S St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 29th JUNE 2022
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
09.30	1.	Employee of the Month Film - June 2022		Verbal	Assurance	Chair
09.45	2.	Apologies for Absence		Verbal	Assurance	Chair
09.50	3.	Declaration of Interests		Verbal		
09.55	4.	Minutes of the Board Meeting held on 25th May 2022		Attached		
		4.1	Correct Record and Matters Arising	Verbal		
		4.2	Action log			
Performance Reports						
10.10	5.	Integrated Performance Report		NHST(22) 046	Assurance	Gareth Lawrence
		5.1	Quality Indicators			Sue Redfern
		5.2	Operational Indicators			Rob Cooper
		5.3	Financial Indicators			Gareth Lawrence
		5.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
10.30	6.	Committee Report – Executive		NHST (22) 047	Assurance	Ann Marr
10.40	7.	Committee Report – Quality		NHST (22) 048	Assurance	Rani Thind
10.50	8.	Committee Report – Finance & Performance		NHST (22) 049	Assurance	Jeff Kozer
11.00	9.	Committee Report – Charitable Funds		NHST (22) 050	Assurance	Paul Growney

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.10	10.	Fit and proper persons annual report	NHST (22) 051	Assurance	Richard Fraser
11.20	11.	Nursing and Midwifery Strategy 2022/2025	NHST (22) 052	Approval	Sue Redfern
11:30	12.	2021/22 Meeting Effectiveness Review	NHST (22) 053	Approval	Nicola Bunce
Closing Business					
11:50	13.	Effectiveness of Meeting	Verbal	Assurance	Chair
	14.	Any Other Business		Information	
	15.	Date of Next Meeting – Wednesday 27th July 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 29th JUNE 2022

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **DEFERRED**	NB/NK	Next Board Time Out
41	30.03.22 (6.2)	Provide additional information about category 2 ambulance performance	RC	29.06.22
42	30.03.22 (7.5)	Include information about cancer survival rates in future reports on the impact of health inequalities	RC	29.06.22
43	27.04.22 (11.6)	Develop plans for the reinstatement of Quality Ward Rounds for consideration at Quality Committee.	SR	29.06.22
44				
45				
46				

47				
48				

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)046
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no Never Events in May 2022. (YTD = 0).

There were no MRSA cases in May 2022. (YTD = 0).

There were 4 C.Difficile (CDI) positive cases reported in May 2022 (3 hospital onset and 1 community onset). (YTD = 9). The annual tolerance for CDI for 2022-23 has not yet been published (the 2021-22 limit is being used in the absence of publication of the 2022-23 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May 2022 was 94.2%. 2022-23 YTD rate is 93.8%.

During the month of April 2022 there was 1 fall resulting in severe harm or death category . (YTD severe harm or above category falls = 1).

There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in April 2022. (YTD = 0).

Community incidents reported in April decreased to 99 compared to 120 incidents in March. 10 were low harm, with 1 moderate harm reported and the remainder were no harm.

Performance for VTE assessment suspended by NHSE since March 2020.

YTD HSMR (April - January) for 2021-22 is 98.1

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 22/23 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: G Lawrence
Date of Meeting: 29th June 2022

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (April 2022) at 90.3%. YTD 90.3%. The 31 day target was achieved in April 2022 with 98.0% performance in month against a target of 96%, YTD 98.0%. The 2 week rule target was not achieved in April 2022 with 82.5% in month and 82.5% YTD against a target of 93.0%. The deterioration in performance for 2 week rule, is related to the significant increase in referrals, compared to the same period in 2019, resulting in capacity challenges.

Accident and Emergency Type 1 performance for May 2022 was 48.7% and YTD 49.7%. The all type mapped STHK Trust footprint performance for May 22 was 72.9% and YTD 73.7%**.** The Trust saw average daily attendances of 340, which is up compared to April, at 321. Total attendances for May 2022 was 10,546.

Total ambulance turnaround time was not achieved in May 2022 with 36 mins on average. There were 2,332 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,142 in April 22.

The UTC had 5,357 attendances in April 2022, which is an increase of 18% compared to the previous month of March. Overall, 99% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in May 2022 was 116 compared with 135 in April. 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 April 2022 with 67.3% compliance and YTD 67.3% (Target 92%). Performance in March 2022 was 68.2%. There were (1642) 52+ week waiters. The 6 week diagnostic target was not achieved in April 22 with 80.5% compliance. (Target 99%). Performance in March 2022 was 84.9%.

There was a slight decrease in referrals received within the District Nursing Service in April; however, the levels are still within average range (517 in April compared to 597 in March). Caseload size is within normal range (1,256 in April compared to 1,233 in March). Community matron caseloads have increased in the month of April to 110 compared to 95 in March. Work has been undertaken with individual PCNs to look at a collaborative approach to patient care.

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

The Trust's 22/23 plan submitted to NHSE in April gave a deficit of £24.5m. At Month 2, we are in line with plan at a £0.9m deficit in month. Following submission of the system wide plans, a further iteration was required in June 2022. Subsequently, a £4.9m deficit was submitted by the Trust. The revised plan will be reflected in the June report.

Surplus/Deficit - At the end of Month 2, the Trust is reporting a deficit position of £3.2m, with £86.1m of income and £89.3m of expenditure year to date.

CIP - The Trust's CIP target for 22/23 was £18.5m. As at Month 2, low risk schemes either delivered or at finalisation stage total £12.9m in year and £3.3m recurrently. The revised plan increases the CIP target to £28.1m (£22.1m recurrent and £6m non-recurrent).

Cash - At the end of M2, the cash balance was £66.0m.

Capital - Capital expenditure for the year to date [including PFI lifecycle maintenance] totals £1.3m. Internally generated depreciation exceeds the 2022/23 capex plan. The plan has been agreed at ICS/ICB level, and includes PDC funding (£15.1m) which is not fully signed off nor drawn down from DHSC.

Human Resources

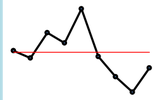
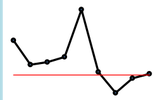
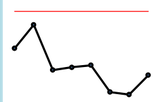
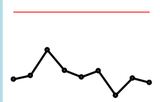
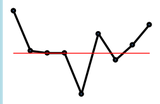
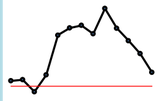
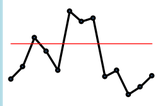
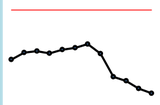
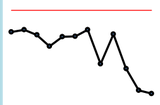
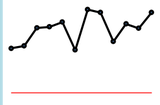
In May 2022, all staff sickness was 6.0% which was a reduction from April (6.7%). All Nursing & Midwifery ward areas was 7.7% which is a decrease from April (9.0%).
Mandatory Training Compliance continues to improve but remains below the target at 77.1%. The Appraisal compliance has reduced in month and is at 60%.

