St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 29th SEPTEMBER 2021
VIRTUALLY, BY TEAMS

AGENDA				Paper	Purpose	Presenter
09:30	1.	Employee of the Month - August and September 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 28th July 2021		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.15	6.	Integrated Performance Report		NHST(21) 055	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						
10.35	7.	Committee Report – Executive		NHST(21) 056	Assurance	Ann Marr
10.45	8.	Committee Report – Audit Including Audit Letter approval		NHST(21) 057	Assurance	Ian Clayton
10.55	9.	Committee Report – Quality		NHST(21) 058	Assurance	Gill Brown
11.05	10.	Committee Report – Finance & Performance		NHST(21) 059	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Break					
Other Board Reports					
11.20	11.	Medical Revalidation Annual Declaration	NHST(21) 060	Approval	Jacqui Bussin
11.35	12.	EPRR Compliance Statement	NHST(21) 061	Assurance	Sue Redfern
11.45	13.	Workforce Race Equality Standard and Workforce Disability Equality Standard 2021 Reports	NHST(21) 062	Assurance	Anne-Marie Stretch
12.00	14.	Gender Pay Gap 2020/21 report	NHST(21) 063	Assurance	Anne-Marie Stretch
12.10	15.	Community Diagnostic Hub development	NHST(21) 064	Assurance	Rob Cooper
Closing Business					
12.30	16.	Effectiveness of Meeting	Verbal	Assurance	Chair
	17.	Any Other Business		Information	
	18.	Date of Next Meeting – Wednesday 27th October 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 28th July 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 (joined at
	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 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 St Helens CCG
	Mr Tony Foy	(TF)	St Helens LA (Observer)
	Mr Alan Lowe	(AL)	Halton LA (Observer)
	Carole Slocombe	(CS)	Patient Experience Manager (Patient Story only)
	Joshua Mackin	(JM)	Trainee Nurse Clinician (Patient Story only)
	Victoria Collins	(VC)	Acting Deputy Director of HR (Observer)
	Elaine Johnson	(EJ)	Member of the public (Observer)
	Ms Katie Fielding	(KF)	Executive Assistant (Minute taker)
Apologies:	Prof R Pritchard-Jones	(RPJ)	Medical Director

1. Employee of the month

1.1. The employee of the month for July was Kenny Jones, Learning Disability Specialist Nurse, at the Trust, who had been nominated for the award by Susan Norbury, Assistant Director of Safeguarding.

Due to COVID social distancing restrictions, Kenny had been filmed receiving his award from SR and the film was presented to Board. The Board noted the citation and congratulated Kenny.

1.2. RF noted that the majority of members will have a friend or family member with special needs and will be aware of the difference someone like Kenny can make to their experience of attending hospital. He congratulated Kenny on the award and thanked him for the impact he was having to improve the experience of this group of patients and their relatives and carers.

2. Patient Story

2.1. CS presented the Patient Story along with JM. Unfortunately, the patient had hoped to attend meeting herself but unfortunately had recently been re-admitted to hospital.

The patient was a lady with a complex medical history, which had resulted in recurrent hospital admissions via the Emergency Department(ED).
Frequently the time for assessment in ED was very long because the staff there were not familiar with her condition or medication regime.

To improve the situation for the patient and her family a case conference was arranged during her last admission to ward 4A. The case conference was attended by the patient and her mother, Mr Gana (Consultant Lead for Urology), Mr Omar (Consultant Urologist), Dr Lechareas (Consultant Radiologist), Karen Barker (Matron) and Joshua Mackin (Urology Nurse Clinician Trainee). The outcome of the case conference was the development of a personalised patient plan which included recommendations from a Consultant Microbiologist and the Acute Pain team about her medication that would accompany her on any future attendances at ED, to prevent any delays in accessing the most appropriate pain management medications for her condition.

The plan also enabled priority access to the Urology hot clinic service Monday to Friday 8am - 4pm and the ability to ring ward 4A and let staff know, with the aim that they will try and prioritise a bed for her. The patient also had the contact numbers of a range of other staff who had been directly involved in her care, for further support.

It was also arranged for the patient to have twice daily district nurse visit at home to flush her nephrostomies and reduce the risk of them blocking and planned admissions every 8 weeks for bilateral exchange of her nephrostomies, to help maintain her independence and prevent future infections.

The patient and her family now feel reassured that they have access to the expertise of the specialist healthcare team who are familiar with her complex condition. She also keeps copies of the plan with her so that she can present them if an admission is necessary.

CS discussed the difference these interventions had made for this patient and the opportunities for wider learning:

- other teams who manage complex chronically ill patients to consider if they could develop and share management plans to improve patient care and experience. In particular for those accessing emergency services.
- Involving patients in the development of their management plans empowers patients and reassures patients

RF commented that this patient and her family have gone through so much and he was pleased that the Trust was able to provide this personalised level of care, for a very complex clinical situation. He thanked the patient for allowing her story to be shared with the Board and hoped she would recover quickly and be able to go home again very soon. RF also thanked the staff who had cared for the patient he felt they were a credit to the Trust.

2.2. SR noted that it was CS last meeting as she was moving to another Trust. The Board thanked CS for her commitment to improving patient experience and wished her well in her new role.

3. Apologies for Absence

As above

4. Declaration of Interests

There were no new declarations of interest.

5. Minutes of the Board briefing held on 30th June 2021

5.1. Correct Record

5.1.1. The minutes were approved as a correct record.

5.2. Action List

5.2.1. Actions 30 and 36 remained deferred due to the impact of the pandemic.
5.2.2. Action 37 was an agenda item
5.2.3. Actions 38, 39 and 40 had been completed following the June Board meeting.

6. Integrated Performance Report (IPR) – NHST (21)044

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

6.1. Quality Indicators

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

6.1.2. There were 0 never events in June, and 0 year to date (YTD).

6.1.3. There had been 0 cases of MRSA in June, and 0 YTD.

6.1.4. There were 6 C. Difficile positive cases reported in June 2021 (3 hospital on-set and 3 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.

6.1.5. There was 3 falls resulting in severe harm in May, and 4 YTD. SR confirmed that an intensive falls prevention plan has been put in place, with ongoing interventions to improve falls awareness and increases risk assessment.

6.1.6. There was 1 hospital acquired grade 3 pressure ulcer with lapse in care in April 2021. SR noted that a thematic review was due to be presented to Quality Committee in September.

6.1.7. VTE reporting remains suspended nationally due to COVID.

6.1.8. HSMR (April to March 2020/21) is 92.7.

6.1.9. The report was noted.

6.2. **Operational Indicators**

6.2.1. RC presented the update on operational performance.

6.2.2. Performance against the 62-day cancer standard was above the target of 85.0% in month (May 2021) at 85.5% and YTD was 85.8%.

The 31-day target was achieved in May 2021 with 98.9% performance in month against a target of 96% and YTD was 99.0%.

6.2.3. The Cancer 2 week wait rule performance in May 2021 was 90.9% in month and 88.7% year to date against a target of 93.0%. (Performance in April was 86.5%).

6.2.4. Accident and Emergency (A&E) 4-hour performance for June was 78.5%, YTD 80.6% (all types mapped). There had been a total of 10,953 attendances in the month.

6.2.5. There were 2,706 ambulance conveyances in June and the average ambulance turnaround time was 34 minutes, which did not achieve the 30 minute standard.

6.2.6. St Helens Urgent Treatment Centre had seen 5,456 patients in May, an increase of 12% compared to April.

6.2.7. St Helens community nursing referrals showed a slight reduction in May. Referrals from acute areas had remained consistent but referrals via the self-referral, GP and other provider routes had reduced..

6.2.8. The average number of super stranded patients in June was 89 (the same as May).

6.2.9. The referral to treatment (RTT) performance in May was 74.4%, YTD 74.4%, against the target of 92%, and the 6-week diagnostic waiting time performance in June was 77.7% against the target of 99%. Both metrics had improved as the impact of the elective recovery plan started to be seen. RC reported that the current performance was 80% for RTT and the 52 weeks waiters had further reduced to 968.

6.2.10. RF reflected that the level of A&E attendances remained very high for the time of year and a significant proportion were acutely ill which was having a knock on impact to the flow of patients through the hospital. RC agreed that there continued to be significant pressure on staff and patient acuity seemed to be higher due to delayed presentations, as a result of the COVID-19 lockdowns.

6.2.11. GB asked for an update about the current impact of COVID on the Trusts capacity. RC explained that the Trust was continuing to do as much as possible but the very recent increase in inpatient numbers had meant critical care capacity had needed to be increased again, which had meant some elective work had now been cancelled, in order that staff could be moved to support more beds in critical care. The plan was review this in 2 weeks and minimise the disruption to the elective programme.

6.2.12. The report was noted.

6.3. **Financial Indicators**

6.3.1. NK presented the update on financial performance.

6.3.2. For H1 (April – September 2021, the Trust plan is for £247m of income and £247m of expenditure giving a breakeven position overall.

6.3.3. 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 accessing the Elective Recovery Fund (ERF) changed for Q2 on the 9th of July. This will affect the H1 (Apr-Sept) financial plan as the threshold increased for elective activity from 85% to 95%. This change will be reflected in the M4 reports.

6.3.4. At the end of Month 3 (June) the Trust has reported a YTD breakeven position in line with the Cheshire & Merseyside system plan for H1.

6.3.5. Year to date expenditure on agency staff was £2.2m, including agency costs incurred in relation to COVID (£0.08m) and Mass Vaccination (£0.3m).

At the end of M3, the cash balance was £61.2m. NK also noted that the Trust continued to achieve above 95% against the better payment practice code. RF felt it was extremely important that the NHS supply chain continued to be paid on time.

6.3.6. 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. The trust has currently spent £1.8m of capital.

6.3.7. The Trust has a H1 CIP target of £3.8m. 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.

6.3.8. There remained no guidance in relation to the financial planning for H2, so the risks were significant. It was unclear of the recently announced 3% pay rise would be funded and if there would be further changes to the ERF. At the current time the estimated risk was circa £3m.

6.3.9. The report was noted.

6.4. **Workforce Indicators**

6.4.1. AMS presented the update on workforce performance and noted the impact the pandemic still had on the performance against these metrics.

6.4.2. In June overall sickness was 6.4% which was a 0.7% increase compared to May. Nursing, Midwifery and HCA's sickness was 9.5% an increase of 1.1% from May. (These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, or pregnant workers over 28 weeks on medical suspension). The increase in overall sickness is partly due to the increase rates of Covid transmissions in the local community which results in higher numbers of staff being infected.

6.4.3. Appraisal compliance is below target at 53.5%. Mandatory training compliance also 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. However, the increase in COVID 19 incidence meant that once again there were pressures on staff and non-clinical activities such as appraisals and training were being cancelled so staff could provide patient care. Therefore AMS felt that recovery of the 85% targets would take longer than had originally been anticipated, if there had not been further spikes of COVID activity.

6.4.4. VD asked will there be a change in process with regards to exposure 'pinging'. AMS explained that earlier on in the week, national guidance was published to confirm that health workers who are 'pinged' by the COVID App could potentially be exempt from having to self-isolate, if they were tested and proved negative for COVID. The Trust had operationalised this guidance and the process included a rigorous risk assessment. This change had already reduced the number of staff that were having to self-isolate because they were suspected contacts. RF acknowledged the dedication and bravery of staff returning to work in these circumstances.

6.4.5. The report was noted.

7. Committee Report – Executive – NHST (21)045

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

7.2. There were 4 Executive Committee meetings in June. No new investment decisions had been taken.

7.3. Following the never events that occurred in theatres during 2020/21, a renewed focus on human factors training had been part of the resulting action plans. The Director of Nursing, Midwifery and Governance had 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. It had been agreed that the proposals should be developed into full business case to evaluate the options and detail the funding commitment that would be needed.

7.4. The Executive Committee had reviewed the reasons for the unprecedented activity in ED, noting that compared to April – May 2019, there had been 15% increase in major's attendances and a 19% increase in paediatric attendances in April – May 2021. It was agreed that the Director of Operations and Performance would bring forward the consideration of winter plans to ensure there was sufficient capacity in the Trust to respond to the increases in demand, for example reopening ward 1A, once the ward lifecycle programme for 2021/22 had been completed in August. AM noted that the situation felt like "a perfect storm" of increased activity and depletion of staff, due to leave, sickness and turnover. Staff had been under continuous pressure for a long time so it was important that they took annual leave and were able to rest and recuperate. Although increases were being experienced by other Trusts in C&M, the increased demand appeared to be disproportionate for the Whiston ED

AM noted that actions were being taken to address the gaps in staffing, such as recruiting HCAs to the staff bank and renewing the plans for overseas recruitment.

VD asked if the increase in Paediatric attendances was causing any particular challenges. SR commented that an increase in respiratory infections amongst children was expected and was likely to increase going into the winter. This was as a result of babies and young children not building natural immunity during the 2020/21 lock downs, which meant they were now more susceptible to infections. RC agreed that the increase in paediatric attendances was likely to continue and that this was also being experienced by Alder Hay and other hospitals that had a Paediatric ED. Some Trust had already started deflecting minor's attendances to Urgent Treatment or Walk in Centre's. RC also confirmed that the Trust continued to work collaboratively with Primary Care, but they too were experiencing an increase in demand.

7.5. VD commented that it is good to see that improvements to the E-Discharge summaries process were being made and she asked if there is confirmation of when Medway (Careflow) will be able to produce all the E-Discharge summaries.. CW explained that an upgrade to Careflow was being planned which would enable a single process for producing the discharge summaries. The objective was to make this as streamlined and easy as possible and integration with the E-Prescribing system would also be essential. The plan is to implement this upgrade in October or November.

7.6. RF commented that IT developments of this sort can really help take pressure off staff and improve patient experience. He hoped that the upgrade could be implemented as quickly as possible.

7.7. IC was concerned about the disparity in vaccination rates across different wards in St Helens and was interested to understand how the CCG and Public Health services were trying to address the differential rates of uptake.

7.8. The remainder of the report was taken as read and noted.

8. Quality Committee Chair's Assurance Report – NHST (21)046

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

8.2. There was a presentation about the implementation plans for a new digital app called perfect ward which will help to monitor quality metrics on the wards and produce quality dashboards.

8.3. From the IPR the committee had particularly focused on falls that had resulted in harm and had asked for a deep dive review to be presented to the committee meeting in September.

8.4. Further analysis was also requested in relation to an increase in reported hospital acquired thrombus/venous thromboembolisms.

8.5. A decrease in claims and PALS concerns relating to communication was reported for quarter 1 of the year, although as visiting had remained restricted this was pleasing but perhaps surprising and the committee agreed to wait until the quarter 2 report to see if this was indeed a trend.

8.6. The quarter 1 Infection Prevention Control report showed the decrease in COVID nosocomial infections, since April 2021.

The committee had discussed the proposals to introduce a Trust-wide patient safety campaign and had supported these plans as a way of re-setting the quality agenda following COVID-19, which had impacted several quality metrics.

8.7. RF commented that he was pleased that the Quality Committee was recognising the challenges staff had faced but that it was appropriate that there was now a quality re-set. It was also encouraging that despite the delta variant the number of nosocomial infections had remained low, which demonstrated the high standards of infection prevention control being practiced.

8.8. The remainder of the report was taken as read and noted

9. Finance & Performance Committee Chair's Assurance Report – NHST (21)047

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

9.2. The committee had reviewed the finance and operational performance sections of the IPR and discussed the some issues that the Board had picked out in its earlier discussions e.g. ED activity and changes to the Elective Recovery Fund (ERF)

9.3. The committee had scrutinised the detailed finance reports and noted the risks to the breakeven position as a result of the in-year changes to the ERF thresholds. The good progress against the H1 CIP target of £3.8m was also noted.

9.4. The committee had been briefed on the changes to the NHS Trust oversight framework and the new finance and use of resources metrics that would be used to monitor performance. These metrics would be reported from month 4.

9.5. There had been a presentation by the Surgical Care Group, which detailed progress against the CIP plan for the Care Group. The assumptions about ERF income now meant these plans were high risk.

9.6. The committee had also received assurance reports from the CIP Council and the Procurement Council.

9.7. The report was noted.

10. Corporate Risk Register Quarterly Report– NHST (21)048

10.1. NB presented the Corporate Risk Register (CRR) report..

10.2. At the end of June there were 693 risks reported across the Trust of which 22 had scored 15 or more and been escalated to the CRR. The increase in overall risks from April reflected the CIP risks for 2021/22, following the suspension of the CIP in 2020/21.The Medical Care Group was reporting the highest number of escalated risks and 15 of the 22 risks related to patient care.

