St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28th JULY 2021
VIRTUALLY, BY TEAMS

AGENDA				Paper	Purpose	Presenter
09:30	1.	Employee of the Month - July 2021		Verbal	Assurance	Chair
09.45	2.	Patient Story		Verbal	Assurance	Sue Redfern
10.00	3.	Apologies for Absence		Verbal	Assurance	Chair
10.05	4.	Declaration of Interests		Verbal		
10.10	5.	Minutes of the Board Meeting held on 30th June 2021		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.20	6.	Integrated Performance Report		NHST(21) 044	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						
10.45	7.	Committee Report – Executive		NHST(21) 045	Assurance	Ann Marr
10.55	8.	Committee Report – Quality		NHST(21) 046	Assurance	Gill Brown
11.00	9.	Committee Report – Finance & Performance		NHST(21) 047	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Break					
Other Board Reports					
11.20	10.	Corporate Risk Register Quarterly Report	NHST(21) 048	Assurance	Nicola Bunce
11.30	11.	Board Assurance Framework Quarterly Report	NHST(21) 049	Approval	Nicola Bunce
11.40	12.	Learning from deaths quarterly report	NHST(21) 050	Assurance	Rowan Pritchard-Jones
11.50	13.	Workforce Strategy and HR Indicators Report	NHST(21) 051	Assurance	Anne-Marie Stretch
12.10	14.	Approval of the Terms of Reference for the Strategic Workforce Committee	NHST(21) 052	Approval	Anne-Marie Stretch
12.20	15.	Data Security and Protection Toolkit/IG Annual Report	NHST(21) 053	Approval	Christine Walters
12.45	16.	Cheshire and Merseyside ICS – Provider Collaborative Terms of Reference	NHST(21) 054	Approval	Ann Marr
Closing Business					
12 55	17.	Effectiveness of Meeting	Verbal	Assurance	Chair
	18.	Any Other Business		Information	
	19.	Date of Next Meeting – Wednesday 29th September 2021		Information	

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 30th June 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:	Ms Michelle Corrigan	(MC)	Insight Programme Placement
	Mr Sultan Taylor	(ST)	Aspiring Chair Programme (Observer)
	Mr Alan Lowe	(AL)	Halton LA (Observer)
	Mrs C Duffy	(CD)	Executive Office Manager (minute taker)
Apologies:	Mr Tony Foy	(TF)	St Helens CCG

1. Employee of the month

1.1. RF read out the citation for Sue Jenkins, Receptionist at Whiston Hospital, who had been nominated independently for the award by Maura Williams, Volunteer and Christine Parsons, Switchboard Operator.

1.2. Due to COVID social distancing restrictions, Sue had been filmed receiving her award from NB and the film presented to Board. The Board noted the citation and congratulated Sue.

2. Apologies for Absence

2.1. Apologies were noted as above.

3. Declaration of Interests

There were no new declarations of interest.

4. Minutes of the Board briefing held on 26th May 2021

4.1. Correct Record

4.1.1. The minutes were approved as a correct record.

4.2. Action List

4.2.1. RF acknowledged that actions 30 and 36 could not be progressed at the moment due to the ongoing social distancing restrictions.

4.2.2. AMS confirmed that the draft terms of reference and annual work plan for the newly created Strategic Workforce Committee will be presented for approval at the July Trust Board meeting.

5. Integrated Performance Report (IPR) – NHST (21)034

5.1. 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.

5.2. Quality Indicators

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

5.2.2. There were 0 never events in May, and 0 year to date (YTD).

5.2.3. There had been 0 cases of MRSA in May, and 0 YTD.

5.2.4. There were five C. Difficile positive cases reported in May 2021 (three hospital onset and two community onset). The annual tolerance level for the Trust has not been published for 2021/22 therefore the 2019/20 tolerance limit of 48 continues to be used. There were 43 C. Difficile infections reported in 2020/21, 15 of which were successfully appealed as not being attributable to the care of the Trust and the outcome of a further two is awaited. This means that the outturn position for 2020/21 is currently 28 hospital attributable cases, which could reduce to 26 if the remaining appeals are successful.

5.2.5. There was 1 fall resulting in severe harm in April, and 1 YTD. SR confirmed that an intensive falls strategy has been put in place, with ongoing interventions to improve falls awareness and assessment.

5.2.6. There had been no hospital acquired grade 3 pressure ulcers with lapses in care in March 2021. SR noted that reducing pressure ulcers was a quality improvement objective for 2021/22 and a thematic review was due to be presented to Quality Committee.

5.2.7. VTE reporting remains suspended due to COVID.

5.2.8. HSMR (April to February 2020/21) is 96.1.

5.2.9. The report was noted.

5.3. **Operational Indicators**

5.3.1. RC presented the update on operational performance.

5.3.2. Performance against the 62-day cancer standard was above the target of 85.0% in month (April 2021) at 86.1% and YTD was 86.1%.

The 31-day target was achieved in April 2021 with 99.1% performance in month against a target of 96% and YTD was 99.1%.

5.3.3. The Cancer 2 week wait rule performance in April 2021 was 86.5% in month and 86.5% year to date against a target of 93.0%. (Performance in March was 96.9%). This had been discussed at Finance & Performance Committee and at Quality Committee and it was noted that Breast Cancer is a particularly pressured area. However, all referrals were seen within 28 days, which is the new faster diagnosis standard and the 62 day pathway performance remained above target.

5.3.4. RC reported on the significant increase in Emergency Department (ED) attendances in May, compared with April 2021. There was another in-month increase, with the average daily attendance at 362, from 352 in April and 325 in March. Numbers had reached as many as 440/450 on some days. The high numbers of GP and UTC referrals was highlighted. Total attendances for May 2021 were 11,525, which is the busiest month on Trust record.

5.3.5. Accident and Emergency (A&E) 4-hour performance for May was 80.7%, YTD 81.7% (all types mapped).

5.3.6. There were 2,888 ambulance conveyances in May and the average ambulance turnaround time was 30 minutes, achieving the standard.

5.3.7. St Helens community nursing referrals showed a slight increase in May. The discussion in Quality Committee on capacity was recalled, and assurance given that the case load is continually monitored to ensure the appropriateness of the referrals and individual caseloads. The level of bed occupancy is rising; therefore, it was noted that a push on discharges is required and this will impact on the referrals to community nursing.

5.3.8. The average number of super stranded patients in May was 89 (compared with 102 in April). Work is ongoing with all system partners to improve the current position to maintain optimum patient flow.

5.3.9. The referral to treatment (RTT) performance in April was 71.0%, YTD 71.0%, against the target of 92%, and the 6-week diagnostic waiting time performance in May was 75.2% against the target of 99%. There were 1345 over 52-week waiters for elective procedures. RC reported that this

had significantly improved during June, with long waiters now down to fewer than 1,000.

5.3.10. RF commented that he was concerned by the continued increase in ED attendances and asked if these numbers could be caused by the difficulty in people obtaining GP appointments. RC explained that there are various reasons, which include an increase in acuity of patients, the lack of alternative services and the difficulty in getting a face to face appointment with a GP. He clarified that primary care was also reporting increased demand and that all capacity was being utilised. Where patients cannot access the care they need, the default position is to attend ED where they know they will be seen. So far, the Trust had managed well, but this was becoming increasingly challenging. A local St Helens GP had visited ED recently, and agreed that 30-50% of presenting patients should have been seen by primary care. RC reported that there is now joint work to agree a deflection process to get appropriate patients back to primary care.

5.3.11. JK commented that there had also been a detailed discussion at the Finance and Performance Committee where members had been assured that the Trust was actively working with system partners and exploring all options to improve the situation.

5.3.12. RF commented that he was pleased to hear about the joint working and hoped the agreed process would be adopted across primary care.

5.3.13. The report was noted.

5.4. **Financial Indicators**

5.4.1. NK presented the update on financial performance.

5.4.2. He explained that the Trust's financial plan has been finalised for the first 6 months of the year, referred to as H1. The Trust plan is for £247m of income expenditure, giving a breakeven position overall. NK praised the organisation for overachieving on delivery against the elective care recovery plan in the first quarter, which had resulted in the Trust earning additional income from the Elective Recovery Fund (ERF), thus enabling the Trust to achieve this financial position.

5.4.3. A full financial settlement for October to March, referred to as H2, has yet to be agreed.

5.4.4. Month 2 had reported a breakeven position, in line with the Cheshire and Merseyside system plan for H1.

5.4.5. There had been £1.3m expenditure on agency staff, which included 0.05m agency costs for COVID and £0.2m for the Mass Vaccination Centre.

5.4.6. NK stated that CIPs had been achieved to date, but he highlighted that these need to be recurring savings.

5.4.7. There were no issues with capital, and the cash balance at the end of Month 2 was £57.1m

5.4.8. RF felt that the Trust approach to the management of CIP was a reason for its successful delivery. He noted that these are achieved consistently year on year and reflects the excellent staff engagement and ownership of CIP.

5.4.9. RF remained concerned about the ICS financial regime where all Trusts share the system risk, if a single organisation could not deliver. NK clarified that the Directors of Finance continued to discuss how this would work in reality, as trusts retained individual responsibilities for their financial position alongside the collective responsibility to the system. NK was also concerned that in the current planning assumptions there was no recognition of the increased demand for urgent and emergency care, which remained under block payments based on 2019/20 levels of activity.

5.4.10. RF expressed his support of the ICS but agreed that individual trust responsibility must be taken on board.

5.4.11. The report was noted.

5.5. **Workforce Indicators**

5.5.1. AMS presented the update on workforce performance and noted the context the pandemic still had on the data.

5.5.2. In May overall sickness was 5.7% which is a 0.2% increase from April. Nursing, Midwifery and HCA absence was 8.4% which is an overall increase of 0.6% since April. AMS reported that the figure includes COVID 19 sickness, but not COVID 19 absence reasons for staff in isolation, etc. She reported that in the past week there had been a significant increase in the number of staff absent for COVID 19 related reasons, which reflected the increase in community prevalence of the delta variant.

5.5.3. Appraisal compliance is below target at 49.6%. An appraisals 'window' has been introduced to allow completion up to the end of September 2021 for Bands 6 and above. Mandatory training compliance remains below target as 75.1%. Compliance for both has fallen slightly in month, in part due to the availability of staff.

5.5.4. GB enquired about the impact of schoolchildren having to isolate on staff who were parents. AMS noted that these absences are coded as COVID related, and this is increasing. AMS noted the challenge this presents and reported that this represents an additional 1.5% on top of sickness absence for the month; thereby total absence is 7.5%, which is very difficult to manage operationally.

5.5.5. GB and LK both acknowledged the difficulty this presents. It was noted that the school holidays begin in three weeks' time, and therefore there may be some improvement.

5.5.6. AL commented that FFP3 masks had been a recent news topic, noting that they were reported as offering better protection for staff. He enquired whether all staff members were supplied with FFP3 masks.

5.5.7. SR described the two types of masks used by Trust staff and explained the differences. SR outlined the fit-testing procedures are necessary for FFP3 masks and confirmed that these masks are already used by all staff members undertaking aerosol generating procedures with patients. All staff had access to the appropriate PPE for the roles they were performing.

5.5.8. AM reported that this was a regular discussion at Executive Committee meetings, and assured Board members that all IPC guidance is rigorously adhered to.

5.5.9. RF thanked VD for her attendance at the recent Chairs' meeting. She had reported back that there was a 60% increase in COVID cases in Merseyside. VD commented on the rapid spread of the Delta variant, particularly in younger people in Liverpool. She commented that therefore this would impact on Trust staff. She enquired about regular testing of staff members.

5.5.10. AMS confirmed that regular staff testing is available using the LAMP tests, but take up is not as high as it could be. Executive members had debated in their recent meetings how to give some impetus to this. It was acknowledged that absences are likely to continue to rise in line with community infection rates as they have done previously. At the current time the Test and Trace rules meant that staff still had to isolate even if they had been wearing PPE and undertook twice weekly testing, although it was hoped there would be some new guidance on this for doubly vaccinated staff, following research that had been undertaken with some pilot trusts.

5.5.11. AMS fed back on a question posed at Quality Committee about staff working from home. During shielding there had been hundreds of staff who could not come to work or had to exclusively work from home, but since shielding ended, these staff had returned to work. She reported that there are also thousands of staff members who are currently 'agile working' to maintain social distancing. The Trust is in the process of providing managers with a 'tool-kit' to help them support workers who are agile working, and there is a project in place to assess the benefits of formalising the principles to continue post pandemic. It was noted that this is work in progress.

5.5.12. RF agreed that this flexibility will help staff to feel valued.

5.5.13. AL commented that it is clear to see that the staff at the Trust are cared for as well as the patients.

5.5.14. The report was noted.

6. Committee Report – Executive – NHST (21)035

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

6.2. No business cases had been considered during May.

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

6.4. Approval had been given to the extension of temporary procurement support staff to assist with the stock management and distribution of PPE as a result of the pandemic.

6.5. AM highlighted the focus on maternity KPIs following the recommendations of the Ockenden report, this report had subsequently been presented for assurance to the Quality Committee, as reported in the Chair's assurance report in May.

6.6. AM described the very positive feedback received from stakeholders to the 2020/21 Quality Account. Stakeholders had noted the achievements despite the impact of the pandemic and had appreciated the openness and transparency of the organisation.

6.7. The good progress made on the patient pathway programme was noted, with advancement being made to complete the patient reviews and ensure continued surveillance.

6.8. The Executive Committee had received the report of the investigation into the unexpected increase in Hospital Standard Mortality Ration (HSMR) in April, which had identified that there had been a reporting error which meant the patient comorbidities had not been factored into the national system. This had now been resolved and the HSMR figure has returned to its expected range.

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

6.10. JK enquired if there was an update on the Community Diagnostic Hub. RC confirmed that the Trust had submitted its application and had received the green light to be in the first of the early adopters. This is now set up to commence in early July; however, there are some concerns around availability of workforce. Work is ongoing with Cheshire & Merseyside to look at 'HR passports' to staff the hub from across the system.

6.11. JK thanked RC for the update and noted that he was assured that the Trust was working so hard to reduce the diagnostic backlog.

6.12. VD enquired about the NHS net zero target and the potential financial impact of achieving it. NB reported that the Trust already had sustainability plans, working with its PFI partners and was on track to produce a net zero plan by January 2022. Examples of actions already taken to reduce carbon emissions included: having energy efficient buildings, the combined heat and power plant at Whiston Hospital, the provision of electric vehicle charging points, for which grant funding had been obtained, and switching to carbon neutral energy suppliers. She reported that the aim is to achieve this on a cost neutral basis, but the challenge over the forthcoming years was acknowledged.

6.13. AMS reported that there had also been discussion at Executive Committee about the Trust becoming an 'Anchor Institution'. This relates to the organisation being tied to the wellbeing of the local population it serves, reducing its environmental impact and supporting its local community. The Trust is exploring this and is looking to achieve a social value award.

6.14. VD was assured by the obvious progress that was already being made.

6.15. Following recent reports in the media, RF enquired about the availability of PPE supplies to meet requirements going forward. AM confirmed that the Trust procurement team had been very agile in their management of this, and as a result the Trust had not experienced any shortages of PPE.

6.16. GB asked about the Trust plans with the imminent lifting of legal COVID-19 restrictions and asked if there had been any guidance received from centre for healthcare settings. AM recounted the many discussions had about restricting visiting. The organisation has been generally risk averse to protect staff and other patients from contracting the infection; however, there was also a negative impact on the psychological health and wellbeing of patients if they were isolated from friends and family. No national guidance has yet been issued but from 19 July, the organisation will need to reconsider its approach to visiting and the other COVID-19 restrictions, such as social distancing and mask wearing, depending on the government's approach. AM commented that these decisions would be easier when younger adults have also received both doses of the vaccine.

6.17. RF was concerned about the expectations of the public and acknowledged that changes in behaviour could lead to an increase in nosocomial infections within hospitals after 19 July. He felt the health and social care sector should retain many of the current restrictions for the protection of both staff and patients, and if there was no national guidance the Trust would need to take its own view based on the risks locally.

6.18. AL commented that some high-profile national figures, including politicians had been photographed at recent events without face covering, and he felt this set a poor example for the public.

7. Quality Committee Chair's Assurance Report – NHST (21)036

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

7.2. GB noted that safety culture questionnaire in theatres had been reopened to ensure wider representation of views from all staff groups.

7.3. Further work had been undertaken to improve performance figures in sending electronic discharge summaries from ED/SDEC.

7.4. The committee had received assurance that contact was maintained with patients on waiting lists, including information provided to GPs on the length of time patients would have to wait for routine appointments, as the Trust tried the reduce the backlog of activity caused as a result of the pandemic.

7.5. Assurance was also provided on the ongoing work with system partners to reduce the number of super stranded patients and support timely discharge from hospital.

7.6. GB reported on the positive feedback given to Critical Care from the Intensive Care National Audit and Research Centre (ICNARC), relating to Trust research recruitment and good outcomes.

7.7. RPJ noted that consideration has been given to a dedicated research facility at the Trust with Liverpool Universities. RF asked that the report be circulated to all Board members.
Action: NB

7.8. GB also highlighted the positive independent assurance report from MIAA in relation to the production of the annual Quality Account.

7.9. RF thanked GB and the team, noting the development of a separate strategic workforce committee but the importance of maintaining close links between workforce and quality committees because of the close interrelationship.

7.10. The report was noted.

8. Finance & Performance Committee Chair's Assurance Report – NHST (21)037

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

8.2. JK noted that the committee had reviewed the operational and financial metrics in the IPR. He reported that the improvement plans for urgent care pathways will be brought back to committee when approved.

8.3. JK noted that even though some appraisals are delayed, he wanted to point out that staff members are being contacted by their managers and supported. He felt that AMS' teams had done a splendid job of supporting staff under very difficult circumstances.

8.4. JK confirmed that committee members had been assured by the report provided on cancer performance by RC, particularly the challenges for the Head and Neck and Breast Cancer pathways.

8.5. Committee had received a report on the Clinical Support Services Care Group CIP schemes, and progress to date. A high proportion of the schemes were expenditure reductions, which JK noted was very encouraging.

8.6. RF commented on the meeting attendance list at the beginning of the report. He stated that it was very informative and should be rolled out on all committee chairs' assurance reports going forward. **ACTION: NB**

8.7. The report was noted.

9. Audit Committee Chair's Assurance Report – NHST (21)038

9.1. IC presented a summary of the key issues discussed at the Audit Committee meeting in June.

9.2. IC reported that the meeting delivered full assurance, with items reassuringly dependable. He recognised that this is because the organisation is doing so well.

9.3. IC reported that the committee had received the annual meeting effectiveness review report and it had been noted that attendance at all the Board committees had been satisfactory during 2020/21.

9.4. RF commented that he was assured by the report and encouraged by the meeting effectiveness review feedback.

9.5. NK updated members on progress with the roll out of the electronic Conflicts of Interest Register, which has been well received.

9.6. The report was noted.

10. Charitable Funds Committee Chair's Assurance Report – verbal

10.1. PG provided a verbal update to members on key issues discussed at the committee meeting in June. He reported that it had been a very positive meeting.

10.2. PG reported spending commitments and the plans for the grants received from the NHS Charities Together.

10.3. The challenges to fund raising in the last year due to the impact of COVID were noted. The monies received from the Captain Sir Tom Moore Foundation via NHS Charities Together had made a huge difference, enabling sufficient funds to compensate for the current downturn in income from the usual programme of activities.

10.4. PG updated members on forthcoming events and opportunities. He reported on the positive inroads being made with local businesses and schools.

10.5. PG reported that the committee was in the process of appointing an auditor for the charitable fund accounts for 2020/21.

10.6. PG reported the need for a refreshed membership of the committee to involve more clinical staff, following the retirement of the clinical and operational manager representative. NK confirmed he has asked for expressions of interest.

10.7. RF commented that the Charitable Funds Committee is very well monitored and chaired by PG. He expressed gratitude to Captain Sir Tom Moore and noted that he would be remembered for his strength and generosity to the NHS.

10.8. NB noted the clash of dates had caused a delay with the written committee report but will ensure that this is circulated to members after the meeting. **Action: NB**

11. Fit and Proper Persons Regulations – NHST(21)039

11.1. RF noted the importance of the item, which was to provide assurance that the Trust Board has met the requirements of the CQC Fit and Proper Persons Regulations.

11.2. RF thanked the HR team for supporting him to undertake the annual reviews for the declaration and confirmed that all Directors' fit and proper persons status had been reviewed.

11.3. It was noted that Val Davies should be recorded as the Trust Deputy Chair.

11.4. The annual declaration was approved by Board members.

12. CNST Maternity Incentive Scheme Year 3 - Trust Board declaration – NHST(21)040

12.1. SR presented the report to provide assurance that the Trust had met the 10 CNST maternity safety actions for 2020/21 to qualify for the Maternity Incentive Scheme discount. This is the third year of the scheme, and the completed Board declaration must be submitted by 15 July 2021.

12.2. SR reported that the 2020/21 scheme had been relaunched in October 2020, and the criteria were revised again in January and March 2021.

12.3. SR confirmed that the Trust had met the criteria to declare it had achieved all 10 actions; however, she required members to approve the relating neonatal workforce action plan which has been compiled in agreement with the Cheshire and Merseyside Neonatal Operational Delivery Network (ODN). The action plan details the Trust plans to achieve a dedicated doctor for evening rota cover, to meet the recently changed BAPM standards. A post is currently being advertised, and the ODN are satisfied that the standards will be met within the next two years, which are the maternity incentive scheme criteria. SR assured members that the neonatal service was safe currently, as a paediatrician was always available, but they were not solely dedicated to the neonatal unit.

12.4. The Board approved the neonatal workforce action plan

12.5. LK commented that she was aware from her role as maternity champion that a huge amount of work that had gone into achieving the CNST safety actions. She enquired whether SR had enough operational management support within the service.

12.6. SR confirmed that there is currently a vacancy for the Head of Midwifery (HOM) position. Recent recruitment had resulted in a candidate being offered the position, but they had subsequently withdrawn, and the post was being re-advertised. In the meantime, SR confirmed she was being supported by colleagues.

12.7. SR summarised the evidence that supported the declaration of achievement of the 10 safety actions.

12.8. LK commended SR and the maternity team on this achievement given the challenging circumstances during 2020/21.

12.9. In response to a question from IC, SR confirmed that the CNST maternity premium discount was 10% and had a value to the Trust of c £400k.

12.10. The report was noted, and the Board approved the maternity incentive scheme declaration.

13. Learning lessons to improve people practices – NHST(21)041

13.1. AMS outlined the reasons for recent changes to the NHS's disciplinary policies. A member of staff at an NHS trust in London had taken his own life whilst the subject of a disciplinary procedure. The investigation that followed had identified many shortcomings in the processes in place. As a result, a national advisory group had been established, and their findings shared with other NHS organisations to improve people practices with regard to disciplinary processes.

13.2. Local review had resulted in changes to the Trust's internal processes and the revision of the Trust's disciplinary policy. AMS outlined the review pathway undertaken, noting the involvement of lots of stakeholders including staff who had been through the disciplinary process, staff side colleagues and managers. She expressed her gratitude for the positive way that everyone had approached the review and the level of engagement in the symposiums that had taken place across the organisation.

13.3. AMS reported that the language now used in the new policy is more inclusive with an emphasis on fairness and openness, and it embraces the philosophy of a Just and Learning Culture. The link to the Trust's ACE behavioural standards has also been strengthened.

13.4. AMS outlined the key principles of the new policy for members. She pointed out that the introduction of a 72 hour pause process is one of the important changes. She confirmed that a legal view of the revised policy has also taken place to ensure that it is fit for purpose and continues to meet the ACAS Code of Practice.

13.5. LK was aware that investigations could be very time consuming and asked if AMS felt the Trust had sufficient capacity to undertake these in a timely way. AMS confirmed that the capacity of managers and the HR service was a concern, and a business case is being prepared for additional funding to support this. However, she hoped that as a result of the new policy there would be fewer cases progressing to formal investigation

13.6. Having Board oversight is one of the national review recommendations, and LK as workforce champion, is fulfilling this role through her involvement with the workforce scrutiny group. LK is also supporting the development of a Board assurance report going forward. AMS confirmed that the new Strategic Workforce Committee will also have a role in providing assurance to the Board.

13.7. VD recognised the length of time investigation can take and asked if there were any national standards or benchmarks, so that the Trust could monitor its own performance.

13.8. AMS explained that there is currently no national benchmarking, but she expected that as a result of these recommendations this would start to be benchmarked and monitored nationally.

13.9. IC asked if the new Trust policy would also be used for Lead Employer staff. AMS confirmed that it would, and that specialist training will be necessary for everyone involved in the process, including for NEDs who are assigned Lead Employer cases.

13.10. RF was very supportive of the changes that the Trust was making to improve the disciplinary process and commended AMS on an excellent report.

13.11. The report was noted, and the proposed Board level oversight reporting arrangements were approved.

14. Effectiveness of Meeting

14.1. RF asked AL and ST for their comments on the effectiveness of the meeting.

14.2. AL commented that he felt it had been an outstanding meeting. He noted that all directors were able to respond to any questions posed straight away, with no forewarning. He considered that this was the sign of a great organisation.