The following key applies to the Integrated Performance Report:

▲ = 2022-23 Contract Indicator
▲£ = 2022-23 Contract Indicator with financial penalty
● = 2022-23 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

May-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	May-22	2.1%	2.4%	No Target	2.6%		Post wave 3 of COVID, performance is encouraging.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits. We continue to independently benchmark performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Jan-22	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Jan-22	97.0		100.0	98.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jan-22	100.6		100.0	105.5					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Dec-21	92.7		100.0	94.3		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	Performance remains within expected range.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jan-22	85.8		100.0	87.0		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	Jan-22	112.5		100.0	101.3					
% Medical Outliers	F&P	T	May-22	1.4%	1.7%	1.0%	2.1%		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	May-22	36.0%	33.3%	52.5%	46.8%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Apr-22	63.8%	63.8%	90.0%	74.3%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team has been involved to find a sustainable solution particularly in A&E. This has now gone live and reporting will reflect it subsequently OP attendance letters - deterioration reflects staff sickness and increased activity pressures has caused a backlog in typing. Action plan is in place with operational colleagues. Audit confirms >90% urgent letters sent in 7 days.		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. We have worked with CCG colleagues to confirm the change in policy and now gone-live with action plan in place to monitor impact and quality of summary being sent out. Dip in reporting reflects the changeover of process and current reporting evidences 82%.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Apr-22	21.8%	21.8%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Apr-22	97.9%	97.9%	95.0%	97.2%					

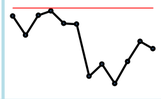
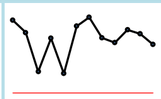
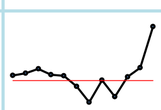
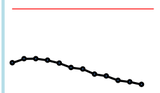
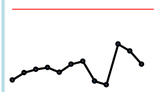
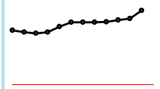
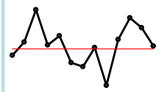
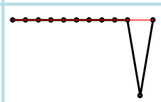
May-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q4	84.9%		83.0%	84.8%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement of required 80% of patients have spent 90% of their stay in the stroke unit	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲ £	May-22	0	0	0	1		No never events YTD	Quality and patient safety		SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20			98.9%			Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	May-22	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Consistent good performance is supported by the EPMA platform.	RPJ
Number of hospital acquired MRSA	Q F&P	▲ £	May-22	0	0	0	2		There were no MRSA cases in May 2022. (YTD = 0). There were 4 positive C Diff samples in May 2022. YTD = 9. The annual tolerance for CDI for 2022-23 has not yet been published (the 2021-22 limit is being used in the absence of publication of the 2022-23 objectives). Internal RCAs on-going with more recent cases of C. Diff.	Quality and patient safety	The annual tolerance for CDI for 2021-22 was set at 54. Improvement actions in place and completed based upon RCA .	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	May-22	4	9	54	32					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		May-22	3	5	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Apr-22	0	0	No Contract target	2		No validated category 3 pressure ulcer YTD.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from reported pressure ulcer incidents and learning.	SR
Number of falls resulting in severe harm or death	Q	▲	Apr-22	1	1	No Contract target	22		1 falls resulting in severe harm category in April 2022 (Ward 5B).	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Feb-20			95.0%			**March 20 to May 22 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway with thematic review expected. All cases reviewed. Appropriate prescribing and care identified.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-21	4		No Target	12					
To achieve and maintain CQC registration	Q		May-22	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	May-22	94.2%	93.8%	No Target	92.1%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	May-22	1	3	No Target	30					

May-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Apr-22	82.5%	82.5%	93.0%	84.6%		2WW referrals remain high. This has been accepted as the new norm. Capacity remains a challenge due to increased demand coupled with staff sickness and vacancies.	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity, including communication with GPs around correct process and management of waiting lists/patient hot lines. 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 CDC 8. Cancer Specific PTL supporting to expedite delays prior to patient breaches.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Apr-22	98.0%	98.0%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Apr-22	90.3%	90.3%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Apr-22	67.3%	67.3%	92.0%	68.2%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. 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. urgent, cancers and long waiters remain the priority patients for surgery at Whiston with application of P- codes effectively implemented. This is being worked through. Removal of P5 is on target and of D5 is complete.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Apr-22	80.5%	80.5%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Apr-22	1,642	1,642	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	May-22	0.83%	0.9%	0.8%	0.82%		Underperformance in cancelled ops has been due to staff sickness/absence and medical NEL pressures. The team is confident that this will recover going forward, although performance remains at risk.	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Apr-22	100.0%	100.0%	100.0%	99.8%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0						
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	May-22	48.7%	49.7%	95.0%	55.8%		Accident and Emergency Type 1 performance for May 2022 was 48.7% and YTD 49.7%. The all type mapped STHK Trust footprint performance for May 22 was 72.9% and YTD 73.7%. The Trust saw average daily attendances of 340, which is up compared to April, at 321. Total attendances for May 2022 was 10,546. Total ambulance turnaround time was not achieved in May 2022 with 36 mins on average. There were 2,332 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,142 in April 22.	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	▲	May-22	72.9%	73.7%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	May-22	0	0	0	0					

May-22

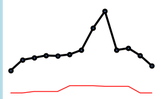
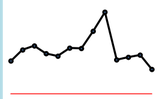
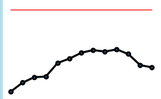
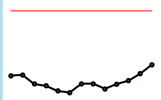
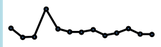
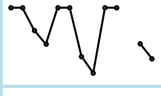
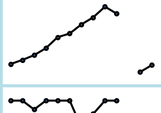
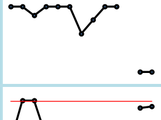
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	May-22	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	May-22	13	28	No Target	254		% new (Stage 1) complaints resolved within agreed timescales remains below the target, however more complaints are being closed than received, which is reducing the number of open complaints. Number of complaints received has reduced slightly in the last two months.	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%. Additional temporary resources remain in place to increase response rates within the Medical Care Group which has the largest number of open complaints.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	May-22	33	55	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	May-22	63.6%	65.5%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to May 22 submissions suspended.** In February 2020, the average number of DTOCS (patients delayed over 72 hours) was 24.		COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity/reduce delays. The absence of face to face assessments from social workers is causing some delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	May-22	343	349		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	May-22	116	126		108					
Friends and Family Test: % recommended - A&E	Q	▲	May-22	81.7%	81.9%	90.0%	79.0%		Recommendation rates are above target for inpatients and postnatal community, but below target for the remaining areas. Recommendation rates for ED increased slightly in April/May compared to March.	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.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	May-22	95.4%	94.9%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		May-22	86.0%	93.1%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	May-22	90.2%	92.7%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		May-22	100.0%	92.2%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		May-22	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	May-22	94.2%	94.1%	95.0%	93.8%					