10.3. VD commented that many of the patient care risks were as a result of staffing concerns and asked if there were action plans in relation to these that were monitored. NB confirmed that staffing pressures due to the number of patients requiring 1 to 1 observations, staff absences including COVID and self- isolation were creating pressure. All the CRR risks have an action plan in place which is monitored on a regular basis by the care group and the lead Director. There was a module in Datix to track the action plans and outstanding actions were reported to the Risk Management Council on a regular basis to provide assurance that they were being completed and closed on the system.

10.4. RF was glad that the increase in total risks could be linked to the CIP programme and that such care was taken to ensure that proposed CIPs did not adversely impact on patient care.

10.5. The report was noted.

11. Board Assurance Framework (BAF) Quarterly Report – NHST (21)049

11.1. NB presented the report.

11.2. The BAF had been updated to reflect progress in a number of areas, but overall there was not a recommendation to change any of the BAF risk scores, on this occasion. The Board approved the changes to the BAF as recommended.

11.3. GB asked for further information about the Community Diagnostic Hub at St Helens Hospital. RC explained that this was an initiative to reduce waiting times for diagnostics that had increased during the pandemic when routine activity was suspended. The Community Diagnostic Hubs were facilities that would create a net increase in capacity and could be utilised by several Trusts in a locality as part of the restoration and recovery plans. RC agreed that it would be useful to share

more detail of how the Community Diagnostic Hub had been established and the impact on waiting times at the September Board meeting. **Action: RC**

11.4. RF felt it was very encouraging to see the continued collaboration between Trusts to combine forces to tackle the backlogs of patients who needed diagnostic tests.

12. Learning From Deaths Quarterly Report – NHST(21)050

12.1. NB presented the Learning from Deaths quarterly report on behalf of RPJ. The report covered January – March 2021 (Q4)

12.2. This report covered the period where the Trust had experienced its highest number of deaths due to COVID-19. Due to the operational pressures not all the structured judgement reviews from this period had been completed, but it was anticipated the backlog of reviews would be eliminated by the end of Q1.

12.3. Of the 176 deaths identified for review under the learning from deaths criteria, 128 had been completed of which 120 identified no concerns, 7 were being further investigated and for 1 learning had been identified.

12.4. One of the themes emerging from these reviews was the importance of communication of DNACPR decisions and the review of these decisions if circumstances changed.

12.5. VD asked if the Board could be assured that the DNACPR decision making process was robust. SR responded that there was an established process in place, which had been unified across the system a few years previously (purple forms that accompanied the patient), however it was acknowledged that during the height of the pandemic difficult decisions had been made in the best interests of the patient. Sometimes, due to visiting and other restrictions there had been issues with communicating these decisions to the patient's family, where they were situational. Elspeth Worthington the Learning from Deaths lead was working with the Medical Care Group to review the DNACPR process and the Trust was also participating in a national audit to ensure the Trust was following best practice.

12.6. PG who was a member of the Mortality Surveillance Group reported that there were a number of ideas and suggestions being considered to improve the process.

12.7. RF thanked all the clinicians who undertook the reviews and hoped that the numbers of reviews needed each month would return to normal levels. It was always concerning for the Board to hear about patient deaths but it was also important to support and encourage the culture of openness and learning that was embodied by the Learning from Deaths process.

12.8. The report was noted.

13. Workforce Strategy and HR Indicators Report – NHST(21)051

13.1. AMS presented the Workforce Strategy and HR Indicators report for the 12 months to July 2021.

13.2. AMS also drew attention to the new format of the report, which was designed to make it more accessible and asked for feedback from Board members.

13.3. AMS highlighted some of the metrics to the Board, including international recruitment, hard to recruit staff groups, staff retention and turnover rates and staff absence rates.

13.4. IC felt the new format was excellent with a mix of data, commentary, trend analysis and benchmarking comparisons. GB agreed and felt this format provided more assurance and focused on the right questions.

13.5. VD felt this was an excellent basis to develop a workforce dashboard for the new Strategic Workforce Committee.

13.6. VD also asked if there was a breakdown of the reasons for voluntary resignations in the turnover section. AMS explained that the reasons for leaving within the Electronic Staff Record (ESR) system were set nationally and there was no further breakdown of the information. However, AMS felt this highlighted the importance of meaningful exit interviews to gain local intelligence about why staff chose to resign.

13.7. LK asked for clarification about the Retention of Employment (ROE) staff. AMS confirmed that these were the ancillary staff that were managed by Medirest as part of the Trusts PFI contract but still employed by the Trust. Traditionally this group of staff tended to have higher rates of sickness absence. NB clarified that the staff who were employed directly by Medirest were not included in the reported figures.

13.8. LK also asked about the impact of the collaborative staff bank in the North West. AMS commented that currently there were concerns about escalating pay rates on the collaborative bank for Junior Doctors as all Trusts competed for the same group of staff with the skills they needed. This was being discussed by the Human Resource Directors and Chief Executives.

13.9. RF asked if AMS there had been an impact of BREXIT on recruitment. AMS stated that so far the impact had been minimal and contacts with European Universities continued to be developed in relation to medical staff recruitment.

13.10. The report was noted.

14. Approval of the Terms of Reference for the Strategic Workforce Committee – NHST (21)052

14.1. AMS sought approval from the Board for the Terms of Reference (ToR) for the new Strategic Workforce Committee that the Board had agreed to establish following the Board and Committee effectiveness review for 2020/21.

14.2. AMS confirmed that the draft ToR reflected those of other organisations that had established a dedicated Workforce Committee, and she recommended them to the Board, whilst acknowledging that further changes may be required once the Committee had met a few times. The ToR were intended to create space for in depth analysis and the development of strategic plans, rather than be a vehicle for monitoring monthly performance and this was reflected in the proposed frequency of the meetings.

14.3. The Board approved the Strategic Workforce Committee ToR.

15. Information Governance and freedom if Information Annual Report 2020/21 – NHST (21)053

15.1. CW presented the Information Governance (IG) annual report and results of the Data Security and Protection Toolkit (DSP Toolkit) submissions for 2020/21

15.2. The Trust had completed the DSP toolkit evidence submission for end of June deadline and had met the standards required against all 111 criteria.

15.3. Audit of the submissions had been undertaken by MIAA (Internal Auditors) and for the 8th year running had received substantial assurance on the accuracy of the submission.

15.4. The Freedom of Information (FOI) Annual Report summarised how the Trust had performed in 2020/21 against the standards.. In relation to freedom of information requests performance had improved significantly but was still not meeting the performance standard of 20 days. The actions agreed in 2020/21 had identified that there was an improvement journey and this would continue as a priority for 2021.22.

15.5. The Board noted the outcome of the DSP toolkit assessment and approved the annual reports.

16. Cheshire and Merseyside Integrated Care System (ICS) – Provider Collaborative Terms of Reference – NHST (21)054

16.1. AM sought approval from the Board for the Terms of Reference for the new Cheshire and Merseyside ICS – Provider Collaboratives. It was noted that the Trust would be part of the Acute and Specialist Trust Provider Collaborative and the Mental Health, Learning Disabilities and Community Services Provider Collaborative due to the range of services it delivered.

16.2. VD noted the different approaches from the two Provider Collaboratives and asked why this was. AM confirmed that national guidance on the role of the Provider Collaboratives as part of the NHS legislation was awaited and her preference as the lead for the Acute and Specialist Services Provider Collaborative had been to adopt a light touch approach at this stage, recognising that the role and scope of the Provider Collaboratives might change. VD felt that Provider Collaboratives could have a significant impact on the role of Trust Boards and Non-Executive Directors and suggested the Board set aside some time to think about the implications of these changes once the guidance was issued.

16.3. GB suggested that it would be a good idea if the members of the Acute and Specialist Trust provider collaborative should be listed in the ToR.

16.4. The Board approved the ToR of both Provider Collaboratives

17. Effectiveness of Meeting

17.1. RF asked Victoria Collins for her observations on the effectiveness of the meeting. VC thanked RF for allowing her to observe the Board. She had found HR Indicators feedback very valuable. VR observed that the board is very collaborative. The discussions and how open they were was refreshing.

17.2. RF also asked EJ to share her observations.. EJ stated she had found the meeting informative and was interested to understand how the board operates.

18. Any Other Business

18.1 RF asked the Board to note that PG had been asked to become a visiting lecturer at John Moores University, in recognition of his work in the voluntary and charitable sectors. The board congratulated PG.

19. Date of Next Meeting

19.1 Wednesday 29th September 2021

Chairman: ……

Date: ……

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)055
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 August 2021. (YTD = 1).

There were no cases of MRSA in August 2021. (YTD = 1).

There were 6 C.Difficile (CDI) positive cases reported in August 2021 (4 hospital onset and 2 community onset). YTD there have been 31 cases (19 hospital onset and 12 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 August 2021 was 90.8%. 2021-22 YTD rate is 91.9%.

The number of incidents reported in community services for July was 101 (similar levels to June 96).

During the month of July 2021 there were 3 fall resulting in severe harm. (YTD severe harm falls = 9)

There were no grade 3 hospital acquired pressure ulcers with lapse in care in June 2021. (YTD 2021-22 = 1).
No category 2 pressure ulcer with lapse in care in June 2021 (YTD = 5).

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

YTD HSMR (April - May) for 2021-22 is 95.8

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: 29th September 2021

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (July 2021) at 86.2%. YTD 85.9%. Performance in June 2021 was 85.7%. The 31 day target was achieved in July 2021 with 96.9% performance in month against a target of 96%, YTD 98.3%. Performance in June 2021 was 98.4%. The 2 week rule target was not achieved in July 2021 with 91.1% in month and 88.6% YTD against a target of 93.0%. Performance in June 2021 was 86.0%. 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 August 2021 was 54.3% and YTD 59.5%. The all type mapped STHK Trust footprint performance for August 21 was 76.9% and YTD 78.7%**.** The Trust saw average daily attendances of 317, which is down compared to July, at 355. Total attendances for August 2021 was 9,823.

Total ambulance turnaround time was not achieved in August July 2021 with 48 mins on average. There were 2,431 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,578 in July 21.

The UTC saw 5068 in August 2021, which is a decrease of 14% (809) compared to the previous month. However, August 2021 saw a 5% increase when compared with August 2019. Overall 98% of patients were seen and treated in 4 hours.

An increase in new referrals was seen within the District Nursing Service (641 in July in comparison with 600 in June). This increase has come from all areas including GP, hospital and direct patient referrals.

Community matron caseloads have remained consistent at 161 in June and July. There is still capacity within the service and is therefore continuing to engage with individual GP practices to support identification of appropriate patients.

The average daily number of super stranded patients in August 2021 was 103 compared with 81 in July. Note this excludes Duffy and Newton IMC beds. Work is ongoing both internally and externally, with all system partners, to improve the current position with acute bed occupancy remaining high with subsequent congestion in ED as a result.

The 18 week referral to treatment target (RTT) was not achieved in August 2021 with 75.3% compliance and YTD 75.3% (Target 92%). Performance in July 2021 was 75.8%. There were (1163) 52+ week waiters. The 6 week diagnostic target was not achieved in August 21 with 79.5% compliance. (Target 99%). Performance in July 2021 was 78.9%.

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 (M1-M6, referred to as 'H1'). The Trust's final financial plan for H1 gave a breakeven position. In July, thresholds for achievement of ERF income in Q2 (M4-M6) were increased from 85% to 95% of 19/20 delivery, and as a result the Trust forecast a H1 deficit of £3.3m in our Month 4 reporting. Since then, options to address this deficit have been discussed with the Cheshire & Merseyside ICS in the context of the need for the system as a whole to breakeven. As there are now considered to be feasible options to address the £3.3m gap through working with the system, the Trust's Month 5 reporting again reflects a forecast breakeven position for H1.

Surplus/Deficit - At the end of Month 5, the Trust has reported a £2.3m deficit, relating to the change in thresholds for achievement of ERF income (£1.4m in Month 4 and £0.9m in Month 5). This is expected to be recovered utilising Trust and system solutions to deliver a H1 breakeven outturn at the end of Month 6.

Agency - Year to date agency expenditure is £3.8m, including agency costs incurred in relation to COVID (£0.2m) and Mass Vaccination (£0.4m).

Cash - At the end of Month 5, the cash balance was £59.3m. The current NHSE/I assumption is to utilise cash balances instead of Emergency PDC capital to support the capital programme, which could deteriorate the Trust's cash balance over the long term.

Capital - A capital programme of £10.97m (excluding PFI lifecycle expenditure), supported by £5.43m Emergency PDC capital was submitted to NHSE/I. Emergency PDC must be agreed by DHSC before the Trust is able to draw funds. Currently the Trust does not expect this to be agreed as there is an assumption that providers utilise their cash balances before PDC funding.

Human Resources

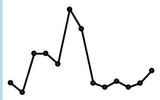
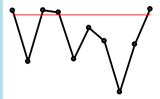
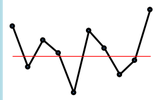
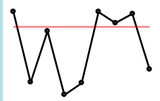
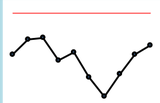
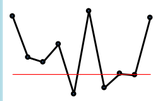
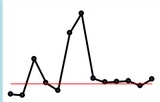
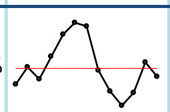
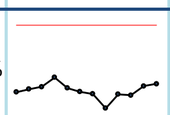
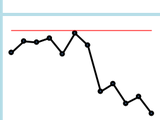
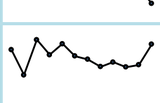
In August overall sickness was 6.7% which was a 0.2% increase from July. Front line Nursing, Midwifery and HCA sickness was 9.1% which is a decrease of 0.8% since July. Front line Nursing and Midwifery sickness was 7.4 % which was an decrease of 0.3% since July. These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.
Appraisal compliance has improved however is below target at 56.1%. Mandatory training compliance remains below the target at 74.0%.

The following key applies to the Integrated Performance Report:

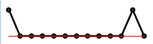
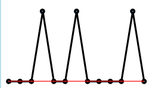
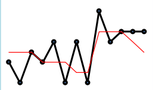
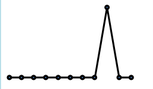
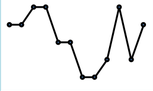
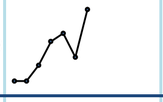
▲ = 2021-22 Contract Indicator
▲£ = 2021-22 Contract Indicator with financial penalty
● = 2021-22 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Aug-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

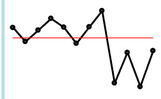
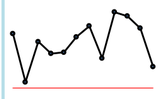
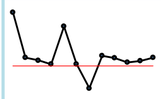
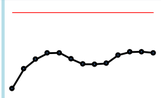
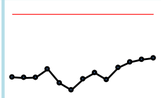
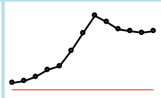
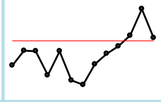
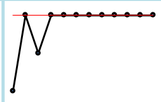
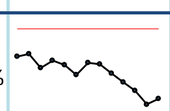
	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Aug-21	2.7%	2.3%	No Target	3.1%		Post wave 3 of COVID, performance 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	▲	Apr-21	1.06		1.00						
Mortality: HSMR (HED)	Q	▲	May-21	102.2	95.8	100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	May-21	121.5	110.4	100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Apr-21	96.1	96.1	100.0	98.8		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	A spike in readmissions reflects COVID third wave but remains within expected range and is improving.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	May-21	94.5	93.7	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	May-21	118.0	108.5	100.0	104.7					
% Medical Outliers	F&P	T	Aug-21	1.4%	1.1%	1.0%	1.6%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	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	Aug-21	48.6%	44.9%	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	▲	Jul-21	77.0%	75.6%	90.0%	74.8%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team also being involved to find a sustainable solution particularly in A&E. Specific wards have been identified and new processes developed to support improvement. OP attendance letters - a recent deterioration reflects staff sickness and annual leave pressures. 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	▲	Jul-21	72.5%	76.4%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jul-21	97.3%	96.8%	95.0%	96.8%					

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	▲	Q1	86.5%	86.5%	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	▲ £	Aug-21	0	1	0	3		One never event reported in July 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	Aug-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	▲ £	Aug-21	0	1	0	2		There were no cases of MRSA in August 2021. YTD = 1.	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	▲ £	Aug-21	6	31	48	28		There were 6 positive C Diff sample in August 2021. YTD there have been 31 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Aug-21	2	17	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	▲	Jun-21	0	1	No Contract target	1		No hospital acquired category 3 or 4 pressure ulcers with lapse in care in June 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	▲	Jul-21	3	9	No Contract target	31		3 fall resulting in severe harm category in July 2021 (Ward 5A, Bevan 2 and 1D).	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 August 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 with thematic review expected.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Feb-21			No Target	69					
To achieve and maintain CQC registration	Q		Aug-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	Aug-21	90.8%	91.9%	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	Aug-21	3	18	No Target	49					

