy are:

- Ensures good working relationships and resolves behavioural concerns promptly, fairly, and as close as possible to the point of origin.
- It supports moving on positively in a culture of no blame and learning.
- Encourages managers and employees to seek an early resolution to behavioural concerns quickly and effectively.
- Provides support and resources to enable managers and employees to resolve behavioural concerns informally through compassionate leadership.
- Promotes a high level of trust through appropriate use of language and respectful and learning-oriented conversations.
- Applies a triage process using a set of objective criteria to assess the most effective route to resolve each case.
- Encourages all employees to be open and honest when a mistake is made and for managers to take that into account when reaching a decision about next steps.
- Encourages managers and employees to seek opportunities for a restorative outcome in disciplinary cases wherever possible.
- Ensures that all workplace issues are treated fairly and consistently.
- Encourages positive employee relations and helps resolve concerns constructively and effectively.
- Encourages open communication between employees, their colleagues, and managers so that questions and problems can be aired and, where possible, resolved quickly and to the satisfaction of all concerned.

- Ensures employees will not be dismissed for a first breach of discipline except in the case of serious conduct.

4.3 The introduction of the 72 hour pause enables a triage process to take place to ensure there is time to evaluate the situation and decide whether a formal process is appropriate or are there other interventions we can use such as Expectations Meetings, Facilitated Conversations, Development Plans and 72 hour Pause.
4.4 There is greater emphasis on the Fast-Track process to encourage employees and managers to choose this option as it reduces the time it takes to achieve an agreed outcome and reduces the impact on the employees well-being due to uncertainty
4.5 There is an increased emphasis on employee well-being throughout the policy through referrals to HWWB, and Pastoral Support (buddies) that are assigned to the employee at the first stage of the process as a case becomes formal.
4.6 Increased training for all employees involved in the process as Case managers, Investigation officers will be provided.
4.7 Disciplinary and Appeal Authorities have specific time frames when cases have to be reviewed.
4.8 There is increased governance with the introduction of ER Oversight Group, Lessons learned discussions, ER reports to NED for dissemination to Trust Board.
4.9 The inclusion of BME and Disability support at formal meetings.

5.0 Action for Trust Boards

Trust Boards have been asked to ensure that HR Departments review and assess current procedures and processes and, importantly, make adjustments where required to bring Trusts in line with the best practice recommendations shown in section 3.

The recommendations also included that NHS managers ensure staff involved in a patient safety incident are treated fairly and the principles of a just culture to support a culture of openness to maximise opportunities to learn from mistakes. This fair treatment will make staff feel confident to speak up when things go wrong, rather than fearing blame.

By the 30th June 2021, the Trust has met national recommendations by delivery of the following:

- Engagement symposiums involving, managers, staff aside and HR colleagues to discuss lessons learnt and how we can improve our people practices.
- Obtained a legal review of the disciplinary policy to ensure it meets national recommendations and the ACAS code of practice.
- Alignment of the disciplinary policy to the learning from the Imperial College Healthcare NHS Trust case study.
- Agreement of the changes to the disciplinary policy approved by management, HR and staff side colleagues for publication on the Trusts intranet following discussion at the Trust Board on the 30th June 2021.

6.0 Recommendation

The Trust Board is asked to note the Trust’s response to the national review and approve the Board level oversight proposed.