Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board

To be held at 10.00 on Wednesday 27 September 2023
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10:00	1.	**Employee of the Month Films (August and September 2023)** *Purpose: To **note** the Employee of the Month films for August and September 2023*	Verbal	Chair *(10 mins)*
10.10	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Verbal	Chair *(10 mins)*
10.20	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**MWL TB23/028 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 26 July 2023*	Report	
	6.	**MWL TB23/029 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.30	7.	**MWL TB23/030 Corporate Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	R Cooper obo S Redfern L Neary AM Stretch G Lawrence *(20 mins)*

Committee Assurance Report				
10.50	8.	**MLW TB23/031 Committee Assurance Reports** 8.1. Executive Committee 8.2. Audit Committee (including approval of Audit Letters) 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*	Report	A Marr I Clayton G Brown L Knight J Kozer *(30 mins)*
Other Board Reports				
11.20	9.	**MWL TB23/032 Medical Revalidation Annual Declaration** 9.1. STHK 9.2. S&O *Purpose: To **approve** the Medical Revalidation Annual Declaration*	Report	P Williams K Clark *(20 mins)*
11.40	10.	**MWL TB23/033 Emergency Planning Response and Resilience (EPRR)** 10.1. STHK Annual Report 2022/23 10.2. Statement of Compliance with National Core Standards *Purpose: To **approve** the EPRR Compliance Declaration*	Report	L Neary obo S Redfern *(10 mins)*
11.50	11.	**MWL TB23/034 Protecting and Expanding Elective Capacity Declaration** *Purpose: To **approve** the Protecting and Expanding Elective Capacity Declaration*	Report	L Neary *(15 mins)*
12.05	12.	**MWL TB23/035 Patient Safety Incident Response Framework (PSIRF) – Priorities for 2023/24** *Purpose: To **approve** the Patient Safety Incident Response Framework (PSIRF) Priorities for 2023/24*	Report	P Williams obo S Redfern *(10 mins)*
12.15	13.	**MWL TB23/036 Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case (OBC) for a Laboratory Management Information System (LIMS)** *Purpose: To **approve** the Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case (OBC) for a Laboratory Management Information System (LIMS)*	Presentation	C Walters *(10 mins)*
12.25	14.	**MWL TB23/037 Gender Pay Gap Report** *Purpose: To **note** the Gender Pay Gap Report for assurance*	Report	AM Stretch *(15 mins)*
12.40	15.	**MWL TB23/038 Freedom to Speak Up - Response to the NHSE Letter**	Report	AM Stretch *(10 mins)*

		*Purpose: To **note** the Trust's response to the requirements set out in the NHSE letter dated 18 August 2023 and to consider any further steps the Trust should take to improve the Freedom to Speak Up (FTSU) and Whistleblowing process*		
12.50	16.	**MWL TB23/039 Staff Vaccination Campaign 2023/24** *Purpose: To **note** the Staff Vaccination Campaign 2023/24*	Report	AM Stretch *(5 mins)*
12.55	17.	**MWL TB23/040 Committee Terms of Reference** 17.1. Trust Board 17.2. Audit Committee 17.3. Executive Committee 17.4. Charitable Funds Committee 17.5. Remuneration Committee 17.6. Quality Committee 17.7. Strategic People Committee 17.8. Finance and Performance Committee *Purpose: To **approve** the Trust Board and Board Committee Terms of Reference for MWL*	Report	N Bunce *(5 mins)*

Concluding Business

13.00	18.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
	19.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*		
		Date and time of next meeting: Wednesday 25 October 2023 at 09:30		**13.05 close**

Break (10 minutes)

Chair: Richard Fraser

Mersey and West Lancashire Teaching Hospitals NHS Trust

Southport & Ormskirk Patient Story

Rhys's Story
As told by his mother Alison

Can you tell us what happened to Reece?

So, what happened next?

How was your experience of Rhys's stay at Southport?

Can you sum up your experience?

Mersey and West Lancashire Teaching Hospitals NHS Trust

Thank you to Rhys, Alison and all our patients, families and carers who have and continue to share their stories with us.