May-22

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	May-22	6.0%	6.3%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In May 2022, all staff sickness was 6.0% which was a reduction from April (6.7%). All Nursing & Midwifery ward areas was 7.7% which is a decrease from April (9.0%). 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 analyse the hotspots and provide targeted support to managers. HWWB are contacting employees who are absent with Covid to provide support. In addition, there's a bi-weekly review of absence matters between the HR Operations Team and the Clinical Lead to ensure that the wellbeing of staff remains a priority.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	May-22	7.7%	8.3%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	May-22	60.0%	60.0%	85.0%	65.9%		Appraisal compliance in May is 60% this is a slight reduction from April (61.1%) Mandatory training compliance continues to improve in May at 77.1% (April 75.7%)	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Recovery of both Appraisal and Mandatory Training continue to be impacted by operational pressures and staff absence, with both remaining below target. For staff on AFC, the annual appraisal window opened on 1st April. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area to be monitored through Workforce Council and Quality Committee.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	May-22	77.1%	77.1%	85.0%	74.7%					
NHS National Quarterly Pulse Survey : % recommended Care	Q	▲	Q3 2021-22	79.4%					Staff Friends and Family test superseded by the Quarterly staff survey in Q3.	Staff engagement, recruitment and retention.	Results published on the 30th March 2022 as part of the National Staff survey. The actions associated with the responses to these 2 questions form a key component of the Staff Survey action pan for 2022. This action plan will be to be monitored through the Executive Committee and People Council.	AMS
NHS National Quarterly Pulse Survey : % recommended Work	Q	▲	Q3 2021-22	68.5%								
Staffing: Turnover rate	Q F&P UOR	T	May-22	1.0%		No Target	14.0%		Staff turnover remains stable and below the national average of 14%.			AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	May-22	Discontinued	Discontinued	N/A	Discontinued			Delivery of Control Total		GL
Progress on delivery of CIP savings (000's)	F&P	T	May-22	4,856	4,856	18,520	10,776					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	May-22	(3,224)	(3,224)	(24,470)	-					
Cash balances - Number of days to cover operating expenses	F&P	T	May-22	29	29	10	30					
Capital spend £ YTD (000's)	F&P	T	May-22	1,300	1,300	26,100	6,500					
Financial forecast outturn & performance against plan	F&P	T	May-22	(24,470)	(24,470)	(24,470)	-					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	May-22	93.5%	93.5%	95.0%	85.7%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	2022-23 YTD	2022-23 Target	FOT	2021-22	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	100.0%	93.1%	93.1%	85.0%		96.0%		
	Total > 62 days		0.0	1.0	1.0	1.0	0.0	0.5	0.5	0.0	1.0	1.0	0.0	0.0	1.0	1.0			6.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.5		
Lower GI	% Within 62 days	▲ £	61.1%	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	86.7%	90.5%	90.5%	85.0%		79.7%		
	Total > 62 days		3.5	3.5	0.0	1.0	2.5	0.0	3.0	4.0	3.0	2.0	1.0	1.0	1.0	1.0			24.5		
	Total > 104 days		0.0	0.0	0.0	0.0	1.5	0.0	0.0	1.5	1.0	0.0	0.0	0.0	0.0	0.0			4.0		
Upper GI	% Within 62 days	▲ £	100.0%	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	36.4%	90.0%	90.0%	85.0%		83.2%		
	Total > 62 days		0.0	0.0	0.0	1.0	3.0	1.0	0.0	0.0	1.0	0.0	0.0	3.5	0.5	0.5			9.5		
	Total > 104 days		0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.5			3.0		
Urological	% Within 62 days	▲ £	80.0%	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	93.9%	90.0%	90.0%	85.0%		80.5%		
	Total > 62 days		2.0	2.0	4.5	1.5	4.5	2.0	1.0	3.5	0.5	8.5	1.5	1.0	1.5	1.5			32.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.5	2.0	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0			4.0		
Head & Neck	% Within 62 days	▲ £	0.0%	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	16.7%	16.7%	85.0%		24.4%		
	Total > 62 days		1.0	3.0	1.0	2.0	1.0	1.0	2.0	0.5	2.0	0.0	1.0	1.0	2.5	2.5			15.5		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			2.0		
Sarcoma	% Within 62 days	▲ £	100.0%	100.0%		100.0%									100.0%	100.0%	85.0%		100.0%		
	Total > 62 days		0.0	0.0		0.0									0.0	0.0			0.0		
	Total > 104 days		0.0	0.0		0.0									0.0	0.0			0.0		
Gynaecological	% Within 62 days	▲ £	83.3%	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	60.0%	75.0%	75.0%	85.0%		67.3%		
	Total > 62 days		0.5	0.0	0.5	0.0	2.5	2.0	1.0	0.5	3.0	0.0	5.0	2.0	1.0	1.0			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.0	1.0	1.0			2.5		
Lung	% Within 62 days	▲ £	100.0%	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	55.6%	50.0%	50.0%	85.0%		77.2%		RC
	Total > 62 days		0.0	2.0	0.0	2.0	0.0	2.5	3.0	1.5	1.0	2.5	1.5	2.0	1.5	1.5			18.0		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0			1.5		
Haematological	% Within 62 days	▲ £	57.1%	100.0%	37.5%	37.5%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	0.0%	100.0%	100.0%	85.0%		60.5%		
	Total > 62 days		3.0	0.0	5.0	5.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	2.0	0.0	0.0			17.0		
	Total > 104 days		1.0	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0			5.0		
Skin	% Within 62 days	▲ £	92.9%	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	100.0%	97.7%	97.7%	85.0%		93.3%		
	Total > 62 days		2.5	3.0	3.0	0.0	1.0	3.5	4.0	4.5	3.0	3.0	2.0	0.0	1.0	1.0			29.5		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			1.5		
Unknown	% Within 62 days	▲ £			50.0%		100.0%		100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	85.0%		88.2%		
	Total > 62 days				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		
All Tumour Sites	% Within 62 days	▲ £	86.1%	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	86.3%	90.3%	90.3%	85.0%		85.2%		
	Total > 62 days		12.5	14.5	16.0	13.5	14.5	12.5	14.5	15.5	15.5	17.0	12.0	12.5	10.0	10.0			170.5		
	Total > 104 days		2.0	1.0	1.0	4.0	3.0	2.5	1.5	2.0	1.5	0.5	2.0	3.0	1.5	1.5			24.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £			100.0%		100.0%	100.0%	100.0%		100.0%			100.0%	66.7%	66.7%	85.0%		100.0%		
	Total > 31 days				0.0		0.0	0.0	0.0		0.0			0.0	1.0	1.0			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(22)047
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during May 2022. There were four Executive Committee meetings held during this period. The investment decisions made were: 1. Maternity Digital Transformation Programme – implementation plans 2. Capital investment to improve the traffic management at Whiston Hospital. At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration.
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 June 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in May 2022.

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

2. 5th May 2022

2.1 E- Expenses Provider

The Deputy CEO/Director of HR presented the paper which detailed the changes to the E-Expenses provider that was part of the national Electronic Staff Record (ESR) contract. The existing provider was no longer continuing to deliver this functionality via the national contract and a central procurement process had been undertaken to secure a new provider. Migrating to this provider would be at no cost to the Trust. There were other providers in the market, but these would be at an additional cost. An options appraisal has been undertaken and the recommendation was to migrate to the new provider linked to the national ESR contract. The recommendation was approved.

2.2 Enabling the Workforce for Elective Recovery

The Deputy CEO/Director of HR summarised the recent letter received from NHSE/I which detailed opportunities for optimising the workforce capacity of the NHS to manage the elective recovery plans. Committee reviewed the actions already being taken by the Trust and what more could be done. It was noted that the Consultant Local Negotiating Committee had requested consideration of a pension opt out and payback scheme for anyone impacted by the pension tax rules; where this could prevent them from undertaking additional work for the NHS to support the elective recovery targets. It was agreed that a proposal should be drafted for consideration, and if supported by the committee would then need to be approved by the Trust Board Remuneration Committee.

2.3 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agenda for the May meeting for review and agreement.

2.4 Maternity Digital Transformation Programme

The Director of Nursing, Midwifery and Governance and Director of Informatics presented the business case to implement Careflow Maternity. The Trust had made a successful bid for national funding (capital and revenue) from the NHSX Digital Maternity Fund to implement the system. The system would enable the service to have digital patient records that could be accessed remotely and comply with the new maternity minimum contract data set requirements. The implementation business case was approved.

2.6 Southport and Ormskirk Hospitals NHST (S&O) update

The Deputy CEO/Director of HR reported that a S&O Start of the Year Conference was planned for 13th May.

There was an update on the review of predicted activity and capacity requirements to re-open the Paediatric ED from 12 midnight to 8.00am.

There were several bids which had been submitted to access additional capital in 2022/23 to support the elective recovery programme and reduce backlog maintenance.

2.8 Disabled car parking – Whiston Hospital

The Director of Corporate Services presented proposals to create a filter lane into the patient disabled car park to improve traffic management and safety on the Whiston Hospital main site. This was one of several actions being planned to increase the number of disabled parking spaces and improve the traffic flow, which were currently in development. The proposal was approved, and the Estates and FM team were asked to review any other short-term measures that could be taken to alleviate the pressures at peak times; which had resulted since the reintroduction of visiting (in the afternoon) and the increase in outpatient activity to support elective recovery.

3. 12th May 2022

3.1 Development of the new Integrated Performance Report (IPR)

The Director of Finance and Information introduced the presentation which summarised the progress that had been made and the timescales for launching the new IPR. The Executives were asked to agree which of the metrics from the 2022/23 planning guidance needed to be added to the Trust IPR (i.e., those applicable to acute and community services).

The target launch date for the revised Board level IPR was July 2022, with the committee level data being added in October 2022. The Business Intelligence (BI) team would be working with a range of stakeholders including a Non-Executive Director to ensure the new IPR included all the information needed and was intuitive to understand. It was noted that many of the data sources were still manual, and more work was required for all the data extracts to be automated.