14.3. AL also commended AMS on her report, and the way in which the Board had embraced the openness and transparency of the new disciplinary process.

14.4. ST thought that the structure of the meeting had been excellent and felt there was learning he could take back into his own organisation. He echoed the comments of AL on the openness and transparency, and the time for questions and debate.

14.5. ST commented that he was pleased to note that the Trust had a BAME action plan.

14.6. RF noted that he always marked up the papers before the meeting, with the questions he wanted answers to, and inevitably NED colleagues always raised the same questions before him. This offered him assurance that the NED team were doing their job.

14.7. RF thanked AL and ST for their comments.

15. Any Other Business

15.1. VD asked why there had not been a patient story this month. NB confirmed that in accordance with the agreed Board work plan, patient stories come to Board six times a year, in the months when Public Board is not followed by a Strategy Board meeting. There had been a patient story in May and the next one will be in July.

15.2. RF thanked VD for undertaking Chair's events on his behalf.

15.3. RF thanked AM and the Executive team for their ongoing efforts.

16. Date of Next Meeting

16.1. Wednesday 28 July 2021 at 0930

Chairman: ……

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 28 JULY 2021

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **Deferred due to COVID-19**	NB/NK	**TBC**
36	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **Deferred due to COVID-19**	AM	**TBC**
37	26.05.21 (14.4)	AMS and NB to develop draft ToR and an annual work plan for the newly created Strategic Workforce Committee for consideration by the Board in July, with the consequent changes to the Quality Committee ToR and annual work plan	AMS/ NB	**28.07.21**
38	30.06.21 (7.6)	NB to circulate the ICNARC report on research outcomes to members	NB	**28.07.21**
39	30.06.21 (8.6)	NB to amend Committee Chair's assurance report template	NB	**28.07.21**
40	30.06.21 (10.8)	NB to circulate the Charitable Funds Committee Chair's report to members	NB	**28.07.21**

HR Indicators Report

- New report format focusses on key themes from NHS People Plan and HR Strategy:
  - **Responding to new challenges and opportunities** – working differently, smarter
  - **Looking after our people** in particular actions to keep our people safe, health and well both physically and psychologically
  - **Growing for the future** – in particular building on interest in NHS careers, working to developing, strengthening and retaining our workforce
  - **New ways of working and delivering patient care** – in terms of workforce this relates to making effective use of our workforce skills, learning and experiences
  - **Belonging in the NHS** – highlighting the support and actions our workforce need to create and feel part of a compassionate culture that we all feel we belong to
- Outlines workforce activity; highlighting success, risks and progress updates during the Covid-19 Pandemic and since Board received the previous HR Indicators Report in July 2020

Responding to new challenges

Learning from Covid-19

Restoration & Reconnection

Use of Technology

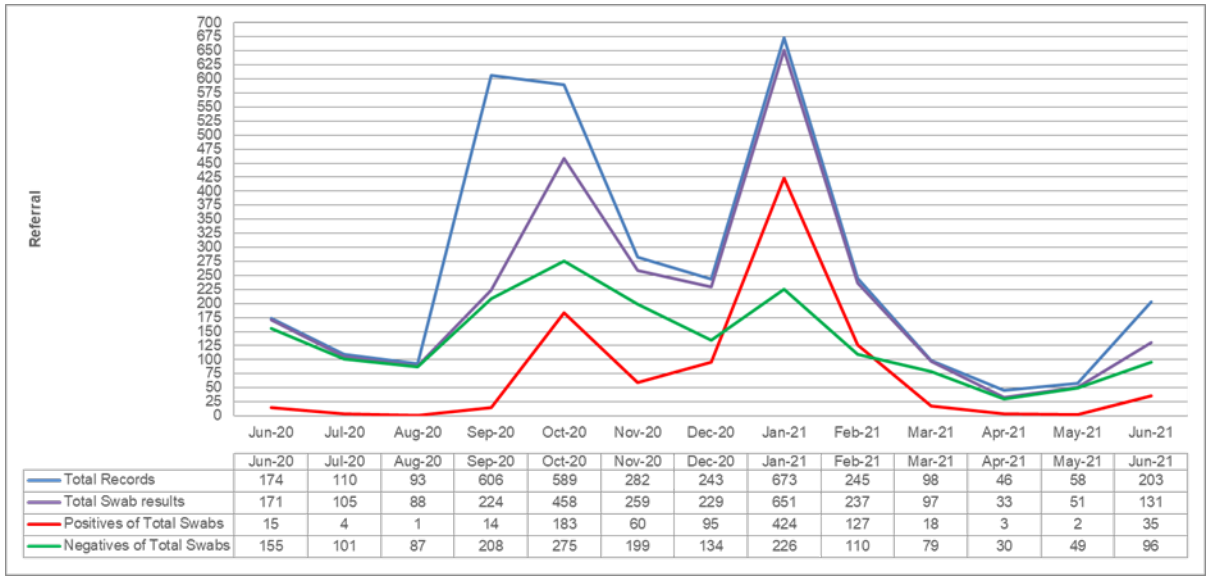
- 197 attendances at Virtual Welcome
- Virtual interviews and assessment centres
- Virtual pre-employment checking
- Virtual HR meetings & hearings

Redeployment Hub

Month	Staff redeployed	Of which deployed to ICU
October	39	14
November	47	34
December	51	3
January	101	48
February.	170	63
March	102	34
April	29	0
May	16	0

Self-Isolation Hub

Statistics June 2020 – June 2021:	
Number of referrals	3,420
Number of swabs taken	2,734
% positive PCR result	36%



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Total Records	174	110	93	606	589	282	243	673	245	98	46	58	203
Total Swab results	171	105	88	224	458	259	229	651	237	97	33	51	131
Positives of Total Swabs	15	4	1	14	183	60	95	424	127	18	3	2	35
Negatives of Total Swabs	155	101	87	208	275	199	134	226	110	79	30	49	96

HR Indicators report

Responding to new challenges

Progress to Date

- Restoration workshops focus on values, behaviours and experiences during Pandemic garnering positive feedback
- Establishment of self-isolation hub to provide essential support to staff as well as maximising available resource by aiding swift return to work where possible
- Covid-19 Staff Redeployment Hub supported the deployment and re-deployment of staff following risk-assessments, shielding and the requirements for new services
- Maximisation of technological advancement to offer virtual interviews, pre-employment checks, staff meetings, virtual welcome. Technology has aided staff wellbeing including reduction of isolation for those self-isolating or working virtually

Areas of Risk and Mitigation

- Deep dives into sickness, support for self-isolating staff and acceleration of recruitment to key posts continues to ease operational pressures in the hospitals

Progress Highlights

- Volume of activity managed during Pandemic, particularly during peaks in demand and within context of rapidly changing landscape

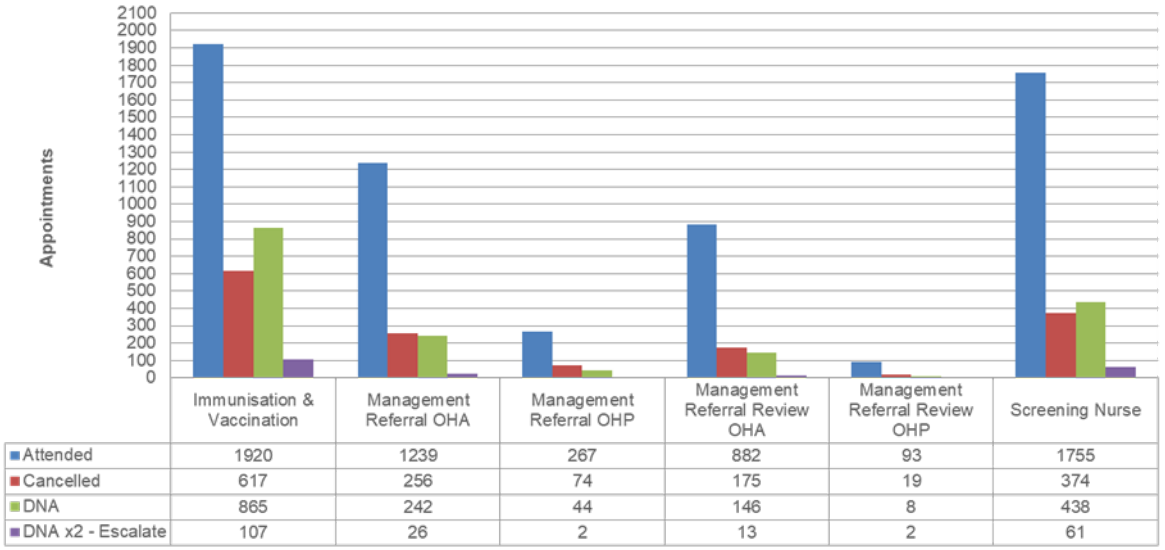
Work in Progress with estimated completion date/s

- Self-Isolation hub deployment extended to support current operational demands until March 22 dependent on need
- Virtual approaches to induction and core mandatory training continue with lessons learned from Pandemic established for reset and recovery
- Staff redeployment hub stepped down in May 2021

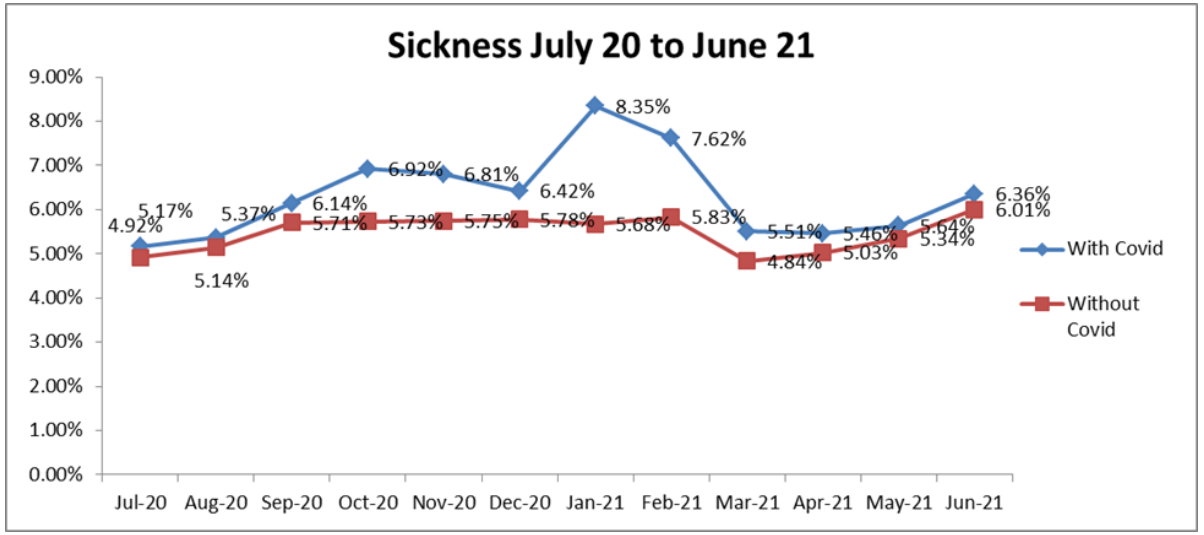
NHS People Plan

Looking after our People

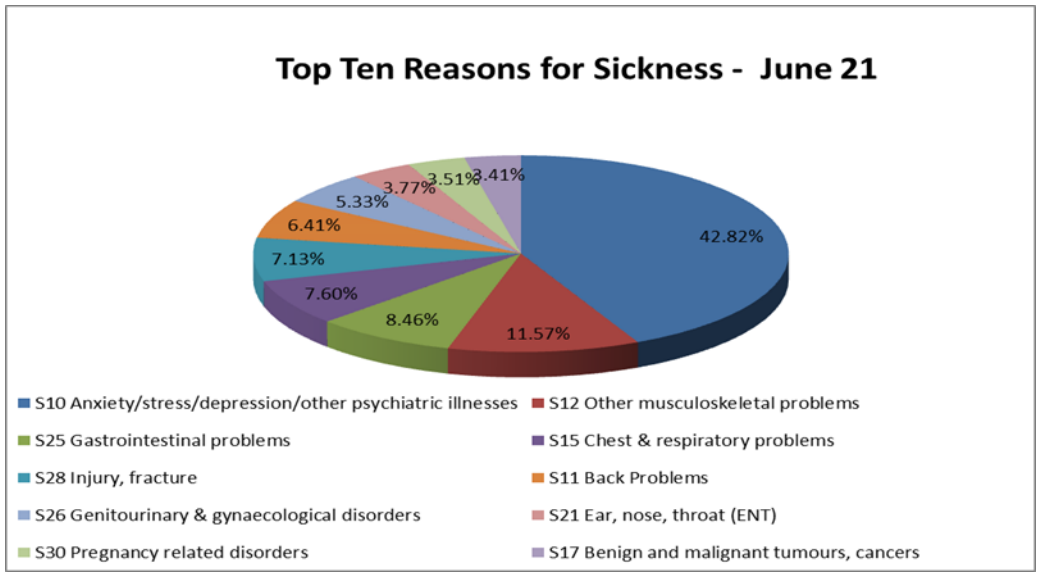
July 2021



	Immunisation & Vaccination	Management Referral OHA	Management Referral OHP	Management Referral Review OHA	Management Referral Review OHP	Screening Nurse
Attended	1920	1239	267	882	93	1755
Cancelled	617	256	74	175	19	374
DNA	865	242	44	146	8	438
DNA x2 - Escalate	107	26	2	13	2	61



Excluding Covid Sickness	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Clinical Support Services	5.11%	5.35%	5.41%	5.31%	6.00%	5.50%	4.98%	5.05%	4.57%	4.63%	5.00%	5.23%
Community Services	4.35%	5.60%	6.51%	6.18%	6.74%	6.69%	7.00%	8.32%	7.15%	7.78%	8.01%	8.41%
Corporate Services	2.37%	2.50%	2.87%	3.09%	2.46%	2.95%	2.26%	2.17%	2.55%	2.76%	3.05%	3.54%
Medical Care Group	4.69%	4.76%	5.18%	5.25%	5.70%	5.61%	5.92%	5.92%	4.44%	4.67%	5.63%	5.90%
Medirest	9.13%	8.59%	9.23%	10.36%	9.57%	11.51%	11.05%	10.02%	9.84%	8.50%	7.11%	9.83%
Non-Clinical Support	0.00%	0.00%	2.99%	3.62%	3.58%	3.50%	4.29%	5.25%	3.50%	5.25%	3.50%	3.50%
Surgical Care Group	6.10%	6.22%	7.23%	7.10%	6.50%	6.54%	6.59%	7.07%	5.40%	5.71%	5.54%	6.77%
Grand Total	**4.92%**	**5.14%**	**5.71%**	**5.73%**	**5.75%**	**5.78%**	**5.68%**	**5.83%**	**4.84%**	**5.03%**	**5.34%**	**6.01%**



	Performance					
	first dose	second dose	total this period	total last period	YTD	National Position
Flu Vaccination			95%	93.90%	95%	2nd
Covid-19 vaccination (all)			91.90%		91.90%	
Covid-19 vaccination (pt.facing)	91.42%	85.90%	91.34%		91.34%	
Covid-19 vaccination (BAME)			89.98%		89.98%	
Covid-19 vaccination (BAME pt. facing)			89.83%		89.83%	

NHS People Plan

Looking after our People

July 2021

Wellbeing Hub Bespoke Sessions or Events July 2020 - June 2021		
77 sessions, 669 attendees delivered by face to face sessions (booked and drop-in) and video calls (booked and drop-in)		
Agendas	**Reasons**	**Areas of Work**
Crisis Management Listening Events Resilience Sessions Mindfulness Sessions Men's health Time to Talk Tai Chi Menopause Café COVID-19 Suicide and Bereavement Pause space Self-care Agile working Relaxation Sleep hygiene Voices against domestic violence Walk challenge Smoke free Wellbeing champions MHFA start the conversations	Targeted Events COVID-19 Suicide and Bereavement Stress, Anxiety and Depression PTSD Working environments and exposures returning to work	Trust Wide ICU/ED Remote Workers Community Services HR / L&D COVID-19 Wards and Areas Corporate Services (Alex Park)

On a Scale of 1-10 how did you feel (1=Struggling and 10=Fantastic)	
Before the session - Average	**After the session - Average**
5.5	8

The staff wellbeing network has been brought together to create a comprehensive support service for staff across all areas of the organisation. This offer has been recently rebranded to help staff and the Trust easily identify the support available. The brand name; "The Wellbeing Hub" with a supporting strapline "Working Well | Living Better" gives clear indication in what the wellbeing network sets out to achieve. The following areas of the staff wellbeing network are detailed below, including a provisional infographic representing the network:

The Wellbeing Hub
Working Well | Living Better

Wellbeing Hub Referrals (only) July 2020 - June 2021			
Support	**Total Appointments**	**Appointment Utilisation**	**COVID-19 Related**
Counsellor	1,158	95%	22%
Mental Health Nurse	518	85%	30%
Psychologist	517	90%	25%
EAP (Local)	192		
Physiotherapy	225		
Totals	**2,610**	**90% (average)**	**26% (average)**

HR Indicators report

Looking after our people

Progress to date

- Wellbeing guardian appointed April 2021 as check and challenge within context of compassionate workplace culture
- 9625 formal HWWB appointments July 20 to June 21 to support staff (excludes wellbeing hub and pre-employment)
- 2472 pre-employment screens processed; 65.8% of new starters deemed fit to practice full duties and 19.6% needed workplace adjustments
- Efforts continue to reduce levels of sickness absence including key principles agreed with Staffside extended to 31st December 2021. Principles were adopted following the national pause in absence management during April –June 2020
- The Wellbeing Hub has been successfully established including active staff networks, wellbeing champions and bespoke sessions available to support staff to bring their best selves to work. Appointment utilisation is 90% with staff reporting positive impacts following attendance at sessions using the wellbeing scale.

Areas of risk and mitigation

- 10.1% DNA rate for formal HWWB appointments (excludes wellbeing hub and pre-employment). Staff offered reminders and line managers notified in event of DNA
- The highest sickness reason in June 2020 was Chest & Respiratory problems.
- Stress & Anxiety is highest reason for sickness from Jan 21 with 31.96% of all sickness, and 44.82% of all sickness in June 21

Progress Highlights

- It has been recognised nationally that the North West deprivation index appears to be impacting on sickness levels and further research into this matter will take place across the region supported by NHSE/I in the coming months
- StHK sickness levels benchmark favourably across Cheshire and Merseyside for June 21 at 6.36% including Covid-19 sickness. Other C&M Trust sickness including Covid-19 is up to 7%
- Benchmarking of StHK staff update of Flu and Covid-19 vaccinations against other Trusts is positive with 95% and 91.9% respectively. Efforts continue to encourage all staff to take the vaccine to protect patients, their families, colleagues and wider population.

Work in Progress with estimated completion date/s

- Wellbeing hub sessions continue with managers encouraged to release staff to attend
- Efforts to recover sickness absence position continue with deep dives taking place into key roles and sickness reasons to maximise productivity and accelerate support offer.

NHS People Plan

Growing for the future

July 2021

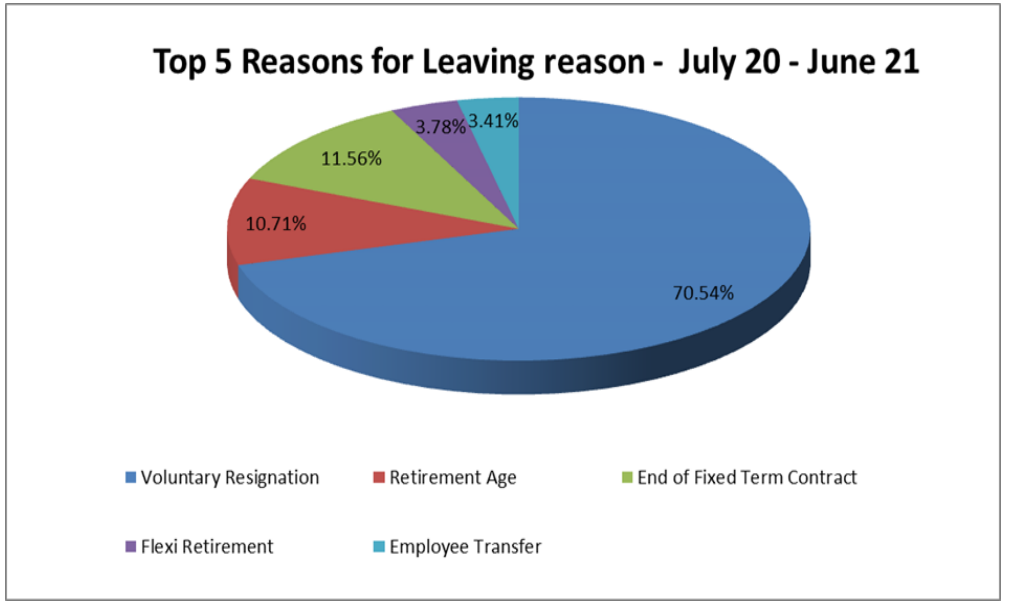
Turnover

Staff Group	01-07-2020 - 30-06-2021		
	Average FTE	Leavers FTE	%
Add Prof Scientific and Technic	99.44	9.07	9.12%
Additional Clinical Services	1169.51	133.45	11.41%
Administrative and Clerical	1285.64	137.05	10.66%
Allied Health Professionals	388.71	45.25	11.64%
Estates and Ancillary	294.58	18.64	6.33%
Healthcare Scientists	182.06	17.52	9.62%
Medical and Dental	504.49	105.53	20.92%
Nursing and Midwifery Registered	1728.28	224.32	12.98%
Grand Total	**5652.71**	**690.82**	**12.22%**

Reasons for leaving by Headcount

Staff Group	Employee Transfer	End of Fixed Term Contract	Flexi Retirement	Retirement Age	Voluntary Resignation
Add Prof Scientific and Technic		1.00		1.00	6.00
Additional Clinical Services	3.00	7.00	7.00	20.00	115.00
Administrative and Clerical	5.00	10.00	13.00	22.00	105.00
Allied Health Professionals		1.00		2.00	46.00
Estates and Ancillary				15.00	3.00
Healthcare Scientists				3.00	14.00
Medical and Dental	7.00	47.00	1.00	2.00	49.00
Nursing and Midwifery Registered	11.00		14.00	50.00	179.00
Grand Total	26.00	66.00	35.00	115.00	517.00

Care Group	Employee Transfer	End of Fixed Term Contract	Flexi Retirement	Retirement Age	Voluntary Resignation
409 Clinical Support Services L4		10.00	5.00	18.00	97.00
409 Community Services L4	1.00	2.00	2.00	15.00	42.00
409 Corporate Services L4	5.00	7.00	6.00	10.00	63.00
409 Medical Care Group L4	17.00	32.00	2.00	20.00	172.00
409 Medirest L4		0.00	0.00	14.00	1.00
409 Surgical Care Group L4	3.00	15.00	20.00	38.00	142.00
Grand Total	26.00	66.00	35.00	115.00	517.00