Aug-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	▲ £	Jul-21	91.1%	88.6%	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	▲ £	Jul-21	96.9%	98.3%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jul-21	86.2%	85.9%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Aug-21	75.3%	75.3%	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	▲	Aug-21	79.5%	76.1%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Aug-21	1,163	1,163	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Aug-21	0.8%	0.9%	0.8%	0.4%		July's underperformance in cancelled ops has been due to staff sickness/absence, and theatre staff being re-deployed temporarily to support ITU, both at the end of July and in the first two weeks of August. 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	▲ £	Jul-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	▲	Aug-21	54.3%	59.5%	95.0%	78.0%		Accident and Emergency Type 1 performance for August 2021 was 54.3% and YTD 59.5%. The all type mapped STHK Trust footprint performance for August 21 was 76.9% and YTD 78.7%. The Trust saw average daily attendances of 317, which is down compared to July, at 355. Total attendances for August 2021 was 9,823. Total ambulance turnaround time was not achieved in August 2021 with 48 mins on average. There were 2,431 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,578 in July 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	▲	Aug-21	76.9%	78.7%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Aug-21	0	0	0	0					

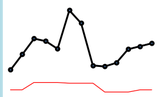
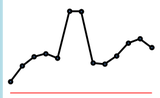
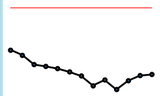
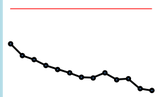
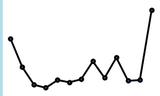
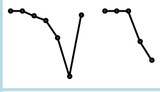
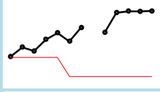
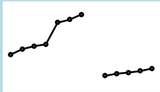
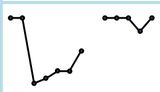
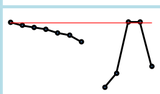
Aug-21

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 (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-20			0			**March 20 to August 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	Aug-21	28	117	No Target	242		% new (Stage 1) complaints resolved within agreed timescales dipped below the 90% target in quarter 1 and continues to remain challenging.	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 have been 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 pandemic and ongoing operational challenges in being able to meet the 90% target is evident in recent months. This is being closely monitored to bring it back above target.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Aug-21	25	93	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Aug-21	84.0%	83.9%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to August 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	Aug-21	316	298		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Aug-21	103	93		72					
Friends and Family Test: % recommended - A&E	Q	▲	Aug-21	75.6%	77.8%	90.0%	88.4%		FFT submissions recommenced from January 2021, with recommendation rates above target in month for inpatients, and postnatal community, but below target for the remaining areas.	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. At least two members of staff have been identified in each area to produce 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 continuing to cause a higher number of negative responses and comments, with work ongoing to reduce this.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Aug-21	95.6%	95.7%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Aug-21	95.5%	89.5%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Aug-21	90.7%	91.8%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Aug-21	94.4%	95.3%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Aug-21	100.0%	100.0%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Aug-21	93.6%	93.6%	95.0%	94.2%					

Aug-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	▲	Aug-21	6.7%	6.2%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In August overall sickness was 6.7% which was a 0.2% increase from July. Front line Nursing, Midwifery and HCA's was 9.1% which was an decrease of 0.8% since July. 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 to analyse the hotspots and HWWB are contacting employees who are absent with Covid to provide support.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Aug-21	9.1%	9.0%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Aug-21	56.1%	56.1%	85.0%	51.3%		Appraisal compliance has increased by 0.4% and is below target at 56.1%. Mandatory training compliance has reduced by 0.2% and is below the target at 74.0%. Both continue to be impacted as a consequence of operational activity, recovery plans and higher than normal staff absence.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance for Mandatory Training continues to be impacted by operational pressures and high staff absence. Appraisal has seen increasing compliance in month with both remaining below target. 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	Aug-21	74.0%	74.0%	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 closed 12th August 2021. Publication of the results is expected in September.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Aug-21	2.2%		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/I regarding retention of Nurses and this is part of our wider retention strategy and action plan for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Aug-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	Aug-21	4,916	4,916	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Aug-21	(2,300)	(2,300)	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Aug-21	30	30	10						
Capital spend £ YTD (000's)	F&P	T	Aug-21	3,000	3,000	17,600						
Financial forecast outturn & performance against plan	F&P	T	Aug-21	-	-	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Aug-21	85.0%	85.0%	95.0%						

APPENDIX A

			Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-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	▲£	100.0%	100.0%	38.5%	77.8%	100.0%	100.0%	96.3%	100.0%	97.4%	100.0%	94.7%	92.0%	89.5%	94.2%	85.0%		91.1%		
	Total > 62 days		0.0	0.0	4.0	3.0	0.0	0.0	0.5	0.0	0.5	0.0	1.0	1.0	1.0	3.0			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	▲£	100.0%	75.0%	85.7%	90.0%	80.0%	82.6%	78.9%	58.6%	87.5%	61.1%	78.1%	100.0%	86.7%	82.4%	85.0%		78.7%		
	Total > 62 days		0.0	1.0	1.0	1.0	2.0	2.0	2.0	6.0	1.0	3.5	3.5	0.0	1.0	8.0			22.0		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	0.0	0.0	0.0			6.0		
Upper GI	% Within 62 days	▲£	100.0%	100.0%	100.0%	80.0%	81.8%	83.3%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	77.8%	95.2%	85.0%		83.1%		
	Total > 62 days		0.0	0.0	0.0	1.5	1.0	1.0	0.0	0.0	3.5	0.0	0.0	0.0	1.0	1.0			11.5		
	Total > 104 days		0.0	0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	1.0			4.0		
Urological	% Within 62 days	▲£	100.0%	90.9%	95.7%	88.0%	79.5%	88.2%	82.8%	92.3%	79.2%	80.0%	88.6%	75.7%	84.2%	81.7%	85.0%		85.6%		
	Total > 62 days		0.0	1.0	0.5	1.5	4.0	2.0	2.5	1.0	2.5	2.0	2.0	4.5	1.5	10.0			21.0		
	Total > 104 days		0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0			6.0		
Head & Neck	% Within 62 days	▲£	100.0%	50.0%	0.0%	20.0%	100.0%	0.0%	33.3%	57.1%	50.0%	0.0%	14.3%	50.0%	0.0%	17.6%	85.0%		51.4%		
	Total > 62 days		0.0	1.0	1.5	2.0	0.0	1.0	1.0	1.5	1.0	1.0	3.0	1.0	2.0	7.0			9.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0			0.0		
Sarcoma	% Within 62 days	▲£			100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	85.0%		83.3%		
	Total > 62 days				0.0	0.0	1.0	0.0	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	▲£	100.0%	100.0%	66.7%	73.3%	69.2%	66.7%	55.0%	60.0%	57.1%	83.3%	100.0%	90.9%	100.0%	92.3%	85.0%		66.3%		
	Total > 62 days		0.0	0.0	1.0	2.0	2.0	1.0	4.5	1.0	3.0	0.5	0.0	0.5	0.0	1.0			17.5		
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	▲£	88.9%	60.0%	100.0%	86.7%	81.8%	75.0%	100.0%	80.0%	100.0%	100.0%	63.6%	100.0%	78.9%	84.9%	85.0%		83.9%		RC
	Total > 62 days		1.0	2.0	0.0	1.0	1.0	2.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	4.0			10.0		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0			1.0		
Haematological	% Within 62 days	▲£	66.7%	80.0%	100.0%	100.0%		100.0%	50.0%		75.0%	57.1%	100.0%	37.5%	37.5%	45.8%	85.0%		77.9%		
	Total > 62 days		1.0	1.0	0.0	0.0		0.0	3.0		1.0	3.0	0.0	5.0	5.0	13.0			8.0		
	Total > 104 days		0.0	1.0	0.0	0.0		0.0	0.0		0.0	1.0	0.0	1.0	2.0	4.0			1.0		
Skin	% Within 62 days	▲£	97.5%	100.0%	92.1%	92.4%	93.9%	100.0%	96.8%	86.0%	94.6%	92.9%	89.3%	92.8%	100.0%	94.3%	85.0%		93.6%		
	Total > 62 days		1.0	0.0	3.0	3.0	2.0	0.0	1.0	4.0	2.5	2.5	3.0	3.0	0.0	8.5			25.5		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	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%			50.0%		50.0%	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		1.0			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5			0.0		0.0			0.5		
All Tumour Sites	% Within 62 days	▲£	87.7%	96.1%	92.3%	86.2%	85.8%	85.2%	90.4%	85.3%	82.0%	86.1%	85.5%	85.7%	86.2%	85.9%	85.0%		86.7%		
	Total > 62 days		7.5	3.0	6.0	11.0	15.0	13.5	9.0	14.5	14.5	12.5	14.5	16.0	13.5	56.5			137.5		
	Total > 104 days		3.5	0.0	4.0	0.5	1.5	3.0	0.0	1.0	3.0	2.0	1.0	1.0	4.0	8.0			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%			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		0.0			0.0		
	Total > 104 days			0.0		0.0		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)056
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 July and August 2021. There were seven Executive Committee meetings held during this period. The new investment decisions made were: 1. To start the process of recruitment so that Ward 1A could be re-opened as a winter escalation ward 2. Approval of a patient booking system for the phlebotomy service 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, 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: 29th September 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were seven Executive Committee meetings in July and August 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.

2. 1st July 2021

2.1 Medical Bed Capacity

The Director of Operations and Performance introduced a paper that reviewed the current pressures on bed capacity and the increases in demand for non-elective care. It was agreed that plans to re-open ward 1A as a medical escalation ward should be progressed as soon as was practical. It was acknowledged that opening the ward was dependent on being able to recruit sufficient staff, and it was therefore agreed to start recruiting to these posts immediately, so that the beds could be opened as soon as possible. A further paper describing the planned use of the ward including the level of patient acuity would be brought to the committee in September.

2.2 Ward Moves

In response to the inpatient survey results the Director of Operations and Performance had reviewed the data and reported that between October 2018 and May 2021 inpatients had an average of 1.63 ward moves per stay with 33% of these moves happening between 10.00pm and 8.00 am. The data did not differentiate internal moves (on the same ward) as a subset of the total, but this will be collected going forward to create a better understanding of why patients are moved and allow planning of appropriate actions to reduce the impact on patient experience.

2.3 Elective Recovery Fund (ERF) - Gateways

The Director of Finance and Information briefed the committee on the Trust's achievement of the 28 gateway requirements needed to be able to access the ERF funding. The Trust could directly influence the delivery of 18 of the gateways and the other 10 were system gateways. The Acute and Specialist Trust Provider Collaborative had been asked to assess each Trusts performance against the gateway criteria. Achieving these gateways and the planned elective activity trajectories were essential to achieving the planned ERF income for the 2021/22 financial plan.

2.4 COVID Issues

The Director of Transformation provided an update from St Helens CCG on the work of the Outbreak Management Board and COVID Vaccine Steering Group in overseeing the access to the vaccination programme for hard-to-reach groups across the Borough.

There were a range of initiatives in place, including a vaccine bus that targeted the population groups who had not yet come forward for their vaccine.

3. 8th July 2021

3.1 Whiston Hospital – Additional Theatres

The Director of Corporate Services provided an update on the feasibility work that had been undertaken to assess the number of additional theatres that could be accommodated in the available non-clinical space on level 4 at Whiston Hospital. It was possible to fit 4 theatres into the space, but the mechanical and engineering costs were prohibitive as the plant would need to be situated on the hospital roof. The optimum configuration was 2 theatres with the plant co-located. This left some undesignated space that could be developed into supporting clinical facilities. The Director of Operations and Performance outlined the modelling work undertaken by the Surgical Care Group, which indicated that once the COVID backlog had been tackled the underlying growth in demand could be undertaken with two additional theatres for complex work, on the Whiston hospital site. It was therefore agreed to take forward this option for detailed design and tender and to bring back a full business case in 3 months.

3.2 Office Accommodation

The Director of Corporate Services presented a business case for the future offsite office accommodation for some corporate services staff. The options available could be achieved within the same cost envelope and would also facilitate the moves of more corporate functions to offsite accommodation, freeing space in Nightingale House for staff that would be displaced from level 4 in the main Whiston hospital building to accommodate the additional theatres. Subject to successful negotiation of the lease terms the business case was approved.

3.3 Board Assurance Framework (BAF)

The Director of Corporate Services presented the BAF which had been reviewed and updated ahead of presentation to the Trust Board in July. Although the actions had been updated, there were no proposed changes to any of the BAF risk scores on this occasion.

3.4 Trust Board Agenda

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

3.4 Transfer Lounge Utilisation

The Director of Operations and Performance introduced a paper that reviewed the utilisation of the Transfer Lounge, since the new larger facility had opened in May 2021. The throughput was an average of 19.3 patients per day, but it was recognised that the full potential of the Transfer Lounge to support patient flow had not yet been realised. Further work with Pharmacy and the electronic prescribing system would enable take home medicines to be delivered to the Transfer Lounge, allowing patients to be moved from the wards earlier on the day of discharge. Further analysis of utilisation based on occupancy per hour that the Transfer Lounge was open was also being undertaken.

3.5 COVID Issues

Expenditure requests for extension of free patient TV and Resident Medical Officer (RMO) cover for St Helens Hospital were approved.

The current infection and hospitalisation rates were reviewed, noting that Liverpool City region had the highest incidence rates in the North West which in turn was higher than many other parts of the country. Although infection rates were increasing, hospitalisation rates were significantly lower than in previous waves, which indicated the effectiveness of the vaccine in preventing serious illness.

Committee considered the impact of the imminent lifting of COVID restrictions by the Government. No specific guidance for healthcare settings had been issued, but members agreed that the Trust stance should be to retain all the practices recommended by Public Health England for staff and patients.

Staff absence had increased and was causing operational pressures. A significant proportion of the absence was now caused by staff being contacted by the COVID app as potential contacts of someone who had tested positive. New national guidance had been issued in respect of essential workers and this was being implemented across the Trust and would hopefully reduce the number of staff who had to self-isolate.

4. 15th July 2021

4.1 Strategic Workforce Committee Terms of Reference (ToR)

The Deputy CEO/Director of Human Resources presented the draft ToR for the new Strategic Workforce Committee that was being established by the Board. Directors were asked for any comments on the draft before they were taken to the July Board meeting for formal approval, so that the new committee could start to meet in the autumn.

4.2 Anchor Institution

The Deputy CEO/Director of Human Resources presented a proposal for the Trust to work towards the Social Value Award and become an anchor institution to promote the health and wellbeing of the wider community. The proposal was supported as a logical next step in building on a number of existing initiatives, such as working with schools and universities that would demonstrate the Trust's contribution to addressing health inequalities.

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

The Director of Corporate Services presented the chairs assurance report from the July RMC meeting. There were 22 risks rated as high which were escalated to the CRR, including three new CRR risks escalated during June.

The council also received assurance reports from the Claims Governance Group and the CIP Group.

4.4 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for month 3 and members reviewed the metrics and commentary.

4.5 Elective Recovery Fund – Threshold changes

The Director of Finance and Information reported that the activity thresholds to access payments from the ERF had been increased from 85% to 95% for quarter 2 of the year. This would have a significant impact on the Trust's financial plan income assumptions.

4.6 COVID Issues

An expenditure request for additional surgical middle grade cover was approved to support the restoration and recovery plan.

The latest statistics indicated that infection rates in the North West were stabilising overall but the infection rates amongst young adults had doubled in the previous two weeks. This is the group who remain unvaccinated.

The Committee agreed the communications to staff, patients and visitors ahead of the easing of general COVID restrictions for the general public from Monday 19th July. All restrictions and infection prevention control measures were being retained in healthcare settings, which included visiting restrictions. It was agreed that the visiting restrictions would be reviewed again once the impact of the lifting of other restrictions on infection rates in the wider population was known.