The inclusion of a Trust objectives dashboard within the IPR was also discussed, as this would allow tracking of the progress of the objectives where there are SMART measures of success and trajectories of improvement throughout the year.

The Executives thanked the Business Intelligence team for their work so far in developing the new IPR.

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

The Director of Corporate Services presented the Chair's assurance report from the RMC meeting of 10th May. There were 809 risks on the trust risk register of which 35 were

escalated to the CRR. One risk had been de-escalated from the CRR during April and 4 new risks had been added. Two of the new CRR risks related to the capacity to respond to urgent and emergency care demand. One related to an equipment business continuity risk in endoscopy and the final escalated risk was queried by the RMC as being a duplicate or sub section of an existing CRR risk relating to the management of cancer pathways.

The report also included updates from the CIP Council; Claims Governance Group; and Information Governance Group.

The RMC had approved the Emergency Department Major Incident Plan and the revised Health and Safety Policy.

3.3 Board Time Out

The Director of Corporate Services presented a draft agenda for the planned Board time out in July 2022 for discussion. Based on these discussions the programme would be revised and circulated to allow time for speakers to prepare.

3.4 Neonatal Transformation Programme

The Director of Integration provided a briefing from the Women's and Children's Programme Board for the Northwest. The focus had been on reviewing neonatal intensive care provision and a case for change was being developed that would then be peer reviewed by the North East Clinical Senate. The relationship between the number of births at each maternity unit in Cheshire and Merseyside and the number of neonatal cots was discussed and the potential service implications at STHK and S&O.

3.5 Urgent COVID Issues

The Director of Nursing, Midwifery and Governance reported that nosocomial infections had reduced to 2% and there was now only one ward outbreak. It was agreed that going forward reports would come to committee by exception due to the reduced incidents and changes to national guidance on patient testing.

3.6 Southport and Ormskirk NHS Trust update

The Deputy CEO/Director of HR reported that a review was being undertaken to determine priority areas for management support within the Clinical Business Units.

The Director of Transformation recruitment was progressing with interviews scheduled for the following week.

The next ALTC quarterly joint meeting was scheduled for 8th June.

3.7 Strategic Issues

The Chief Executive fedback from the Cheshire and Merseyside shadow Integrated Care Board (ICB) on the proposed quality governance arrangements from 1st July. The ICB had also discussed the bids from across the system for the Targeted Investment Fund (TIF), Elective Hubs, Community Diagnostic Centres and JAG accreditation.

4. 19th May 2022

4.1 Maternity Services

The Director of Nursing, Midwifery and Governance introduced the Q4 maternity assurance report and Ockenden recommendations gap analysis. In accordance with the national guidance, this report would be presented at the May Trust Board meeting. Committee agreed that there needed to be a review of the maternity performance dashboard to ensure that this aligned with the Ockenden recommendations.

4.2 Safer Staffing

The Director of Nursing, Midwifery and Governance introduced the month one (April) safer staffing report. The overall RN fill rate was 93.36% and the HCA fill rate 112% (including supplementary care). This was an improvement on month twelve (March). Red flag incidents were analysed and triangulated with staffing levels at the time. The report also summarised the actions taken to monitor staffing and improve both recruitment and retention of nursing staff.

4.3 Year-end Review of Trust Objectives

The Director of Corporate Services presented the summary of progress in delivering the 2021/22 Trust Objectives ahead of reporting to the Trust Board in May. The proposed ratings were debated, and some changes were agreed.

4.4 Mandatory Training Compliance

The Deputy CEO/Director of HR presented the mandatory training compliance figures for May. The new style report gave details of compliance by care group and staff group to allow more focussed remedial action. The requirement to achieve 95% Information Governance training compliance by the end of June to meet the Data Security and Protection Toolkit (DSPT) requirement was noted.

4.5 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – Review

The Director of Nursing, Midwifery and Governance had undertaken a review of DNACPR decisions that had given rise to a complaint, PALs concern or Ask Ann enquiry in the period 1st April 2021 – 30th April 2022. Of the 122 cases reviewed 10.6% had a DNACPR in place on admission, 88.5% had a DNACPR put in place on admission, and for 6.5% the decision was made during a MET call. Seventeen of the patients had asked for their family not to be informed. It was agreed that further analysis was required to understand how many DNACPR decisions were reversed if the patient was discharged.

5. 26th May 2022

5.1 Discharge lounge – improvement plans

The Director of Operations and Performance presented the analysis of the utilisation of the discharge lounge which had identified opportunities for improvement. Optimising the capacity available in the discharge lounge allows more patients to be discharged from the

ward earlier in the day, freeing beds for other patients. Targets for the number of patients in the discharge lounge had been set for 10.00am and 12.30pm and a number of other initiatives agreed in relation to final TTO checks by pharmacy; earlier identification of patients who could wait in the discharge lounge; transport to be booked from the discharge lounge; and a change in opening hours, so patients could be taken to the discharge lounge earlier in the day. The changes would be evaluated after one month and an evaluation report brought back to committee.

5.2 Comparative analysis of Staff Friends and Family Test (FFT) and the National Quarterly Pulse Survey (NQPS)

The Deputy CEO/Director of HR introduced the report. The NQPS had been introduced in April 2021 and replaced the staff FFT, which had been suspended during COVID-19.

The NQPS asks advocacy questions (would you recommend?) and engagement questions (I am statements) which reflect those used in the annual staff survey. NQPS data for each NHS body is published on the Model Health platform. Only the previous quarters data is published and there is no data on response rates or benchmarking information. The NQPS are open to all staff employed at the time of each survey and cannot be rotated around the care groups (as we did with the Staff FFT). This means that staff are now being surveyed 5 times a year – 4 NQPS and the National Staff Survey and this has impacted response rates which has now been recognised nationally as an issue.

The paper compared the NQPS results for each Care Group from the Q4 (January 22) and Q1 (April 22) surveys. The committee reflected on the response rates in each Care Group and the other events that had been taking place at this time, which were reflected in the results and free text comments. Actions resulting from the NQPS results were added to the Trust's staff survey action plan.

The Trust had been asked to join a group with NHS England and the NQPS survey provider to improve the ability to analyse the results, develop the questions and create a distinction between the NQPS and annual staff survey.

5.3 Anchor Institution and Social Value Award

The Director of Integration briefed the committee on the development of the Trust application for the Social Value Award as an Anchor Institution within the local community. The application covered social, economic, environmental and innovation and the Director of Integration was leading a working group drawn from across the Trust to develop the application document with the aim of submitting in June. Work would then continue, on the development plan to take forward the Trust's role as an Anchor Institution.

5.4 Southport and Ormskirk Hospital NHS Trust (S&O) – update

The Deputy CEO/Director of HR reported on discussions with the national transaction team and potential timetable.

The Director of Finance and Information reported that discussions were taking place between the two procurement teams, and they were developing a proposal for collaborative working that would be presented to the committee in June 2022.

The Director of Operations and Performance provided an update on the Community Diagnostic Centre (CDC) bid for Southport and the clarification received from NHSE in relation to the criteria.

Nina Russell had been appointed to the substantive post of Director of Transformation for S&O, following a robust selection process.

Clare Duggan from NHSE North West had visited the Emergency Department at Southport Hospital.

5.5 Bariatric Surgery

The Director of Operations and Performance briefed the committee on the development of the bid to provide Bariatric surgery at the Trust. If successful, the contract for the service for the North West would commence in November 2022.