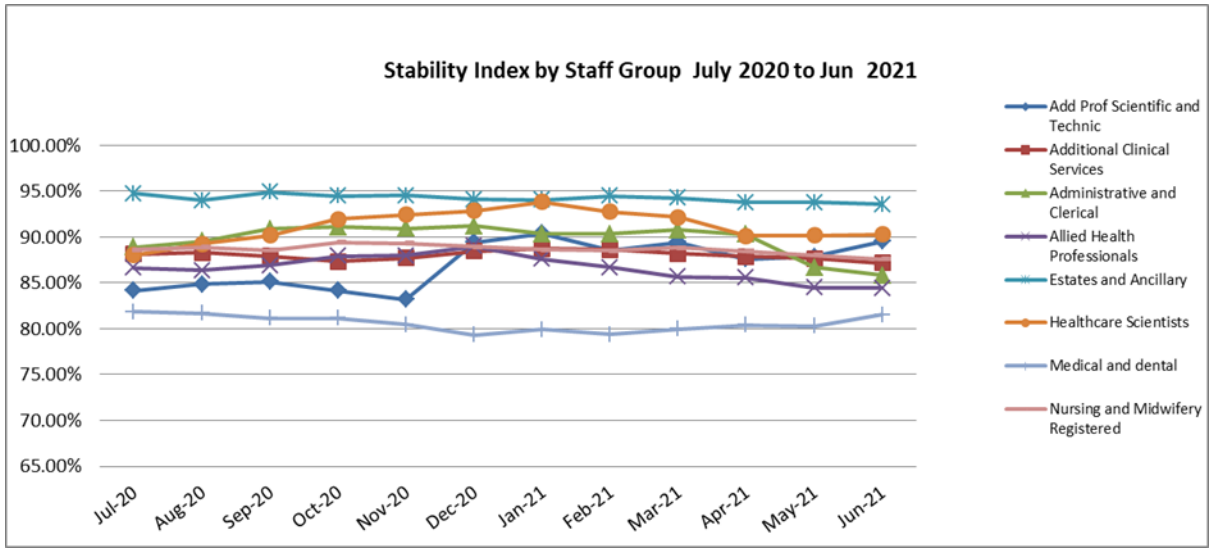


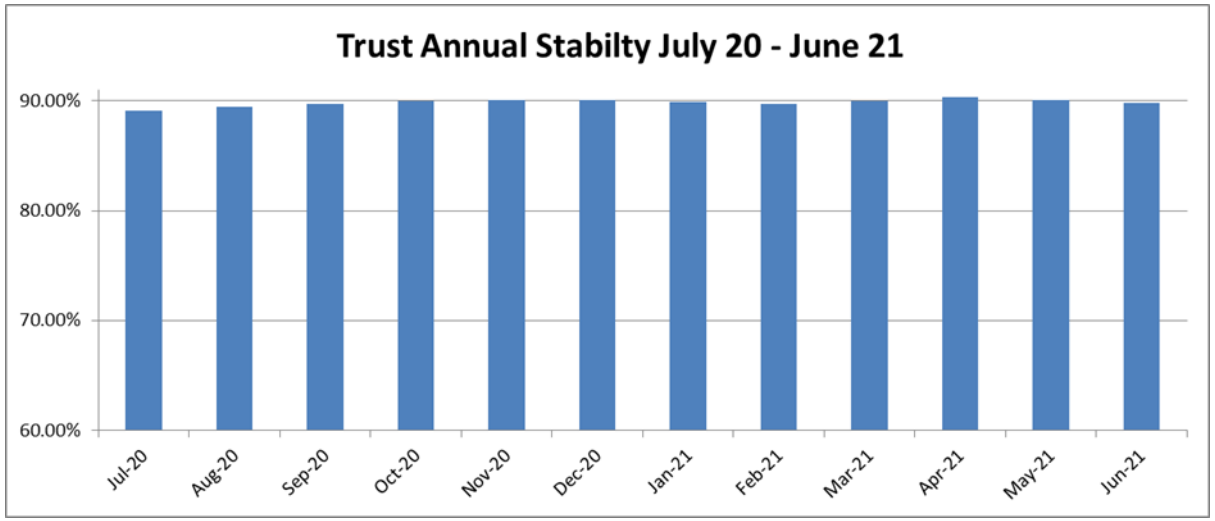
NHS People Plan

Growing for the future

July 2021

Age Band	Headcount	%	FTE
<=20 Years	26	0.39	25.63
21-25	491	7.45	470.33
26-30	775	11.76	728.90
31-35	814	12.35	734.88
36-40	763	11.58	673.42
41-45	673	10.23	590.19
46-50	824	12.50	743.68
51-55	925	14.03	813.10
56-60	759	11.52	608.19
61-65	413	6.27	292.74
66-70	100	1.52	63.23
>=71 Years	27	0.41	13.98
Grand Total	**6,590**	**100.00**	**5758.25**

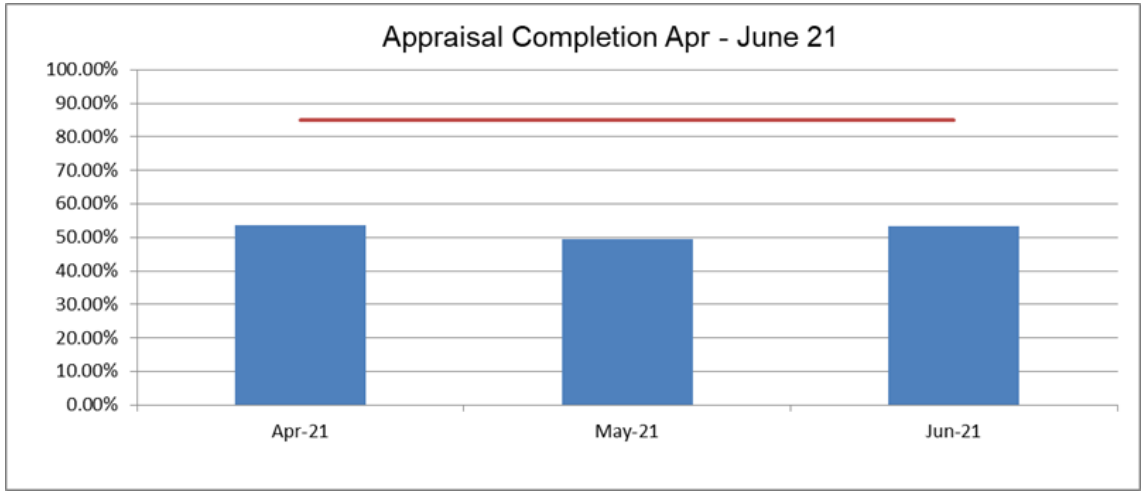


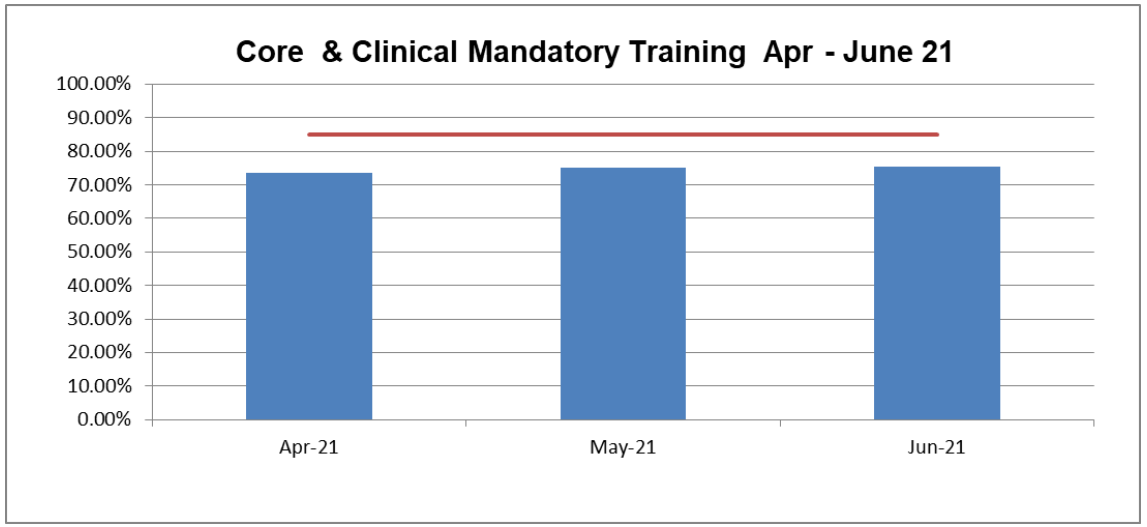


Internal transfer scheme

Stages	Overall Since re-launch (June 2020)
Confirmed Transfers	59
Waiting List	8
Undergoing checks	9
Not eligible for scheme	19
Withdrawn	15
Removed from waiting list	7
Total Transfer Request Forms	117

- To enable a transfer to be considered the following criteria must apply:
  - Registered Staff will have a minimum of 6 months post registration experience and have completed the Preceptorship Programme (as applicable)
  - Staff will be compliant in their mandatory training and appraisal
  - Staff will have a worked a minimum of 6 months in their current role
- Staff within rotational posts, where applicable, will not be able to utilise this scheme to leave their rotation early





NHS People Plan

New ways of working & delivering care

July 2021

The development and implementation of the **North West Doctors in Training Collaborative Staff Bank** - an initiative led by the Trust and Patchwork Health - is on track to transform NHS temporary staffing in the region. 18 Trusts are now fully onboarded onto the initiative, which is the largest of its kind, with others on track to join in the coming weeks.

NHS North West Collaborative Bank

HR Indicators report

Growing for the Future

Areas of Focus

- Mandatory training is now almost exclusively online and led by subject matter experts who are leading a recovery plan to meet compliance
- Appraisal paperwork has been overhauled and a pilot window has been introduced for band 6 and above staff as a test of concept
- Clinical Education has altered curricula and provision of either synchronous or asynchronous remote teaching dominating as a learning from the Pandemic
- Working with the North West Deanery, Schools of Medicine and Higher Education Institutes, the clinical education team are well underway in their recovery planning to ensure all learners are provided with appropriate education to mitigate any lost learning opportunities faced due to the pandemic
- Collaborative working and development of Academy approach across ICP
- The FTE stability index reports the percentage of employees who remain employed within a Staff Group within StHK within the July 2020 – June 2021 based on FTE

Areas of risk and mitigation

- It should be noted that both mandatory training and appraisals were suspended between March and September 2021 due to the pandemic
- the appraisal process was completely overhauled in 2020 and a new e-form piloted and then established in December 2020.
- Executive Committee approval of transitional programme to move to an appraisal window across the period 2021-23. Therefore the current compliance figure is not representative and is artificially low, the true figure will be available in October 2021
- Medical and Dental turnover percentages are influenced by trainee rotation so Board members are asked to take this into account when reviewing the data

Progress to date

- Development of Schwartz rounds across ICP to support staff post pandemic
- Mandatory Training compliance reporting is 75.6% with Appraisal compliance sitting at 53.5%
- Successful restoration and reconnection workshops provided to Trust staff post Pandemic
- Review of Trust behavioural standards underway

Work in Progress with estimated completion date/s

- Band 6 and above appraisal window open until end September 2021
- Recovery planning to recover position for trainee lost learning during Pandemic continues

HR Indicators report

Growing for the future & new ways of working

Areas of Focus

- Managing levels of turnover to maintain stability allows retention of key skills and experience whilst enabling provision of support to new talent
- Talent pipelines via international nurse recruitment, apprentice HCA's, widening participation, nurse apprentices, Advanced Practitioners all mitigate future workforce gaps within a pressured national landscape
- Strategic Resourcing collaboration with Education & Training and Corporate Nursing to support entry to health care careers including an Apprenticeship HCA position. Regional funding used to implement a 2-day training course for new staff alongside longer-term pastoral support
- Established offer of apprenticeships to band 2-4 staff continues with wide publication of opportunities via bulletins
- Model hospital turnover data benchmarks StHK favourably as at April 21, with StHK reporting 0.81% against the peer median of 1.02%

Progress to date

- 45 International Nurses were successfully appointed in the 2020/21 Financial Year
- 77 International Nurse recruits are planned for the current Financial Year with 18 Staff in Post 21/22 Year to Date
- The Trust is one of 12 NHS organisations working together as part of the Pan-Mersey International Nurse Recruitment Collaborative to source international nurses to fill vacancies.
- 18 Trusts signed up to the NW Lead Employer collaborative Bank for Doctors in Training, making the collaborative the largest and most successful of its kind

Areas of risk and mitigation

- External attraction to apprenticeship opportunities hampered by operational pressures and availability of support from experienced colleagues
- Medical numbers – because of trainee turnover levels

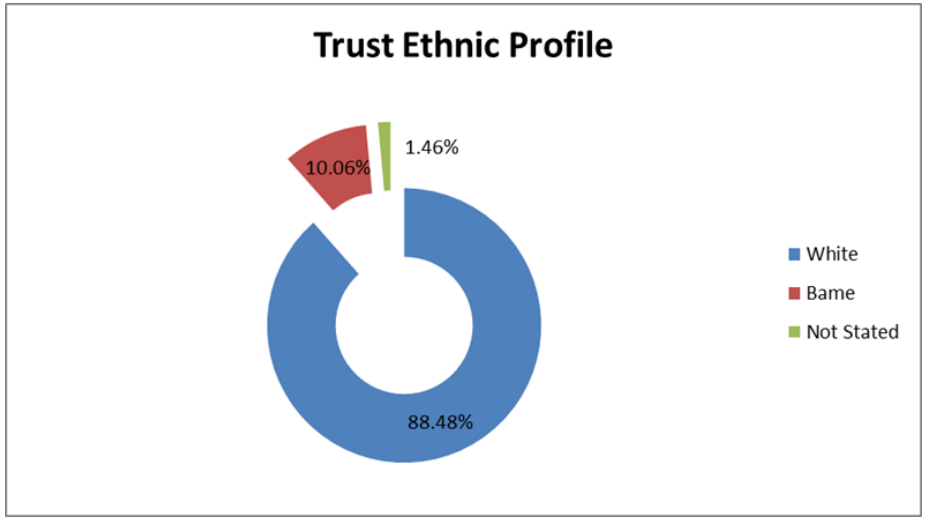
Work in Progress with estimated completion date/s

- Discussions are ongoing to develop retention strategy
- Opportunities to develop new roles and models of working continue including options to pilot single ward deployment of nurse apprenticeships to support development of new ways of working

NHS People Plan

Belonging in the NHS

July 2021



Disability Flag	Headcount	% Headcount
No	5,518	83.7
Not Declared	870	13.2
Prefer Not To Answer	2	0.0
Unspecified	8	0.1
Yes	192	2.9
Grand Total	**6,590**	**100.0**

Gender	Headcount	% Headcount
Female	5,393	81.8
Male	1,197	18.2
Grand Total	**6,590**	**100.0**

Vacancy Rate	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Staff Group	%	%	%	%	%	%
Add Prof Scientific and Technic	0.60%	-3.06%	0.00%	0.12%	0.00%	0.00%
Additional Clinical Services	4.76%	4.74%	3.81%	3.31%	3.31%	2.90%
Administrative and Clerical	3.84%	3.50%	2.51%	3.22%	3.42%	3.45%
Allied Health Professionals	-0.46%	0.04%	1.45%	0.85%	4.60%	3.89%
Estates and Ancillary	0.14%	-0.64%	0.00%	1.18%	0.68%	0.40%
Healthcare Scientists	9.24%	9.14%	9.65%	9.80%	8.29%	12.83%
Medical and Dental	6.70%	5.35%	4.00%	4.97%	5.12%	5.48%
Nursing and Midwifery Registered	4.82%	5.41%	4.25%	5.97%	6.83%	7.21%
Grand Total	**4.23%**	**4.07%**	**4.00%**	**4.16%**	**4.58%**	**4.77%**

Retirement Age 65

Staff Group	Retirements Due	Within 3 Months	Within 6 Months	Within 9 Months	Within 12 Months	Within 5 Years
Add Prof Scientific and Technic	1	1	1	1	1	6
Additional Clinical Services	52	58	66	70	74	195
Administrative and Clerical	52	56	61	65	70	170
Allied Health Professionals	4	4	6	6	6	10
Estates and Ancillary	35	38	44	47	51	120
Healthcare Scientists	7	7	8	8	8	11
Medical and Dental	10	14	14	14	16	35
Nursing and Midwifery Registered	29	31	33	35	36	123
Grand Total	**190**	**209**	**233**	**246**	**262**	**670**

Employment Relations

Closed Cases Oct 20 - June 21

Activity	Number
Employment Tribunals	6
County Court cases	2
Investigations	14
Fast tracks	27
Disciplinary	19
Grievances	15
Long term sick terminations	9

Current Cases as at end June 2021

Activity	Medical Care Group	Surgical Care Group	C&PC	Corp, CSSG and Medirest	Medical
Employment Tribunals	0	1	1	0	2
County Court cases	0	0	0	0	0
Investigations	14	0	2	3	5
Fast tracks	1	3	0	2	0
Disciplinary	1	5	0	4	0
Grievances	4	1	2	7	2

Our Values and Behaviours

HR Indicators report

Belonging in the NHS

Areas of Focus

- 10.06% of the Trust workforce is of Black, Asian and Minority Ethnic (BAME) origin which is favourable compared to the BAME communities of St Helens and Knowsley; 3.6% and 4.4% respectively
    - (Source - 2011 census information)
- 83.7% of the workforce do not declare a disability compared with 2.9% reporting a disability. 15.10% are undeclared or unspecified.
- Levels of turnover, vacancies, age profile and retire & return data informs OD activity and deep dives by Learning & Education colleagues and HR Business Partners
- The Trust ACE behavioural standards are under review with a new behavioural framework in draft form to foster a positive workplace culture where staff feel empowered, engaged and productive.
- Employee relations activity is monitored to ensure our organisational values are reflected to ensure provision of 5 star patient care
- Model hospital data benchmarks StHK favourably when reviewing nursing & midwifery based on March 21 data

Progress to date

- The Trust has reviewed its employee relations processes in line with Improving People Practices
- Employee Relations Oversight Steering Group established January 2020.
- Trust Disciplinary Policy redesigned to encourage informal interventions using 72 hour pause & reflect to encourage Fasttrack interventions
- ED&I strategic advisory group is working on a refresh to the strategy which is due to be launched Autumn 2021.

Areas of risk and mitigation

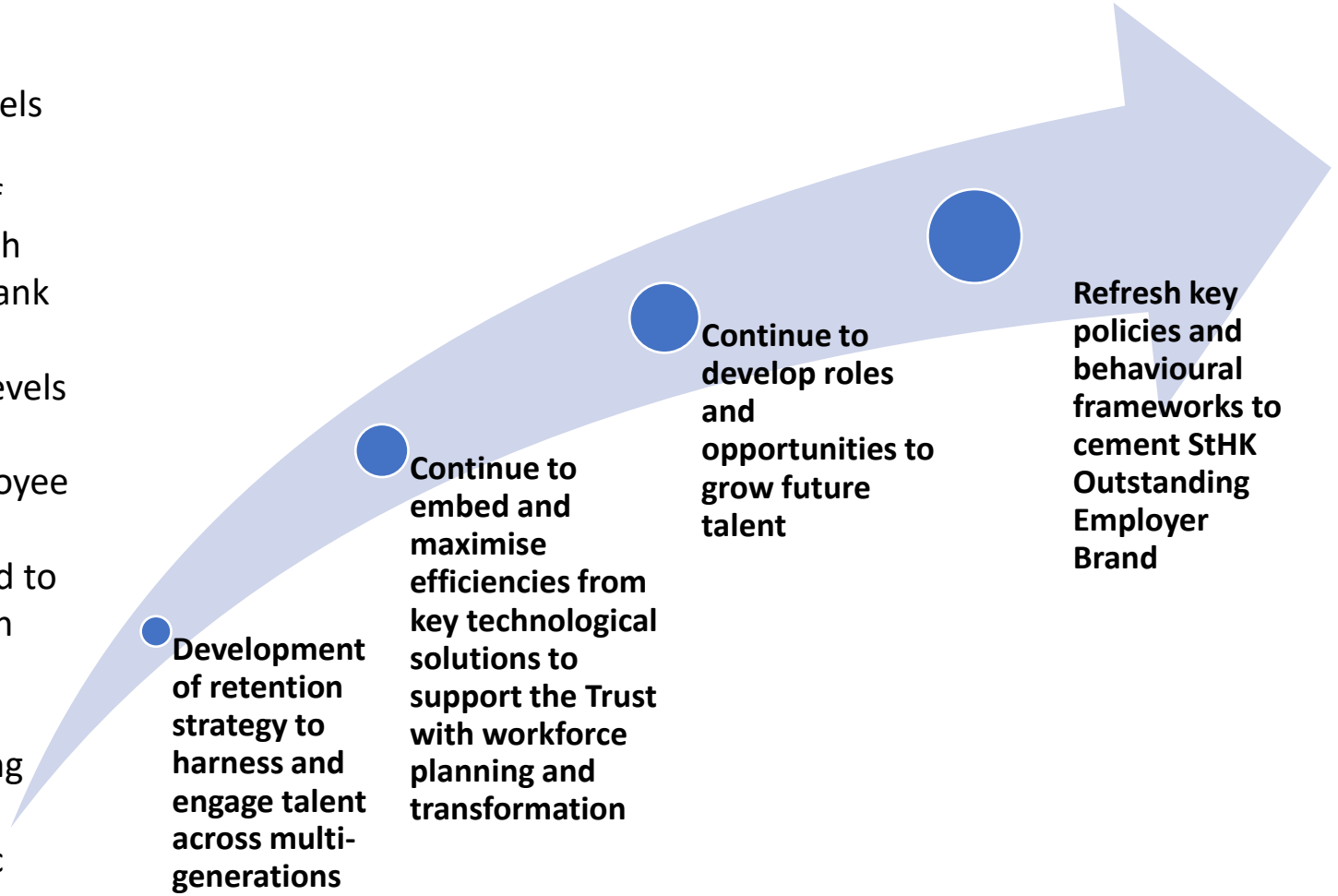
- Reporting of a disability may be under-reported in ESR; the Trust continues to make reasonable adjustments to support staff who develop an underlying health condition during employment. Health discussions and risk assessments are available to ensure staff are supported
- During the period Oct 20-June 21 there has been a 20% increase in Employee Relation cases in particular Grievances were there has been a breakdown in the relationship between Managers and the Teams due to the pressures of the pandemic.
- The HR team has been particularly busy dealing with a number of cases in particular case that have escalated to Employment Tribunals

Work in Progress with estimated completion date/s

- Work to support diversity in senior roles is progressing as part of reset and recovery to ensure delivery of WRES, WDES and Gender Pay Gap action plans. Action plan updates due to present to Board September 2021
- ESR gender data does not currently include categories of ‘non-binary’ or ‘gender neutral’ – this is being reviewed by the national team as acknowledges no longer meets the needs of Trusts or employees

Highlights and Future Plans

- The HR directorate has managed significant levels of activity within the context of Covid-19.
- Temporary staffing has managed a high level of demand; c. 11,000 – 14,000 requests per month with 80% of filled shifts being undertaken by bank staff
- HR operations management of high caseload levels due to Covid-19
- Step into virtual solutions for resourcing, employee relations, education and training
- Payroll and Employment Services has continued to provide consistent continuity of business within the context of the Pandemic
- Lead Employer has successfully established the largest collaborative bank for Doctors in Training
- Health, Work & Wellbeing have established essential support services during the Pandemic whilst creating a staff wellbeing hub
- Update of staff flu and Covid-19 vaccinations is among the highest performing nationally



INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)044
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 June 2021. (YTD = 0).

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

There were 6 C.Difficile (CDI) positive cases reported in June 2021 (3 hospital onset and 3 community onset). YTD there have been 19 cases (11 hospital onset and 8 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 June 2021 was 92.8%. 2021-22 YTD rate is 92.7%.

The number of incidents, reported within St Helens community services in May has reduced (91). 73 of these (79.7%) were related to pressure ulcer or skin damage. The number of incidents is back to usual reporting levels seen in March (98) rather than the spike in reporting in April (133).

During the month of May 2021 there were 3 falls resulting in severe harm. (YTD severe harm falls = 4)

There was 1 grade 3 hospital acquired pressure ulcers with lapse in care in April 2021. (YTD 2021-22 = 1)

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

YTD HSMR (April to March) for 2020-21 is 92.7

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: 28th July 2021

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (May 2021) at 85.5%. YTD 85.8%. Performance in April 2021 was 86.1%. The 31 day target was achieved in May 2021 with 98.9% performance in month against a target of 96%, YTD 99.0%. Performance in April 2021 was 99.1%. The 2 week rule target was not achieved in May 2021 with 90.9% in month and 88.7% YTD against a target of 93.0%. Performance in April 2021 was 86.5%. 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 June 2021 was 58.9% and YTD 59.7%. The all type mapped STHK Trust footprint performance for June 21 was 78.5% and YTD 80.6%**.** The Trust saw average daily attendances of 365, which is down compared to May 2021 at 372. Total attendances for June 2021 was 10,953, which was our second busiest month on record.

Total ambulance turnaround time was not achieved in June 2021 with 34 mins on average. There were 2,706 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2888 in May 21

The UTC saw 5456 in May 2021, which is an increase of 12% (582) compared to the previous month. Compared to attendances May 2019 (4928), the increase in activity is 10%. Overall 99% of patients were seen and treated in 4 hours.

St Helens community nursing referral numbers have shown a reduction in May from the previous month (514 in May compared with 609 in April). Referrals from acute areas has remained at consistent levels, however self-referrals, GP referrals and referrals from other providers have reduced in month. Community matron caseloads have reduced slightly (156 in May compared with 171 in April) although, significantly higher than in previous months. The Service continues to engage directly with GP practices via MDT discussions to support reduction in emergency hospital admissions.

The average daily number of super stranded patients in June 2021 was 89 compared with 89 also in May. Work is ongoing both internally and externally, with all system partners, to improve the current position.

The 18 week referral to treatment target (RTT) was not achieved in May 2021 with 74.4% compliance and YTD 74.4% (Target 92%). Performance in April 2021 was 71.0%. There were (1199) 52+ week waiters. The 6 week diagnostic target was not achieved in June 21 with 77.7% compliance. (Target 99%). Performance in May 2021 was 75.2%.

The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. All patients 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. The guidance for achieving the ERF changed for Q2 on the 9th July. This will affect the FCO of the H1 (Apr-Sept) financial plan as the threshold increased from 85% to 95%. The changes will be reflected in the M4 reports.

Surplus/Deficit - At the end of Month 3 the Trust has reported a YTD breakeven position in line with the Cheshire & Merseyside system plan for H1 as outlined above.
Agency - Year to date agency expenditure is £2.2m, including agency costs incurred in relation to COVID (£0.08m) and Mass Vaccination (£0.3m).
Cash - At the end of M3, the cash balance was £61.2m. The cash balance continues to be high due to advanced receipt of income in 2020/21.
Capital - A capital programme of £10.97m (excluding PFI lifecycle expenditure), supported by £5.43m Emergency PDC capital has been submitted to NHSE/I. Emergency PDC capital must be agreed by DHSC before the Trust is able to draw the funds.
CIP - The Trust has a H1 (M1-M6) CIP target of £3.8m, issued by the HCP. As at Month 3, sufficient savings had been identified in order to deliver this target recurrently. The Trust continues to plan internally for a higher efficiency target in H2.