MINUTES OF THE TRUST BOARD PUBLIC MEETING
HELD ON WEDNESDAY 26TH JULY 2023
Boardroom, 5th Floor, Whiston Hospital

BOARD MEMBERS	
Richard Fraser (RF)	Chairman (Chair)
Ann Marr (AM)	Chief Executive
Anne-Marie Stretch (AMS)	Deputy Chief Executive & Director of Human Resources
Rob Cooper (RC)	Managing Director
Jeff Kozer (JK)	Non-Executive Director
Gill Brown (GB)	Non-Executive Director
Rani Thind (RT)	Associate Non-Executive Director
Nicola Bunce (NB)	Director of Corporate Services
Christine Walters (CW)	Director of Informatics
Peter Williams (PW)	Medical Director
Geoffrey Appleton (GA)	Non-Executive Director (Deputy Chair)
Ian Clayton (IC)	Non-Executive Director
Gareth Lawrence (GL)	Director of Finance & Information
Sue Redfern (SR)	Director of Nursing, Midwifery & Governance
Lesley Neary (LN)	Chief Operating Officer
Lisa Knight (LK)	Non-Executive Director
IN ATTENDANCE	
Denise Baker	Executive Assistant (Minutes)
Juanita Wallace (JW)	Assistant to Director of Corporate Services (via MS Teams) (Observer)
Richard Weeks (RW)	Corporate Governance Manager (Observer)
Angela Ball (AB)	Halton Council Representative (Stakeholder Representative)
Yvonne Mahambrey (YM)	Matron, Quality Improvement & Clinical Audit Team (Item 2) (via MS Teams)
Tracy Greenwood (TG)	Head of Nursing & Quality, Community Services (Item 2) (via MS Teams)
Laura Hall (LH)	Matron, Patient Experience (Item 2) (via MS Teams)
APOLOGIES	
Paul Growney (PG)	Associate Non-Executive Director

RF opened the meeting with welcome and introductions to the first MWL Trust Board Meeting.

1.	**Employee of the Month Film**	**RF**
	1.1. The MWL Employee of the Month for July 2023 was Caroline Ingham, Ward Manager, Ward 5A, Whiston Hospital. 1.2. The Board watched the film of SR reading the citation and presenting the award to Caroline.	

	1.3. The S&O Employee of the Month for June 2023 was Alison Taylor, Clerical Assistant, Patient Access Team, Ormskirk Hospital. 1.4. The Board watched the film of LN reading the citation and presenting the award to Alison. 1.5. The Board congratulated both winners.	
2.	**Patient Story** **STHK** 2.1. Yvonne Mahambrey (YM) and Tracy Greenwood (TG) joined the meeting via MS Teams to present the STHK patient story. 2.2. The presentation was shared on screen and provided an insight into the patient's experience at St Helens Urgent Treatment Centre (UTC). The patient had attended the UTC with an imminent heart attack. The patient was an NHS worker himself and had been able to recognise the symptoms and known he needed urgent medical attention. The UTC had been the nearest source of help and had responded immediately giving life saving care until the patient could be transferred to Whiston ED department. The patient had been very grateful for the quick reactions and expertise of the UTC staff. 2.3. Following the incident, the Resuscitation Team had undertaken a review of the facilities at the UTC and made recommendations to upgrade equipment to allow defibrillation and monitoring, a separate paediatric resus trolley and a protocol for staff debrief following a traumatic event, and ensuring there is a Standard Operating Procedure (SOP) in place outlining roles and responsibilities of those on duty during emergency situations. 2.4. All recommendations and lessons learned will be shared as appropriate, including colleagues at Bridgewater Community Services NHSFT for the Widnes UTC. **S&O** 2.5. Laura Hall (LH) joined the meeting via MS Teams to present the S&O patient story. 2.6. The presentation was shared on screen and outlined the patient's experience of Ormskirk Maternity Unit. 2.7. The patient had had a positive experience on Delivery Suite, however, had encountered several challenges when she was transferred to the ward, late in the evening.	**RF**