5.6 Monkeypox

The Medical Director provided an update on the spread of Monkeypox and confirmed that cases had now been detected in Cheshire and Merseyside. Guidance had been issued to clinicians and services where patients with suspected Monkeypox may present.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)048
Reporting from: Quality Committee
Date of Committee Meeting: 21st June 2022
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery & Governance Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance Stephen Beckett, Head of Quality, Clinical Support Services Tracy Greenwood, Head of Quality and Nursing, Surgical Care Group **In Attendance:** Peter Williams, Deputy Medical Director Teresa Keyes, Deputy Director of Nursing and Quality Rajesh Karimbath, Assistant Director of Patient Safety Anne Rosbotham-Williams, Deputy Director of Governance Lynn Ashurst, Associate Head of Nursing and Quality, Quality and Risk Su Hobbs, Associate Head of Nursing and Quality Urgent Care Jacqui Kourellias, Maternity Matron for Quality and Safety, for Maternity items Amy Helmy, Community/Midwife-led Unit Matron, for Maternity items
Matters Discussed **Action Log** All open actions reviewed and closed, noting in particular the actions undertaken to increase capacity within the rapid access chest pain clinic. **Integrated Performance Report** (IPR) highlighted: • No new Never Events or MRSA bacteraemia reported in May and no category 3 or 4 hospital acquired pressure ulcers reported in April • 4 cases of C difficile reported in May and 1 fall resulting in severe harm reported in April • Safer staffing fill rate for registered nurses/midwives for May 2022 was 94.2% and year-to-date rate 93.8% • Continued achievement of 62-day and 31-day targets in April • 2-week rule target was not achieved due to significant increase in referrals, however 75% faster diagnosis was achieved • Continued challenges in meeting emergency care access targets, however 99% of patients were seen and treated within 4 hours at the Urgent Treatment Centre,

an increase from March. Ambulance turnaround times were not achieved, but have improved from the previous month
- Average daily number of super stranded patients (length of stay over 21 days) decreased from 135 in April to 116 in May
- 18-week referral to treatment and 6-week diagnostic targets were not achieved
- Continued decrease in sickness absence noted in May, with improvement in mandatory training noted; work continues to improve training compliance and appraisal rates

The Committee was informed about:
- Increased number of COVID positive patients
- Guidance in place for staff if patients were to present with suspected Monkeypox virus
- Increased number of Child and Adolescent Mental Health Service (CAMHS) patients currently in the hospital and the actions being taken with partner organisations to try to ensure they receive timely, safe and appropriate placements

The Committee noted that work is being undertaken to ensure the right maternity metrics are included in the new IPR, which reflect the requirements of the Ockenden report. Members reiterated the good work in achieving the 62 day cancer target.

Patient Safety Council Report
A number of reports were received including controlled drugs (CD) storage, Clinical Support Services quarter 4 report, infection prevention, incidents, patient safety, manual handling and safety alerts.

The Committee noted that actions were being taken to improve compliance with infection prevention and sepsis training and that there were no concerns raised re CD storage. The Committee noted the immediate actions taken as a result of lessons learned from a StEIS incident relating to a hypoglycaemic event and that additional actions and learning would be identified and implemented following the conclusion of the investigation.

Freedom to Speak Up Report
The report noted the wide range of methods available for staff to raise concerns, with assurance given that feedback is provided to staff, wherever possible, on the outcome. Engagement events to raise awareness and support staff will be held with all areas where the staff survey scores were below the Trust average. It was also stated that there will be three training packages, for staff, managers and senior managers, which will become mandatory in the future.

Continuity of Carer Action Plan
Update provided on the revised model and timescales, highlighting the move to a mixed risk geographical team that will become the default model for all eligible women, to be phased in over time starting with the most vulnerable women. The Committee acknowledged the steps that need to be taken prior to being in a position to implement this safely, with the right staffing levels and building blocks in place. Learning has been identified from the existing team within StHK, which will support the wider implementation of the revised teams going forward and the organisational development required. The sharing of good practice and planned peer reviews with Southport and Ormskirk Hospital NHS Trust were highlighted.

Perinatal Mortality Quarter 2 & 3 reports
The Committee noted the reports and the learning identified following the reviews. It was noted that none of the cases required reporting as serious incidents.

Patient Experience Council report
The Council received a number of reports, including a patient story previously presented to the Board, complaints and PALS, Healthwatch Knowsley, estates and facilities, end of life, discharge planning and spiritual care. The ongoing work to improve discharges and the re-instigation of bereavement services for babies and critical care patients were noted in particular.

Clinical Effectiveness Council report
Diabetes and Endocrinology Team reports received, noting in particular the work to address backlog of clinic patients resulting from the pandemic and the need to ensure blood glucose monitoring is transferred from paper to electronic record in line with other observations. A number of policies were approved and reports were presented relating to, IPR, mortality, clinical audit 2021-22 annual report and plan for 2022-23, national emergency laparotomy audit and Council effectiveness report. A review of the reasons for the high number of missing residual (R) codes for patients who have died without a final diagnosis was being undertaken in order to identify and address the issue.

Clinical Audit Programme and Annual Report
The Committee noted the achievement of 93% of 2021-22 clinical audit programme and the plan for 2022-23.

Meeting Effectiveness Review
The recent effectiveness review of the Quality Committee noted that it was effective and achieved its purpose, with actions to be taken to ensure earlier circulation of the papers.

Assurance Provided:

- Reduction in pressure ulcers due to lapses in care
- Moderate and above harm incidents were at lower levels than the national average
- 100% of referrals to the Specialist Palliative Care Team were seen in 24 hours
- 93% compliance with the delivery of the 2021-22 clinical audit plan
- Ability to widely share learning from perinatal mortality reviews with other organisations

Decisions Taken:

- Falls Strategy approved
- Freedom to Speak Up Strategy approved

Risks identified and action taken: The Committee requested the following actions be taken:

- Confirm timescales to transfer blood glucose monitoring from paper record to electronic recording on Careflow
- Ongoing comprehensive review and management of risks in relation to staffing levels and processes that need to be in place prior to implementing Continuity of Carer

• Updated report to be presented to the Committee regarding the actions taken following two previously reported Never Events in theatres, including Human Factors training
Matters for escalation: • Need to ensure delivery of Continuity of Carer within Maternity Services is safe and effective prior to launch, supported by comprehensive evidence that all risks have been adequately addressed
Recommendation(s): That the Board note the report, the assurances provided and the actions being taken to address areas of concern.
Committee Chair: Rani Thind, Non-Executive Director
Date of Meeting: 29th June, 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)049

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 23rd June 2022

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton – NED
P Growney – NED
A Sharples – Board Advisor
G Lawrence – Director of Finance & Information
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
P Williams – Deputy Medical Director
J McCabe - Divisional Medical Director
C Barrow – Deputy Director of Finance & Information
C Oakley – Deputy Director of Finance & Information
A Matson – Assistant Director of Finance – Financial Management
J White – Senior Management Accountant (observing)

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was above the 85% target in April, at 90.03%.
- Target 31 day performance was met in April, at 98% against a target of 96.%.
- Target 2 week wait cancer performance was not achieved in April, at 82.5% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 48.7% in May and 49.7% year to date. All type mapped STHK Trust footprint performance was 72.9% in May and is 73.7% year to date. The Trust saw average daily attendances of 340, which is an increase compared to April. Total attendances for May 2022 were 10,546.
- The ambulance turnaround time target was not achieved in May, at 36 minutes on average. There were 2,322 ambulance conveyances in May, with the Trust being the busiest in C&M and 3rd busiest in the NW.
- In May all staff sickness was 6% which is a reduction from 6.7% in April.

B) Finance Report Month 2

- At Month 2, the Trust is reporting a YTD deficit of £3.2m which was in line with plans.
- The position includes ERF funds that were allocated by C&M ICS. It is assumed that ERF performance will be reviewed quarterly in arrears for the system.
- As at M2 the Trust has identified and delivered CIP schemes of c£13m in year and continues to work towards the recurrent target.
- The Trust's full capital allocation is expected to be utilised by the end of the 22/23 financial year. The Trust awaits decisions on external business cases for capital.

- At Month 2, the Trust has a cash balance of £66m and is acheiving the Better Payment Practice Code (BPPC) target, at 99% performance (non-NHS invoices by value).

C) CIP Programme Update (CIP)

- The committee received the report on the Trust's CIP programme.
- The committee were assured with the level of schemes that have been identified for this year especially given the increased CIP target following the revision of the plan.
- The committee noted that the recurrent position of CIP was not where it needed to be but were reassured when compared to the previous years levels.