Human Resources

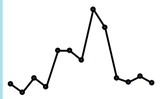
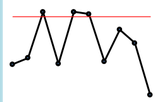
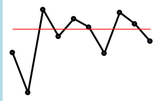
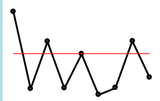
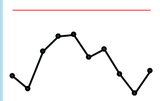
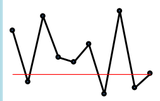
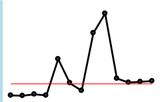
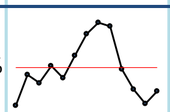
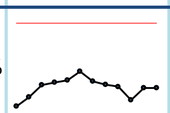
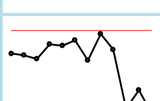
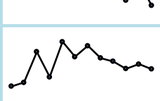
In June overall sickness was 6.4% which is a 0.7% increase from May. Front line Nursing, Midwifery and HCA's was 9.5% which is an increase of 1.1% since May and Front line Nursing and Midwifery only was 7.0% which was an increase of 0.2% since May. (These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension). The increase in overall sickness is partly due to the increase rates of Covid transmissions within the local community which in turn translates to higher numbers of staff being infected. Appraisal compliance is below target at 53.5%. Mandatory training compliance remains below the target at 75.6%. Compliance for both has improved 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

Jun-21

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	Jun-21	2.1%	2.2%	No Target	3.1%		Post wave 3 of COVID, performance is encouraging. 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. We continue to independently benchmark the COVID performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Feb-21	1.07		1.00						
Mortality: HSMR (HED)	Q	▲	Mar-21	71.2		100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Mar-21	91.5		100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Feb-21	96.7		100.0	98.6		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	Mar-21	89.5		100.0	90.3		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	Mar-21	100.2		100.0	104.7					
% Medical Outliers	F&P	T	Jun-21	1.2%	1.16%	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	The current number of medical outliers is above target owing to the full occupancy of the medical bed base. Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Jun-21	40.6%	38.5%	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	▲	May-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 reflects staff sickness. Action plan is in place.		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 for go-live with SOP, training and audit in place. Information teams are testing through to ensure data submissions are accurate	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	May-21	77.4%	79.9%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	May-21	96.6%	96.7%	95.0%	96.8%					

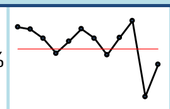
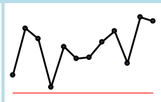
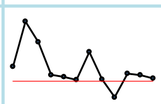
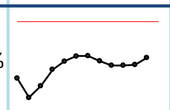
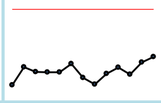
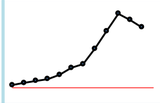
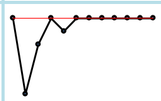
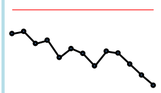
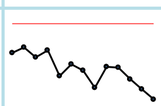
Jun-21

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	▲ £	Jun-21	0	0	0	3		No never events reported in June 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	Jun-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	▲ £	Jul-21	0	0	0	2		There were no cases of MRSA in June 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	▲ £	Jul-21	6	19	48	28		There were 6 positive C Diff sample in June 2021. YTD there have been 19 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jul-21	1	10	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	▲	Apr-21	1	1	No Contract target	1		1 hospital acquired category 3 or 4 pressure ulcer with lapse in care in April 2021.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April 21.	SR
Number of falls resulting in severe harm or death	Q	▲	May-21	3	4	No Contract target	31		1 fall resulting in severe harm and 2 death category in May 2021 (reported from ward 4C, Bevan 1 and GPAU).	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 June 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 national 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		Jun-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	Jun-21	92.8%	92.7%	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	Jun-21	3	11	No Target	49					

Jun-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

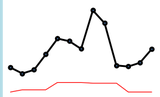
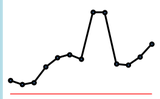
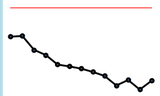
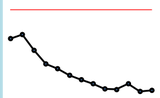
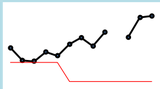
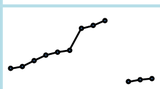
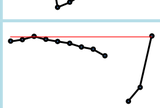
	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	May-21	90.9%	88.7%	93.0%	94.3%		There has been a significant increase in 2WW referrals. 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 7. Funding approved to support RDS implementation aligned to CDH	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	May-21	98.9%	99.0%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	May-21	85.5%	85.8%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-21	74.4%	74.4%	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	▲	Jun-21	77.7%	74.2%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-21	1,199	1,199	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jun-21	0.9%	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. June's underperformance in cancelled ops has been due to staff availability through having to self-isolate. The team is confident that this will recover going forward.	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	▲ £	May-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	▲	Jun-21	59.0%	63.9%	95.0%	78.0%		Accident and Emergency Type 1 performance for June 2021 was 58.9% and YTD 59.7%. The all type mapped STHK Trust footprint performance for June 21 was 78.5% and YTD 80.6%. The Trust saw average daily attendances of 365, which is down compared to May 2021 at 372. Total attendances for June 2021 was 10,953, which was our second busiest month on record. Total ambulance turnaround time was not achieved in June 2021 with 34 mins on average. There were 2,706 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2888 in May 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. <u>Flow through the Hospital</u> COVID action plan to enhance discharges commenced in April 20 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	▲	Jun-21	78.5%	80.6%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Jun-21	0	0	0	0					

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 June 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	Jun-21	22	69	No Target	242		% new (Stage 1) complaints resolved within agreed timescales dipped below the 90% target in quarter 1, but improved in June to 88.2%.	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 quarter 1. This is being closely monitored to bring it back above target.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jun-21	17	53	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jun-21	88.2%	81.1%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to June 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	Jun-21	294	297		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Jun-21	89	93		72					
Friends and Family Test: % recommended - A&E	Q	▲	Jun-21	76.3%	80.6%	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. Waiting times in ED are causing a higher number of negative responses and comments, with work ongoing throughout the Trust to reduce this.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jun-21	95.5%	95.8%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jun-21	50.0%	83.3%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jun-21	91.1%	94.3%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jun-21	93.8%	94.4%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jun-21	100.0%	100.0%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jun-21	93.3%	93.7%	95.0%	94.2%					

Jun-21

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	▲	Jun-21	6.4%	5.9%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In June overall sickness was 6.4% which is a 0.7% increase from May. Front line Nursing, Midwifery and HCA's was 9.5% which was an increase of 1.1% since May. 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	Jun-21	9.5%	8.6%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Jun-21	53.5%	53.5%	85.0%	51.3%		Appraisal compliance in June has increased by 3.9% and is below target at 53.5%. Mandatory training compliance has also improved and is below the target at 75.6%. Both continue to be impacted as a consequence of the post COVID 19 operational activity, recovery plans and increasing sickness absence.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance continues to be impacted by COVID 19 with both increasing in month and remaining below target. Flexible electronic options still form the primary method available to support remote completion and enable improved compliance. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area and continues to be monitored through Workforce Council.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jun-21	75.6%	75.6%	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.	New Quarterly staff survey operational and will close 12th August 2021.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Jun-21	0.8%		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	Jun-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	Jun-21	3,063	3,063	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Jun-21	(108)	(108)	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Jun-21	30	30	10						
Capital spend £ YTD (000's)	F&P	T	Jun-21	1,800	1,800	17,600						
Financial forecast outturn & performance against plan	F&P	T	Jun-21	(108)	(108)	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jun-21	95.2%	95.2%	95.0%						

APPENDIX A

			May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021-22 YTD	2021-22 Target	FOT	2020-21	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	88.2%	76.5%	100.0%	100.0%	38.5%	77.8%	100.0%	100.0%	96.3%	100.0%	97.4%	100.0%	94.7%	96.7%	85.0%		91.1%		
	Total > 62 days		1.0	2.0	0.0	0.0	4.0	3.0	0.0	0.0	0.5	0.0	0.5	0.0	1.0	1.0			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Lower GI	% Within 62 days	▲£	83.3%	76.5%	100.0%	75.0%	85.7%	90.0%	80.0%	82.6%	78.9%	58.6%	87.5%	61.1%	78.1%	72.0%	85.0%		78.7%		
	Total > 62 days		1.0	2.0	0.0	1.0	1.0	1.0	2.0	2.0	2.0	6.0	1.0	3.5	3.5	7.0			22.0		
	Total > 104 days		0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	0.0			6.0		
Upper GI	% Within 62 days	▲£	80.0%	66.7%	100.0%	100.0%	100.0%	80.0%	81.8%	83.3%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	85.0%		83.1%		
	Total > 62 days		0.5	2.0	0.0	0.0	0.0	1.5	1.0	1.0	0.0	0.0	3.5	0.0	0.0	0.0			11.5		
	Total > 104 days		0.0	2.0	0.0	0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0			4.0		
Urological	% Within 62 days	▲£	71.4%	100.0%	100.0%	90.9%	95.7%	88.0%	79.5%	88.2%	82.8%	92.3%	79.2%	80.0%	88.6%	85.5%	85.0%		85.6%		
	Total > 62 days		2.0	0.0	0.0	1.0	0.5	1.5	4.0	2.0	2.5	1.0	2.5	2.0	2.0	4.0			21.0		
	Total > 104 days		2.0	0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0			6.0		
Head & Neck	% Within 62 days	▲£	100.0%	100.0%	100.0%	50.0%	0.0%	20.0%	100.0%	0.0%	33.3%	57.1%	50.0%	0.0%	14.3%	11.1%	85.0%		51.4%		
	Total > 62 days		0.0	0.0	0.0	1.0	1.5	2.0	0.0	1.0	1.0	1.5	1.0	1.0	3.0	4.0			9.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0			0.0		
Sarcoma	% Within 62 days	▲£	100.0%				100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	85.0%		83.3%		
	Total > 62 days		0.0				0.0	0.0	1.0	0.0	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		0.0	0.0	0.0			0.0		
Gynaecological	% Within 62 days	▲£	33.3%	100.0%	100.0%	100.0%	66.7%	73.3%	69.2%	66.7%	55.0%	60.0%	57.1%	83.3%	100.0%	90.9%	85.0%		66.3%		
	Total > 62 days		3.0	0.0	0.0	0.0	1.0	2.0	2.0	1.0	4.5	1.0	3.0	0.5	0.0	0.5			17.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	▲£	100.0%	100.0%	88.9%	60.0%	100.0%	86.7%	81.8%	75.0%	100.0%	80.0%	100.0%	100.0%	63.6%	85.7%	85.0%		83.9%		RC
	Total > 62 days		0.0	0.0	1.0	2.0	0.0	1.0	1.0	2.0	0.0	1.0	0.0	0.0	2.0	2.0			10.0		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			1.0		
Haematological	% Within 62 days	▲£	66.7%	100.0%	66.7%	80.0%	100.0%	100.0%		100.0%	50.0%		75.0%	57.1%	100.0%	62.5%	85.0%		77.9%		
	Total > 62 days		0.5	0.0	1.0	1.0	0.0	0.0		0.0	3.0		1.0	3.0	0.0	3.0			8.0		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0		0.0	0.0		0.0	1.0	0.0	1.0			1.0		
Skin	% Within 62 days	▲£	86.8%	92.5%	97.5%	100.0%	92.1%	92.4%	93.9%	100.0%	96.8%	86.0%	94.6%	92.9%	89.3%	91.3%	85.0%		93.6%		
	Total > 62 days		5.0	1.5	1.0	0.0	3.0	3.0	2.0	0.0	1.0	4.0	2.5	2.5	3.0	5.5			25.5		
	Total > 104 days		0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.5	0.0	1.0	1.0			3.0		
Unknown	% Within 62 days	▲£			100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	80.0%				85.0%		92.3%		
	Total > 62 days				0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5						1.0		
	Total > 104 days				0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5						0.5		
All Tumour Sites	% Within 62 days	▲£	81.4%	81.9%	87.7%	96.1%	92.3%	86.2%	85.8%	85.2%	90.4%	85.3%	82.0%	86.1%	85.5%	85.8%	85.0%		86.7%		
	Total > 62 days		15.0	13.0	7.5	3.0	6.0	11.0	15.0	13.5	9.0	14.5	14.5	12.5	14.5	27.0			137.5		
	Total > 104 days		2.0	2.0	3.5	0.0	4.0	0.5	1.5	3.0	0.0	1.0	3.0	2.0	1.0	3.0			23.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£				100.0%		100.0%		100.0%	100.0%	100.0%	100.0%				85.0%		100.0%		
	Total > 31 days					0.0		0.0		0.0	0.0	0.0	0.0						0.0		
	Total > 104 days					0.0		0.0		0.0	0.0	0.0	0.0						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																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)045
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 June 2021. There were four Executive Committee meetings held during this period. There were no new investment decisions made in June. 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: 28th July 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in June 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 increased again in June, to reflect the increase in community prevalence and hospital admissions for patients with the Delta Coronavirus variant.

2. 3rd June 2021

2.1 Safecare Reporting Project Update

The Director of Nursing, Midwifery and Governance provided an update on the project that was being undertaken to improve safer staffing reporting. The working group had continued to meet and the report included an update on the agreed actions. The group continued to work with the system suppliers to ensure that all shifts worked would be attributed to the correct ward and included in the safer staffing calculation. The thresholds for which exception reporting was needed were also reviewed and the report template will be revised to provide a higher level of clarity and assurance.

2.2 Human Factors Training

The Director of Nursing, Midwifery and Governance presented proposals for the re-introduction of a systematic 3 tier model of human factors training for theatre staff to improve safety practices and comply with the National Safety Standards for Invasive Procedures (NatSSIPs) guidelines. Executive Committee members debated the benefits of making the human factors training mandatory for staff working in theatre against the impact on capacity. It was agreed that the proposals should be developed into a business case to evaluate the options and detail the cost.

2.3 Integrated Performance Report (IPR) Review

The Director of Finance and Information presented the plans to review the Trust IPR format and metrics, and the process for involving stakeholders over the coming months to agree the new format to ensure all contractual performance and mandatory standards were tracked.

3. 10th June 2021

3.1 CNST Maternity Incentive Scheme 2020/21 Submission

The Director of Nursing, Midwifery and Governance presented a summary of the Trust position in respect of the 10 safety actions to qualify for the 2020/21 maternity incentive scheme CNST premium discount. The deadline for submission was 15th July and the

Trust Board was required to make a declaration confirming the Trust position against each action. Action 4 required an approved action plan to achieve compliance and this was covered in a separate agenda item.

3.2 Safety Action 4 – Neonatal Medical and Nursing Workforce action plans

The Director of Nursing, Midwifery and Governance explained that the action was to meet the British Association of Perinatal Medicine (BAPM) staffing standards or demonstrate an action plan to achieve the standards within the next two years.
In relation to the nursing standard the Trust met the required standards, but for the medical workforce the BAPM standards recommended dedicated medical cover for neonatal service 24/7. Currently the cover for neonatal unit is shared at less busy times with paediatrics but plans have been developed to recruit the additional staff required to create the required dedicated cover. The Executive Committee approved the action plan, and this would also be reported to Trust Board with the Maternity Incentive Scheme declaration.

3.3 Risk Management Council and Corporate Risk Register Report

The Director of Corporate Services presented the Chair's assurance report from the Risk Management Council meeting on the 8th June. During May two new high risks had been escalated to the Corporate Risk Register. Both new risks related to consultant medical capacity to meet the increased demand for urgent and emergency care.

3.4 Trust Board Agenda

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

3.4 Urgent COVID-19 Issues

The committee approved a funding application to extend for 3 months the additional support to the hospital discharge team.

4. 17th June 2021

4.1 Care Quality Commission (CQC) Insight Report – March 2021

The Director of Nursing, Midwifery and Governance presented the key points from the latest published CQC Insight report for the Trust. This contained the most recent published data on 79 indicators used by the CQC over all the assessment domains. Of the indicators 12 were categorised as much better or better than the national average. 63 of the indicators were compared to the position 12 months previously, with 3 improving and 5 declining. There was an action plan in relation to these indicators which will continue to be monitored.

4.2 Integrated Performance Report (IPR)

The Director of Finance and Information presented the draft IPR for review and each Director agreed the necessary changes to the commentary.

4.3 NHS National Standards of Cleanliness (NSOC)

The Director of Corporate Services presented an overview of the new NSOC, which for the first time encompassed all cleaning requirements (clinical and environmental) and all healthcare settings. The standards were to be implemented by May 2022 with 2021/22 being a transitional year. The paper included a proposed approach to the implementation of the new standards, which was in two phases and would be delivered by the existing facilities management and infection prevention control infrastructure. The first phase is to assess the current cleaning practices and schedules against the new standards for each functional area and the second phase is implementation. The new standards reflected learning from the pandemic and could result in the need for permanent increased investment in cleaning. The implementation plan was approved and it was agreed that the Director of Corporate Services would be the Board lead. A progress report would be made at the end of implementation phase one.

4.4 Mandatory Training and Appraisal Performance

The Deputy CEO/Director of HR presented the figures for the staff reporting to each director. It was noted that the appraisal window for staff on band 6 and above would continue until September.

4.5 Staff Survey Action Planning

The Deputy CEO/Director of HR presented an update on the work that had been undertaken since the publication of the 2020 staff survey to develop local action plans where specific issues had been identified for improvement in care groups or services.

It was also noted that the staff survey will change from 2021 and the Trust is participating in the review and testing of potential questions. This survey would be sent to all Trust staff rather than a representative sample. In addition to the annual survey there would be 3 national pulse surveys each year, which would replace the staff friends and family test surveys.

4.6 Safer Staffing Report – April 2021

The Director of Nursing, Midwifery and Governance presented the safer staffing report for April. The overall Registered Nurse (RN) fill rate was 90.7% and the Health Care Assistant (HCA) overall fill rate was 104.0%. The report was presented in the proposed new format and committee members provided feedback on the effectiveness of this in providing the required level of assurance.

4.7 Urgent COVID 19 Issues

The committee members discussed the recent updated guidance into the use of non-valved FFP3 facemasks and reviewed the Trust position. The impact of the planned lifting on hospital visiting was also reviewed, in light of increasing infection rates locally and guidance from the Chief Nurse. Staff testing rates using the LAMP tests was also discussed as return rates had fallen since this was first introduced.

The Director of Operations and Performance confirmed that as a result of the increasing community infection rates locally and the number of COVID-19 positive patients being

seen in ED and admitted, the frequency of Gold Command meetings was being increased.

The Director of Integration presented the latest incidence figures which confirmed the growth in cases of the Delta Coronavirus variant locally. Across Cheshire and Merseyside the infection rates had doubled in 7 days.

4.8 Health Work and Wellbeing (HWWB) – Key Performance Indicators

The Deputy CEO/Director of HR presented the latest dashboard which included the improvement indicators agreed when additional investment in the HWWB service had been approved in June 2020. Nine of the 15 indicators were being achieved and the remaining six had improved against the baseline position but not yet achieved the target due to the impact of the pandemic. The committee commended the service on the progress they had made in the last 12 months and reflected on the contribution it had made to the Trust response to COVID-19 and to supporting staff.

5. 24th June 2021

5.1 E-Discharge Process Changes

The Medical Director set out proposals to change the e-discharge process to eliminate the duplication currently required in Same Day Emergency Care (SDEC). The Emergency Department (ED) has been completing e-discharge summaries using Medway Careflow rather than the ICE system still used by the rest of the inpatient wards. However, only e-discharge summaries generated by ICE had been reported against the performance target. It was agreed that going forward all e-discharge summaries should be counted towards the key performance indicator and contractual targets. In the future all services would transfer to Careflow reporting as part of the informatics strategy. It was agreed that the critical issue was that GPs were informed of a patient's treatment and on-going care and medication requirements as soon as possible after a hospital attendance or admission.

5.2 Emergency Department (ED) Attendances

The Director of Operations and Performance presented a comparison of ED attendances April – May 2019 with April – May 2021 to illustrate how attendance patterns had changed. The analysis showed there had been a 16.3% increase in total attendances; which included a 15% increase in majors and 19% increase in paediatric attendances. There had been a 3% increase in non-elective admissions. Total attendances for minors had reduced, reflecting a reduction in minor injuries as people stayed at home, but an increase in minor ailments. Most of the increase in attendances was from the local area but there had also been an increase in attendances from South Liverpool. Committee members discussed how the Trust could respond to the increase, including the advancement of winter plans to re-open the decant ward as soon as the summer refurbishment programme was completed. The Director of Operations and Performance agreed to bring detailed proposals, including the staffing requirements to the committee as soon as possible.

5.3 Data Security and Protection Toolkit (DSPT) – Information Governance Training

The Director of Informatics presented a paper detailing the assurance statement in relation to Information Governance (IG) training, which formed part of the evidence for the DSPT submission. Due to the pandemic the assessment period was extended to 18 months and 94% of staff had completed IG training in this period.

5.4 Urgent COVID 19 Issues

The Director of Integration briefed the committee on the latest public health surveillance information that showed COVID-19 infection rates were increasing rapidly and had doubled in 7 days across Cheshire and Merseyside, but the rates were rising fastest in the Liverpool City Region. The infection rates were rising most in the younger age groups who were less likely to be vaccinated. Vaccination rates across St Helens showed disparity which reflected deprivation status and more information was requested from St Helens CCG about their plans to address this.

Gold Command had made the decision to re-introduce visiting restrictions in response to the increased population infection rates and number of COVID-19 positive inpatients.

5.5 Careflow System Upgrade

The Director of Informatics confirmed that the planned system upgrade would go ahead on Saturday 10th July, following testing of the system. Business continuity and support plans were in place.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)046
Reporting from: Quality Committee
Date of Committee Meeting: 20th July 2021
Reporting to: Trust Board
Attendance: Gill Brown, Non-Executive Director (Chair) Val Davies, Non-Executive Director Anne-Marie Stretch, Deputy CEO/Director of HR Sue Redfern, Director of Nursing, Midwifery & Governance Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services **In Attendance:** Teresa Keyes, Deputy Director of Nursing & Quality Peter Williams, Deputy Medical Director Anne Rosbotham-Williams, Deputy Director of Governance Rajesh Karimbath, Assistant Director of Patient Safety Gareth Lawrence, Deputy Director of Finance Susan Norbury, Assistant Director of Safeguarding (agenda item 9) **Observers:** Ian Clayton, Non-Executive Director Stacy Burrows, Haematology Operational Manager Michelle Corrigan, attending as part of her Aspirant Non-Executive Director course

Matters Discussed:
• **COVID update** provided, noting:
  ○ An increase in positive patients, including those in Critical Care Unit
  ○ Impact of current situation on staffing levels, which were challenging in all areas and in particular with healthcare assistant roles.
  ○ Daily staffing meetings increased to twice daily
  ○ Process being developed to get staff identified as COVID contacts safely into work within the new self-isolation rules following test and trace alert
  ○ Work ongoing regionally to address challenges with maternity staffing Continued high demand on urgent and emergency care services
• Benefits of **Perfect Ward**, a digital application to support ward audits were discussed, noting:
  ○ Reduced administrative time required to input findings
  ○ Ability to receive real-time results and develop quality dashboards at ward/directorate/Care Group/Trust-wide level
  ○ Focus on delivering improvements
  ○ The Chair requested an update be brought to the Committee in October
• **Integrated Performance Report** highlighting:

- Staffing - Increase in absence, both COVID and non-COVID related
- Slight improvement in appraisals and mandatory training in month
- One category 3 pressure ulcer reported and under investigation
- Achievement of 62 and 31 day cancer targets, with improvement in two week wait performance, noting high volume of referrals
- High levels of ED attendances impacting on achievement of targets, with the team doing everything they can to reduce waiting times and ambulance turnaround time; however noted that 99% of patients attending St Helens Urgent Treatment Centre were seen within 4 hour target, despite the increase in attendance
- Decrease in referrals to community nurses from GPs and other providers with work being undertaken to ensure all relevant patients are referred
- Continued work with the system to reduce the number of super-stranded patients
- Reduced number of 52 week waits and improvement in 6 week diagnostic performance reported
- The Committee requested further detail relating to treatment of head and neck cancer patients and genitourinary medicine services

- **Patient Safety Council**
  - Total number of falls is decreasing, however 3 falls resulting in severe harm and above in May. The Committee discussed the actions being taken to reduce falls and the Chair requested that further assurance on the work undertaken is reported to September's Committee meeting
  - Increased number of serious incidents, due in part to the increase in falls, strengthening of the learning from death process and changes in reporting requirements for maternity incidents. Chair requested rescheduled SUI Themes assurance report is presented to September's Quality Committee.
  - The Committee requested further detail on the increased number of hospital acquired thrombus/venous thromboembolisms
- **Safeguarding report**
  - The Committee noted the increased activity within the team and the complexity of the cases, including 5 domiciliary homicide reviews, as well as the lack of a national code of practice for the Liberty Protection Safeguards due to be implemented from April 2022. This will require a significant training programme to ensure the Trust can achieve the additional responsibilities
- **Patient Experience Council report** highlighted
  - Effective working relationship with Healthwatch continues
  - Internal feedback from the inpatient survey
  - Work of the Research Team to increase number of research participants and feedback to the annual research experience survey
  - Carer's passport developed by STHK Quality Matron in conjunction with members of the Carer's Centre and LUFT
- **Complaints, Claims, PALS and Friends and Family Test** report outlined:
  - High number of open complaints, compared to previous quarters
  - Decrease in number of claims, which is expected to return to more normal levels in coming months
  - Fall in PALS concerns relating to communications
  - Negative FFT responses in ED relating to waiting times and in maternity services, with the re-instigation of daily senior midwife walkabouts to address concerns

- **Infection prevention report** noting:
    - Low rate of COVID related nosocomial infections since April 2021
    - No further MRSA colonisation relating to ward 5A following deep clean
    - C Diff infections – DoH has not yet published annual target
    - Ongoing work to improve training rates and further reduce infections
    - Antimicrobial prescribing audit
- **Clinical Effectiveness Council**
    - Presentations received from Dermatology and Clinical Psychology outlining key developments and challenges with both services.
    - Survey being undertaken to gain views from CEC membership to aid evolution of the Council.