5. 22nd July 2021

5.1 Inpatient Survey - 2020

The Director of Nursing, Midwifery and Governance introduced the paper which summarised the interim results of the 2020 inpatient survey. The full report with comparisons to the national data would be published later in the year. The survey had been delayed due to COVID-19 and had been undertaken in November 2020, rather than July. This was when the Trust was experiencing the 2nd wave of COVID and it was accepted that changes to the way services were delivered e.g., restrictions on visiting and social workers not being on site would have impacted on the experience of patients at this time. 468 patients had responded to the survey, of which 76% (366n) had been emergency admissions. The survey included 44 questions relating to patient experience and quality of care. Compared to the Trust's 2019 survey results 30 responses showed an improvement, 6 responses showed deterioration, 6 remained the same and 2 were new questions that could not be compared. Areas that needed improvement included support for patients at mealtimes, patient and family involvement in discharge planning and information about discharge/aftercare, which were similar to previous years. It was noted that improvements had been seen in those areas that had been set as Trust wide objectives in 2020/21. An action plan was being developed to respond to those areas which had deteriorated. A full report would be shared with the Quality Committee once the national comparative data had been published.

5.2 Flexible Working

The Deputy CEO/ Director of Human Resources introduced the proposals to formalise flexible working for staff where this was to the benefit of the individual and the organisation. Many staff had adapted to working from home during the pandemic and the policy was designed to be a route for departments to formalise a hybrid approach where it could be demonstrated that there would not be a negative impact on performance, productivity, or staff engagement. Managers would need to go through an assessment process, with periodic impact assessment reviews for their department as a whole and for different staff roles. Managers would have to demonstrate how staff would be supported to ensure they could work effectively and safely following specialist policies and guidance for this purpose. It was agreed that this approach should be trialled with a number of the corporate services, with the results reported back to Committee pending a final decision.

5.3 COVID Issues

The frequency of Gold Command had been increased to weekly in response to the increasing operational pressures.

Hospital admission rates for COVID had increased by 10% in Cheshire and Merseyside in the previous 7 days.

6. 29th July 2021

6.1 Safer Staffing Report

The Director of Nursing, Midwifery and Governance presented the nurse safer staffing report for June with the detailed analysis of the May data. For June the overall Registered Nurse (RN) fill rate was 92.82% and the Health Care Assistant overall fill rate was 103.27%. In May the overall RN fill rate had been 94.55%. It was noted that staffing had been extremely challenging during July.

The report highlighted that in May there were 11 of 34 wards had a fill rate for RN staff of less than 90% of which 4 had a fill rate of less than 85%. Committee discussed the actions that were being taken, including expediting the recruitment process and reviewing the supplementary care criteria.

Patient incidents were reviewed but were found to have occurred when the wards had appropriate staffing levels.

6.2 COVID Issues

Expenditure requests were approved to; re-escalate the CPAP and NIV capacity on ward 2C, which required specialist nurse cover, increase consultant cover for ICU for a period of two weeks whilst the unit opened additional bed capacity, continuation of funding for the staff redeployment hub to maintain safe staffing.

A funding request for locum plastic surgeons for a period of 6 months was also approved non-recurrently to maintain operating capacity to achieve the planned recovery trajectory.

7. 12th August 2021

7.1 Phlebotomy Service Booking System Business Case

The Director of Operations and Performance presented the case for investment in a patient booking system for the phlebotomy service. There were established systems available that could be procured and implemented quickly to give each patient an appointment and this would prevent long queues at the hospital and improve patient experience. The business case was approved.

7.2 National Costing Collection 2019/20

It was reported that the national collection team had changed its approach to the treatment of some costs that previously fell outside of the collection methodology. This change had resulted in the Trusts submission being excluded from the national benchmarking exercise for 2019/20; however, the reference costs would still be calculated for internal comparison.

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

The Committee received the assurance report from the August RMC meeting. There were a total of 711 risks on the Trust risk register, 21 of which were rated as high risks and escalated to the CRR. Two CRR risks had been removed or de-escalated since the previous report and 1 new high risk added.

7.4 COVID Issues

Members discussed options for improving the uptake of the COVID vaccines amongst pregnant staff, following the publication of research findings on the impact of the delta variant on pregnant women and their babies.

8. 26th August 2021

8.1 Annual Leave Flexibilities

The Deputy CEO/Director of Human Resources outlined options to increase the flexibility of annual leave provision, to enable staff to buy or sell annual leave from the Trust. Similar policies had been adopted by other Trusts and appeared to have been popular with staff. Members explored how such a policy could be implemented fairly but without resulting in increased operational staffing pressures. There was also concern that for 2021/22 staff would still have leave they could not take because of the impact of the pandemic. It was agreed to explore further the impact similar policies had in other Trusts and then revisit the proposal once the current issues with untaken leave had been resolved.

8.2 Safer Staffing Report

The Director of Nursing, Midwifery and Governance introduced the nurse safer staffing report for July. This provided the high-level staffing rates for July and a detailed analysis of staffing for the previous month. In July the overall RN fill rate was 90.88% and the HCA overall fill rate 102.38%. In June the RN fill rate had been 92.82%

The report highlighted that there were 9 of 34 wards had a fill rate for RN staff of less than 90% of which 6 had a fill rate of less than 85% in June. Committee discussed the actions that were being taken, including progress with recruitment, and the impact of self-isolation instructions to staff who were contacted by the COVID app, prior to the exemptions for essential workers being allowed.

Patient harm incidents were reviewed and in all but one case the areas had been appropriately staffed at the time. In this case, a category 2 pressure ulcer, the investigation was on going and would establish if staff levels at the time had been a contributory factor.

8.3 New ED Performance Standards

The new ED performance standards were to be introduced in the near future, which would replace the 4-hour waiting time target with a time in the department metric. It was agreed that the Trust should start to collect and monitor this metric in shadow form as soon as possible.

8.4 COVID Issues

The Committee discussed concerns about staffing gaps due to sickness and other absence and contingency plans for the bank holiday weekend and the major incident arrangements being put in place for the Creamfields Festival to minimise the impact for the local NHS.

The recruitment pipeline and staff turnover of unqualified staff was also reviewed because the NHS was facing more competition in the labour market as the hospitality and entertainment sector re-opened.

The Executive Committee did not meet on the 5th or 19th August.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)057
Reporting from: Audit Committee
Date of Committee/Council Meeting: 25 August 2021
Reporting to: Trust Board
Attendance: Ian Clayton (Chair), Jeff Kozer, Gill Brown.
Matters discussed This meeting of the Audit Committee was solely held for the purpose of considering external audit matters, and reviewing the *Annual Report and Accounts 20/21,* and the Trust's Letter of Representation, on behalf of the Board. This is consistent with the Committee's Terms of Reference. As discussed and approved previously, the Trust's VfM Conclusion is to be delivered separately, in September.
Assurance provided With regards to the for-audit material presented, the Committee was provided with assurance in the following matters. 1. The high quality of reporting, including the lack of adjustments. 2. The rigour of the audit process in terms of the depth of testing and changes in the nature of auditing, particularly relating to ISA540 procedures on estimates.
Decisions taken The *Annual Report and Accounts 20/21* was received and approved - to be recommended to the Board and signed off by the Chief Executive - with compliments to the Finance team and to the Director of Corporate Services.
Risks identified and action taken None.
Matters for escalation None.
Recommendation

The Trust's *Annual Report and Accounts 20/21* is recommended to the Board.
Committee Chair: Ian Clayton
Date of Meeting: 29 September 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)058
Reporting from: Quality Committee
Date of Committee Meeting: 21st September 2021
Reporting to: Trust Board
Attendance: Gill Brown, Non-Executive Director (Chair) Val Davies, Non-Executive Director Lisa Knight, Non-Executive Director Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Nik Khashu, Director of Finance Rowan Pritchard-Jones, Medical Director Teresa Keyes, Deputy Director of Nursing and Quality (deputising for Sue Redfern) **In Attendance:** Ash Bassi, Divisional Medical Director Debbie Stanway, Head of Nursing and Quality, Medical Care Group Tracy Greenwood, Head of Nursing and Quality, Surgical Care Group Jacqui Scott, Head of Nursing and Quality, Community and Primary Care Group Anne Rosbotham-Williams, Deputy Director of Governance Rajesh Karimbath, Assistant Director of Patient Safety Sue Orchard, Head of Midwifery Susan Norbury, Assistant Director of Safeguarding (agenda item 11)

Matters Discussed:
• **COVID update** provided, noting the continued impact of the pandemic as well as ongoing non-COVID challenges, including the need to maintain high levels of infection prevention measures, the increased number of frail, acutely unwell patients accessing services and the commencement of the booster vaccination programme for staff
• Noted that a review of genitourinary medicine services is underway to ensure the services being commissioned by the Local Authority are as optimal as possible
• A regional review of Tier 4 CAMHS provision has identified key recommendations to improve the consistency of services delivered to all providers, including StHK
• **Integrated Performance Report** highlighting:
  ○ Actions taken as a result of the Never Event to prevent a reoccurrence
  ○ No recent MRSA bacteraemia
  ○ 31 C. Difficile infections reported (April to August) against an annual threshold of 54. Appeals regarding some infections are awaited. The Committee sought assurance that actions were being taken to reduce the number of infections

- Safer staffing fill rate of 91.9% year to date, with challenges due to the number of patients requiring supplementary care (including 1-1 nursing)
- HSMR year to date of 95.8, noting weekend rate of 121.5 in August, which remains within expected range (84-165)
- 62 and 31 day cancer targets were met, with work ongoing to achieve all targets.
- Delayed discharges :It was noted that Directors of Adult Social Care attended the Trust to support the work on reducing discharge delays across all boroughs and that there has been increased presence of social workers at board rounds, including those conducted virtually
- Focus continues on improving mandatory training and appraisal rates

- A report was presented on progress in delivering the **Trust objectives aligned to the Quality Committee,** noting progress in most areas. Discussions focussed on those indicators which were not being achieved including triage in ED due to the activity demands; discharges before noon due to availability of social care and mandatory/appraisal compliance.
- **Patient Experience Council report** highlighted the following:
  - Work ongoing to improve complaint response times to pre-pandemic levels
  - Management of interpreting contract to improve face-to-face fill rates
  - Latest National GP Survey - Improvements in areas of focus following previous GP survey for Marshall's Cross, including increased levels of satisfaction in getting through to the practice by telephone, satisfaction with offer of appointment times and patients being able to see their preferred GP.
  - Improvements in feedback from the internal Children and Young People survey report
  - Progress in delivering the Trust's equality objectives, with action being taken to increase engagement with local organisations, following a decrease during the pandemic
- **National and Local Patient Survey Reports.** Committee received verbal update on initial feedback. Detailed reports will be reported to a future Quality Committee.
- **Patient Safety Council** highlighted the following:
  - Update on the total number of incidents reported and actions taken as a result of serious incidents
  - The Council received a report on infections in quarter 1, with the learning identified from a review of incidents
  - Reports also received relating to CAS alerts, falls and decontamination services
- **Maternity Services** reports were presented to provide an update on:
  - Staffing levels which confirmed that the ratio of midwives to births achieved the target of 1:28 in quarter one and 1:1 care for women in labour, although there was an increase in red flag incidents and were considerable pressures on staff with closures due to the high acuity experienced in the Delivery Suite. It was noted that there have been similar challenges in maternity units across the region. The new Head of Midwifery is working with the team to look at appropriate actions to reduce the number of red flag incidents
  - Use of perinatal mortality review tool, noting the actions taken as a result of improvements identified, including establishment of preterm birth clinic and review of triage area
  - Progress in achieving year 4 of CNST incentive scheme, due by June

2022
    - The work required to be compliant with continuity of carer by 2023, including a revised action plan and consultation with staff
- **Safeguarding Annual Report 2020-21.** Committee approved and commended this comprehensive report which highlighted significant achievements during the year, despite extremely challenging circumstances due to COVID. 'Next steps' for 2021-22 were detailed with focus on recovery of mandatory training compliance. Inclusion of case studies was particularly useful, illustrating the extraordinary work undertaken by staff to keep patients safe when challenging safeguarding issues arise.
- **Pressure ulcer update report** outlined the ongoing delivery of preventative measures and the impact this is having to reduce pressure ulcer incidents
- **Falls presentation** outlining the outcome of a review of falls since April 2019, identifying the underlying factors leading to the rise in falls in 2020-21 and the improvement actions being taken to achieve a reduction this year. The Chair requested that consideration be given to including more meaningful metrics in the revised IPR in order to support ongoing monitoring and overview of the impact of the measures being taken to reduce falls
- **Clinical Effectiveness Council report** highlighted the following:
    - Highlighted the improvement in Immediate Life Support and the requirement for this to continue
    - Key information shared in relation to the Trauma Unit, including meeting the reaccreditation standards and work to improve access to CT scans following head injuries
    - Presentations received from Critical Care, Medical Emergency Team, Resuscitation Services and Trauma Team
    - The approval of the Acute Abdominal Pathway to improve the patient journey, which will impact on patient safety. An audit will be undertaken following the launch of the pathway
- **Clinical and Quality Strategy 2021-22.** Committee approved and commended the strategy which describes the need for a period of transition as the Trust emerges from the pandemic. The document describes a one-year interim strategy focusing on recovery and restoration and will allow time for wider stakeholder engagement as the local healthcare system evolves into an ICS.

Assurance Provided:

- Systems in place to ensure the stroke access targets are met are effective and any patients not meeting these are reviewed to identify learning
- Quality Review undertaken in ED. Ongoing work with strategic partners to improve timely and safe discharge
- Ongoing comprehensive delivery of safeguarding services across the all Trust areas, with increased numbers of DoLS referrals, proactive support for patients with learning disabilities and input into wide range of forums both internal and external to the Trust, with positive feedback received
- Establishment of a consultant led preterm birth clinic
- Strategic falls action plan in place to support achievement of falls reduction in 2021-22
- Reduced number of pressure ulcers where there have been lapses in care
- Confirmation that HSMR for patients with acute kidney injury is improving month on month

Decisions Taken: The following were approved: Safeguarding Annual Report 2020-21 Clinical and Quality Strategy 2021-22
Risks identified and action taken: • Ongoing focus on achieving compliance with appraisals and mandatory training, including safeguarding, life support (in particular immediate life support) and infection prevention
Matters for escalation: None
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: 29th September 2021

TRUST BOARD

Paper No: NHST(21)059

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 23rd Sept 2021

Summary

Meeting attended by:

J Kozer – NED & Chair
P Growney - NED
N Bunce – Director of Corporate Services
N Khashu – Director of Finance & Information
G Lawrence – Deputy Director of Finance & Information
R Cooper – Director of Operations & Performance
R Pritchard Jones – Medical Director
A Bassi – Divisional Medical Director
D Stafford – Assistant Director of Operations Medical Care
M Duffy – Head of Financial Management

Agenda Items

For Assurance

A) Integrated Performance Report

- Target 62 day and 31 day performance was met in July, at 86.2% and 96.9% respectively.
- Target 2 week wait cancer performance was not achieved in July, with delivery of 91.1% against a target of 93% due to the ongoing impact of the pandemic. This represents an improvement against June's performance which was 86%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 54.3% in August and 59.5% year to date. The all type mapped STHK Trust footprint performance was 76.9% in August and 78.7% year to date. The Trust saw average daily attendances of 317, which is down compared to July, at 355. Total attendances for August 2021 were 9,823.
- The ambulance turnaround time target was not achieved in August. The Trust was the busiest in C&M and third busiest across the North West.
- In August overall sickness has increased by 0.2% from July. Front line Nursing, Midwifery and HCA sickness was 9.1% which is a decrease of 0.8% since July. Staffing challenges around self-isolation and annual leave are ongoing. 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 committee is assured that plans are in progress to address underachievement of appraisal and mandatory training compliance.

B) Finance Report Month 5

- The Trust is reporting a £2.3m deficit position as at the end of month 5, relating to the changes in thresholds for achievement of ERF income. This is expected to be recovered and the trust to deliver a H1 breakeven outturn at the end of Month 6.
- Schemes are fully identified to meet the Trust's H1 CIP target of £3.8m.

- As well as the CIP target issued by the HCP, a further non recurrent contribution was requested from the ERF. This equated to £3.3m for H1. Due to the changes to the ERF thresholds from M4 onwards, only the M1-M3 element of £1.9m has been delivered.
- As at Month 5, the Trust had a cash balance of £59.3m and continues to achieve PSPP.
- The Trust has a total 2021/22 capital plan of £17.7m which is on plan to deliver.

C) H1 Forecast Update

- Despite the changes to ERF thresholds in months 4 & 5 and subsequent non delivery of contribution, the trust have continued to incur costs. The subsequent £3.3m deficit and expected to be managed, through additional STHK savings (£0.9m), implementation of the HCP 20-21 agreement (£1.0m) and System Investment not transferred (£1.4m). An update on H2 will follow when full guidance is received.

D) Committee Objectives

- The committee received the report on the Trust objectives that have been assigned to the committee and noted and discussed their progress.