D) Financial Plan

- The committee noted the revised plan that had been submitted on the 20th June.
- The committee noted the significant challenge on CIP, as well as the risks with system delivery on ERF.
- While there was significant risk within the plan it was noted that its was important for the Trust to support system delivery where it could.
- The committee noted that £6m of the additional challenge was non recurrent and that we should inform partners that if delivered this should not form a recurrent challenge for the Trust alone.

E) Capital Plan

- The committee noted the capital plan for 2022/23 and that the internal plans were well underway to deliver before year end.

F) Community Care Group – CIP

- The committee noted the report and the work being undertaken on integration that supports efficiency.
- The committee noted the ownership and engagement within the care group and the challenges within services that support acute services.
- The committee were assured around the progress being made in cash and non cash releasing savings.

For Approval

N/A

For Information

G) Business case benefits realisation update

- The committee noted the contents of the report and the progress and learning being undertaken around benefits realisation.

H) Council Updates

- The committee noted the updates from:
    - CIP Council
    - Procurement Council

Risks noted/items to be raised at Board • Risks associated with 22/23 financial plan and the continued use of historic block contracts that no longer reflect activity within organisations.
Corporate objectives met or risks addressed: Finance and Performance
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: 29th June 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)050

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 23rd June 2022

Summary:

Meeting attended by:

P Growney – NED & Chair
L Knight – NED
G Lawrence – Director of Finance
K Hughes – Assistant Director of Communications
D Pye – Financial Accountant

Apologies Received from C Barrow, K Brayley

Agenda Items:

1) Investment Portfolio Update – The committee reviewed the funds within the portfolio which had fallen slightly since year end.

2) Income & Expenditure Position – overview given but nothing of note to report.

3) Fundraising Update – The committee had a long discussion over the future strategy of the Charity and fundraising opportunities. Options are to be drawn up over the coming months on how the charity can develop over the coming years.

4) The annual effectiveness review was undertaken for 2021/22 and recommendations noted and approved by the Committee. The conclusion is that the purpose and remit of the Committee remains appropriate, and the meetings are judged as effective.

There were no issues to escalate to the Board.

Corporate objective met or risk addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board is asked to note the contents of the report.

Presenting officer: Paul Growney, Chair, Charitable Funds Committee

Date of meeting: 29th June 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)051
Title of paper: Fit and Proper Persons Regulations – Annual Declaration
Purpose: To provide assurance to the Trust Board that the Trust has met the requirements of the Care Quality Commission (CQC) Fit and Proper Persons Regulations (Regulation 5).
Summary: The Fit and Proper Persons Regulations (FPPR) have been in place since 2014, with additional guidance being issued by the CQC in January 2018. The Trust has a robust FPPR Policy that is reviewed annually. The regulations require that all providers of NHS services; "*are able to show evidence that appropriate systems and processes are in place to ensure that all new and existing directors are, and continue to be, fit and that no appointments meet any of the unfitness criteria*" In additional to undertaking checks on new Directors as part of the recruitment process, the Trust has also put in place a process whereby every Director makes an annual declaration of their fitness to be a Director. In addition annual checks are undertaken by the Human Resources Department, to ensure that no new information has come to light that could affect the Directors "fitness" for the role. The Chairman reviews the declarations and the results of the checks and provides assurance to the Board that the organisation continues to meet the requirements of CQC regulation 5. Appendix 1 – Fit and Proper Persons Regulations Annual Declaration 2022.
Trust objectives met or risks addressed: The Trust is compliant with all the CQC regulations and can maintain registration.
Financial implications: None arising directly from this report.
Stakeholders: Members of the public**,** Patients, Staff, Commissioners, Regulators
Recommendation(s): That the annual declaration be noted
Presenting officer: Richard Fraser, Chairman
Date of meeting: 29th June 2022

Appendix 1

Annual Fit and Proper Person Requirement Declaration 2022

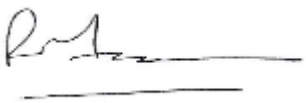
The table below certifies that the appropriate checks by the HR department and self-declarations have been completed for all Board Directors and that these have been reviewed by the Chairman who has confirmed that, based on the evidence presented, all Directors meet the requirements.

The DBS checks for all Board members are either in date (14) or in the process of being undertaken or renewed (2).

Board Member	Position	F&PPR Checks Completed	F&PPR Self-Declaration Reviewed	Meets Requirements /Comments
Richard Fraser	Chairman	29/04/22	03/05/22	✓*
Geoffrey Appleton	Non-Executive Director (designate)	05/05/22	17/05/22	✓
Jeff Kozer	Non-Executive Director	28/04/22	03/05/22	✓
Paul Growney	Non-Executive Director	28/04/22	03/05/22	✓
Gill Brown	Non-Executive Director	28/04/22	03/05/22	✓
Ian Clayton	Non-Executive Director	30/05/22	17/06/22	✓
Lisa Knight	Non-Executive Director	28/04/22	03/05/22	✓
Rani Thind	Non-Executive Director	28/04/22	03/05/22	✓
Ann Marr	Chief Executive	28/04/22	03/05/22	✓
Anne-Marie Stretch	Deputy Chief Executive/Director of HR	28/04/22	03/05/22	✓
Peter Williams	Medical Director (designate)	15/06/22	17/06/22	✓
Sue Redfern	Director of Nursing, Midwifery and Governance	29/04/22	03/05/22	✓
Gareth Lawrence	Director of Finance and Information	09/02/22	10/02/22	✓
Rob Cooper	Director of Operations and Performance	28/04/22	03/05/22	✓
Christine Walters	Director of Informatics	28/04/22	03/05/22	✓
Nicola Bunce	Director of Corporate Services	28/04/22	03/05/22	✓