Assurance Provided:

- Reports to Patient Safety Council provided assurance that:
    - Central Alerting System (CAS) alerts were acted on and completed as appropriate
    - Medication incidents continue to be reported even during times of escalation, with no patient harm incidents occurring
    - Controlled drug prescribing is in line with other trusts regionally
- Inpatient Friends and Family Test recommendation rates remain significantly above target
- Green assurance rating received in relation to majority of safeguarding targets, with ongoing work to improve training figures impacted on by the pandemic
- Number of deprivation of liberty safeguards referrals have continued to increase and are in line with other trusts
- Full compliance with the requirements of the updated Infection Prevention Board Assurance Framework
- Increased completion of actions plans developed following clinical audits, providing assurance that improvements are being made.

Decisions Taken: No formal approvals required at the meeting

Risks identified and action taken:

- Work to reduce demand on Emergency and Urgent Care, including diverting patients to Urgent Treatment Centres and primary care
- Infection prevention summit planned for August to reduce the number of C diff cases
- Work with Care Groups to reduce the number of open complaints and increase the number of responses issued within the timescale agreed with the complainant
- Ongoing work on fall reduction
- Trust wide Patient Safety Campaign discussed by Executive Team.

Matters for escalation: Ongoing challenges presented by the pandemic and extreme dedication and hard work of staff to maintain the quality of service provision

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

Committee Chair: Gill Brown, Non-Executive Director

Date of Meeting: 28th July 2021

TRUST BOARD

Paper No: NHST(21)047

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 22nd July 2021

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
N Bunce – Director of Corporate Services
A Stretch – Director of Human Resources
S Redfern – Director of Nursing & Midwifery
P Williams – Deputy Medical Director
G Lawrence – Deputy Director of Finance & Information
A Matson – Assistant Director of Finance – Financial Management
P Nee – Assistant Director of Operations – Surgical Care
D Miles – Assistant Director of Finance – Surgical Care

Agenda Items

For Assurance

A) Integrated Performance Report

- Target 62 day and 31 day performance was met in May, at 85.5% and 98.9% respectively.
- Target 2 week wait cancer performance was not achieved in May, with delivery of 90.9% against a target of 93% due to the ongoing impact of the pandemic. This represents an improvement against April's performance which was 86.5%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 58.9% in June and 59.7% year to date. The all type mapped STHK Trust footprint performance was 78.5% in June and 80.6% year to date. Improvement plans covering the full urgent care pathway will be shared with the Committee once approved.
- The ambulance turnaround time target was not achieved in June. The Trust was the busiest in C&M and third busiest across the North West.
- Overall sickness has increased by 0.7% since May. Front line Nursing, Midwifery and HCA sickness has increased by 1.1%. Staffing challenges around self-isolation and annual leave are ongoing. An assessment of the potential impact of new national guidance allowing staff who have been contacted by Test & Trace to work provided they are risk assessed and test negative is in progress.
- The committee is assured that plans are in progress to address underachievement of appraisal and mandatory training compliance, but note that progress may be affected by current staffing challenges.

B) Finance Report Month 3

- The Trust is reporting a breakeven position for Month 3, in line with system planning. This includes expenditure of £128.2m year to date.
- The Month 3 year to date position includes £7.5m Elective Recovery Fund (ERF) income, based on activity performance since April. Changes to the national ERF thresholds were announced in June, reducing planned ERF income for Q2 from £3.5m to £0.2m.

- Schemes are fully identified to meet the Trust's H1 CIP target of £3.8m.
- System CIP for H1 assumed a £3.3m contribution from Elective Recovery Fund income, of which £1.4m related to Q2 and will now be unavailable due to the changes to ERF thresholds. Combined with additional expenditure of around £1.5m, there is risk against the H1 plan of c. £2.9m which will be raised with the HCP.
- As at Month 3, the Trust had a cash balance of £61.2m.
- The Trust has a total 2021/22 capital plan of £17.7m.

C) NHS Oversight Metrics – Finance & Use of Resources Update

- Recent NHSE/I guidance on the NHS System Oversight Framework for 21/22 includes details of the metrics Trusts, ICSs and CCGs will be monitored against under the 'Finance and use of resources' theme.
- From Month 4 21/22, finance reports provided to the committee will include additional information on run rates, the underlying position and overall trend to allow assurance and oversight against the specific metrics identified.
- There is also national focus on the Better Payment Practice Code (BPPC), with a target of 95% of non-NHS invoices by value being paid within 30 days or within contractual terms. Trust performance is currently 97.5%. This information will continue to be provided in monthly reports to the committee.

For Approval

N/A

For Information

D) Surgical Care CIP Presentation

- The committee were encouraged by the progress made by the care group in identifying CIP during H1.
- The majority of the £1.8m identified as high risk relates to activity driven income generation and therefore cannot currently be transacted, as funding arrangements in H2 and future financial years remain unknown.
- It was noted that historically CIP delivery by the care group has related largely to innovative improvements and growth of services with associated increases in income. The impact of current funding arrangements on the Trust will continue to be raised externally in system level discussions in order to inform and influence decisions on future financial arrangements. Focus in the care group for delivery of 21/22 CIP will remain on potential reductions in expenditure.

CIP Programme Update – Update noted by committee
CIP Council report – Update noted by committee
Procurement 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: 28th July 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)048

Title of paper: Corporate Risk Register

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

Summary:

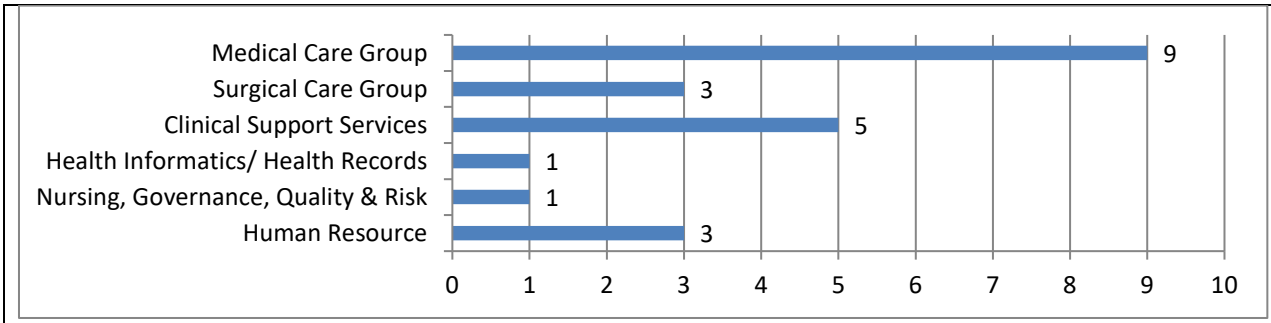
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

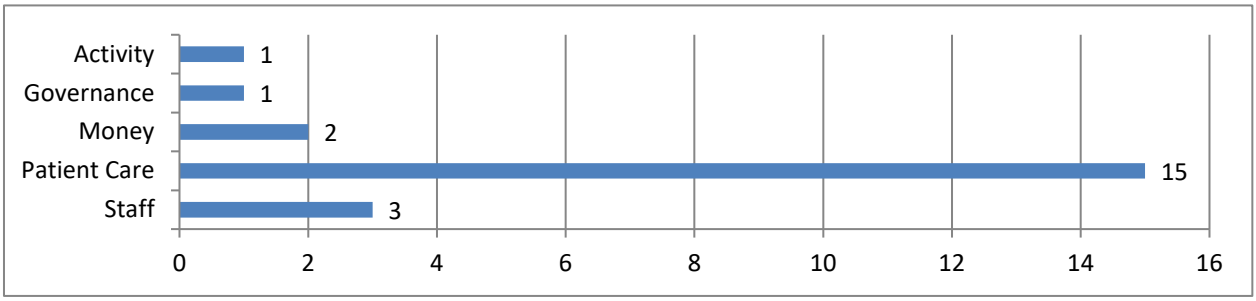
This report covers all the risks reported and reviewed until the end of June 2021 and is a snap shot, rather than a summary of the previous quarter. A comparison with the previous Board report in April 2021 is included to illustrate the movement in risks during the period. The report shows;

- The total number of risks on the risk register is 693 compared to 627 in April. The increased number of risk reflects the inclusion of new 2021/22 CIP risks, following the suspension of the CIP programme in 2020/21.
- 63% (439) of the Trusts risks are rated as moderate or high compared to the same percentage 59% but 369 risks in April.
- 22 risks that scored 15 or above had been escalated to the CRR (Appendix 1) compared to 18 risks escalated in April.

The spread of CRR risks across the organisation is;



The risk categories of the CRR risks are;



The report also includes comparisons of the Trust risk profile with the previous quarterly report (April 2021) and against the same period last year – July 2020 (Appendix 2 and 3).

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

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Commissioners, Regulators.

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 28th July 2021

CORPORATE RISK REGISTER – JULY 2021

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period July 2021	Previous Reporting Period April 2021
Number of new risks reported	67	7
Number of risks closed or removed	17	20
Number of increased risk scores	1	3
Number of decreased risk scores	7	4
Number of risks overdue for review	96	114
Total Number of Datix risks	**693***	**627***

*includes risks that have been reported but not yet scored in Datix as it is a live system.

The number of risks overdue for review had reduced to 67 by the time of the Risk Management Council (RMC) meeting on 13th July. The RMC reviewed how many of these risks had not been reviewed in the previous two months and this was 17 risks. This provides assurance that risks are being reviewed regularly even if the exact review date in DATIX is missed.

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
13	**22**	**16**	**70**	**8**	**122**	**57**	**185**	**35**	**140**	**9**	**6**	**7**	**0**
51 = 7.39%			**200 = 28.99%**			**417 = 60.43%**				**22 = 3.19%**			

**Based on 690 scored and approved risks*

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

2.1 Surgical Care Group – 133 risks reported 19.27% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**4**	**1**	**11**	**3**	**26**	**13**	**36**	**9**	**27**	**2**	**0**	**1**	**0**
5 = 3.76%			**40 = 30.08%**			**85 = 63.91%**				**3 = 2.26%**			

2.2 Medical Care Group – 107 risks reported 15.51% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**7**	**1**	**8**	**0**	**21**	**3**	**22**	**12**	**18**	**3**	**1**	**5**	**0**
14 = 13.08%			**29 = 27.10%**			**55 = 51.40%**				**9 = 8.41%**			

2.3 Clinical Support Care Group – 111 risks reported 16.08% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**2**	**1**	**10**	**0**	**19**	**15**	**31**	**4**	**22**	**3**	**1**	**1**	**0**
5 = 4.50%			**29 = 26.13%**			**72 = 64.86%**				**5 = 4.50%**			

2.4 Primary Care and Community Services Care Group – 42 risks reported 6.08% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**0**	**0**	**5**	**0**	**5**	**6**	**10**	**4**	**12**	**0**	**0**	**0**	**0**
0			**10 = 23.81%**			**32 = 76.19%**				**0**			

2.5 Corporate – 297 risks reported 43.04% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**9**	**13**	**36**	**5**	**51**	**20**	**86**	**6**	**61**	**1**	**4**	**0**	**0**
27 = 9.09%			**92 = 30.97%**			**173 = 25.07%**				**5 = 1.68%**			

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

	High	Moderate	Low	Very low	Total
Health Informatics/Health Records	1	15	15	4	**35**
Estates and Facilities Management	0	6	11	3	**20**
Nursing, Governance, Quality & Risk	1	17	8	3	**29**
Finance	0	9	10	4	**23**
Medicines Management	0	24	35	5	**64**
Human Resource	3	102	13	8	**126**
Total	**5**	**173**	**92**	**27**	**297**

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

Risks of 15 or above are added to the CRR (Appendix 1).

ENDS

Appendix 1

Corporate Risk Register – JULY 2021

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Last Review Due	Target Risk Score I x L	Action plan in place with target completion date	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies **then** there is a risk to being able to provide safe care and agreed levels of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	09/03/2021	4 x 2 = 8	Action plan in place	Quality Committee
2	Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 4 = 16	3 x 5 = 15	17/03/2020 Sue Redfern	18/05/2021	4 x 2 = 8	Action plan in place	Executive Committee
3	Money	1152	**If** there is an increase in bank and agency staff usage **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	09/03/2021	4 x 3 = 8	Action plan in place	Quality Committee
4	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	23/06/2021	4 x 3 = 12	Action plan in place	Executive Committee
5	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance **then** it will fail the national access standard.	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	01/07/2021	4 x 2 = 8	Action plan in place	Finance and Performance Committee
6	Patient Care	2082	**If** there is not sufficient medical capacity for review of medical patients who remain in the ED/EAU **then** this could result in patient harm	3 x 4 = 12	3 x 5 = 15	19/05/2021 Rob Cooper	26/06/2021	3 x 2 = 6	Action plan in place	Executive Committee
7	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** this will negatively adversely affect the admission of medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	28/06/2021	2 x 2 = 4	Action plan in place	Executive Committee
8	Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	11/06/2021	3 x 2 = 6	Action plan in place	Quality Committee
9	Patient Care	2671	**If** there is not sufficient Consultant cover on Ward 3C **then** there is a risk to patient safety, quality of care and experience.	3 x 3 = 9	3 x 5 = 15	28/04/2021 Rob Cooper	05/05/2021	3 x 2 = 6	Action plan in place	Executive Committee
10	Patient Care	2708	**If** a large number of senior medical staff are adversely impacted by the NHS pension tax rules **then** the Trust could experience reduced senior clinical capacity	4 x 4 = 16	4 x 4 =16	04/07/2019 Anne-Marie Stretch	30/06/2021	4 x 2 = 8	Action plan in place	Executive Committee
11	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	01/07/2021	5 x 2 = 10	Action plan in place	Executive Committee
12	Staff	2758	**If** DMOP wards do not have sufficient junior doctors to meet staffing requirements **then** there is a risk to patient safety and patient flows.	4 x 5 = 20	4 x 5 = 20	02/06/2021	02/06/2021	4 x 1 = 4	Action plan in place	Executive Committee

						Rowan Pritchard Jones				
13	Money	2830	If the Maternity service does not achieve the maternity incentive scheme, then a 10% reduction on the annual CNST premium will not be delivered.	3 x 5 = 15	3 x 5 = 15	24/11/2020 Sue Redfern	25/05/2021	3 x 2 = 6	Action plan in place	Quality Committee
14	Patient Care	2848	**If** the trust does not have sufficient anaesthetic and obstetric on call cover, **then** there is a risk of delayed medical management if there should be simultaneous medical emergencies.	5 x 3 = 15	5 x 3 = 15	21/02/2020 Rowan Pritchard-Jones	25/05/2020	5 x 2 = 10	Action plan in place	Quality Committee
15	Patient Care	2932	**If** a patient's fluid balance is not recorded, **then** there is a risk that the patient could become dehydrated or fluid overloaded.	4 x 5 =20	4 x 5 = 20	30/09/2020 Rowan Pritchard Jones	29/06/2021	4 x 2 = 8	Action plan in place	Quality Committee
16	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.	5 x 4 = 20	5 x 4 = 20	21/10/2020 Rob Cooper	28/05/2021	5 x1= 5	Action plan in place	Executive Committee
17	Patient Care	2964	**If** there are not sufficient dieticians to meet the increased incidence of gastro-intestinal cancers **then** this could impact on their treatment outcomes	3 x 5 = 15	3 x 5 = 15	13/10/2020 Sue Redfern	11/06/2021	3 x 1 = 3	Action plan in place	Executive Committee
18	Patient Care	2985	**If** there are not sufficient Phlebotomy staff able to attend work due the COVID absences **then** there will be an impact on service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	01/07/2021	3 x 2 = 6	Action plan in place	Executive Committee
19	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	29/10/2020 Sue Redfern	16/06/2021	3 x 2 = 6	Action plan in place	Executive Committee
20	Patient Care	3046	**If** Cardio-Respiratory is unable to provide sufficient staff to cover ECG provision throughout the whole of the Trust **then** here is a risk that ECG's are not undertaken in a timely manner.	4 x 5 = 20	4 x 4 = 16	21/04/2021 Rowan Pritchard Jones	07/07/2021	4 x 2 = 8	Action plan in place	Executive Committee
21	Patient Care	3057	**If** there are insufficient stroke consultants in post**, then** a 1:8 rota cannot be sustained	4 x 5 = 20	4 x 5 = 20	25/05/2021 Rob Cooper	25/05/2021	2 x 3 = 6	Action plan in place	Executive Committee
22	Patient Care	3161	If the required staff are not available to fill the rota for the Mass Vaccination Site **then** the service cannot be provided effectively	4 x 4 = 16	4 x 4 = 16	30/06/2021 Rob Cooper	05/07/2021	4 x 3 = 12	Action plan not recorded in Datix	Executive Committee

Blue text = New risks escalated to the CRR since the April Trust Board report

Risks that have been de-escalated or closed from the CRR since April 2021 are;

Risk Category	Risk ID	Subject
Patient Care	1605	**If** there are insufficient medical SPR doctors to cover the rota, **then** there is a risk to patient care.
Staff	2980	**If** there is not sufficient staff to provide 24/7 cover in the blood sciences labs **then** there may not be sufficient capacity to meet demand
Patient Care	3042	**If** GPs do not receive patient discharge letters in a timely manner **then** there is a risk to patient safety and continuity of care

Appendix 2

Trust Risk Profile – April 2021

Comparison of the Trust risk profile in the last Board Report

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
14	**23**	**18**	**70**	**9**	**116**	**57**	**138**	**32**	**124**	**8**	**5**	**5**	**0**
55 = 8.89%			**195 = 31.50%**			**351 = 56.70%**				**18 = 2.91%**			

Trust Risk Profile – July 2020

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

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
48	**32**	**22**	**91**	**9**	**154**	**58**	**122**	**32**	**139**	**4**	**9**	**2**	**0**
102 = 14.13%			**254 = 35.18%**			**350 = 48.48%**				**15 = 2.08%**			

Appendix 3

CRR – July 2020

Comparison of the CRR risks reported 12 months previously with the risks highlighted that remain or have been re-escalated to the current CRR

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

New Risk Category	Datix Ref	Risk	Current Risk Score I x L	Target Risk Score I x L	Governance
Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 2 = 8	Quality Committee
Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 5 = 20	4 x 2 = 8	Executive Committee
Money	1152	**If** there is an increase in bank and agency **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 3 = 8	Quality Committee
Patient Care	1353	If activity at St Helens Hospital continues to be increased, **then** there is a risk that the current medical cover will not be sufficient	5 x 3 = 15	5 x 1 = 5	Quality Committee
Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	4 x 3 = 12	Executive Committee
Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance **then** it will fail the national access standard	4 x 5 = 20	4 x 2 = 8	Finance & Performance Committee
Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 4 = 16	2 x 4 = 8	Executive Committee
Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	3 x 2 = 6	Quality Committee
Patient Care	2502	**If** there is a no deal Brexit **then** there could be an adverse impact on the supply of medical consumables and devices	4 x 4 = 16	3 x2 = 6	Finance and Performance Committee
Patient Care	2641	**If** the community midwives do not have access to technology to enable contemporaneous patient notes, **then** there is a risk to patient care	3 x 5 = 15	3 x 2 = 6	Executive Committee
Patient Care	2708	**If** a large number of senior medical staff are adversely impacted by the NHS pension tax rules **then** the Trust could experience reduced senior clinical capacity	4 x 4 =16	4 x 2 = 8	Executive Committee
Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient	5 x 3 = 15	5 x 2 = 10	Executive Committee
Patient Care	2848	**If** the trust does not have sufficient anaesthetic and obstetric on call cover, **then** there is a risk of delayed medical management if there should be simultaneous medical emergencies.	5 x 3 = 15	5 x 2 = 10	Quality Committee
Patient Care	2871	**If** there is disruption to the supply of PPE **then** there could be a risk to patient and staff safety without sufficient supply to respond to COVID-19	4 x 4 = 16	3 x 3 = 9	Executive Committee
Patient Care	2872	**If** routine antenatal appointments cannot be completed during the COVID-19 pandemic **then** there could be a risk of harm to women and their babies	4 x 5 = 20	4 x 2 = 8	Executive Committee

Trust Board

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)049
Title of paper: Review of the Board Assurance Framework (BAF) – July 2021
Purpose: For the Executive Committee to review and agree any changes to the BAF to be presented to the Trust Board.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in April 2021. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** No changes to the BAF risk scores are proposed as a result of this review.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE/I, CQC, Commissioners.
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 28th July 2021

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2021/22 Objectives and Long Term Strategic Aims

2021/22 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Initial Risk Score	Key Controls	Sources of Assurance	Residual Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSE/I Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20	~~CRAB Medical Implementation and risk reporting for routine outcome monitoring~~ Implementation of the improvement plan longer term solutions to ensure all patients whose treatment has been suspended are monitored and receive timely follow up (September 2021)	Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, inquests and mortality reviews Development of the 2020 – 2023 Nursing Strategy – currently subject to consultation (Revised to September 2021 for Board approval) Development of ward quality accreditation tool and real time quality dashboard (Perfect Ward) (October 20201) Reduce hospital acquired AKI (March 2022)	Review of patient information to improve accessibility and understanding (March 2022) Delivery of never event improvement plans and human factors training (May 2022) Deliver the Ockenden 1st stage report action plan (September 2021) Pressure Ulcer review to be presented to Quality Committee (July 2021) Deteriorating patient improvement project (January 2022)	5 x 1 = 5	R P-J/ SR

Risk 2 —Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSE/I monthly reporting • Contract Monitoring Board • NHSE/I Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board • COVID-19 exceptional expenditure financial governance process	4 x 4= 16	Continue collaboration across C&M to deliver transformational CIP contribution Reporting of management plans to deliver GiRFT recommendations to the F&P Committee	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances ~~Deloitte audit of COVID expenditure – to be reported to Audit Committee when finalised~~	Seek all possible sources of capital funding including national bids to support capacity planning (Ongoing) Deliver the financial and activity plan agreed with C&M ICS for the first 6 months of 2021/22 (October 2021) Conclude H2 income allocation – September 2021	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool • COVID-19 EPRR operational command and control structure in place	4 x 5=20	Implementation of routine capacity and demand modelling	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow for winter 2020/21 and beyond COVID-19 and restoration escalation plans to release capacity and trigger mutual aid in place and operational.	Implement new contractual arrangements for Widnes UTC (Revised to August 2021) Develop a urgent and emergency care improvement / winter plan with system partners for 2021/22 to cope with increasing demand (September 2021) Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) Achievement of the elective activity recovery trajectories agreed with C&M ICS (March 2022) Implement the new emergency care and cancer national performance standards (October 2021) Implementation of a Community Diagnostic Hub at St Helens Hospital (September 2021)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • IPR • Staff Survey • COVID pandemic reflections staff feedback • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSE/I Segmentation Rating	4 x 2 = 8	Regular media activity reports , including social media, to the Executive Committee	Establishment of a Strategic Workforce Committee of the Board (September 2021)	Finalise and implement the 2020 staff survey action plan (March 2022) ~~Update the Trust website (Revised to May 2021)~~ Maintain COVID staff communications bulletin and pandemic staff engagement, support and recovery initiatives (On-going)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending StHK Board and Trust NED attending Governing Body • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care System governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN • Annual staff engagement events programme • COVID -19 Command and Control structure and Hospital Cell • Equality, Diversity & Inclusion Delivery Group	4 x 3 = 12	Work with the local Boroughs to develop plans for Integrated Care Partnerships (ICPs) from April 2022	C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks	Continue participation with the Collaboration at scale board and work streams (Suspended due to COVID-19) Continued engagement with C&M ICS senior leadership as part of the system response to COVID-19. Membership and participation with the 2 Provider Collaboratives for C&M ICS – including ratification of the MOU and ToR (October 2021) Continue as a full partner of St Helens cares, contributing to the delivery of the improvement objectives Work with NHSE/I and other Providers to provide management support for fragile services	4 x 2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career and leadership development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES and WDES reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Steering Group Other • Annual workforce plans • HR benchmarking • Nurse & Midwifery staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment process and redeployment hub	5 x 4 = 20	Implementation of emergency staffing plans and ratios in line with national guidance. Equality Delivery System 2 – action plan	Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3 Capacity to deliver the recovery and restoration plans for activities suspended due to COVID-19 Attendance management COVID-19 recovery plan	Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going) Develop the Trust longer term Agile Working Strategy (Revised to July 2021) Delivery of the NHS People Plan local action plans for 2021/22 (Revised to March 2022) C&M Lead Provider role for the COVID vaccination programme – including planned autumn booster programme for staff (On going) Restoration of appraisal and mandatory training compliance with the 85% target (October 2021)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning and social distancing (COVID-19)	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • PAM benchmarking • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.	Implementation of new National Standards of Cleaning (May 2022) Implementation of the national Hospital Food Review recommendations and mandatory standards Compliance with the new Protect legislation for premises security (October 2021)	3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2022) Estates and accommodation strategy to respond to increasing demand and new ways of working (Revised to September 2021) ~~Develop theatre expansion options to support COVID recovery and restoration (May 2021)~~ Complete Whiston Theatres feasibility and option appraisal (July 2021) Premises Assurance Model (PAM) submissions (31st July 2021)	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M STP Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval Annual Corporate Governance Structure review Technical Development	ISO27001 Service Improvement Plans IT Communications Strategy Digital Maturity Assessment	ISO27001 (revised to March 2022 due to COVID) Medway Careflow/ DAP benefits realisation programme delivery (revised to September 2022) Implementation of IPS Intrusion Prevention System) that detects cyber-attacks within the network. 50% complete (revised to December 2021 due to global component shortage) Migration from end-of -life operating systems – 85% complete. Extended support in place for the remaining 15%, which will be migrated by January 2022. Delivery of the Digital Aspirant Programme (2020 - 2022) Delivery of Community EPR (March 2022)	4 x 2 = 8	CW

TRUST BOARD

Paper No: NHST(21)050

Title of paper: Learning from Deaths Quarterly Report Q4 2020/2021

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

Summary:

Month	**Total**	Green	Green with learning	Amber	Red
January 2021	**74**	36	20	2	0
February 2021	**61**	33	9	3	0
March 2021	**41**	19	3	2	1
Total	**176**	**88**	**32**	**7**	**1**

The number of reviews for Q4 was the highest we had seen since commencing Learning from Deaths due to COVID. As a result of this increased volume and ongoing operational pressures all reviews for Q4 are not yet complete.