For Approval

N/A

For Information

E) Medical Care CIP Presentation

- The care group confirmed that £3.6m worth of schemes have been identified in year against a CIP target of £4.3m; of which £2.9m of these schemes are recurrent.
- MCG have reinstated the 95% challenge meetings with all budget holders between now and the end of the calendar year; meetings which had previously been paused as a result of Covid 19 pressures.
- Further internal control measures on budgets have now been implemented to ensure robust monitoring of budgets, to include reviews on Housekeeping, Vac Panels and Medical Premium Payments.

CIP Programme Update – Update noted by committee
CIP Council report – Update noted by committee
Procurement Council report – Update noted by committee, with reference to the challenges and mitigations in supply and performance of Supply Chain.

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: 23rd September 2021

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

St Helens & Knowsley Teaching Hospitals NHS Trust
September 2021

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board of St Helens & Knowsley Teaching Hospitals can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

A business case is being prepared to source additional funds which would reflect the increased demand on the appraisal and medical revalidation team to support the responsible officer

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes, this is co-ordinated through different teams within the Trust.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The current Medical Appraisal & Revalidation Policy was out to consultation with the trust's Local Negotiating Committee (LNC). The policy was approved and is now in place. The Responsible Officer Advisory Group (ROAG) meetings have now restarted as virtual meetings and take place quarterly.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Not occurred due to Covid but a peer review will happen in the future.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

The Trust provides support with appraisal and revalidation for all doctors whom the Trust is their designated body. This includes some doctors who work on the Trust's medical bank or have short-term contracts with the Trust. A doctor can request their individual information in the form of complaints and significant events from the Quality and Risk Department. The Trust will provide information to the doctor's Responsible Officer to assist their revalidation when requested.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

A doctor can request information relating to them in the form of complaints and significant events from the Quality and Risk Department. Individual specialties have access to outcome data relating to their specialty.

The Trust adopted the Appraisal 2020 model with effect from October 2020. Feedback from doctors has been positive particularly around the emphasis on verbal reflections and the reduced requirements and preparation.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

The Trust has implemented the Appraisal 2020 model

The current arrangements will remain in place until at least March 2022. We are expecting updated guidance from NHS England and the GMC regarding requirements for appraisal and will implement this when it is published.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes. The revised policy was approved in accordance with Trust's governance processes and is available on the Trust intranet.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The number of doctors with a prescribed connection to the Trust increases year on year.

Recruiting new appraisers is an ongoing challenge due to doctors taking on other roles and competing priorities.

Between September 2020 and August 2021 we have successfully trained 13 new appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Appraisers are expected to attend an in-house appraiser support group once a year. These groups are facilitated by the Trust's Responsible Officer or the Clinical Appraisal Lead.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

The appraiser support group meetings were suspended through the pandemic. They will be restarting at the end of September 2021.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The appraisal system is reviewed by the ROAG and the minutes of the ROAG meeting are shared with the Workforce Council.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	480
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	181
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	299
Total number of agreed exceptions	299

The data show a significant number of doctors who had agreed exceptions. In line with NHS England guidance, appraisals were suspended from April 2020 to October 2020. In addition, doctors working in specialties which were hard-pressed due to the pandemic (such as those working in critical care) were given additional time to complete their appraisals. A number of doctors who had special circumstances, such as maternity or sick leave, were granted an agreed exception. We expect the number of agreed exceptions to reduce significantly next year.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

The Responsible Officer meets the Trust GMC Employer Liaison Advisor (ELA) 3 times per year and will have an early discussion with the ELA when necessary about any other concerns which may arise.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

The Responsible Officer informs the doctor when a positive recommendation has been made.

If the Responsible Officer plans to make a recommendation of deferral, the doctor is informed prior to the deferral and a plan is put in place to avoid further deferrals.

The Responsible Officer follows the Trust policy for management of non-engagement with appraisal and revalidation. As part of the policy, the doctor will have met the Responsible Officer to discuss a recommendation of non-engagement before the recommendation is made.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Trust is undertaking a review of its processes for clinical governance for doctors using the GMC guidance on governance for doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Concerns raised about doctors are managed using the relevant Trust policies.

All doctors can contact the Quality and Risk department to access their individual information relating to complaints and incidents.

All doctors are required to document any complaints and significant events within their appraisal.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The Trust has a number of policies in place to include – Remediation, Maintaining High Professional Standards, Handling Medical Concerns, Raising Concerns and Respect and Dignity at Work.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

The Trust has an Employee Relations Oversight Steering Group (ERSOG) which reports to the Trust Board via the Quality Committee. The ERSOG oversees local investigation and disciplinary procedures for all staff groups. These meetings were suspended at the beginning of the pandemic but have now restarted. The Equality, Diversity and Inclusion Lead ensures Workforce Race/Disability Equality Standard (WRES & WDES) reports are completed and actioned. The reports around exclusion and exception data are presented and discussed by the Board.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

The Trust continues to use the Medical Practice Information Transfer (MPIT) forms when a doctor takes up or leaves employment with the Trust to request information from a previous Responsible Officer or to share information with a doctor's new Responsible Officer.

The Responsible Officer will make contact with other Responsible Officers or Clinical Governance leads on an ad hoc basis when concerns are raised about doctors.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

The ERSOG oversees local investigation and disciplinary procedures for all staff groups.

The Trust seeks advice from the GMC's ELA and also from NHS Resolution's Practitioner Performance Advice service (PPA) when necessary.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

The Trust continues to adhere to NHS Safer Recruitment Standards.

The medical resourcing team have a robust process in place to ensure a doctor meets the criteria for qualifications, references and GMC requirements.

Section 6 – Summary of comments, and overall conclusion

The Covid-19 pandemic has been a huge challenge for the Trust and has meant some plans for development of the Trust's Medical Appraisal and Revalidation systems have

been delayed or put on hold.

The revised Medical Appraisal and Revalidation policy has been approved and is being implemented.

The GMC and NHS England are reviewing the requirements for appraisal in the light of the introduction of a streamlined process during the pandemic. We are expecting further guidance to be published in 2022.

Overall conclusion:

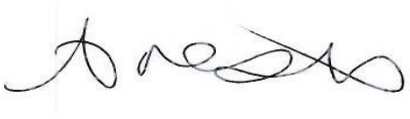
The Trust can confirm they are compliant with the Responsible Officer Regulations.

Section 7 – Statement of Compliance:

The Board of St Helens & Knowsley Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: St Helens & Knowsley Teaching Hospitals NHS Trust

Name: Anne-Marie Stretch Signed: 

Role: Deputy Chief Executive

Date: 21st September 2021

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)061

Title of paper: Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2021/22

Purpose: The Trust's annual statement of compliance with EPRR national core standards to be approved by Trust Board, prior to submission to Public Health England and NHSE

Summary:

The purpose of the EPRR annual assurance process is to assess the preparedness of the NHS, (Commissioners and providers), against NHS EPRR Core Standards. As part of the NHSE EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

In July 2021 amended NHS Core Standards for EPRR were published for 2021/22, which are the minimum requirements expected. It is a requirement that a Statement of Compliance with the core standards is presented to the Trust Board for approval before 29 October 2021.

In 2020/21 the EPRR assurance process was light touch due to COVID-19 and the Trust was only required to provide a progress report and assurance on the four actions where it had not been fully compliant with in the 2019/20 submission. In addition NHS organisations were required to provide an overview of lessons learnt from the 1st wave of COVID-19 and a brief summary of the Trust winter plan

In 2019/20 the Trust achieved substantial compliance with 93.75%. 4 standards were assessed as partially compliant which all related to chemical, biological, radiological and nuclear defence (CRBN) training.

1. CBRN decontamination capability 24/7 – additional staff need to be recruited in ED team
2. CBRN Training programme – refresher training was required for previously trained staff
3. HAZMAT/CBRN training trainers – previously trained staff were required to attend the National Ambulance Resilience Unit (NARU) 'train the trainer' training. This training is provided by NWAS and has limited places. The Trust has requested places on the next available course and has secured support from the Cheshire and Merseyside EPRR lead to be able to deliver this training in- house;
4. CBRN staff training in decontamination - refresher training was required for previously trained staff.

For 2021/22 the core standards have been reduced for 69 to 46, the Trust's self-assessment indicates that the Trust is fully compliant with 44 of the 46 standards and partially compliant with 2 standards. This achieves a substantial compliance score of 95.6%.

The 2 areas where the Trust is partially compliant are;

- To increase number of HAZMAT/CBRN train the trainers to 6 - 3 have been trained in the last 18 months
- CBRN staff training in decontamination – due to Covid -19 impact and staff turnover in the department the plan is that 85% of the required staff will have received refresher training by March 2022.

To mitigate these areas of partial compliance the Emergency Department has issued every staff member with guidance on how to identify and respond to patients presenting at the department following incidents related to bio hazards. The department staffing roster ensures a minimum of 5 HAZMAT/CBRN trained staff on each shift (24/7). A decontamination training programme is also in place.

The EPRR primary focus of 2020/21 has been the continued response to the coronavirus pandemic, which NHS England declared as a Level 4 national incident in January 2020. Through the national response to the COVID-19 pandemic a number of factors have been identified that inhibited the ability of the NHS to increase inpatient capacity. One of these factors related to internal piped oxygen system capacity, which has a number of interdependent components needed to increase volume and flow rates. In order to better understand the resilience of each organisations internal piped oxygen systems, the 2021-2022 EPRR annual deep dive focuses on this area. The deep dive is applicable to all providers of NHS funded care that utilise internal piped oxygen systems, including acute, community and mental health trusts.

The Trust has self-assessed against the 7 deep dive standards and is fully **compliant with them all.** This is monitored via the Trust's oxygen steering group which reports to the patient safety council.

The 2021-22 Statement of Compliance is attached at Appendix A

Corporate objectives met or risks addressed: Compliance with EPRR National Core Standards required by regulators and commissioners and ensuring the continued and effective safety and care of patients, staff, partner agencies, visitors and others in the event of a Major Incident or business continuity disruption.

Financial implications: No new financial implications as a result of this paper

Stakeholders: Staff, patients, commissioners, regulators, partner agencies, Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) partners

Recommendation(s): The Trust's statement of compliance with EPRR national core standards is attached for approval by Trust Board

Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance and Trust EPRR Lead Director.

Date of meeting: 29th September 2021

1. Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services. This programme of work is referred to as emergency preparedness, resilience and response (EPRR).

The purpose of the EPRR Annual Assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. NHS England has set out NHS Core Standards for EPRR, which are the minimum requirements expected.

The Emergency Preparedness, Resilience and Response (EPRR) Core Standards 2021-2022, were issued on 23rd July 2021. Stephen Groves, National Director of EPRR NHS England and NHS Improvement wrote to all hospital trusts outlining the process in which each NHS organisation had to undertake a self-assessment and assess itself against these core standard to determine the Trust's current resilience status, this is in alignment with its statutory obligations. It is a requirement that the Statement of Compliance with the amended national core standards for Emergency Planning Response & Resilience for 2020/21 is presented to Trust Board before 29 October 2021.

The Local Health Resilience partnership will work with their constituent organisations to agree a process to gain confidence with organisational ratings and provide an environment to promote the sharing of good practice across their region.

NHS England and NHS Improvement regional heads of EPRR are required to submit the assurance ratings for each of their organisations and description of their regional process to Stephen Groves before Friday 31 December 2021.

2. Trust self-assessment

Previously the Trust has been required to self-assess against 64 questions (applicable to the Trust) on Major Incident preparedness and business continuity, including questions on HAZMAT/ CBRN preparedness and for 2019-20 the Trust was 'fully compliant' with 60 of the 64 questions and was 'partially compliant' with 4 questions. The Trust achieved substantially compliance with 93.75%.

The 4 questions with partial compliance all related to chemical, biological, radiological and nuclear defence (CRBN) training.

For 2020-21 EPRR assurance submission, the process was light touch, the Trust was required to provide progress and assurance on the four actions that they were not fully compliant with in the previous year's submission , to provide an overview or lessons learnt from the 1st wave of COVID-19 and brief summary of the Trust winter plan.

For 2021-22, due to the impact of the Covid-19 pandemic the self-assessment process was adjusted to represent the impact that the response to covid-19 was having within the

field of EPRR .The amended EPRR assurance submission requires a self-assessment against 46 (previously 65) core standards.

The self-assessment indicated the Trust is fully compliant in 44 of the 46 standards and partially compliant with 2 standards. This provides a Trust overall compliance of 95.6% (Substantial compliance)

The 2 areas for focus are the same as the previous years:

- To increase number of HAZMAT/CBRN train the trainers: 3 have been trained in the last 18 months. The plan is to increase this to 6 as soon as possible.
- CBRN staff training in decontamination – due to the impact of Covid -19 and staff turnover in the department. The plan is to achieve 85% of applicable staff to receive refresher training by March 2022.

The 2 actions will be monitored via the EPRR steering group.

Risks:

- Capacity to release staff as this training is needed to be face to face practical session i.e. wearing PRP suits and establishing decontamination tents
- limited numbers attending session due to social distancing requirements
- further waves of COVID -19 pandemic

3. Deep Dive

The primary focus of 2020/21 has been the continued response to the coronavirus pandemic, which NHS England declared as a Level 4 national incident in January 2020, Through the national response to the COVID-19 pandemic a number of factors have been identified that inhibited the ability to increase inpatient capacity. One of these factors related to the internal piped oxygen system capacity, which has a number of interdependent components to increasing volume and flow rates. In order to better understand the resilience of the internal piped oxygen systems, the 2021-2022 EPRR annual deep dive focuses on this area. The deep dive is applicable and to all providers of NHS funded care that utilise internal piped oxygen systems, including acute, community and mental health trusts.

The Trust has self-assessed against the 7 deep dive questions and is fully **compliant with each standard.** This is monitored via the Trust's Medical Gas Committee (Oxygen steering group) which report to the patient safety council.

The Deep dive questions are:

1. **Medical Gas Governance** -The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.
2. **Medical Gas Planning-**The organisation has robust and tested Business Continuity and/or Disaster Recovery plan for medical gases
3. **Medical Gas Planning-**The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.
4. **Medical Gases Workforce -** The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.

5. **Oxygen system escalation** -The organisation has a clear escalation plan and processes for management of surge in oxygen demand
6. **Oxygen systems** -Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)
7. **Oxygen systems-**The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6

4. Other Issues reviewed

Reinforced autoclaved aerated concrete (RAAC)

Reinforced autoclaved aerated concrete (RAAC) is a form of lightweight concrete sometimes referred to as planks. RAAC planks were used in the roofs, floors and walls of NHS buildings between the 1960s and 1980s and had an expected lifespan of around 30 years. As the St Helens and Whiston Hospitals were built after this time frame, RAAC planking was not used and therefore no further information was required from the Trust as part of this submission.

IT/Cyber resilience

Whilst the core standards are the minimum standards that an NHS organisation should meet, they do not cover in detail IT/Cyber resilience. Therefore, in order to provide additional assurance to NHS England & NHS Improvement that there is an adequate level of resilience in the NHS IT sector across Cheshire and Merseyside the NHS England & NHS Improvement – North West, IT and Digital Technology Team was requested to develop a set of specialised assurance questions on cyber preparedness at local level. Each Trust was required to provide a response to the questions by 24th September 2021, the questions related to:

- Digital hardware resilience for failover and backup of services
- Detail the current status of supported v unsupported software and hardware and confirm that plans are in place to transition and maintain all products in a supported state
- The processes for the safe management of data
- Remote access procedures you have in place
- Resilience and business continuity approach in the event of partial or total loss of digital services. This should include your return-to-service approach
- Advise resilience and business continuity approach in the event of partial or total loss of digital services. This should include your return-to-service approach

The IT team and operational services provided robust evidence for the submission on the system in place to ensure IT and cyber resilience.