*Reviewed by the Deputy Chair

Chairman's Signature: Date: 23rd June 2022

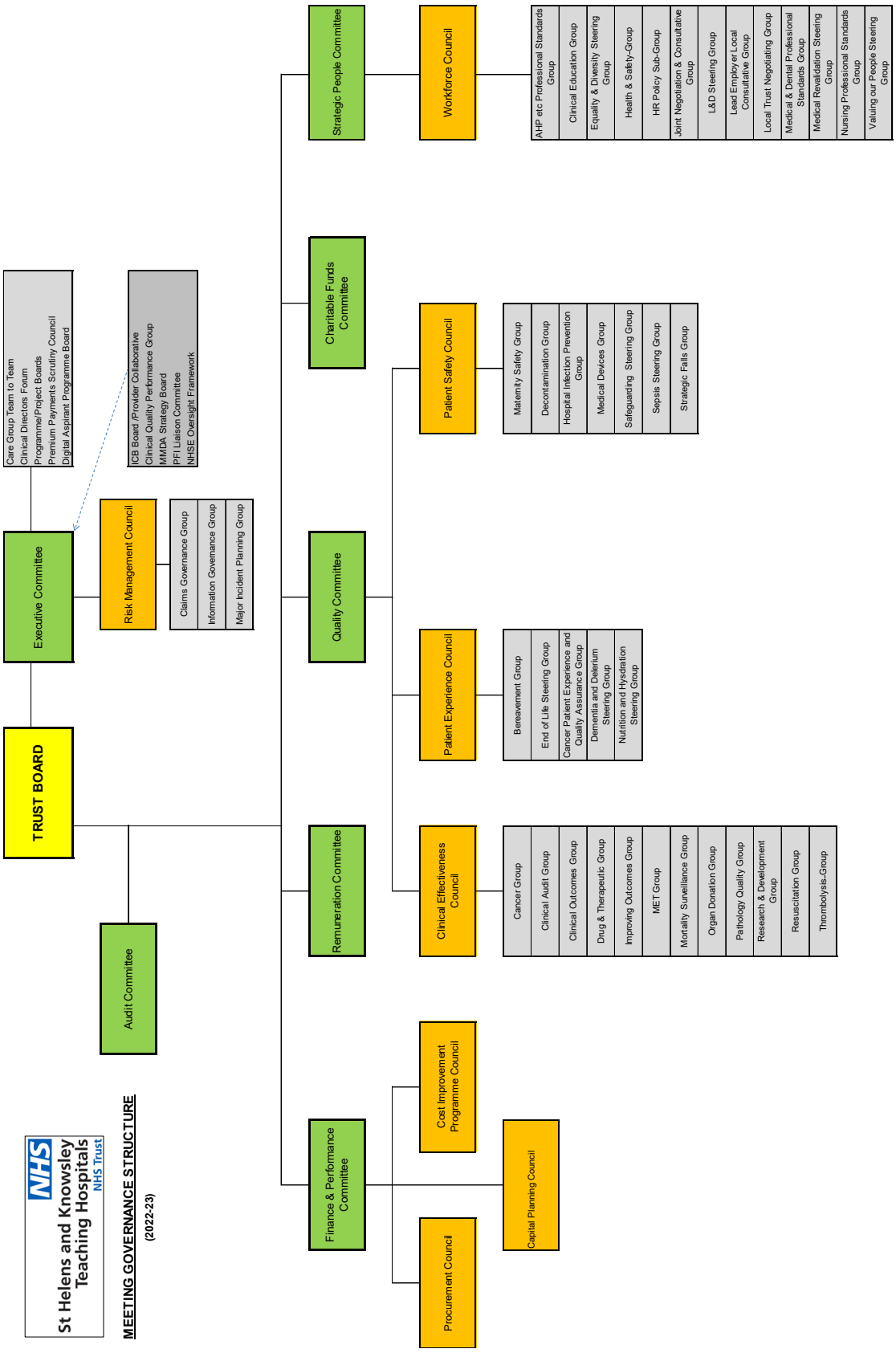


St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)053
Title of paper: Trust Board and committee effectiveness review – Revised Terms of Reference (ToR).
Purpose: To provide the Board with a pack of revised Board and Committee ToR that reflect the outcomes of the 2021/22 meeting effectiveness review process.
Summary: 1. The annual effectiveness review of the Board and its Committees has been undertaken, reflecting the meetings that took place in 2021/22. 2. The detailed review of each committee has been shared with the committee chair and has or will be reported at its next scheduled meeting. 3. A summary of the findings of each review has been reported to the Audit Committee. 4. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement. 5. The final part of this review is the issuing of revised ToR incorporating any agreed changes from the reviews (in red text). 6. The changes ensure that as a whole the Board governance structure remains comprehensive and there are clear lines of accountability.
Trust objective met or risk addressed: Supports the Trust to maintain effective systems of governance to meet best practice and regulatory requirements
Financial implications: None directly from this report.
Stakeholders: Directors, Staff, Patients, Regulators and other stakeholders.
Recommendation(s): 1. Approve the updated ToR that reflect the outcome of the 2021/22 Board and Committee effectiveness reviews.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 29th June 2022.

GOVERNANCE STRUCTURE 2022/23



TERMS OF REFERENCE 2022/23

TRUST BOARD – Terms of Reference 2022-23	
Authority	St Helens and Knowsley Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 2446) amended by 1999 (No 632) (the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board, and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Workforce Committee vi) Charitable Funds Committee vii) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman a minimum of 10 days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.

Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	Each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the ToR.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 5 Non-executive Directors (one of which will be appointed Vice Chair) ~~and one appointed as the senior independent director~~ Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be the nominated Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.

Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference (2022/23)	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: - All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. - The structures, processes and responsibilities for identifying and managing key risks facing the organisation. - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. - The operational effectiveness of policies and procedures via internal audit reviews. - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Agency (NHSCFA) 2. The Committee will: - Provide an overview of the effectiveness of the assurance framework; - Provide an oversight role in respect of the governance structure and the linkages with other committees; - Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); - Review the arrangements and their effectiveness for which staff may raise, in confidence, any concerns; - Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity; - Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility; - Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control. - Request assurance of the delivery of the annual trust objectives aligned to the Committee

	Internal Audit 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. External Audit 6. Establish an auditor panel with formal terms of reference to consider the appointment of the External Auditor and to ensure the on-going independence of the Auditor, making recommendations to the Trust Board. (See Appendix A.) (The Audit Committee should assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement and by a number of factors – for example, recent employment with the Trust, close family ties to its directors, members, advisors or senior employees or a material business relationship with the Trust.) 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account in line with DHSC guidance. 11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. Financial Reporting and Governance 12. Review the Annual Report and Accounts before recommendation to the Board, focusing particularly on: - The Annual Governance Statement; - Changes in, and compliance with, accounting policies and practices; - Unadjusted mis-statements in the Financial Statements; - Letters of representation; - Major judgemental areas, and; - Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board. 15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.

Review	Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.
Membership	Core Members The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members. In attendance The Director of Finance, the Head of Internal Audit and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be 2 members.
Accountability & Reporting	The committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

QUALITY COMMITTEE – Terms of Reference 2022/23 Review	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on patient safety, clinical effectiveness, patient experience and workforce issues 2. Identify, prioritise and monitor risk arising from clinical care 3. Ensure the effective and efficient use of resources through evidence-based clinical practice 4. Protect the health and safety and wellbeing of Trust employees 5. Ensure compliance with legal, regulatory and other obligations.
Duties	The Committee will undertake the following duties:- 1. To provide assurance to the Board on the delivery of the Trust's Clinical and Quality Strategy, based on the Trust's vision for 5-star patient care, through scrutiny of relevant quality indicators in the IPR 2. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes 3. To monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances 4. Request assurance of the delivery of the annual trust objectives aligned to the Committee 5. To identify areas for action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board 6. To oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval 7. To provide assurance on the delivery of the agreed Annual Quality Account priorities through Council reports 8. To approve policies and procedures in respect of quality and if necessary make recommendation to the Board 9. To agree the ToR and the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately

	10. To receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews or commission independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. complaints, infection control, safeguarding, medicines management, mixed-sex declaration, CQC compliance, the clinical audit programme, and medical revalidation 11. To assess the equality impact of proposed service developments or service changes 12. To undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils 13. To provide assurance that appropriate quality governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each.
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core members** Non-Executive Director (chair) Non-Executive Directors x 2 Chief Executive* Director of Human Resources /Deputy CEO* Director of Finance Medical Director Director of Nursing, Midwifery and Governance Director of Operations & Performance Director of Corporate Services *Remain core members but it is recognised that may not attend regularly due to the Trusts additional responsibilities in relation to the S&O ALTC and the Cheshire and Merseyside ICS. The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. **In attendance** In addition to core members the Deputy Medical Director, Assistant Medical Directors, Deputy Director of Nursing & Quality, Deputy Director of Governance, Deputy Director of Human Resources, Deputy Director of Operations, Care Group Heads of Nursing & Quality (or Head of Quality), Head of Safeguarding, Assistant Director of Patient Safety, Head of Midwifery may be asked to be in attendance. The Committee shall also be able to require the attendance of any other Director or member of staff for specific agenda items.

	Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair and Director of Nursing, Midwifery and Governance will be in the accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution is via the office of the Director of Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2022/23)	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance and Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives, and maintain the Trust as a going concern. To contribute to the overall governance framework, and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties:- 1. To review and make recommendations to the Board on the annual financial and business/activity plan and the assumptions which underpin it, and the Trust's longer-term financial and operational strategies 2. To review the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Integrated Performance Report (IPR) including against national and contractual waiting time and access standards. To make recommendations to the Board on key risks, and actions to ensure the Trust performs to the optimum level and operates within the resources available 3. To oversee the Trust's commercial activity and the decision making underpinning service developments and market strategy 4. To review proposed cost improvement programme and to monitor implementation and report, to the Board, proposals for corrective actions considered if required 5. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment 6. To approve policies and procedures in respect of finance and performance and if necessary make recommendations to the Board 7. Based on forecast resources available, to plan the five year rolling capital programme and in year delivery of the agreed capital programme 8. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability; escalating any concerns to the Board 9. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 10. To review the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately

	11. To receive assurance reports from the Council chairs following each meeting of the Procurement, CIP and Capital Planning councils and to request in-depth reviews or commission independent audits where necessary. 12. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils 13. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external benchmarking reports (including Model Hospital and GIRFT report recommendations) and assessing the Trust's performance against each 14. Request assurance of the delivery of the annual trust objectives aligned to the Committee
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-executive Director x 2 Director of Finance Deputy CEO/Director of HR Medical Director Director of Operations & Performance The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to core members the Director of Corporate Services, Deputy Director of Finance, Assistant Director(s) of Finance and nominated deputy to the Director of Operations may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.

Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

STRATEGIC PEOPLE COMMITTEE – Terms of Reference 2022/23	
Delegated Authority	The Trust shall establish a Committee to be known as Strategic People Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, education and training, employee health and wellbeing, learning and development, employee engagement, organisational development, leadership, workforce development, workforce planning and culture, diversity and inclusion. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the Committee to review specific aspects of workforce performance where the Board requires additional scrutiny and assurance.
Role	The Committee will provide assurance to the Board of the achievement of the Trust's strategic and operational objectives and specifically the Trust's People Strategy. To enable the Board to obtain assurance that high standards of workforce and peoples practices and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 6. Provide assurance to the Board on all workforce issues 7. Identify, prioritise and monitor risk arising from workforce and people policies and practice 8. Ensure the effective and efficient use of resources through benchmarking and evidence-based practice 9. Protect the health and safety and wellbeing of Trust employees 10. Ensure compliance with legal, regulatory and other obligations. The Committee has established a People Council and may recommend additional Councils aligned to key areas of its activity as it deems appropriate. Triangulation with other committees of the Board to ensure themes are identified and actions are progressed to support the development of the people agenda and delivery of high quality services.
Duties	The Committee will undertake the following duties: 14. Consider and recommend to the Board, the Trust's overarching People Strategy and associated action/implementation plans.

	15. Obtain assurance of the delivery of the People Strategy through the associated action/implementation plans. 16. Consider and recommend to the Board the key people and workforce performance metrics and improvement targets for the Trust. 17. Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. 18. Review the people and workforce risks of the corporate risk register and the Board Assurance Framework. 19. Receive reports in relation to internal and external quality and performance targets relating to people and workforce and associated activity/implementation plans. 20. Conduct reviews and analysis of strategic people and workforce issues and to recommend the Board level response. 21. Review and make recommendations to the Board in respect of regulatory and statutory workforce publications and returns, such as; Annual Gender Pay Gap, ~~Freedom to Speak Up Annual Assessment,~~ the annual staff survey, WDES/WRES and workforce planning
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Directors x 2 Deputy CEO/ Director of Human Resources Director of Nursing, Midwifery and Governance Director of Operations & Performance Director of Corporate Services Deputy Director of HR x 2 Deputy Director of Finance The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to core members the Deputy Medical Director, Assistant Director of Patient Safety, Assistant Director of Organisation Development, Assistant Director of Workforce Development & Resourcing may be asked to attend all or part of the meetings to present on specific issues. Other officers of the Trust may be co-opted or requested to attend as considered appropriate. Members are selected for their specific role or because they are representative of a function of service. As a result members are expected to:

	- Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary as a Chairs report of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet 4 times per annum
Agenda Setting and papers	Agendas agreed by the Chair and Director of HR/Deputy CEO, will be in accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution is via the Executive office. Items for the agenda must be sent to the Chair a minimum of 5 working days prior to the meeting. Urgent items may be raised under any other business. The agenda will be sent out to the Committee members at least 3 working days prior to the meeting date together with the updated action list and other associated papers. Formal minutes shall be taken of all Committee meetings. Once approved by the Committee the Chair will produce an assurance report for the following Trust Board. Assurance reports from the People Council (and associated groups) will be received by the Committee along with the reports as agreed.

REMUNERATION COMMITTEE – Terms of Reference (2022/23)	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Directors and Associate Directors with due regard to market rates, NHS guidance, affordability and equal value.
Terms of Reference	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene including: - Guidance on Executive remuneration from the Department of Health or NHS England. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice). 5. Ratify the appointment of new Directors and approve the remuneration and terms of service if outside the parameters agreed for previous appointments to the role. 6. Approve novel or potentially contentious changes to the pay or terms and conditions of other staff working for the Trust
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Members Membership will comprise the Chairman and all Non-Executive Directors. In attendance The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. The Director of Human Resources shall be Secretary to the Committee and shall attend to take minutes of the meeting. The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings,

	- Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Deputy Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Remuneration Committee is a Non-Executive function and its decisions must be agreed by a majority of the Non-Executive Directors and reported in accordance with the Trust's publication scheme, via the annual report and accounts.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Human Resources will be responsible for all administrative arrangements.

CHARITABLE FUNDS COMMITTEE – Terms of Reference 2022/23	
Delegated Authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in these terms of reference.
Terms of Reference	The Committee will oversee the administration of charitable funds in line with the Charities Commission requirements and relevant legislation. The Committee will undertake the following duties: • To manage the affairs of the St Helens and Knowsley Hospitals Charitable Fund within the terms of its declaration of Trust. • Develop policies in respect of the management of charitable funds including investments, donated income, spending, fundraising, use of reserves and other relevant matters. • Appoint an investment advisor to advise on investment arrangements for Charitable Funds. • Request assurance of the delivery of the annual trust objectives aligned to the Committee • Approval of expenditure requests in accordance with charitable funds expenditure approval procedures reviewing the financial position of charitable funds on at least a four monthly basis. • To ensure funding decisions are appropriate and are consistent with the St Helens and Knowsley Hospitals Charitable Fund objectives, to ensure such funding provides added value and benefit to the patients and staff of the trust, above those afforded by the Exchequer funds. • To implement as appropriate, procedures and policies to ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate. • To approve the annual accounts and report and to ensure that all relevant information is disclosed.
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	<u>Core Membership</u> Core membership will comprise; two Non-Executive Director one of whom will chair meetings of the Committee; the Director of Finance or his nominated officer, two Trust senior officers (preferably clinical). <u>In attendance</u> The Charitable Funds Financial Accountant, Charitable Funds Officer, Head of Media and Communications and the Hospital Charity Fundraiser will be in attendance. The Chairman and Chief Executive are invited to attend the Charitable Funds Committee at any time. Representatives of Internal and External Audit and other Trust Senior Managers may be invited to attend meetings in an ex-officio capacity. In addition, the Committee may establish appropriate time limited working groups to consider specific issues on a project basis. The terms of reference of such groups will be agreed by the Committee with minutes of such groups presented to the Committee.
Attendance	Core Members are expected to attend a minimum of 60% (2 of the 3 meetings) of meetings per year. Members are expected to:

	- Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Committee would be considered quorate with 50% attendance, with at least one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and will provide a written report setting out the basis of recommendations made.
Meeting Frequency	The Committee will meet at least three times per year. Meetings may also be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Finance will be responsible for all administrative arrangements.

EXECUTIVE COMMITTEE – Terms of Reference (2022/23)	
Delegated Authority	The Trust shall establish a Committee to be known as the Executive Committee which will formally be constituted as a Committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year. 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant tender/bid documents submitted by the Trust for new services 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council and other appropriate supporting groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee
Review	Each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee Terms of Reference.
Membership	Core membership of the meeting will comprise: - Chief Executive (chair) - Deputy CEO/Director of Human Resources (vice chair) - Medical Director

	- Director of Nursing, Midwifery and Governance - Director of Finance and Information - Director of Operations and Performance - Director of Corporate Services - Director of Informatics - Director of Integration The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is envisaged for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

ENDS