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

Financial implications: None arising from this report

Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners

Recommendation(s): To approve the report, policy and good practice guide

Presenting officer: Rowan Pritchard-Jones, Medical Director

Date of meeting: 28th July 2021

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Learning from Deaths Quarterly Report Q4 2020/2021

1. Executive Summary

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

In Quarter 4: 2020/21 a total of 176 SJR's were requested 68% (120n) of the reviews had an outcome of no concerns (Green or Green with learning). 3.97% (7n) had an AMBER outcome all of which are receiving further input or investigation. Finally 0.57% (1n) had a RED outcome. There are 48n reviews still awaiting completion for Q4

See Appendix 1 for the case selection contributing to Mortality Surveillance Group MDT / Learning from Deaths Quarterly Report.

1.1. Shared learning for Q4

Q2	Documentation – identify yourself Our record keeping policy clearly states : "*Records should be accurately dated, timed, signed, and the signature printed to ensure that each entry can be attributed to an individual*" It is your responsibility to ensure that you practice within the confines of the policy and the standards contained within. In addition to this, good practice would be also to include the ward concerned.	**DNACPR – we're getting there** During the COVID pandemic, early discussion and consideration of DNACPR status was encouraged for all patients. The junior doctors rose to this challenge well with many of these conversations taking place over the phone, rather than face to face. However we failed to follow trust policy, as below: *Every DNACPR decision made during their inpatient stay MUST be reviewed upon discharge by the Senior Clinician authorising the discharge* this led to a number of complaints from patients and their families.

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

1.2 Sharing and embedding learning

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

2. ANALYSIS

2.1 Total number of reviews completed for Q4 2020/21

Month	Total	Green	Green with learning	Amber	Red
January 2021	74	36	20	2	0
February 2021	61	33	9	3	0
March 2021	41	19	3	2	1

The number of reviews for Q4 was the highest we had seen since commencing Learning from Deaths due to COVID. As a result of this and due to ongoing operational pressures the reviews for Q4 are not yet complete.

A comparison to Q4 2019/20 has taken place to ensure that although numbers are larger, that there is no increase in any particular category, i.e. concern deaths

	19/20 Q4	20/21 Q4
Cardiac Arrest Death	16	9
Concern Death	16	25
COVID 19	3	1
CRAB Mortality Triggers*	0	35
Diagnosis Group Death*	28	18
Learning Disabilities Death	2	11
Maternal death	0	0
Medical Examiner Referral	0	1
Post operative death	26	28
Random Selection Death	44	48
Severe Mental Illness Death	0	0
Internal request – not in any other category	1	0

*The diagnosis group deaths have reduced in Q4 2021 due to the fact that in 2021 we began to review CRAB mortality triggers and those which had previously been recorded as a Diagnosis Group Death in 2020 may now fall under CRAB mortality in 2021

Following a review of all completed SJRs we have been able to determine a consistently low level of RED and AMBER cases. This reflects an earlier identification of when things go wrong and an improving care picture.

2.2 Specified Groups breakdown for Q4 2020/21 (See Appendix 1)

	Jan 2021	Feb 2021	Mar 2021	Total
Cardiac Arrest Death	4	3	2	9
Concern Death	17	6	2	25
COVID 19	1	0	0	1
CRAB Mortality Triggers	11	11	13	35
Diagnosis Group Death	8	5	5	18
Learning Disabilities Death	5	3	3	11
Medical Examiner Referral	1	0	0	1
Post operative death	13	10	5	28
Random Selection Death	14	23	11	48
Total	74	61	41	176

**25% of all deaths or 30n (whichever is greater) are reviewed each month*

3. CONCLUSION AND RECOMMENDATIONS

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

- SJR process is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised
- Where concerns have been identified these have received further peer review and escalated as appropriate.

Appendix 1

Total Deaths in Scope[1]

Check against NWB downloaded LD List **'Learning Disability Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[5]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
Random Sample, include all low risk deaths[4] **'Sample Deaths'**	SJR
Cardiac Arrests that result in death **'Cardiac Arrest Deaths'**	SJR

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

TRUST BOARD

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)051
Subject: HR/Workforce Strategy & HR Indicators Report
Purpose: This paper provides Trust Board with details of achievement of the delivery of the Trust's Workforce Strategy over the last 12 months and provides updates and assurance on the management of workforce matters during Covid-19.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce in line with our Trust objectives. This paper provides an update on governance assurance during this time of Covid-19 and summarises achievements/progress to date.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: None at this time
Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues
Recommendation(s): The Trust Board is requested to: • note the content of this paper and that actions are in place to ensure continued delivery of the Trust's Workforce Strategy; • note that the COVID-19 Workforce Assurance Framework is providing assurance and oversight that the Trust has been appropriately exercising, and is continuing to exercise, its duty of care to its workforce.
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Trust Board: Wednesday 28 July 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)052
Title of paper: Strategic People Committee – Terms of Reference
Purpose: To seek approval of the terms of reference for the new Strategic People Committee to support the delivery of the national and local People Plan and associated workforce objectives.
Summary: The Trust Board have decided to establish a committee to be known as the Strategic People Committee which will be a formally constituted committee of the Board. The committee shall provide assurance to the Board on all matters pertaining to the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. Board approval is sought for the attached draft terms of reference for the new Strategic People Committee.
Corporate objectives met or risks addressed: Objectives relating to developing organisational culture and supporting our workforce.
Financial implications: None identified
Stakeholders: Trust Board, staff, HR directorate, NHSE/I, CQC, other external stakeholders.
Recommendation(s): To approve the draft terms of reference for the new committee
Presenting officer: Anne-Marie Stretch, Deputy Chief Executive/Director of Human Resources
Date of meeting: 28th July 2021

STRATEGIC PEOPLE COMMITTEE – Terms of Reference 2021/22	
Delegated Authority	The Trust shall establish a Committee to be known as Strategic People Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, education and training, employee health and wellbeing, learning and development, employee engagement, organisational development, leadership, workforce development, workforce planning and culture, diversity and inclusion. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the Committee to review specific aspects of workforce performance where the Board requires additional scrutiny and assurance.
Role	The Committee will provide assurance to the Board of the achievement of the Trust's strategic and operational objectives and specifically the Trust's People Strategy. To enable the Board to obtain assurance that high standards of workforce and peoples practices and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on all workforce issues 2. Identify, prioritise and monitor risk arising from workforce and people policies and practice 3. Ensure the effective and efficient use of resources through benchmarking and evidence-based practice 4. Protect the health and safety and wellbeing of Trust employees 5. Ensure compliance with legal, regulatory and other obligations. The Committee has established a Workforce Council and may recommend additional Councils aligned to key areas of its activity as it deems appropriate. Triangulation with other committees of the Board to ensure themes are identified and actions are progressed to support the development of the people agenda and delivery of high quality services.
Duties	The Committee will undertake the following duties:- 1. Consider and recommend to the Board, the Trust's overarching People Strategy and associated action/implementation plans. 2. Obtain assurance of the delivery of the People Strategy through the associated action/implementation plans.

	3. Consider and recommend to the Board the key people and workforce performance metrics and improvement targets for the Trust. 4. Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. 5. Review the people and workforce risks of the corporate risk register and the Board Assurance Framework. 6. Receive reports in relation to internal and external quality and performance targets relating to people and workforce and associated activity/implementation plans. 7. Conduct reviews and analysis of strategic people and workforce issues and to recommend the Board level response. 8. Review and make recommendations to the Board in respect of regulatory and statutory workforce publications and returns, such as; Annual Gender Pay Gap, Freedom to Speak Out declarations, the annual staff survey, WDES/WRES and workforce planning
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Directors x 2 Director of Human Resources /Deputy CEO Director of Nursing, Midwifery and Governance Director of Operations & Performance Director of Corporate Services Deputy Director of HR The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to core members the Deputy Medical Director, Assistant Director of Patient Safety, Assistant Director of Learning Development, Assistant Director of Workforce Development and Resourcing, may be asked to attend all or part of the meetings to present on specific issues. Other officers of the Trust may be co-opted or requested to attend as considered appropriate. Members are selected for their specific role or because they are representative of a function of service. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.

Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet 4 times per annum
Agenda Setting and papers	Agendas agreed by the Chair and Director of HR/Deputy CEO, will be in accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution is via the Executive office. Items for the agenda must be sent to the Chair a minimum of 5 working days prior to the meeting. Urgent items may be raised under any other business. The agenda will be sent out to the Committee members at least 3 working days prior to the meeting date together with the updated action list and other associated papers. Formal minutes shall be taken of all Committee meetings. Once approved by the Committee the Chair will produce an assurance report for the following Trust Board. Assurance reports from the Workforce Council (and associated groups) will be received by the Committee along with the reports as agreed.

TRUST BOARD

Paper No: NHST(21)053
Title of paper: Information Governance Annual Report (including Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Teaching Hospitals Trust operates within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.
Summary: This report summarises the Trust's current status of the Data Security and Protection Toolkit (DSPT) for its 2020-21 submission. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to and process patient / personal data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly and in line with data protection legislation. When considering data security as part of the 'Well Led Key Line of Enquiry' as part of the Care Quality Commission (CQC) inspections, they will consider how organisations are assuring themselves against these standards. This year due to the pandemic the submission date was moved from March 2021 to the end of June 2021. The Trust has submitted the DSPT assessment at the end of June 2021 for the 2020/21 submission and was able to submit evidenced items for all the assertions as required as part of the submission, the Trust achieved a "standards met" rating for the submission. A number of the assertions and evidenced items have been audited by Mersey Internal Audit Agency (MIAA). The Trust has received the rating of 'Substantial Assurance' against its DSPT. The Freedom of Information annual report is appended. This report is designed to update the Trust Board on its compliance level with the Freedom of Information Act. This report summarises the key points of FOI compliance for 2020-2021.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board and Commissioners.
Recommendation(s): • The Board to note and approve the content of this paper. • Be assured that robust arrangements are in place to effectively manage the Information Governance Agenda within the Trust.
Presenting officer Christine Walters, Director of Informatics
Date of meeting: 28th July 2021

Information Governance Annual Report and Freedom of Information Annual Report 2020/21

Introduction

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

The Trust has its own IG strategy which sets out the approach it takes in developing and implementing a robust Information Governance framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further support IG work including the Corporate Records Management Policy, Confidentiality Code of Conduct Policy, and Data Quality Policy. All of which are made available to staff via the intranet.

The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. It is based on the National Data Guardian ten data security standards (covering topics such as staff responsibilities and continuity planning (National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) and legal rules relevant to IG and personal data (UK General Data Protection Regulation 2016 and the Data Protection Act 2018).

All organisations that have access to and process patient / personal information must provide assurances that they are practising good information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The DPST this year contained 111 mandatory 'assertions' that required evidencing. Each mandatory requirement has to be addressed in order to submit a successful assessment - if this was not achieved the Trust would have been considered non-compliant.

The DSPT submission is usually required to be made in March, however the deadline for 2020-21 was extended until 30 June 2021, and NHS Digital recognised that the pandemic took priorities elsewhere. The Trust submitted a successful DSPT before the deadline and met all mandatory requirements.

Larger organisations, such as Acute Trusts, are also required to have their DSP Toolkit submission externally audited to ensure the accuracy of their submission. The objective of this exercise is to provide independent assurance over a nationally determined sample of evidence items and to highlight areas for improvement to inform the 2021-22 DSPT submission.

Failure to complete the Data Security and Protection Toolkit can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact the Trust's ability to bid for new services in the future. In addition, could place the Trust's reputation at risk. The Information Commissioner has also indicated that satisfactory completion of the Data Security and Protection Toolkit can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2020/21 Submission

Evidence has been provided for the self-assessment against the 10 standards and the associated assertions that sit under each standard. These items are recorded under assertions and represent an indicator of maturity in that area. There are in total 44 assertions and 111 mandatory assertion items that require evidence.

For example, in order to comply with part of Section 1 for 'Personal Confidential Information', the Trust has to provide evidence for the assertions as detailed below:

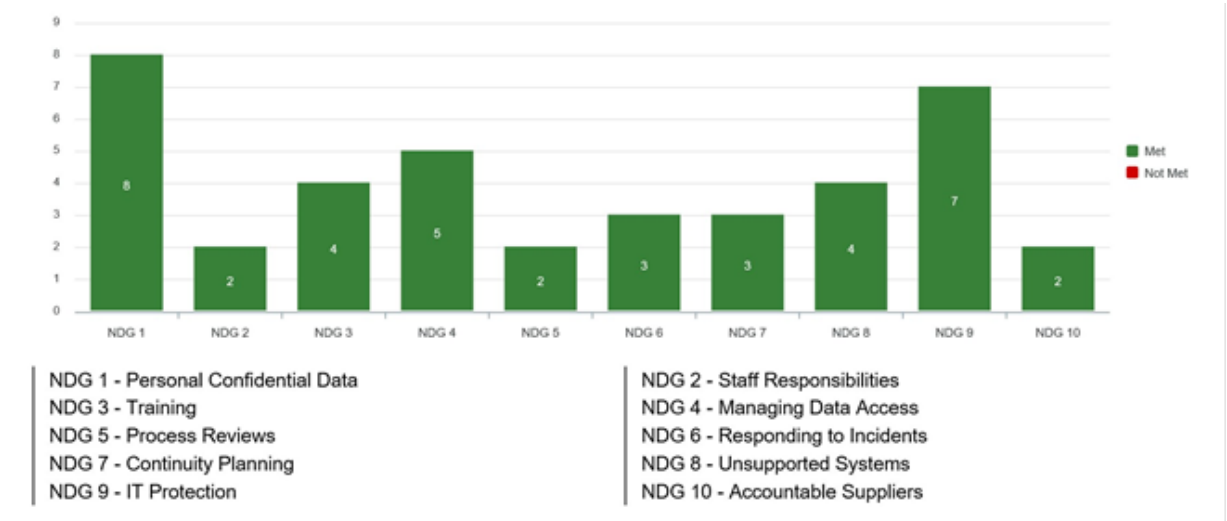
1.1	**There is senior ownership of data security and protection within the organisation.**	
1.1.1	Has SIRO Responsibility for data security been assigned?	Mandatory **COMPLETED**
1.1.2	List the names and job titles of your key staff with responsibility for data protection and/or security.	Mandatory **COMPLETED**
1.1.3	Are there clear lines of responsibility and accountability to named individuals for data security?	Mandatory **COMPLETED**
1.1.4	Is data security direction set at board level and translated into effective organisational practices?	Mandatory **COMPLETED**

1.2	**There are clear data security and protection policies in place and these are understood by staff and available to the public**		
1.2.1	Are there board-approved data security and protection policies in place that follow relevant guidance?	Mandatory	**COMPLETED**
1.2.3	How are data security and protection policies made available to the public?		**COMPLETED**

1.8	**There is a clear understanding and management of the identified and significant risks to sensitive information and services**		
1.8.1	Does your organisation operate and maintain a data security risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility?	Mandatory	**COMPLETED**
1.8.3	What are your top three data security and protection risks?	Mandatory	**COMPLETED**

For the Trust to have achieved “standards met”, the Trust has had to complete all of the items in the DSPT. Our baseline assessment was submitted to NHS Digital in February 2021.

The Trust has successfully completed the DSPT in time for the end of June 2021 submission date. A summary of how the 2020/21 submission looked is shown below:



Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of the Trust's DSPT submission (as required of larger NHS organisations) during two visits in February and March 2021 to assess the Trust's compliance against these standards. MIAA audited assertions which covered each standard of the DSPT including, Personal Confidential Data, Staff Responsibilities, Business Continuity Planning and Unsupported Systems. These areas cover thirteen assertions (see below), which this year have been selected by NHS Digital. Due to the involvement of NHS Digital the audits have changed significantly with additional evidence and assurance required in all areas being reviewed. The scope of the review included mandatory elements only.

Area	Description
1.6	The use of personal information is subject to data protection by design and by default.
1.8	There is a clear understanding and management of the identified and significant risks to sensitive information and services
2.2	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards.
3.1	There has been an assessment of data security and protection training needs across the organisation.
4.2	Organisation assures good management and maintenance of identity and access control for its networks and information systems
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents.
6.2	All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway.
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents.
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.
8.3	Supported systems are kept up-to-date with the latest security patches.
8.4	You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service.
9.2	A penetration test has been scoped and undertaken
10.2	Basic due diligence has been undertaken against each supplier that handles personal information in accordance with ICO and NHS Digital guidance.

The Trust received the audit report from MIAA in June which has confirmed a rating of 'Substantial Assurance,' this is the same as last year, although the audit this year was far more stringent.

Substantial Assurance

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2020-21.

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

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

Roles and Responsibilities

The Role of the SIRO

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

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

The key responsibilities of the SIRO are to:

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

The SIRO also takes overall ownership of the Trust's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk

on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

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

The SIRO has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The focus of DSPT is on setting standards and providing tools to achieve them. The standards provide assurance across ten areas.

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

The Role of the Caldicott Guardian

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

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

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

The Trust Caldicott Guardian is supported by the Director of Informatics in her role as Senior Information Risk Owner (SIRO) and the Head of Information Governance & Data Protection Officer and her team.

Data Protection Officer

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

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

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

The named DPO must be:

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

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

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

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee accountable to the Trust Risk Management Council and ultimately the Trust Board. The Group, which has been operational since January 2008, oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader Information Governance Agenda and provide the Trust Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust.

The IGSG is chaired by the Trust Caldicott Guardian Mr Alex Benson, with the Trust SIRO as Deputy Chair. Core membership includes Trust Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG has also seen the Group address the following topics in addition to achieving DSP Toolkit compliance –

- Continued embedding the Data Protection Impact Assessments (DPIAs) process across the Trust and seeing a rise in the completion and approval of DPIAs.
- Supported a number of projects related to information sharing as part of the Covid Pandemic response.
- Continued to build on a closer working relationship with the IT security team.
- Revised training to include online sessions offering more flexibility for staff when attending the sessions.
- Carried out supplier due diligence checks on new and existing suppliers.

Reportable Incidents

The Trust has a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2020/21 there was one incident. None of the incidents reported required the Trust to take further action.

A breakdown of those incidents that have been reported to the ICO is below:

July 2020	An employee of the Trust was found to have viewed a number of colleagues HR records when they were not authorised to do so.

There have been no fines issued by the ICO to the Trust in 2020-21.

Reporting & Monitoring

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

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

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

The Year Ahead

The next 12 months will continue to see the Trust continue to embed its Information Governance strategy and ensure it remains compliant with the DSPT, data protection legislation and its own IG framework. Maintaining compliance will occur through planning and day to day activities which will need to be balanced against the requirements of the organisation.

It is important that key IG processes are monitored, revisited and updated where necessary. This ensures that they remain relevant and work in line with other Trust policies.

For 2021-22 an Information Governance work plan has been introduced which will be monitored by the IGSG and will highlight progress in each area. The IG work plan details the work the hospital will need to carry out during the course of this financial year to ensure it remains on track with its compliancy.

This year the following areas will be of primary focus:

- **IAO (Information Asset Owner) engagement and complying with responsibilities** – specific IAO training will be developed and delivered to all IAOs to ensure they understand their IG responsibilities and how an IAO provides support to the SIRO and the IG team.

- **Implementing new Information Asset Registers (IARs)** - a new IAR has been developed incorporating ICO and data protection legislation requirements. There is a need to understand where Trust personal data is being processed and to ensure this data can be processed legally, is being held as securely as possible and to identify any risks. The new IAR template has been approved by the IGSG in April. Work will commence this year to collate robust IARs for each area with the support of the IAOs. Any high risks will be highlighted to the SIRO.

- **Use of the Data Breach Investigation Report** – When a data breach occurs, whether that is a serious near miss or an actual breach. it is important that a full report is carried out with lessons learned and an action plan. This report will be able to provide the SIRO and Caldicott Guardian (and any relevant parties) with assurance that the breach was fully investigated. This is a new report template which was approved by IGSG in April 2020 and will be used in conjunction with Trust departments going forward.

- **Review and update of the DPIA procedure and template** – uptake and completion of DPIAs has increased in the last year, however there is a need to make the DPIA template more user friendly so that staff are aware of who should complete what sections (this is an IG risk assessment form whereby all staff involved in the project should input, rarely it is a document that can be completed by one person). Once updated there will be a drive to communicate what DPIAs are, when they should be completed and by whom.

Conclusion

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

This year will continue to see new systems and processes being implemented that will involve the use of the personal data not only for use at the Trust but wider across the Cheshire and Mersey ICS and the North West. This is welcomed and required for cross organisational and collaborative working. It is therefore important that the IG Steering Group continue to monitor the progress of the Information Governance Agenda within the Trust, to

ensure the IG team receive full support, so that compliance is maintained, processes are improved upon and proactive involvement occurs.

ENDS

Appendix 1

Freedom of Information Act Annual Report 2020/21

Introduction

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

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

The Chief Executive who has overall responsibility in the Trust for the FOI Act has delegated the responsibility for the implementation and monitoring of the Act to Anne-Marie Stretch, the Deputy Chief Executive and Director of Human Resources (also known as the Executive FOI lead). The Executive FOI Lead ensures that the Trust is complying with the legislation and takes overall ownership of the Trust's FOI Policy, making sure systems and procedures are established and reviewed to support the FOI process.

The Information Governance team through dedicated resources, process, coordinate, monitor and report all FOI requests. This includes following all administration procedures and record keeping in line with the Trust's FOI policy and the FOI Act.

This report summarises the key points of FOI compliance for 2020/2021.

Statistical analysis of the requests and responses for 2020/21 are shown here, with comparisons to previous years where relevant.

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

Performance

- The overall compliance figure shows an improvement on the previous year's compliance levels both in terms of compliance with the 20-working day timescale and the overall response rate, this is despite the Covid pandemic.

- 486 requests received in total; this is a decrease from last year's total of 661.

- Out of the 486 requests received in the year, 13 areas of the Trust account for 75% of those requests received.

- Three areas of the Trust received the most requests HR (68), Information (67) and Informatics (51).

- 43% of requests were answered within the 20-working day timescale, this is an increase on previous year's 35%.

- 84.5% of all requests received in the 2020-2021 financial year have been responded to.

- Commercial, Public and Press remain the categories of requester who the Trust receives the most requests from.

- The top 3 categories of requests that were received were: Lists & Registers, Our Services and About the Trust.