5. EPRR update

Over the last 12 months, the Trust has delivered the following:

- An Incident Management Team (IMT: bronze, silver gold and COVID Executive meetings) attended by members of the senior leadership team. This structure continues to oversee the Trust's ongoing response to Covid -19 which includes

risks, lateral flow testing programme, the distribution of personal protective equipment, etc.
- Continued safe service delivery alongside recovery planning.
- This is supported by using innovative methods to deliver care packages e.g. using virtual appointments alongside face to face appointments and accessing digital platforms
- Maintaining Covid secure environments to reduce the spread of the virus to keep staff and patients protected
- Regular communications with staff on the latest guidance on safer working and infection protection and control procedures
- Consistent messaging and signposting on staff emotional health & wellbeing
- Supported staff working from home
- Liaising with hard to reach community groups around vaccine hesitancy ¬
- Supporting the Mass Vaccination centre in its business continuity planning Further strengthening relationships with our health partners and the wider resilience system in the localities to provide a more cohesive response to incidents
- Pro-active Trust wide business continuity planning exercises for recurrent and emerging risks; future anticipated Covid surges and winter planning 2021-2022
- Trust wide response regarding EU exit

The Trusts EPRR work programme for 2021/22 is aligned to the national work plan and includes:

- Ongoing response to the coronavirus pandemic and implementation of the learning identified from the pandemic response during 2020/21
- Review of the Trust EPRR guidance to ensure remains aligned to the National Incident Response Plan, EPRR Framework and supporting procedural documents
- Continue to updating plans and standard operating procedures to take account of Continue to changes to the National Security Risk Assessment (NSRA) and National Risk Register
- Ensure key staff are trained for and supported the response to the pandemic continue to receive training for future significant incidents that need support from the wider organisation.
- Undertake a table top exercise re hospital evacuation (Planned for December 2021)
- The EPPR.STHK@sthk.nhs.uk email address will remain in place as a Trust mailbox for receipt of urgent messages, instructions, guidance and demands for data from NHSNW.EPRR. It is monitored by senior managers, key staff and the submissions team and is a robust conduit for information sharing going forward.
- The COVID webpage on the trust intranet is a valuable repository of information and FAQs for staff that they have become accustomed to consulting. This style of communication continues to be used for any key information.
- Business continuity plans are continually reviewed by the care groups and relevant leads including shortages and loss of staffing, equipment, PPE and other supplies, medicines and estates
- Support to engage an interim EPRR lead

ENDS

Appendix A

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, STHK will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
46	**0**	**2**	**44**

Standards: Acute providers: **46,** Specialist providers: **38,** Community providers: **37,** Mental health providers: **37,** CCGs: **29**

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____ _____

Signed by the organisation's Accountable Emergency Officer — Date signed

_____ _____ _____

Date of Board/governing body meeting — Date presented at Public Board — Date published in organisations Annual Report

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(21)062
Title of paper: Workforce Equality, Diversity & Inclusion Update – Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
Purpose: To inform and provide the Trust Board with an update relating to the Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES) results and actions.
Summary: Implementing the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) is a requirement for NHS commissioners and NHS provider organisations. The Trust is monitored against the 9 and 10 indicators respectively and this report provides an update on action taken to date.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce.
Financial implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to note and approve the updated WRES report and actions.
Presenting officer: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Date of meeting: 29th September 2021

1. Introduction

Workforce Race Equality Standard Annual Update 2021 (WRES)

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda.

The WRES is made up of nine indicators; the first four measure staff experience over a 12-month period for harassment, bullying, or abuse from patients, relatives, or the public. Another four measure workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator nine considers BME representation on executive boards, in relation to the workforce.

The main purpose of the WRES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- ✓ to improve BME representation at the Board level of the organisation.

The data presented refers to the following periods

Indicator 1	1st April 2020 – 31st March 2021
Indicator 2	1st April 2020 – 31st March 2021
Indicator 3	1 April 2020 – 31 March 2021
Indicator 4	1st April 2020 – 31st March 2021
Indicator 5,6,7 & 8	Staff Survey Results 2020
Indicator 9	31st March 2021

Workforce Disability Equality Standard Annual Update 2021 (WDES)

The NHS Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. It has been designed to improve workplace experience and career opportunities for disabled people working or seeking employment in the NHS.

The WDES is made up of ten indicators; which cover such areas as the Board, recruitment, bullying and harassment, engagement, and the voices of disabled staff. The main purpose of the WDES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,
- ✓ to improve representation at the Board level of the organisation.

Please note that at the time of this report the WDES National Report has not been produced so there is nothing to benchmark the Trust results against.

The data presented refers to the following periods

Indicator 1	Snapshot as at 31st March 2021
Indicator 2	1st April 2020 – 31st March 2021
Indicator 3	This Metric will be based on data from a two-year rolling average of the current and previous year.
Indicator 4,5,6,7,8 & 9a	Staff Survey Results 2020
Indicator 9b	Time of completing report
Indicator 10	Snapshot as at 31st March 2021

3. WRES & WDES Results and Actions

WRES Indicator Results
Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. • BME Staff in Workforce: 9.9% • White Staff in Workforce: 88.2% • Not disclosed Ethnicity Data: 1.9%
Indicator 2: Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts. Relevant likelihood of White staff being appointed from shortlisting is 1.06 times greater than BME Staff in comparison with 1.32 times higher in 2020. A figure below "1" would indicate that White candidates are less likely than BME candidates to be appointed from shortlisting. The National NHS figure in England is 1.61.
Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. • BME staff: 1.44 in 2020 compared with 1.14 in 2019 A figure below "1" would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process. The National NHS figure in England is 1.16.
Indicator 4: Relative likelihood of staff accessing non-mandatory training and Continuing Personal Development. • 2020 results = 0.87 • 2019 results = 0.97 A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff. The National NHS figure in England is 1.14.

Indicator 5: relates to Staff Survey findings.
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

- White Staff: 20.2% in 2020 compared with 22.5% in 2019
- BME Staff: 20.5% in 2020 compared with 30.2% in 2019

The National NHS figure is BAME staff 30.3% and White staff 27.9%

Indicator 6: relates to Staff Survey findings. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

- White Staff: 16% in 2020 compared with 15.5% in 2019
- BME Staff: 22.7% in 2020 compared with 30.2% in 2019

The National NHS figure is BAME staff 28.4% compared with White staff 23.6%.

Indicator 7: relates to Staff Survey findings. Percentage believing that the Trust provides equal opportunities for career progression or promotion

- White: 95.5% in 2020 compared with 94.5% in 2019
- BME: 69% in 2020 compared with 70% in 2019

The National NHS figure is BAME staff 71.2% compared with White staff 86.9%

Indicator 8: relates to Staff Survey findings. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues

- White: 2.5% in 2020 compared with 4.3% in 2019
- BME: 16.3% in 2020 compared with 16.7% in 2019

The National NHS figure is BAME staff 14.5% compared with White staff 6%.

Indicator 9: Percentage difference between the organisations' Board voting membership and its overall workforce.

Trust Board BME is 6.3%. The overall workforce by ethnicity is 9.9%.
The Trust Board figure as at 31st March 2021 was made up of 16 board members, inclusive of Non-Executive Directors.

WDES Indicator Results
Indicator 1: Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff in the overall workforce. • Non-Disabled Staff in Workforce: 83.1% • Disabled Staff in Workforce: 3% • Not Disclosed Disability Status:13.9%
Indicator 2: Relative Likelihood of Disabled Staff compared to Non-Disabled Staff being appointed from shortlisting across all posts. Relevant likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff: 1.02 A figure above 1:00 indicates that Non-Disabled staff are more likely than Disabled staff to be appointed from shortlisting.
Indicator 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Relevant likelihood of Disabled staff entering the formal capability process compared with Non-Disabled staff: 5.63 (It should be noted that this was a total of 2 staff over a two-year period) A figure above 1.00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process.
Indicator 4a): Percentage of Disabled Staff compared to non-disabled staff experiencing harassment, bullying or abuse from: Patients/service users, their relatives, or other members of the public: • Disabled Staff: 29% in 2020 compared with 34% in 2019 • Non-Disabled Staff: 18.3% in 2020 compared with 20.6% in 2019

Managers: • Disabled Staff: 12.3% in 2020 compared with 10.8% in 2019 • Non-Disabled Staff: 8.2% in 2020 compared with 6.5% in 2019 Other colleagues: • Disabled Staff: 15.9% in 2020 compared with 20.4% in 2019 • Non-Disabled Staff: 10.7% in 2020 compared with 11% in 2019
Indicator 4b): Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. • Disabled Staff: 54.1% in 2020 compared with 66.7% in 2019 • Non-Disabled Staff: 44.2% in 2020 compared with 42.9% in 2019
Indicator 5: Percentage of Disabled Staff compared to Non-Disabled Staff believing that the Trust provides equal opportunities for career progression or promotion. • Disabled Staff: 92.4% in 2020 compared with 93.2% in 2019 • Non-Disabled Staff: 93.6% in 2020 compared with 92.6% in 2019
Indicator 6: Percentage of Disabled Staff compared to Non-Disabled Staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. • Disabled Staff: 29.2% in 2020 compared with 20.3% in 2019 • Non-Disabled Staff: 20% in 2020 compared with 14.1% in 2019
Indicator 7: Percentage of Disabled Staff compared to Non-Disabled Staff saying that they are satisfied with the extent to which their organisations value their work. • Disabled Staff: 53.3% in 2020 compared with 54.3% in 2019 • Non-Disabled Staff: 61.1% in 2020 compared with 59.1% in 2019
Indicator 8: Percentage of Disabled Staff saying their employer has made adequate adjustments to enable them to carry out their work. • Disabled Staff: 84.9% in 2020 compared with 81.8% in 2019
Indicator 9a: The staff engagement score for Disabled Staff compared to Non-Disabled Staff and the overall engagement score for the organisation.

• Disabled Staff: 7.3 in 2020 compared with 7.2 in 2019 • Non-Disabled Staff: 7.7 in 2020 compared with 7.6 in 2019
Indicator 9b: Has your Trust taken action to facilitate the voices of Disabled Staff in your organisation to be heard? Yes
Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce disaggregated • By voting membership of the Board. Disabled Staff: 0% in 2020 compared with 0% in 2019 Non-Disabled Staff: 60% in 2020 compared with 60% in 2019 Not Disclosed disability status 40% in 2020 compared with 40% in 2019 • By Executive membership of the Board. Disabled Staff: 0% in 2020 compared with 0% in 2019 Non-Disabled Staff: 60% in 2020 compared with 60% in 2019

Action	Action Owner	By When	Measure of Success	Indicator
Inclusive & Compassionate Leadership				
Equality, diversity, and inclusivity will be threaded through the Trust's corporate objectives and into Board and Executive level, departmental and individual objectives	Chief Executive	April 2022	Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
Ensure that an understanding of race and inequality is woven through both discussion and decision making. At least one board member (outside of Human Resource responsibility), will enrol on the new WRES Advisors programme and include an expectation that makes an explicit commitment to identifying and sponsoring BAME talent to attend the board.	Chief Executive	April 2022	Improved diversity of Board and Leadership composition Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10

Develop a competency framework and development programme for all core managers, supervisors, and line managers throughout the organisation. March 2021 (not yet published) will see the publication of a national competency framework for board level leaders. We recommend taking a broader approach, including core managers, supervisors, and line managers.	Assistant Director of OD	December 2022	Improved diversity of Board and Leadership composition Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
Implement an allies programme, only those in power can make the necessary changes. We need allies to take up the responsibility for change, so that we can look towards a better future with a much more diverse leadership group.	Assistant Director of HR & Inclusion	July 2022	Improved diversity of Board and Leadership composition Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
Establish a Board sponsor of each network	Assistant Director of HR & Inclusion	March 2022	Improved diversity of Board and Leadership composition	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
Ensure our employees are supported to participate in national development programmes including the NHS Leadership Academy 'Stepping Up' programme for aspiring black, Asian and minority ethnic (BAME) colleagues	Assistant Director of OD	September 2022	Improved diversity of Board and Leadership composition Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
Participation in the development of a North West BAME Senior Leaders Role Model Programme (opportunity for this to be expanded to other Equality Groups)	Director of HR	September 2022	Improved diversity of Board and Leadership composition Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
Provide placements for the NHS NeXt Director scheme - The NExT Director Scheme is a development programme created and designed to help find and support the next generation of talented people from groups who are currently	Director of HR	December 2022	Improved diversity in apprenticeship take up levels	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10

under-represented on our NHS boards into these important non-executive roles.				
Engage in the NHS Reciprocal Mentoring scheme	Director of HR	April 2023	Improved diversity of Board and Leadership composition Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WRES Indicator 9 WDES indicator 1 WDES Indicator 10
We Will Actively Listen and Give Everyone a Voice				
Develop our Staff Networks to align their deliverables to the ED&I strategy, ensure the workforce are supported to undertake their network roles and encourage membership of Staff Networks	Assistant Director of HR & Inclusion	April 2022	Improved WRES and WDES scores Increased representation at Staff Networks Measurable outcomes from Staff Network activity Celebrated key diversity events throughout the year	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Staff ED&I lived experiences to be heard at Board and ED&I Strategic Advisory Group	Chief Executive	April 2022	Improved WRES and WDES scores Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Support employees to have an Active part in decision making including Ask Ann, Executive Listen and Learn sessions with employees	Chief Executive	April 2022	Improved WRES and WDES scores Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Create the role of ED&I champions (employees and Staffside). Develop the role of champions by supporting them to complete the RCN cultural ambassador programme	Assistant Director of HR & Inclusion	September 2022	Improved WRES and WDES scores Improved staff experience amongst those from diverse backgrounds as measured in the staff survey Increased representation at Staff Networks Measurable outcomes from Staff	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9

			Network activity	
Ensure our Freedom to Speak Up champions are accessible across the Trust to all staff	Assistant Director of Patient Safety	September 2022	Improved staff experience amongst those from diverse backgrounds as measured in the staff survey	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Ensure all programmes of change and significant decision making have a robust equality impact assessment to ensure inclusivity for all and employees are skilled to complete the assessments	Assistant Director of HR & Inclusion	September 2022	No staff are directly or indirectly discriminated as a result of change programmes	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Celebrate the diversity of our workforce, through events, communications (newsletter, intranet) and engagement - this should become part of how we work, not just token or isolated campaigns	Head of Communications	April 2022	Improved WRES and WDES scores Improved staff experience amongst those from diverse backgrounds as measured in the staff survey Increased representation at Staff Networks Measurable outcomes from Staff Network activity Celebrated key diversity events throughout the year	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Enhance data to inform actions through surveys, deep dives and focus groups including inviting anonymous feedback from staff members who are neurodiverse in relation to their lived experiences and how they could be better supported in the workplace	Assistant Director of HR & Inclusion	December 2022	Improved WRES and WDES scores Improved staff experience amongst those from diverse backgrounds as measured in the staff survey Increased representation at Staff Networks Measurable outcomes from Staff Network activity	WRES Indicator 1 WDES Indicator 1 WDES Indicator 7 WDES Indicator 9
Supported Workforce who are Educated and Aware				

Action 1 - Implement Conflict Resolution training - include lone workers. Review and update Policy for Unacceptable behaviour. Action 2 - Develop Violence Reduction Strategy. Action 3 – Ensure managers are recording all issues on Datix	People Protection and Asset Manager	December 2021	Improved WRES and WDSE figures (bullying and harassment from patients)	WRES Indicator 5 WDES Indicator 4
Improve diversity in middle to senior bands - understand barriers to career progression and gain insight on lived experiences. Outcomes shaped into programmes of work, using the feedback and EDI data to focus the inclusive talent agenda.	Assistant Director of HR & Inclusion Assistant Director of OD	September 2022	Improved WRES and WDES scores Delivery of Model Employer Targets Increased take up of Apprenticeship programmes across all protected characteristic	WRES Indicator 1 WRES Indicator 4 WDES Indicator 1
Engagement and socialisation with stakeholders for the new inclusive talent conversation, Scope for Growth – become an early adopter organisation	Assistant Director of OD	April 2022	Diverse mix of staff engaged in the programme	WRES Indicator 4 WRES Indicator 7 WDES Indicator 5
Develop our people processes to ensure a more collaborative and person-centred learning approach encompassing: o a resolution and accountability framework for managers and employees including; Decision tree checklists – a series of structured questions guiding managers on whether formal action is appropriate; Pre-formal action check - a panel that includes an executive board member review all cases and decide whether they should go to formal action; Post action audits – disciplinary decisions are reviewed to check for biases and systemic weaknesses. o De-bias recruitment and selection processes including; Equality Representatives who will ensure that the interview process is carried out fairly and raise concerns if they observe any	Head of HR Operations Head of Strategic Resourcing	December 2022	Improved WRES and WDES scores Reduction in the number of staff going through formal action Delivery of Model Employer Targets	WRES Indicator 2 WRES Indicator 3 WRES Indicator 7 WDES Indicator 2 WDES Indicator 5

overt bias during the process; inclusive attraction campaigns and advertising				
Educate and support managers to ensure an inclusive approach to people practices including recruitment and selection, disciplinary and grievance; reasonable adjustments; flexible working; absence management	Head of HR Operations Head of Strategic Resourcing	April 2023	Improved WRES and WDES scores Improved Staff Survey Results	WRES Indicator 3 WDES Indicator 6 WDES Indicator 8
Educate and support employees to be aware of the inclusive people practices they can access and utilise including reasonable adjustments, flexible working, carers passport, HWWB	Assistant Director of HR & Inclusion Head of HR Operations Head of HWWB	September 2022	Increased uptake of Health Passport and Carers Passport Improved Staff Survey Results Improved WRES & WDES scores	WDES Indicator 6 WDES Indicator 9
Support our employees with an education programme to include promoting a broad understanding of how bias can influence decision making; ensuring our employees feel empowered to challenge non-inclusive behaviours; civility and respect	Assistant Director of HR & Inclusion	September 2022	Improved WRES & WDES scores (shortlisting to appointed) Improved Staff Survey findings	WRES Indicator 1 WRES Indicator 6 WRES Indicator 7 WRES Indicator 8 WDES Indicator 1 WDES Indicator 4 WDES Indicator 5
Support Network Chair development through attendance at Staff Network Chair Development days	Assistant Director of HR & Inclusion	September 2022	Increased activity and outputs by Staff Networks Increased representation at Staff Networks	WDES Indicator 9