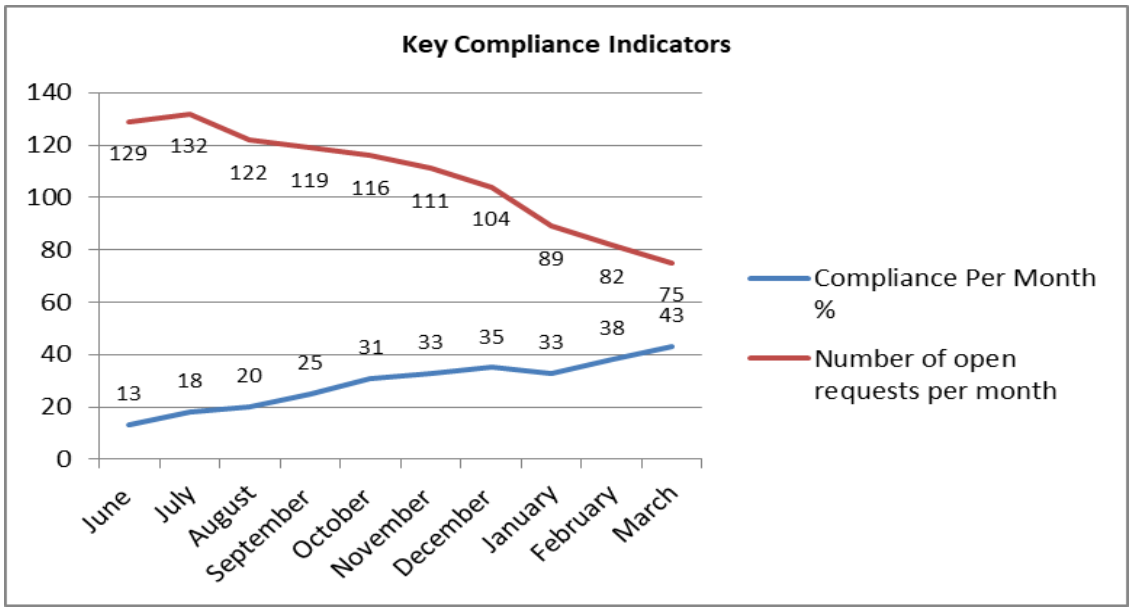
- During 20/21 the FOI process has been reviewed and revised from start to finish, with escalation procedures, increased reporting information and weekly reports for the Executive Team.

- A bespoke system is under development for processing FOI requests; this is being created in house as an additional module to the IT service desk system in order to automate some of the FOI processes.

- Additional staff resource has been added to the IG Team to support the FOI process.

Table 1 below shows the improvements made throughout the year even with the Covid pandemic.

Table 1



Areas of Improvement in 2020/21

- A review has taken place to monitor compliance with all areas of the FOIA and not just the mandatory timescales, compliance is monitored at the Trust's Risk Management Committee.

- The Trust's website has been updated and the FOI Disclosure Log (a log of responses to previous requests made) is now searchable using key words, this will help

requesters find the information they require if it has already been answered and will help reduce requests relating to the same subject area.

- The FOI publication scheme has been reviewed and is currently being updated.

Conclusion

Significant changes and additional resource and reporting has been added to the FOI process, as a result substantial progress has been made in ensuring that the Trust complies with all areas of the FOIA, it is expected that this progress will continue throughout the new financial year.

ENDS

Commencement Date:_____ 2021

MEMORANDUM OF UNDERSTANDING

For a PROVIDER COLLABORATIVE of NHS Mental Health, Learning Disabilities and Community Services Provider Organisations across Cheshire and Merseyside

Between:

(1) ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

(2) BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

(3) CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

(4) MERSEY CARE NHS FOUNDATION TRUST

(5) ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

(6) WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST

No	Comment / Distribution	Date
Drafts 0-0 to 0-4	Shared with members (either individually or collectively) of the Cheshire & Merseyside Community Providers CEO Meetings for their comment and deliberations.	February to May 2021
1	For consideration by the Boards of prospective member organisations.	June 2021

CONTENTS

This **Memorandum of Understanding** (the "**MoU**") is made between

(1) **ALDER HEY CHILDREN'S NHS FOUNDATION TRUST** of Eaton Road, Liverpool, L12 2AP ("**Alder Hey Children's**"); and

(2) **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST** of Europa Point, Europa Boulevard, Warrington, Cheshire, WA5 7TY ("**Bridgewater**"); and

(3) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST** of Redesmere, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1BQ ("**CWP**"); and

(4) **MERSEY CARE NHS FOUNDATION TRUST** of V7 Building, Kings Business Park, Prescot, Liverpool, L34 1PJ ("**Mersey Care**"); and

(5) **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST** of Whiston Hospital, Warrington Road, Prescot, Liverpool, L35 5DR ("**STHK**"); and

(6) **WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST** of St Catherine's Health Centre, Derby Road, Birkenhead, Wirral, CH42 0LQ ("**Wirral Community**").

together referred to in this MoU as the "Parties" and "Party" shall be construed accordingly. Nominated representatives from the above **NHS PROVIDER ORGANISATIONS** - the main NHS Provider Organisations responsible for the provision of **MENTAL HEALTH, LEARNING DISABILITIES** and **COMMUNITY** services to the people **CHESHIRE & MERSEYSIDE** - will be delegated members of the **CHESHIRE AND MERSEYSIDE NHS PROVIDER ORGANISATIONS MENTAL HEALTH, LEARNING DISABILITIES AND COMMUNITY SERVICES COLLABORATIVE** ("**C&M MHLDC Provider Collaborative**" or "**MHLDC Provider Collaborative**")

BACKGROUND

(A) In February 2020 the Secretary of State for Health and Social Care launched the White Paper ***Integration and innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill*** which outlined a number of changes, including establishing **INTEGRATED CARE SYSTEMS** ("**ICS**") through improved system working.

(B) Building upon the work initiated by the work of the **CHESHIRE AND MERSEYSIDE HEALTH AND CARE PARTNERSHIP** ("**C&MHCP**") and the **CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE** ("**Provider Collaborative**"), as we move towards the creation of a local statutory **ICS NHS BODY** and **ICS HEALTH & CARE PARTNERSHIP** envisaged by the White Paper, have come together as the MHLDC Provider Collaborative to (i) provide a joint voice to assist in the development of these new bodies and (ii) work more closely together in tackling variation and innovating the services they provide.

1. PURPOSE AND EFFECT

1.1. The Parties have agreed to work together on behalf of their service users and the populations they serve to deliver the best possible experience and outcomes within available resources as part of the continuing development of ICS. The Parties wish to record the basis on which they will work with each other to this end in this MoU and intend to act in accordance with its terms.

1.2. This MoU sets out:

1.2.1. the Scope, Purpose and Objectives for the MHLDC Provider Collaborative (section 4);

1.2.2. the Principles for working together (section 5);

1.2.3. the governance structures the Parties will put in place (section 7); and

1.2.4. the respective roles and responsibilities of the Parties.

1.3. The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU and save as provided in paragraph 1.4 below, this MoU shall not be legally binding. The Parties enter into this MoU intending to honour all their obligations.

1.4. The paragraphs of this MoU relating to:

1.4.1. Data Sharing and Confidentiality (paragraphs 8.1 to 8.8),

1.4.2. Legal Status (paragraphs 14.1 to 14.2),

1.4.3. Force Majeure (paragraph 17.1),

1.4.4. Partnership (paragraph 18.1), and

1.4.5. Governing Law and Jurisdiction (paragraph 19.1)

shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

2.1. Each of the Parties acknowledges and confirms that as at the date of this MoU it has obtained all necessary authorisations to enter into this MoU and made any necessary amendments to its own internal governance, standing orders and schemes of delegation.

3. DURATION

3.1. This MoU shall commence on the **COMMENCEMENT DATE** and will continue unless and until terminated in accordance with its terms.

4. SCOPE, PURPOSE AND OBJECTIVES

4.1. ***Scope*** – the development of the MHLDC Provider Collaborative provides an opportunity for the Parties to fully contribute to the development of the ICS across Cheshire and Merseyside whilst also ensuring that NHS-provided mental health, learning disabilities and community services, which have often suffered from a lack of longer term strategy, scale and stability – particularly when compared with the development of the NHS-provided acute services – have the ability collectively to expound the case for and benefits of NHS-provided mental health, learning disabilities and community services.

4.2. ***Purpose*** – in particular the MHLDC Provider Collaborative will facilitate a forum through which the NHS Provider Organisations responsible for the provision of the majority of NHS mental health, learning disabilities and community services to the people of Cheshire and Merseyside can contribute to the development and delivery of the local ICS by working together to:

4.2.1. help plan services, balancing the needs of PLACE against the provisions and sustainability of high quality mental health, learning disabilities and community services;

4.2.2. explore and ensure opportunities for the best use of resources supporting the delivery of mental health, learning disabilities and community services (narrowing the performance curve);

4.2.3. tackle variation through transparent data, peer review and support arrangements;

4.2.4. equalise access (tackling inequality across Cheshire and Merseyside) and equalise pressures on individual organisations

4.2.5. maximise the expertise, knowledge and learning opportunities between and across the Parties, to help improve mental health, learning disabilities and community services culture and service provisions locally;

4.2.6. provide opportunities for innovation at scale: shifting the performance curve while guarding against any inequality impact;

4.2.7. work collaboratively to meet workforce challenges.

4.3. ***Objectives*** - the main objectives for the MHLDC Provider Collaborative shall include:

4.3.1. enabling people to take more responsibility for their own health and well-being;

4.3.2. better understanding the clinical needs of our population through the use of a population health management approach and thereby to maximise the opportunity to prevent, and to intervene early to reduce the need for more intensive ongoing care;

4.3.3. reducing health inequalities across the area;

4.3.4. reducing service variation and supporting a standardised approach where appropriate whilst recognising the importance of person centred care;

4.3.5. developing new ways of working that will ensure patients receive consistently high standards of care;

4.3.6. delivering services care closer to home, wherever appropriate;

4.3.7. evolving clinical pathways to be better integrated across providers to improve patient experience;

4.3.8. aligning our strategic direction and whenever possible supporting and developing a shared Quality Strategy and systems and take a single, system wide approach to the delivery and monitoring of quality whilst not taking away from place-based care which is locally needs led;

4.3.9. delivering peer support and clinical governance support to our staff across the MHLDC Provider Collaborative;

4.3.10. improving recruitment and retention of staff across the MHLDC Provider Collaborative;

4.3.11. offering rotational opportunities across the MHLDC Provider Collaborative to staff from the separate organisations to enable career development;

4.3.12. improving staff and workplace wellbeing, and build a sustainable and highly skilled health and care workforce in Cheshire & Merseyside;

4.3.13. whilst working collaboratively across Cheshire and Merseyside, we will also work within our places to improve outcomes with our populations and other parties.

4.4. ***Out of Scope*** – day to day operational issues are not the focus of the MHLDC Provider Collaborative and these will be handled by each Party in liaison with their respective regulator. Examples of operational issues out of scope include but are not limited to information relating to:

4.4.1. contracts with commissioners;

4.4.2. terms and conditions of employment;

4.4.3. the costs or inputs of providing a service; and

4.4.4. future strategy, plans or pricing for service provision.

5. PRINCIPLES

5.1. All Parties agree to the following principles in relation to working together through the MHLDC Provider Collaborative, in order to:

5.1.1. act collaboratively and in the best interest of the collective membership of the MHLDC Provider Collaborative recognising that the success of the

MHLDC Provider Collaborative will maximise benefits for the public, people who access services and each of the members;

5.1.2. act in the best interests of people who access services and an engaged public;

5.1.3. demonstrably improve the quality and clinical outcomes of the learning disability, mental health and community services which the Parties provide to their patients;

5.1.4. work as a partnership of equals;

5.1.5. adopt an open and constructive relationship with each other in relation to the MHLDC Provider Collaborative;

5.1.6. at all times, act in good faith towards one another

5.1.7. be cognisant of the sustainability of the system and the development of the local ICS;

5.1.8. learn lessons and

5.1.9. manage all information supplied by other parties in a confidential manner.

6. PROBLEM RESOLUTION AND ESCALATION

6.1. The Parties agree to adopt a systematic approach to problem resolution which recognises the Principles set out in section 5.

6.2. If a problem, issue, concern or complaint comes to the attention of a Party in relation any matter within the scope of this MoU, such Party shall notify the other and the Parties each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

6.3. Save as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved thorough discussion and / or correspondence between the Chief Executives of the Parties.

7. GOVERNANCE ARRANGEMENTS

7.1. MHLDC Provider Collaborative Forum

7.1.1. The Parties agree to establish the **MHLDC PROVIDER COLLABORATIVE FORUM** ("**Forum**''). For the avoidance of doubt the Forum shall not be a committee of any Party.

7.1.2. The Forum is the group responsible for leading the Parties to:

a) provide a joint voice representing mental health, learning disabilities and community services NHS provider organisations to assist in the development of the local ICS arrangements;

b) work more closely together in tackling unnecessary variation and innovating the mental health, learning disabilities and community services provided by the Parties; and

c) to review the Objectives for the MHLDC Provider Collaborative;

d) other responsibilities as defined in its terms of reference set out in Part 1 of Schedule 2 (MHLDC Provider Collaborative Forum – Terms of Reference).

7.2. MHLDC Provider Collaborative Management Group

7.2.1. The Parties agree to establish the **MHLDC PROVIDER COLLABORATIVE MANAGEMENT GROUP** ("**Management Group**") which will be responsible for coordinating the work of the MHLDC Provider Collaborative and developing recommendations for consideration of the Forum. For the avoidance of doubt the Management Group shall not be a committee of any Party.

7.2.2. The terms of reference for the Management Group shall be as set out in Part 2 of Schedule 2 (MHLDC Provider Collaborative Management Group– Terms of Reference).

7.3. The Parties will communicate with each other clearly, directly and in a timely manner to ensure that the members of the Forum and the Management Group are able to make effective and timely decisions in relation to the Purpose, Scope and Objectives of the MHLDC Provider Collaborative.

7.4. The Parties will ensure appropriate attendance from their respective organisations at all meetings of the Forum and the Management Group and that their representatives act in accordance with the Principles.

8. DATA SHARING AND CONFIDENTIALITY

8.1. For the purposes of any applicable data protection legislation the Parties shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this MoU.

8.2. Where appropriate the Parties agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Parties with reasonable assistance in complying with subject access requests and consulting with other Parties, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this MoU in relation to such requests.

8.3. All Parties will adhere to all applicable statutory requirements regarding data protection and confidentiality. The Parties agree to co-operate with one another with its respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4. The Parties, shall not, (save as permitted by this paragraph) either during or after the period of this Agreement divulge or permit to divulge to any person (including the parties to this MoU) any information acquired by connection with this MoU or in connection with this MoU which concerns:

8.4.1. any matter of commercial interest contained or referred to in this MoU;

8.4.2. all Parties' manner of operations, staff or procedures;

8.4.3. the identity or address or medical condition or treatment of services received by any client or patient of any of the Parties;

8.4.4. unless previously authorised by the parties concerned in writing provided that these obligations will not extend to any information which is or shall become public information available otherwise than by reason of a breach by the Parties of the provisions of this clause

8.5. For the avoidance of doubt, nothing in this MoU shall be construed as preventing any rights or obligations that the Parties may have under the Public Interest Disclosure Act (1998) and / or any obligations that the Parties have or may have to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to his professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6. The Parties acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this MoU Confidential Information means the provisions of this MoU and all information provided in connection with this MoU which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this MoU. The Parties undertake for themselves and their respective Boards and employees:

8.6.1. the disclosing Party shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.6.2. all Parties shall use no lesser security measures and degree of care in relation to any Confidential Information received from the other Party than it applies to its own Confidential Information;

8.6.3. the Parties shall not disclose any Confidential Information of the other Parties to any third party without the prior written consent of the other Parties;

8.6.4. on the termination of this MoU, each Party shall return any documents or other material in its possession that contains confidential information of the other Parties; and

8.6.5. all Parties agree that there may be a need for external contractors to request and access information for the sole purposes of advancing the work of the MHLDC Provider Collaborative which will be made explicit prior to access being given to parties.

8.7. The Parties that are subject to this MoU agree to provide in a timely manner and without restriction all information requested and required by the relevant designated Business Intelligence project team (either internal team or external contractor) to carry out the work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to the proposed changes;

8.7.1. all Parties agree that publicly available information may be shared fully with all other Parties that are subject to this agreement;

8.7.2. non-publicly available information provided to the designated team or contractor as part of this project including (but not limited to) relevant financial, activity, workforce and estates related information will be held securely by the contractor and not shared with the other providers, commissioners connected to this project without the express permission of the relevant originating organisation; and

8.7.3. no information will be shared with parties outside of the membership of the MHLDC Provider Collaborative.

8.8. Paragraph 8.5 shall not apply to any information which is already in the public domain (other than by a breach of this Agreement), or where disclosure is required by law or in relation to any information which is lawfully requested by government, Monitor or NHS England.

9. RESOURCING

9.1. All Parties agree that the success of the MHLDC Provider Collaborative relies on effective resources being made to support the Scope and Purpose

9.2. The MHLDC Provider Collaborative shall apply for funding through the Cheshire and Merseyside Health and Care Partnership (C&MHCP), NHS England / Improvement's Regional Team and other external sources for resources to support the operation and delivery of the Objectives for the MHLDC Provider Collaborative.

9.3. The Forum shall collectively agree the budget and prioritisation of resources in line with the Scope, Purpose, Objectives and Principles outlined in the MoU, based upon recommendations prepared by the Management Group.

9.4. Should bidding for funding be unsuccessful or should the Parties wish to consider developments not funded, each Party will be asked to consider what resources it can make (including in kind) to support the operation and delivery of the Objectives for the MHLDC Provider Collaborative, based upon an equitable split based on the size and capacity of the organisation. If resources do have to be made available through each Party, a schedule will be prepared (Schedule 3) recording these arrangements for attachment to this MoU.

9.5. Where resources are managed jointly on behalf of the Parties these shall be managed on behalf of the Parties by the **HOST ORGANISATION**.

10. APPLYING FOR MEMBERSHIP

10.1. Any NHS Provider Organisation responsible for the provision of mental health and community services for the people of Cheshire and Merseyside (the "**APPLICANT**") may apply for membership of the MHLDC Provider Collaborative in writing (including email) to the Chair of the Forum, who shall in turn pass this to the Chair of the Management Forum and the Host Organisation's Trust Secretary.

10.2. Applications will be considered in the first instance by the Management Group which shall take account:

10.2.1. the Applicants commitment to the Scope, Purpose, Objectives and Principles as set out in this MoU;

10.2.2. the scale of the provision of mental health, learning disabilities and community services to the people of Cheshire and Merseyside by the Applicant; and

10.2.3. any other factors the Management Group determine may be relevant.

10.3. The Management Group shall submit a recommendation to the Forum as to whether or not the Applicant should be invited to join the MHLDC Provider Collaborative, outlining the reasons for its recommendation, including what, if any, other factors it determined were relevant.

10.4. Following consideration of the Management Group's recommendation, the Forum shall determine whether or not to extend an invitation to the Applicant, and the Chair of the Forum will write to the Applicant to inform them of the Forum's decision. If the Forum agrees to extend an invitation, then all Parties understand this MoU will be updated to reflect the Applicant joining the MHLDC Provider Collaborative.

10.5. The decision of the Forum shall be final in all matters relating to an organisation applying to become a member of the MHLDC Provider Collaborative.

11. TERM AND REVIEW

11.1. This MoU commences on the date it is entered into and will continue unless terminated in accordance with paragraph 12.1.

11.2. The MoU shall be reviewed by the Parties at least annually after the commencement date.

12. NOTICE AND TERMINATION

12.1. All Parties reserve the right to withdraw from the MoU at any point without penalty, by informing the other Parties of their intention to do so in writing with a minimum of three months notice

12.2. Reasons for termination may include, but are not restricted to, where it is felt there is a detriment to the performance of any Parties because of this MoU.

13. SEVERABILITY

13.1. If any provision of this MoU is or becomes illegal, void or invalid, that shall not affect the legality and validity of the other provisions.

14. LEGAL STATUS

14.1. With the exception of the Parties' duties of data protection and confidentiality set out above at paragraphs 8.1 to 8.3 (inclusive), the Parties acknowledge that this MoU is a non-binding agreement between the Parties. It has no legal standing and no party will seek redress through any legal process. It is expected, however, that for the duration of the MoU all parties will adhere to the terms of the MoU as outlined.

14.2. Despite the general lack of legal obligation (with exceptions set out above) imposed by this MoU, the Parties have each given proper consideration to the terms set out in this MoU and agree to act in good faith and in accordance with its terms. The legally binding obligations of this MoU will cease to have effect upon termination of this MoU.

15. VARIATION TO THE MEMORANDUM OF UNDERSTANDING

15.1. Should it become necessary, this MoU may be varied in writing subject to mutual MoU by all parties.

15.2. Where mutual agreement cannot be gained then the relevant notices outlined above may be invoked in order to terminate the MoU.

16. ACCRUED RIGHTS AND REMEDIES

16.1. Neither the expiration nor the termination of the MoU shall prejudice or affect any right of action or remedy which shall have accrued or shall thereafter accrue to any party to this MoU.

17. FORCE MAJEURE

17.1. No party to the MoU shall be liable to the other party for any failure to perform its obligations under the MoU where such performance is rendered impossible by circumstances beyond its control, but nothing in this condition shall limit the obligations of all parties to use their best endeavours to fulfil their obligations under the MoU.

18. PARTNERSHIP

18.1. Nothing in this MoU shall create, imply or evidence any partnership or joint venture between the parties or the relationship between them or principal and agent.

19. GOVERNING LAW AND JURISDICTION

19.1. This MoU shall be governed by and construed in accordance with English law and each Party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

19.2. The following Parties have agreed to this MoU, which has been signed on behalf of each Party by the following authorised officer:

Signed by:	*Name*	
	Role	
	Dated:	
On behalf of:	**Alder Hey Children's NHS Foundation Trust**	

Signed by:	*Name*	
	Role	
	Dated:	
On behalf of:	**Bridgewater Community Healthcare NHS Foundation Trust**	

Signed by:	*Name*	
	Role	
	Dated:	
On behalf of:	**Cheshire and Wirral Partnership NHS Foundation Trust**	

Signed by:	*Name*	
	Role	
	Dated:	
On behalf of:	**Mersey Care NHS Foundation Trust**	

Signed by:	*Name*	
	Role	
	Dated:	
On behalf of:	**St Helens and Knowsley Teaching Hospitals NHS Trust**	

Signed by:	*Name*	
	Role	
	Dated:	
On behalf of:	**Wirral Community Health and Care NHS Foundation Trust**	

SCHEDULE 1
DEFINITIONS AND INTERPRETATION

The following words and phrases have the following meanings in this MoU:

Applicant	refers to any **NHS Provider Organisation** seeking to become a **Party** to the **MHLDC Provider Collaborative**
Approved Purpose	the delivery and management as defined in paragraph 4.2 under this **MoU**
Cheshire and Merseyside	the geographical area encompassing the following local authorities: (i) within the county of Cheshire • Cheshire East Council • Cheshire West and Chester Council • Halton Borough Council • Warrington Borough Council (ii) within the county of Merseyside • Knowsley Metropolitan Borough Council • Liverpool City Council • Sefton Metropolitan Borough Council • St Helens Metropolitan Borough Council • Wirral Metropolitan Borough Council
Cheshire and Merseyside Health and Care Partnership or **C&MHCP**	is the local Sustainability and Transformation Partnership representative body for **Cheshire and Merseyside**, envisaged as a building bloc for the development of **Integrated Care Systems**
Cheshire and Merseyside NHS Provider Organisations Mental Health and Community Services Collaborative or **Cheshire and Merseyside Provider Collaborative** or **C&M MHLDC Provider Collaborative** or **MHLDC Provider Collaborative**	the name of the representative body referred to in this document. See also **Provider Collaborative Forum** and **Provider Collaborative Management Group**
Commencement Date	to be confirmed
Community Service(s)	a NHS-funded service that provides a range of mental health, learning disabilities and physical health services in a community rather than a hospital setting in order to keep people well and / or treating and managing acute illness or long-term conditions and / or supporting people to live independently for adults, children or young people

Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Parties and which that Party properly considers is of such a nature that it cannot be exchanged with the other Party without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Party, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this MoU, including Competition Sensitive Information
Data Protection Legislation	(i) the UK General Data Protection Regulation 2018 (UK GDPR); (ii) the Law Enforcement Directive (Directive (EU) 2016/680) and any applicable national Laws implementing them as amended from time to time; (iii) the Data Protection Act 2018; and (iv) all applicable Law about privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality
Dispute	any dispute arising between the Parties in connection with this document or their respective rights and obligations under it
Dispute Resolution Procedure	any dispute shall be addressed between the Chief Executives of the Parties to this MoU in a manner to be agreed by the Chief Executives
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Parties have a duty to have regard (and whether specifically mentioned in this MoU or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Parties by a relevant regulatory body

Host Organisation	the Party to this document which agrees to manage any joint resources and / or host any seconded staff and / or provides administrative resources to support the operation of the MHLDC Provider Collaborative and its governance arrangements
ICS Health and Care Partnership	the statutory body envisaged by Government to represent the NHS, local government and partners in respect of the development and oversight of local **Integrated Care Systems**
ICS NHS Body	the statutory body envisaged by Government comprising of strategic planning function and representatives from NHS Bodies that will be responsible for the day to day running of local **Integrated Care Systems**
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Integrated Care or **Integrated Care Systems** or **ICS**	as is referenced in *Integration and Innovation: working together to improved health and social care for all. The Department of Health and Social Care's legislative proposal for a Health and Care Bill* (Department of Health and Social Care, 11 February 2021)
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	• any applicable statute or proclamation or any delegated or subordinate legislation or regulation; • any applicable judgment of a relevant court of law which is a binding precedent in England; • Guidance; • National Standards (as defined in the NHS Standard Contract); and • any applicable code and "Laws" shall be construed accordingly
Mental Health Service(s)	a NHS-funded service that provides specialist community or inpatient mental health and / or learning disabilities and / or autistic spectrum disorder services for adults, children or young people

MoU or **Memorandum of Understanding**	this document incorporating the Schedules
NHS Provider Organisation(s)	either NHS Trusts or NHS Foundation Trusts who provide mental health, learning disabilities or community services to the populations of **Cheshire and Merseyside**
NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Party or **Parties**	the **NHS Provider Organisations** who are the signatories to this **Memorandum of Understanding**
Provider Collaborative Forum or **Forum**	the group established by the **Parties** pursuant to paragraph 7.1
Provider Collaborative Management Group or **Management Group**	the group established by the **Parties** pursuant to paragraph 7.2
Services	the services provided, or to be provided, by a Party pursuant to its respective Services Contract
Services Contract	a contract entered into by one of the Parties for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires
Term	the Term of this Agreement pursuant to paragraph 11.1

SCHEDULE 2 (PART 1)
CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE FORUM
Terms of Reference

1. PURPOSE

1.1. The purpose of the MHLDC Provider Collaborative Forum (the "Forum") is to lead the Parties to

1.1.1. provide a joint voice representing mental health, learning disabilities and community services NHS provider organisations to assist in the development of the local ICS arrangements;

1.1.2. work more closely together in tackling variation and innovating the mental health, learning disabilities and community services provided by the Parties

in accordance with the Principles set out in the Memorandum of Understanding (the "MoU"). The Forum will hold to account the MHLDC Provider Collaborative Management Group.

2. STATUS AND AUTHORITY

2.1. The Forum is established by the Chief Executives of the Parties, each of which remains a sovereign organisation, to provide a governance framework for the further development of joint working between them in line with the Principles.

2.2. The Forum is not a separate legal entity, and as such is unable to take decisions separately from the Parties, or bind any one of them; nor can one Party 'overrule' the other on any matter. As a result, the Forum will operate as a place for discussion of issues with the aim of reaching consensus between the Parties in line with the Principles.

2.3. The Forum will function through engagement and discussion between its members so that each Party makes a decision in respect of, and expresses its views about, each matter considered by the Forum. The decisions of the Forum will, therefore, be the decisions of the individual Party, the mechanism for which shall be authority delegated by the individual Parties to their representatives on the Forum.

2.4. The Parties will delegate to their representative(s) on the Forum such authority as is agreed to be necessary in order for it to function effectively in discharging its responsibilities in these terms of reference. The Parties will ensure that each of their representatives has equivalent delegated authority, which is in writing, agreed between the Parties and recognised to the extent necessary in their respective Schemes of Delegation (or similar) or through the approval or their respective Boards of Directors (where applicable) . The Parties will ensure that their Forum members understand the status of the Forum and the limits of the authority delegated to them.

3. ACCOUNTABILITY

3.1. The Forum is accountable to each of the Chief Executives of the Parties, who shall be responsible for informing their Boards on the work of the MHLDC Provider Collaborative.

4. RESPONSIBILITIES

4.1. The Forum is responsible for leading the Parties joint working in accordance with the Scope, Purpose and Objectives, in line with the terms of the MoU.

4.2. The members of the Forum will for example:

4.2.1. contribute to the development of the ICS across Cheshire and Merseyside whilst collectively explaining the case for and benefits of NHS-provided mental health, learning disabilities and community services;

4.2.2. help plan services, balancing the needs of PLACE against the provisions and sustainability of high quality mental health, learning disabilities and community services;

4.2.3. explore and ensure opportunities for the best use of resources supporting the delivery of mental health, learning disabilities and community services (narrowing the performance curve);

4.2.4. tackle variation through transparent data, peer review and support arrangements;

4.2.5. equalise access (tackling inequality across Cheshire and Merseyside) and equalise pressures on individual organisations

4.2.6. maximise the expertise, knowledge and learning opportunities between and across the Parties, to help improve mental health, learning disabilities and community services culture and service provisions locally;

4.2.7. provide opportunities for innovation at scale: shifting the performance curve while guarding against any inequality impact;

4.2.8. take account of any recommendation from the Management Group when considering applications to join the MHLDC Provider Collaborative; and

4.2.9. review the MoU – particularly the MHLDC Provider Collaborative's Scope, Purpose and Objectives – on an annual basis.

4.3. The Forum members will make decisions together at Forum meetings in respect of the Scope and Purpose of the MHLDC Provider Collaborative, including in relation to recommendations from the MHLDC Provider Collaborative Management Group.

4.4. When making decisions together at Forum meetings, the members will act in line with the Principles and their respective obligations under the MoU

5. MEMBERSHIP

5.1. The Forum will include the following members:

5.1.1. the Chief Executives (or their representative) from the following:

a) Alder Hey Children's NHS Foundation Trust (specifically in respect of the Child and Adolescent Mental Health Services (CAMHS) they provide),

b) Bridgewater Community Healthcare NHS Foundation Trust,

c) Cheshire And Wirral Partnership NHS Foundation Trust,

d) Mersey Care NHS Foundation Trust,

e) St Helens and Knowsley Teaching Hospitals NHS Trust (specifically in respect of the community services they provide); and

f) Wirral Community Health and Care NHS Foundation Trust.

5.1.2. the Managing Director of the MHLDC Provider Collaborative (as Chair of the MHLDC Provider Collaborative Management Group)

5.2. It is important that members commit to attending Forum meetings. Where a member cannot attend a meeting, the member can nominate a named representative to attend. Deputies must be able to contribute and make decisions on behalf of the organisation they are representing.

6. IN ATTENDANCE

6.1. The following non-voting members will attend Forum meetings:

6.1.1. a Trust Secretary from one of the Parties;

6.1.2. a Minute Secretary from the **HOST ORGANISATION**.

6.2. The Forum may invite others to attend meetings of the Forum as observers. Such observers will not participate in decisions

7. QUORUM

7.1. The Forum will be quorate if four of the Parties' representatives are present, one of whom shall be the Chair or the Deputy Chair. A member shall be deemed present if they are physically at the meeting or joining the meeting by telephone or video-conference.

8. CHAIR AND DEPUTY CHAIR

8.1. The Chair and Deputy Chair shall be selected by the Forum's members.

9. DECISION MAKING

9.1. The Forum will aim to achieve consensus wherever possible.

9.2. Each member of the Forum will be representing their organisation and presently will only make decisions at the Forum in respect of their own organisation in accordance with any delegated authority.

9.3. In the event a vote is required, each Party shall have one vote and decisions will require at least five members to support a proposal.

10. CONDUCT OF BUSINESS

10.1. Meetings of the Forum will be held monthly or such other frequency as may be agreed between the Parties.

10.2. Meetings may be held in person, by telephone or video conference. Members of the Forum may participate (and count towards quorum) in a face-to-face meeting or via telephone or video-conference.

10.3. Any member may call extraordinary meetings of the Forum at their discretion subject to providing at least five working days' notice to Forum members (via the Chair and the Trust Secretary).

10.4. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting.

10.5. In the event members wish to add an item to the agenda they must notify the Chair and / or Trust Secretary who will confirm this with the other members accordingly.

10.6. The Forum will have administrative support from the Host Organisation to:

10.6.1. take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and

10.6.2. maintain a register of interests of Forum members.

10.7. The minutes of Forum meetings will be sent to representative members within 14 days of each meeting. It will be the members' responsibility to disseminate minutes and notes from the Forum inside their respective organisations.

11. CONFLICTS OF INTEREST

11.1. The members of the Forum must refrain from actions that are likely to create any actual or perceived conflicts of interests.

11.2. Forum members must disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties.

11.3. If there is any conflict between these terms of reference and the MoU, the latter will prevail.

12. ADMINISTRATIVE ARRANGEMENTS

12.1. The Trust Secretary will ensure:

12.1.1. that the Forum receives sufficient resources to undertake its duties;

12.1.2. correct minutes of meetings are taken and once agreed by the Chair that they are distributed to the members;

12.1.3. an action list is produced following each meeting and any outstanding action is carried forward on the action list until complete;

12.1.4. conflicts of interest are recorded along with the arrangements for managing those conflicts;

12.1.5. appropriate support to the Chair and Forum members to enable them to fulfil their role;

12.1.6. that advice is provided to the Forum on pertinent areas;

12.1.7. the agenda is agreed with the Chair prior to sending papers to members no later than five working days before the meeting (taking into account any annual cycle of business;

12.1.8. the papers of the Forum are filed in accordance with the host trust's policies and procedures.

12.2. The Trust Secretary (or their nominee) will collate the Forum's annual report and agree the ways of working to enable the Forum to meet the range of responsibilities set out in these terms of reference.

13. REVIEW

13.1. These terms of reference will be reviewed on an annual basis, in line with the review of the MoU.

SCHEDULE 2 (PART 2)

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE MANAGEMENT GROUP

Terms of Reference

1. PURPOSE

1.1. The purpose of the MHLDC Provider Collaborative Management Group (the "Management Group") is to:

1.1.1. assist in coordinating the work of all Parties in achieving the Scope and Purpose of the MHLDC Provider Collaborative;

1.1.2. developing proposals and, where necessary, recommendations for consideration by the MHLDC Provider Collaborative Forum (the "Forum") as to how to take forward the work of the MHLDC Provider Collaborative;

in accordance with the Principles set out in the Memorandum of Understanding (the "MoU"). The Management Group will report to the Forum.

2. STATUS AND AUTHORITY

2.1. The Management Group is established by the Forum which represents the Parties to the MoU, each of which remains a sovereign organisation, as part of the governance framework for the further development of joint working between them in line with the Principles.

2.2. The Management Group is not a separate legal entity, and as such is unable to take decisions separately from the Parties, or bind any one of them; nor can one Party 'overrule' the other on any matter in the Management Group.

2.3. As a result, the Management Group will operate as a place for discussion of issues with the aim of reaching consensus between the Parties around the development of the work for the designated areas of opportunity and for flowing matters to the Forum where required for determination or review.

2.4. The Management Group will function through engagement and discussion between its members so that each of the Parties makes a recommendation in respect of, and expresses its views about, each matter considered by the Management Group. The recommendations of the Management Group will, therefore, be the recommendations of the individual Parties, with these recommendations to be presented to the Forum for its consideration. .

2.5. As has been stated in Part 1 of Schedule 2 (i.e., the *status and authority* section for the Terms of Reference of the Forum), representative(s) of MHLDC Provider Collaborative have delegated authority, which is in writing, agreed between the Parties and recognised to the extent necessary in their respective Schemes of Delegation (or similar) or through the approval or their respective Boards of Directors, through which they have authority as individual parties to make decisions

3. ACCOUNTABILITY

3.1. The Management Group is accountable to the Forum. Any changes to the Management Group's terms of references must be considered and approved by the Forum.

4. RESPONSIBILITIES

4.1. The Management Group is responsible for assisting the Forum by

4.1.1. programme managing the delivery of the MHLDC Provider Collaborative's Objectives through working with all Parties to mobilise staff and resources;

4.1.2. overseeing the day to day delivery of these programmes to ensure the delivery of these Objectives, included the establishment of working groups across the Parties, for example:

a) business intelligence,

b) research and development,

c) digital innovation, and

d) population health management;

4.1.3. assisting with the communication of the MHLDC Provider Collaborative's Scope, Purpose and Objectives with:

a) the Parties and their teams,

b) the Cheshire and Merseyside Health and Care Partnership,

c) other providers across Cheshire and Merseyside, and

d) other stakeholder involved in the development of the local ICS;

4.1.4. developing proposals and recommendations, as appropriate, for the consideration of the Forum, including in respect of the MHLDC Provider Collaborative's Scope, Purpose and Objectives as part of the Forum's annual review of the MoU;

4.1.5. consider and make recommendations to the Forum in respect of any applications from NHS Provider Organisations to join the MHLDC Provider Collaborative.

4.2. The Management Group members will make decisions together at Management Group meetings in respect of the day-to-day delivery of the MHLDC Provider Collaborative's Scope, Purpose and Objectives, including making recommendations to the Forum.

4.3. When making decisions together at Management Group meetings, the Management Group members will act in line with the Principles and their respective obligations under the MoU.

5. MEMBERSHIP

5.1. The Management Group will include the following members:

5.1.1. The Management Director of the MHLDC Provider Collaborative (as chair of the Management Group);

5.1.2. the representatives of the following Parties nominated by the Parties' Chief Executives:

a) Alder Hey Children's NHS Foundation Trust (specifically in respect of the Child and Adolescent Mental Health Services (CAMHS) they provide),

b) Bridgewater Community Healthcare NHS Foundation Trust,

c) Cheshire And Wirral Partnership NHS Foundation Trust,

d) Mersey Care NHS Foundation Trust,

e) St Helens and Knowsley Teaching Hospitals NHS Trust (specifically in respect of the community services they provide); and

f) Wirral Community Health and Care NHS Foundation Trust.

5.1.3. the Chairs of any working groups establishing to support the work of the Management Group.

5.2. It is important that members commit to attending Management Group meetings. Where a member cannot attend a meeting, the member can nominate a named representative to attend. Deputies must be able to contribute and make decisions on behalf of the organisation they are representing.

6. IN ATTENDANCE

6.1. The following non-voting members will attend Management Group meetings:

6.1.1. a Trust Secretary from one of the Parties;

6.1.2. a Minute Secretary from the Host Organisation.

6.2. The Management Group may invite others to attend meetings of the Management Group as observers. Such observers will not participate in decisions

7. QUORUM

7.1. The Management Group will be quorate if four of the Parties' representatives are present, together with the Management Director (or their nominated representative). A member shall be deemed present if they are physically at the meeting or joining the meeting by telephone or video-conference.

8. CHAIR AND DEPUTY CHAIR

8.1. The Chair shall be the Management Director of the MHLDC Provider Collaborative. The Deputy Chair shall be a person nominated by the Managing Director.

9. DECISION MAKING

9.1. The Management Group will aim to achieve consensus wherever possible.

9.2. Each member of the Management Group will be representing their organisation and presently will only make decisions at the Management Group in respect of their own organisation in accordance with any delegated authority.

9.3. In the event a vote is required, each Party shall have one vote and decisions will require at least five members to support a proposal.

10. CONDUCT OF BUSINESS

10.1. Meetings of the Management Group will be held monthly or such other frequency as may be agreed between the Parties.

10.2. Meetings may be held in person, by telephone or video conference. Members of the Management Group may participate (and count towards quorum) in a face-to-face meeting or via telephone or video-conference.

10.3. Any member may call extraordinary meetings of the Forum at their discretion subject to providing at least five working days' notice to Forum members (via the Managing Director and the Trust Secretary).

10.4. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting.

10.5. In the event members wish to add an item to the agenda they must notify the Chair and / or the Trust Secretary who will confirm this with the other members accordingly.

10.6. The Management Group will have administrative support from the host Trust to:

10.6.1. take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and

10.6.2. maintain a register of interests of Management Group members.

10.7. The minutes of Management Group meetings will be sent to representative members within 14 days of each meeting. It will be the members' responsibility to disseminate minutes and notes from the Forum inside their respective organisations.

11. CONFLICTS OF INTEREST

11.1. The members of the Management Group must refrain from actions that are likely to create any actual or perceived conflicts of interests.

11.2. Management Group members must disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties.

11.3. If there is any conflict between these terms of reference and the MoU, the latter will prevail.

12. ADMINISTRATIVE ARRANGEMENTS

12.1. The Trust Secretary will ensure:

12.1.1. that the Management Group receives sufficient resources to undertake its duties;

12.1.2. correct minutes of meetings are taken and once agreed by the Chair that they are distributed to the members;

12.1.3. an action list is produced following each meeting and any outstanding action is carried forward on the action list until complete;

12.1.4. conflicts of interest are recorded along with the arrangements for managing those conflicts;

12.1.5. appropriate support to the Chair and Management Group members to enable them to fulfil their role;

12.1.6. that advice is provided to the Forum on pertinent areas;

12.1.7. the agenda is agreed with the Chair prior to sending papers to members no later than five working days before the meeting (taking into account any annual cycle of business;

12.1.8. the papers of the Management Group are filed in accordance with the host trust's policies and procedures.

12.2. The Trust Secretary (or their nominee) will collate the Management Group's annual report and agree the ways of working to enable the Management Group to meet the range of responsibilities set out in these terms of reference.

13. REVIEW

13.1. These terms of reference will be reviewed on an annual basis, in line with the review of the MoU.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)054

Title of paper: Cheshire and Merseyside Integrated Care System – Provider Collaboratives

Purpose: For the Board to review and approve the governance documents for the newly formed provider collaboratives that will form a key part of the structure of the Cheshire and Merseyside Integrated Care System (ICS).

Summary: The creation of Provider Collaboratives is a key stage in the development of the ICS and is a requirement of the new NHS bill that is currently progressing through parliament.

In Cheshire and Merseyside it has been agreed there should be two Provider Collaboratives;

1. Acute and Specialist Trust Alliance (CMAST)
2. The Mental Health, Learning Disabilities and Community Services Provider Collaborative (Cheshire & Merseyside MHLDC Provider Collaborative)

This configuration has developed from the Hospital and Out of Hospital Cells that were created as part of the command and control structure in response to the COVID-19 pandemic.

St Helens and Knowsley Hospitals Trust will be a member of both the provider collaboratives because it delivers both acute and community services.

Both the provider collaboratives have been developing their initial governance proposals and are now seeking the approval of each member organisation's Board to ratify these as a starting point for the work they will undertake. The aim of the provider collaboratives is to support trusts to act collectively, in the interests of the population, and to respond to the triple aim duty for all NHS providers to:

- Align priorities.
- Support the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making.
- Direct resources to improve service provision.

The Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST) has developed terms of reference for a Provider Collaborative Board, to enable increased collaboration and to support collective decision-making (Appendix 1).

The Mental Health, Learning Disabilities and Community Services Provider Collaborative has developed a Memorandum of Understanding (MOU) which incorporates arrangements

for a Collaborative Forum and a Collaborative Management Group (Appendix 2). These are subject to further changes as national guidance on the role of Provider Collaboratives develops. Any changes would require the further approval of the member organisations.
Corporate objectives met or risks addressed: Work in partnership to improve health outcomes
Financial implications: None arising directly from the approval of this paper
Stakeholders: C&M ICS, Provider Trusts, NHSE/I, Staff, Patients
Recommendation(s): The Trust Board; 1. Approve the Terms of Reference for the C&M Acute and Specialist Services Alliance (Acute and Specialist Trust Provider Collaborative) 2. Approve the Memorandum of Understanding for the Mental Health, Learning Disabilities and Community Services Provider Collaborative
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 28th July 2021

Appendix 1

Cheshire and Merseyside
Health and Care Partnership

Provider Collaborative

Terms of Reference

Acute and Specialist Trust – July 2021

Document revision history

Date	Version	Revision	Comment	Author / Editor
24.01.2021	1.0	Draft circulated to Hospital Cell	None	Ben Vinter
01.06.21	2.0	Fundamental review given acute / specialist determination and leadership steer		Ben Vinter
22.06.21	3.0	Amended language following CEO feedback		Ben Vinter
02.07.21	4.0	Reflect agreed name		Ben Vinter

Review due:
2021/22

Introduction

The Government has brought forward proposals that indicate all NHS provider trusts are expected to be part of a provider collaborative. Within this context there is an expectation that provider collaboratives will support trusts to take on more responsibility for, collectively, acting in the interests of the population and respond to the triple aim duty for all NHS providers to:

- Align priorities.
- Support the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making.
- Direct resources to improve service provision.

This Terms of Reference set out how the Acute and Specialist Trusts intend to initially respond to this agenda by establishing a Provider Collaborative Board (Cheshire and Merseyside Acute and Specialist Trust Alliance -CMAST)

The CMAST is a formal arrangement, to enable increased collaboration and to commit to collective decisions.

Purpose

The purpose of the group is to consolidate the place, purpose and potential of provider collaboration, for Acute and Specialist trusts within Cheshire and Merseyside (C&M). Building upon the solid foundations established within the region.

The group will achieve this by:

- Operating as a facilitator of provider collaboration
- Being a forum for shared decision making
- Solving strategic and operational provider issues where performance or efficiency could be improved
- Continuously improving quality, efficiency and outcomes: including unwarranted variation and inequalities in access and experience
- Acting as a partner and where appropriate a convenor for and on behalf of the C&M Health and Care Partnership to align strategy, delivery and decision making supporting the advancement of improved health and care outcomes and equity of access for our populations
- Developing the approach and governance of provider collaboration within its remit and supporting the development of approaches to sharing of risks and benefits of collective action between providers.

Our aims and objectives are to:

- Provide a forum and appropriate pace of decision making to enable improved patient outcomes and quality of patient care.

- Provide Commissioners with a single, collective view of C&M providers1 on proposals for service change.
- Develop shared clinical, speciality plans and other service responses to initiatives across C&M, including the associated operating delivery and governance models.
- Support financial stability and sustainability through reduced duplication and better use of existing resources.
- Promote best practice and provide input and coordination to the shared provider agenda which it is anticipated will be progressed through a wider C&M Provider Collaborative Forum as represented by the Provider CEO Group.

Responsibilities / duties

The group provides a forum to consolidate shared awareness, to initiate or progress joint work and action focused on delivering:

- Higher quality and more sustainable services
- Supporting fragile institutions and services
- Reduction of unwarranted variation in clinical practice and outcomes
- Coordinating and considering the priorities from and of Strategic Clinical Networks
- Reduction of health inequalities, with fair and equal access across sites
- Workforce planning
- System performance and recovery
- Enablers and infrastructure considerations

Cheshire and Merseyside's provider organisations, through this arrangement and through partnerships at place, will provide a significant transformation contribution: agreeing future service models and structures of provision jointly through ICS governance and delivered through an agreed annual prioritisation and work programme

Delegated Powers and Authority

The group will act as a collective for collaborative action, for acute and specialist trusts, within Cheshire and Merseyside, focusing on system improvement.

Each Trust Board has formally approved the establishment and constitution of the CMAST through adoption of these terms of reference.

It is not initially proposed that any powers or authority is vested in the group, from provider trusts, other than might typically be expected for a CEO or their representatives. Arrangement in this area may develop and be defined, by agreement, over time. The principle of subsidiarity will be applied to the work programme of the CMAST; issues will be addressed at the most appropriate level of decision making.

[1] As per our remit and membership-

The group will act as a coordination or escalation point for matters arising from the system including its Steering Group which will, in the initial period, respond to the requirement for a Hospital Cell, Gold Command and any future iteration of such groups as may be required. CMAST will act as conduit between the designated provider constituency, the ICS and NHSE and vice versa: agreeing work programmes; prioritising activities and actions and making recommendations.

As ICS responsibilities are defined and develop it is anticipated that responsibilities for peer performance review and challenge could be delegated to such a forum.

Membership & Attendance

Members

Members of the group are Provider CEOs or those acting as their representative.

After an initial period of establishment, the group will review its membership and connection with Provider Boards.

In attendance

The group may invite representatives from the wider system, ICS, NHSE/I region or supporting staff such as secretariat, performance, or transformation colleagues as required to support discussions. The group expects to identify a core staff group.

Meetings

Leadership

The group is chaired by Ann Marr – CEO St Helens and Knowsley Teaching Hospitals NHS Trust.

Quorum

The group does not envisage situations where conducting a vote would be a targeted outcome. Decisions will usually be taken by consensus[2].

Regular attendance by Provider CEOs, or from time to time their representative, will support 75% attendance being targeted.

Initial development discussions will include the need for a Decision-Making Framework, thresholds, categorisation, managing conflicts of interest, communication, and any dispute resolution mechanisms (Decision-Making Framework).

Frequency

At least monthly with opportunity for meetings on an alternate weekly basis should the need arise.

[2] Should such a situation arise where voting arrangements may be judged necessary it is expected that a majority would constitute ¾ of the trusts forming the collaborative.

CMAST shall meet at such times and places as the Chair may direct on giving reasonable written notice to members. Meetings will be scheduled to ensure that they do not conflict with Trust Board meetings and are synchronized so that members can properly engage their organisations ahead of meetings.

On occasion it may be necessary to arrange extraordinary meetings at short notice. In these circumstances the Chair will give as much notice as possible to members.

Meetings of CMAST will not, initially, be open to the public.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and usually no later than 4 working days.

Format

An agenda for each meeting will be agreed with the Chair. Periodic calls for items supporting discussion will also be made from the membership.

It is anticipated that the meeting may initially have both a business and developmental focus as it established and defines its role. Sufficient time will be allocated to items to enable full exploration of issues, constructive challenge and reflection.

Confidentiality expectations will apply however outputs of the group will be reported and may be escalated to the ICS and NHSE/I supporting scrutiny, awareness, and interaction.

Advice may be sought from amongst the membership outside of the regular meetings, either as a group or on an individual basis.

Reporting

The outputs of the group will be reported and may be escalated to the ICS and NHSE/I supporting scrutiny, awareness, and interaction.

It is anticipated Provider Boards may request or require periodic updates on the activities of the collaboratives.

Assurance

The assurance required of and from the group is an area which will require development as and when functions and responsibilities may be delegated to it.

Costs and support functions

Costs incurred by and provision of support functions to CMAST will be borne equally by all Trusts unless there are material grounds (agreed in advance by all members) to allocate specific costs on a different basis. Examples of costs likely to be incurred include the CMAST Managing Director, secretariat, and consultancy support where it is appropriate and agreed by members.

Review

The scope, purpose, performance, and role of the group will be reviewed at least annually but initially after no longer than 6 months.