Recognise the contribution of our increasingly diverse workforce and ensure they are fully supported during induction	Assistant Director of OD Head of Strategic Resourcing	April 2022	Decrease in number of leavers before 12 months service Improved Staff Survey findings	WRES Indicator 2 WRES Indicator 3 WRES Indicator 4 WRES Indicator 8 WDES Indicator 2 WDES Indicator 3 WDES Indicator 5 WDES Indicator 8 WDES Indicator 9

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(21)063
Title of paper: Gender Pay Gap Report 2020/2021
Purpose: To update the Committee on the Trust's Gender Pay Gap Reporting submission for 2019.
Summary: Organisations are required by law to report on Gender Pay in line with the Equality Act (Gender Pay Gap Information) Regulations 2017 as part of their public sector equality duty. The Government have provided specific guidance on the calculation of the data and what is required and this report adheres to the guidance provided.
Corporate objective met or risk addressed: Compliance with Trust's Public Sector equality duty.
Financial implications: Potential fine if data isn't reported
Stakeholders: Trust Board, Management, Staff, Patients, NHS England, Commissioners, Staff-Side
Recommendation(s): To note the content of the report.
Presenting officer: Anne-Marie Stretch, Deputy Chief Executive and Director of HR
Meeting date: 29th September 2021

1. What is the gender pay gap report?

1.1. Legislation

Organisations are required by law to report on Gender Pay in line with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 as part of their public sector equality duty.

Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The results must be published on the employer's public-facing website and the government's website. There are six calculations that we must publish:

- mean gender pay gap
- median gender pay gap
- mean bonus gender pay gap
- median bonus gender pay gap
- proportion of males and females receiving a bonus payment
- proportion of males and females in each pay quartile

Specific instructions are provided to employers regarding these calculations and these can be found in Appendix 1.

Alongside the calculations if the organisation is a business or charity it must also publish a "written statement" that confirms that the published information is accurate. This statement must be signed by an "appropriate person" as follows:

- for any corporate body other than a limited liability partnership, this will be a director (or equivalent)
- for a limited liability partnership, this will be a designated member
- for a limited partnership, this will be a general partner
- for any other kind of partnership, this will be a partner
- for an unincorporated body of persons other than a partnership, this will be a member of the governing body or a senior officer
- for any other type of body, this will be the most senior employee

The data and written statement must be published within a year of the "snapshot date" (31 March) and must be published by 30 March each year.

1.2. What does gender pay gap mean?

Gender pay gap and equal pay are two very different subject areas. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

Gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. St Helens and Knoswley Teaching Hospitals NHS Trust Gender Pay Gap Reporting

On 30 March 2021 the Trust will submit Gender Pay Gap information for the financial year 2020-21. As at 31 March 2020 (the Gender Pay Reporting point) the Trust had 6227 members of staff employed. The calculations are based on figures drawn on 31st March 2020 which is refered to as the 'Snapshot' date (it uses the month of March, whatever was paid / put through in that period).

The definition of 'employee' for gender pay gap reporting includes:

- people who have a contract of employment within the organisation
- workers and agency workers (those with a contract to do work or provide services)
- some self-employed people (where they must personally perform the work)

2.1. Mean hourly rate of pay

Gender	Mean Hourly Rate 2019/2020	Mean Hourly Rate 2020/2021
Male	£20.95	£21.42 (> £0.47)
Female	£14.88	£15.34 (> £0.46)
Difference	£6.07	£6.08
% Pay Gap	28.97%	28.38%

Good performance is a low %. The Trusts % mean hourly rate of pay gap has decreased by 0.59% from our 2020 position (28.97%). There has been a 3.18% increase to the female mean hourly rate compared to 2.24% increase to the male mean hourly rate.There has been a decrease in the percentage of women in the lower quartile and in the second quartile there has been an increase in the overall percentage of females. Quartiles are where staff are split into four equally sized chunks based on their hourly earnings and then the gender split is recorded. This ranges from the lower quartile (1) which reflects the lowest hourly rates and the upper quartile (4) which reflects the highest hourly rates (Appendix 1).

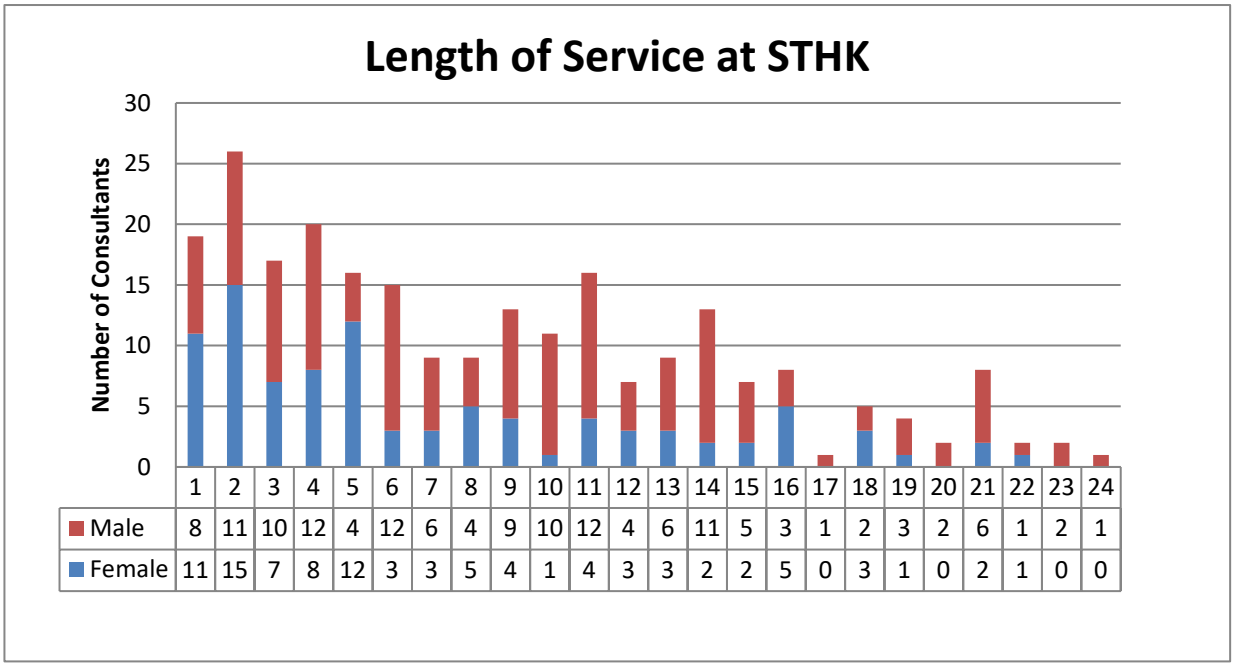
Below is the comparison between Medical & Dental (511 staff) and Agenda for Change (5717 staff) staff groups:

	Mean Hourly Rate – 2019/2020		Mean Hourly Rate – 2020/2021	
Gender	**Medical & Dental**	**Agenda for Change**	**Medical & Dental**	**Agenda for Change**
Male	£38.65	£14.83	£39.02 (>£0.37)	£15.28 (>£0.45)
Female	£34.80	£13.99	£35.25 (>£0.45)	£14.46 (>£0.47)
Difference	£3.85	£0.84	£3.77	£0.82
% Pay Gap	9.96%	5.68%	9.66%	5.37%

The mean hourly rate of pay was as follows:

	Mean Hourly Rate	Number of Staff	Total (Mean Hourly Rate x Number of Staff)	**Overall Mean Hourly Rate
Male	M&D £39.02	295 (25.85%)	£11,510.90	
	AfC £15.28	846 (74.15%)	£12,926.88	
Total		1,141	£24,437.78	£24,437.78 / 1,141 = £21.41
Female	M&D £35.25	216 (4.25%)	£7,614	
	AfC £14.46	4870 (95.75%)	£70,420.20	
		5,086	£78,034.20	£78,034.20 / 5,086 = £15.34

Length of Service M&D Staff (Consultants) March 2020



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Male	8	11	10	12	4	12	6	4	9	10	12	4	6	11	5	3	1	2	3	2	6	1	2	1
Female	11	15	7	8	12	3	3	5	4	1	4	3	3	2	2	5	0	3	1	0	2	1	0	0

Consultant who have 19 years service will reach the top of the payband on the 2003 contract. As at March 2020 there were 15 males in comparison to 4 females that received the highest pay band. NB this data chart does not include Consultants with less than 1 years service.

Please note that the length of service depicted in the charts relates to length of service at St Helens and Knowsley Teaching Hospitals NHS trust and not overall length of service.

2.2. Median hourly rate of pay

The median hourly rate of pay was as follows:

Gender	Median Hourly Rate 2019/2020	Median Hourly Rate 2020/2021
Male	£15.13	£15.68 (>£0.55)
Female	£12.74	£13.15 (>£0.41)
Difference	£2.39	£2.53
% Pay Gap	15.80%	16.13%

Good performance is a low %. The Trusts % median hourly rate of pay gap has increased by 0.33% from our 2019/2020 position. 60.34% of males sit in the upper two qaurtiles this year compared with last year of 59.34%. 47.68% of females sit in the upper two quartiles this year compared with 47.92% last year.

Below is the comparison between Medical & Dental (511 staff) and Agenda for Change (5716 staff) staff groups:

	Median Hourly Rate 2019/2020		Median Hourly Rate 2020/2021	
Gender	**Medical & Dental**	**Agenda for Change**	**Medical & Dental**	**Agenda for Change**
Male	£42.09	£12.42	£42.89	£13.10
Female	£38.48	£12.31	£40.68	£12.80
Difference	£3.61	£0.11	£2.21	£0.30
% Pay Gap	8.58%	0.89%	5.15%	2.29%

2.3. Mean and median bonus gender pay gap

The mean bonus gender pay gap was as follows:

Gender	Avg. Pay	Median Pay
Male	£0.00	£0.00
Female	£0.00	£0.00
Difference	£0.00	£0.00
Pay Gap %	0%	0%

2.4. Proportion of males and females receiving bonus payment

The proportion of males and females receiving bonus payments was as follows:

Gender	Employees Paid Bonus	Total Employees	%
Female	0	5086	0%
Male	0	1141	0%

2.5. Proportion of males and females in each pay quartile

	2019/2020				2020/2021			
Quartile	**Female**	**Male**	**Female %**	**Male %**	**Female**	**Male**	**Female %**	**Male %**
1	1321	219	85.8	14.2	1331	225	85.54	14.46
2	1300	240	84.4	15.6	1330	227	85.42	14.58
3	1299	241	84.4	15.6	1302	255	83.62	16.38
4	1110	429	72.1	27.9	1123	434	72.13	27.87
Overall	**5030**	**1129**	**81.7**	**18.3**	**5,086**	**1,141**	**81.68**	**18.32**

A full breakdown and comparison of staff by pay grade for 2020 and 2019 can be found in Appendix 2.

3. NHS Reporting of Gender Pay

As all employers now have until 5 October 2021 to report their gender pay gap information, as at 9th March 2021 there were only 16 NHS organisationas that had submitted their data.

The below tables detail where the Trust sits in the league table of NHS organisations who have reported their Gender Pay Gap data for 2019-20 and 2020-21. Please note that for reporting purposes onto the GPG data submission the data is to one decimal point and therefore has been rounded up / down.

	Mean Position	**Median Position**
StHK 2020 Report	28.86	15.8
StHK Position (out of 76)	**15**	**11**
StHK 2021 Report	23.4	16.1
StHK Position (Out of 112)	**28**	**23**

Mean – A good performance is a low ranking and our position is 28th out of 112 Trusts.

Median – A good performance is a low ranking and our position is 23rd out of 112 Trusts.

Proportion of males and females in each pay quartile	**Male Lower Quartile**	**Female Lower Qaurtile**	**Male Lower Middle Qaurtile**	**Female Lower Middle Qaurtile**	**Male Upper Middle Qaurtile**	**Female UMQ**	**Male TQ**	**Female TQ**
StHK 2020 Report %	14.2	85.8	15.6	84.4	15.6	84.4	27.9	72.1
StHK Position (out of 76)	**65**	**13**	**62**	**15**	**50**	**27**	**57**	**20**
StHK 2021 Report %	14.5	85.5	14.6	85.4	16.4	83.6	27.9	72.1
StHK Position (out of 112)	**89**	**22**	**90**	**22**	**55**	**57**	**82**	**30**

Quartiles are the % split between male and female staff. As a Trust we have a smaller % of males across the bottom three quartiles compared with females however this does lightly increase in the top quartile.

4. Conclusion and Recommendations

The analysis of the 2020 data clearly shows that there remain some differences in pay between the genders at STHK. In light of the data detailed above the following actions are proposed:

1. Analysis of flexible working requests to identify the working patterns of males and females (by department) and any barriers that females may face when pursuing career opportunities.
2. Educate and support employees to be aware of the inclusive people practices they can access and utilise including reasonable adjustments, flexible working, carers passport and HWWB services.
3. Ongoing work to identify flexible working options to be included on job adverts in order to promote the Trust as a supportive employer.
4. Review of how we welcome back and support staff that may have had a significant amount of time away from work (i.e maternity or adoption leave) and analysis of what the barriers are to further career progression when retunring to work.
5. Undertake a review of recruitment processes to remove any gender bias.i.e at the shortlisting stage or during interviews.

Appendix 1 Calculation Instructions

Mean Gender Pay Gap

The difference between the average hourly rate of pay of male employees and that of female employees.

Mean gender pay gap in hourly pay: how to calculate

1. Add together the hourly pay rates of all male full-pay relevant employees
2. Divide this figure by the number of male full-pay employees – this gives you the mean hourly pay rate for men
3. Add together the hourly pay rates of all female full-pay relevant employees
4. Divide this figure by the number of female full-pay employees – this gives you the mean hourly pay rate for women
5. Subtract the mean hourly pay rate for women from the mean hourly pay rate for men
6. Divide the result by the mean hourly pay rate for men
7. Multiply the result by 100 – this gives you the mean gender pay gap in hourly pay as a percentage of men's pay

Median Gender Pay Gap

This is the difference between the middle value of the hourly rate of pay of male employees and that of female employees.

Median gender pay gap in hourly pay: how to calculate

1. Arrange the hourly pay rates of all male full-pay relevant employees from highest to lowest
2. Find the hourly pay rate that is in the middle of the range – this gives you the median hourly rate of pay for men
3. Arrange the hourly pay rates of all female full-pay relevant employees from highest to lowest
4. Find the hourly pay rate that is in the middle of the range – this gives you the median hourly rate of pay for women
5. Subtract the median hourly pay rate for women from the median hourly pay rate for men
6. Divide the result by the median hourly pay rate for men
7. Multiply the result by 100 – this gives you the median gender pay gap in hourly pay as a percentage of mens' pay

Mean Bonus Gender Pay Gap

This is the difference between the average bonus paid to male employees and that of female employees.

Mean gender pay gap in bonus pay: how to calculate

1. Add together the bonus payments made to all male relevant employees in the 12 months to the snapshot date

2. Divide this figure by the number of male relevant employees – this gives you the mean amount of bonus pay for men
3. Add together the bonus payments made to all female relevant employees in the 12 months to the snapshot date
4. Divide this figure by the number of female relevant employees – this gives you the mean amount of bonus pay for women
5. Subtract the mean bonus amount for women from the mean bonus amount for men
6. Divide the result by the mean bonus amount for men
7. Multiply the result by 100 – this gives you the mean gender pay gap for bonuses as a percentage of men's pay

Median Bonus Gender Pay Gap

This is the difference between the middle value of bonus paid to male employees and that of female employees.

Median gender pay gap in bonus pay: how to calculate

1. Arrange the bonus pay amounts paid to all male relevant employees in the year to the snapshot date from highest to lowest
2. Find the bonus pay amount that is in the middle of the range – this gives you the median bonus pay figure for men
3. Arrange the bonus pay amounts paid to all female relevant employees in the year to the snapshot date from highest to lowest
4. Find the bonus pay amount that is in the middle of the range – this gives you the median bonus pay figure for women
5. Subtract the median bonus pay figure for women from the median bonus pay figure for men
6. Divide the result by the median bonus pay figure for men
7. Multiply the result by 100 – this gives you the median gender pay gap for bonus pay as a percentage of men's pay

Proportion of males and females receiving a bonus payment

Proportion of males and females who got bonus payments: how to calculate

1. Get the number of male relevant employees who were paid bonus pay in the 12 months to the snapshot date
2. Divide this by the number of male relevant employees
3. Multiply the result by 100 – this gives you the percentage of males who were paid a bonus
4. Get the number of female relevant employees who were paid bonus pay in the 12 months to the snapshot date
5. Divide this by the number of female relevant employees
6. Multiply the result by 100 – this gives you the percentage of females who were paid a bonus

Proportion of males and females in each pay quartile

Gender pay gap quartile figures: how to calculate

1. *Divide into quartiles*

Get a listing of the hourly pay rate of all your organisation's full-pay relevant employees in the pay period that covers the snapshot date.

Divide this list into 4 quartiles, with an equal number of employees in each section. From highest paid to lowest paid, these quartiles will be the:

- upper quartile
- upper middle quartile
- lower middle quartile
- lower quartile

If the number of employees isn't divisible by 4, distribute them as evenly as possible. For example, if you have 322 full-pay relevant employees an equal split would mean 80 employees in each quartile, with 2 employees left over.

To distribute the numbers as evenly as possible, you can add one employee to the lower quartile and one employee to the upper middle quartile.

This means there are 81 employees in the lower quartile, 80 employees in the lower middle quartile, 81 employees in the upper middle quartile, and 80 employees in the upper quartile.

2. *Check the gender distribution of matching hourly rates*

If there are employees on the same hourly rate of pay crossing between quartiles, make sure that males and females are split as evenly as possible across the quartiles.

For example, you have 322 full-pay relevant employees and have split the list into quartiles. 40 staff all have the same hourly rate of pay - 36 are female and 4 are male. Of them, 10 have fallen into the lower quartile, while 30 have fallen into the lower middle quartile.

To evenly distribute these staff by gender, you can see that for every 9 females listed, one male should be listed with them. You should list 9 female employees and one male employee in the lower quartile, and 27 female employees and 3 male employees in the lower middle quartile.

3. *Work out the percentage of males and females in each quartile*

For each quartile, you need to:

- divide the number of male full-pay relevant employees by the total number of full-pay relevant employees and multiply by 100 – this gives you the percentage of males in the quartile
- divide the number of female full-pay relevant employees by the total number of full-pay relevant employees and multiply by 100 – this gives you the percentage of females in the quartile

Appendix 2 Breakdown of staff by Grade and Band

	2019-2020			2020 - 2021			Difference (Last 2 years)		
Pay Scales	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Medical & Dental	215	291	506	216	295	511	1	4	5
AFC	4816	838	5654	4870	846	5716	54	8	62
Medical	**2019-2020**			**2020 - 2021**			**Difference (Last 2 years)**		
Medical Workforce (excluding Consultants)	117	141	258	118	139	257	1	-2	-1
NHS|YM53|Consultant (pre 31 Oct) - 3yrs Snr	2	1	3	2	1	3	0	0	0
NHS|YM54|Consultant (pre 31 Oct) - 4yrs Snr	2	3	5	2	4	6	0	1	1
NHS|YM55|Consultant (pre 31 Oct) - 5yrs Snr	2	1	3	2	1	3	0	0	0
NHS|YM56|Consultant (pre 31 Oct) - 6yrs Snr	2	4	6	2	4	6	0	0	0
NHS|YM57|Consultant (pre 31 Oct) - 7-8yrs Snr	3	5	8	2	5	7	-1	0	-1
NHS|YM58|Consultant (pre 31 Oct) - 9yrs Snr		3	3	0	3	3	0	0	0
NHS|YM59|Consultant (pre 31 Oct) - 10yrs Snr	1	3	4	1	2	3	0	-1	-1
NHS|YM60|Consultant (pre 31 Oct) - 11yrs Snr		2	2	1	1	2	1	-1	0
NHS|YM61|Consultant (pre 31 Oct) - 12yrs Snr		1	1	0	2	2	0	1	1
NHS|YM62|Consultant (pre 31 Oct) - 13yrs Snr			0	0	0	0	0	0	0
NHS|YM63|Consultant (pre 31 Oct) - 14yrs Snr		1	1	0	1	1	0	0	0
NHS|YM64|Consultant (pre 31 Oct) - 15yrs Snr		1	1	0	0	0	0	-1	-1
NHS|YM65|Consultant (pre 31 Oct) - 16yrs Snr		1	1	0	1	1	0	0	0
NHS|YM66|Consultant (pre 31 Oct) - 17yrs Snr			0	0	0	0	0	0	0
NHS|YM67|Consultant (pre 31 Oct) - 18yrs Snr			0	0	0	0	0	0	0
NHS|YM68|Consultant (pre 31 Oct) - 19yrs Snr			0	0	0	0	0	0	0
NHS|YM72|Consultant (post 31 Oct)	76	116	192	83	121	204	7	5	12
NHS|YM73|Locum Consultant	10	8	18	6	12	18	-4	4	0
AFC	**2019-2020**			**2020 - 2021**			**Difference (Last 2 years)**		
Band 1**	202	19	221	84	7	91	-118	-12	-130
Band 2	1413	269	1682	1513	261	1774	100	-8	92
Band 3	476	79	555	518	87	605	42	8	50
Band 4	389	55	444	383	66	449	-6	11	5
Band 5	1063	162	1225	1049	149	1198	-14	-13	-27
Band 6	640	103	743	647	120	767	7	17	24
Band 7	438	73	511	468	79	547	30	6	36
Band 8A	135	27	162	143	28	171	8	1	9
Band 8B	35	25	60	33	26	59	-2	1	-1
Band 8C	12	9	21	15	7	22	3	-2	1
Band 8D	5	9	14	6	7	13	1	-2	-1
Band 9	4	3	7	4	3	7	0	0	0
VSM / Executive	4	3	7	4	3	7	0	0	0
Trust Chair	0	1	1	0	1	1	0	0	0
Senior Manager	0	1	1	0	0	0	0	-1	-1
Overall	5148	1270	6418	5086	1141	6227	-62	-129	-191

** There has been a big decrease in Band 1 and an increase in Band 2 as this is part of a national agreement to disestablish the Band 1 grade so staff have been moved into Band 2 automatically if they have opted to do so.

ENDS

Community Diagnostic Hub (CDH)
STHK Early Adopter

Rob Cooper

Director of Operations and Performance

29th September 2021

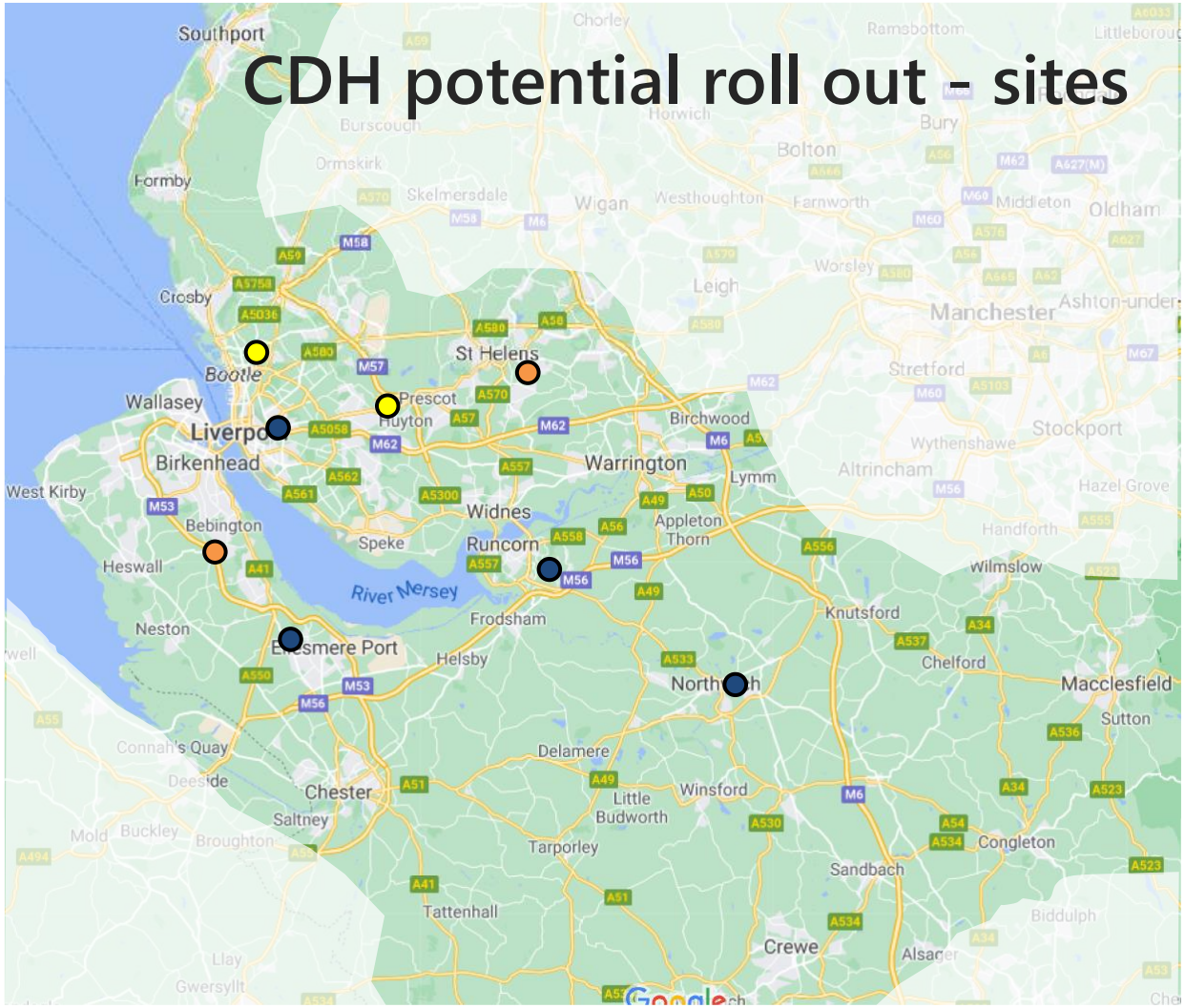
C&M planning for CDHs

- National initiative announced as part of recovery and restoration
- Rationale for sites worked through with the imaging, pathology, endoscopy and cardiac networks
  - Site defined - Early adopters
  - Site defined - CDH +1
  - Site not defined

Key criteria:

- Not a current hot site
- Core facilities in place
- Early adopters needing no capital
- Limited capital implication for CDH 1+
- Ability to expand the capacity/capability of the diagnostics
- Appropriate clinical governance
- Areas of high population/deprivation with existing high demand

CDH potential roll out - sites



- Site defined – Early Adopter
- Site defined
- Site not defined

NB: East Cheshire Trust are linked to CDH plans for GM. They are part of the GM and Eastern Cheshire system

CDH C&M engagement

- Planning group
- Hospital cell
- ICS
- Finance programme
- Site specific details
- Place discussions
- Integration with elective, digital, estates, diagnostic programmes

Site specific detail

Equipment in place – additional capacity to be established

Some equipment in place – capacity and testing increase

At this stage of planning – site will not offer this test

Site Name	CDH wave	Imaging	Testing	Pathology	Endoscopy
St Helens	EA	✓	✓	✓	✓
Clatterbridge General	EA	✓	✓	✓	✓
Ellesmere Port	CDH 1	◐	✓	✓	☒
Halton	CDH 1	✓	✓	✓	✓
Liverpool Women's	CDH 1	◐	◐	◐	✓
Victoria Infirmary	CDH 1	◐	◐	◐	☒
Bootle	CDH 2	◐	◐	◐	☒
Knowsley	CDH 2	◐	◐	◐	☒

Commissioning and Finance

- Initial arrangements in place for 2021/22
- Commissioning model - prime NHS provider with sub-contractors
- ICS development and provider alliance
- Prime provider - Clatterbridge Cancer Centre NHS Foundation Trust
- System finance
- Open book approach - resource requirement and activity volumes
- Capital investment
- Activity volume increases
- Benefits realisation process

CDH enablers

Workforce

- System approach to workforce supply issues
- Increase of new students intake
- Supporting staff to work at the top of their licence
- Reporting to be utilised through digital support where applicable
- Staffing system passport to be utilised to allow cross-site/organisational working
- Development and training programme to cover all diagnostic areas to allowed up-skilling and internal promotion/development

Digital

- CM collaborative approach
  - Radiology Information System (RIS)
  - Picture Archiving Communications System (PACS) .
- National recognition
- Fully integrated shared workflow

CDH timeline – Early Adopters

ICS identification of sites and early adopters

- 6th May 21

Regional submission to national team (post review)

- 20th May 21

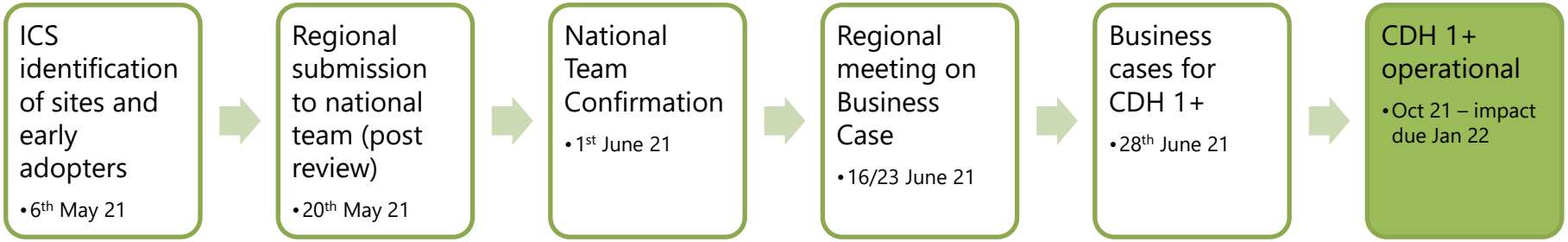
National Team confirmation

- 1st June 21

Early Adopters operational

- July 21 – impact due Oct 21

CDH 1 Business Case timeline



CDH - STHK

- Aim
  - Reduce unnecessary and multiple visits
  - Timely access to diagnostics via one stop pathway
  - Access to multiple diagnostics in one place
  - Move from 2/5 to 3/7
  - Increased access out of normal working hours

- Introduce lead roles to support development:
  - Workforce
  - Business Intelligence
  - Project/operational management

- Key metrics:
  - Activity
  - Waiting list across diagnostics
  - Patients visits per pathway

CDH Activity - STHK

Service	Diagnostic Test	Totals
Imaging		
	Magnetic Resonance Imaging	200
	Computed Tomography	
	Non-obstetric ultrasound	971
	Barium Enema	
	DEXA Scan	
Physiological Measurement	Audiology - Audiology Assessments	
	Cardiology - echocardiography	41
	Cardiology - electrophysiology	
	Neurophysiology - peripheral neurophysiology	
	Respiratory physiology - sleep studies	
	Urodynamics - pressures & flows	
Endoscopy	Colonoscopy	13
	Flexi sigmoidoscopy	44
	Cystoscopy	
	Gastroscopy	74
Pathology	Phlebotomy	
Cardio-Respiratory	Cardiology - electrocardiography	
	Respiratory physiology - non-sleep studies	
	Spirometry	10
Total		**1353**

Total number of extra patients seen from diagnostic waiting lists = **1353**

(since beginning of July 2021= 2 months activity)

Next steps - STHK

Action	Target completion date
Commencement of lead roles	Oct-21
Implementation of strategy to achieve optimum utilisation, across 7 days	Dec-21
Activity across identified diagnostic services	Dec-21
Development of IT solutions	Jan-22
Implementation of recruitment plan	Jan-22
Align pathways with Rapid Diagnostic Services (RDS)	Feb-22