	2.8. As a result of this feedback, the maternity ward had worked with the patient to develop and introduce a 'Welcome to the Ward' information sheet for patients and extended the visiting times for birthing partners. 2.9. The Ormskirk Maternity Unit had also developed a proposal to reintroduce recliner chairs to the S&O maternity ward to allow partners to stay on the ward overnight. SR advised that further work was required on this proposal to ensure that safeguarding and privacy and dignity considerations were assessed. 2.10. RF thanked the patients for sharing their stories with the Board and commented that both illustrated how staff learn from the experiences of patients and stive to improve the services they offer.	
3.	**Apologies for Absence** 3.1. Apologies for absence were as noted above.	**RF**
4.	**Declarations of Interest** 4.1. There were no new declarations of interest in relation to items on the agenda.	**RF**
5.	**Minutes of the Previous Meetings** 5.1. **Minutes of the Previous Meetings** **STHK** 5.1.1. The minutes of the STHK Board Meeting held on 28th June 2023 were reviewed and approved as a correct record. **S&O** 5.1.2. The minutes of the S&O Strategy & Operations Committee meeting held on 7th June 2023 were reviewed; a spelling error was noted on page 10. With this amendment the minutes were approved as a correct record. 5.2. **Action Logs** **STHK** 5.2.1. There were no outstanding STHK actions. **S&O** 5.2.2. Action SO056/23 – Changes were made to the Board Assurance Framework. **Action closed.** 5.2.3. Action SO057/23 – Financial savings linked to Chase Heys Beds will be discussed at a future Finance & Performance Committee meeting in September. **Action closed.**	**RF**

	5.2.4. Action SO109/23 – Changes to the Finance, Performance and Investment Highlight report had been made. **Action closed.**	
	Performance Reports	
6.	**STHK Integrated Performance Report – MWLTB (23)001**	**GL**

GL introduced the STHK performance report for June and noted that this would be the final IPR for STHK.

6.1. Quality Indicators

6.1.1. SR presented the report.

6.1.2. CQC had rated the Trust outstanding in July/August 2018 and have advised that this rating will remain for MWL until the next inspection. It is anticipated that the next full inspection will be 12 months post-transaction; however, because of the Ockenden report there will be a CQC inspection of the Maternity Department before the end of the 2023.

6.1.3. There were no Never Events reported in June 2023 (YTD=0)

6.1.4. There were 2 MRSA cases reported in June 2023 (YTD=2). Root Cause Analysis (RCA) identified that both cases had been avoidable; robust action plans are now in place and will be monitored through Executive Committee and Quality Committee.

6.1.5. There were 4 C.Diff positive cases reported in June, 1 was hospital acquired and 3 were community acquired (YTD=18) against an annual tolerance for 2023/24 of 46.

6.1.6. Overall Safe Staffing fill rate for RN/Ms was 101.6% (YTD 100.6%). Improvements in overall fill rates since the introduction of long shifts were noted.

6.1.7. There were no falls that resulted in severe harm and no pressure ulcers grade 3 or above reported in May.

6.1.8. HSMR (March 2023) was 92.4%.

6.1.9. Friends and Family test recommendation score was 95.1%.

6.1.10. The timescale for completion of complaints has been reduced from 100 days to 60 days, it was noted that complaints received before this change continued to be performance managed against the 100 day target, whilst more recent complaints were being managed against the new target. The reported compliance for all complaints was 76.5% for June.

6.2. Operational Indicators

6.2.1. RC presented the report.

6.2.2. Performance against the 62 day cancer standard was below the target of 85.0% in month (May 2023) at 77.4% (YTD=79.9%). The 31 day target was achieved in May

	2023 at 98.0% against a target of 96%. The 2 week rule target was not achieved in May 2023 at 84.6% (YTD=80.5%) against a target of 93%; acuity and referral volumes continue to affect performance. 6.2.3. Accident and Emergency Type 1 performance for June 2023 was 54.8% (YTD=53.0%). The all types mapped STHK Trust footprint performance for June 2023 was 72.1% (YTD= 73.9%). Average daily attendances were 340, compared to 333 in May. Total attendances for June 2023 were 10,194. 6.2.4. The total ambulance turnaround time target was not achieved in June 2023 with an average of 51 minutes. Bed occupancy was reported at 108%. Several new handover processes had been introduced in ED and these were starting to have a positive impact on turnaround times. 6.2.5. There were 2,269 ambulance conveyances in June compared with 2,422 in May 2023. 6.2.6. The Urgent Treatment Centre (UTC) had 4,589 attendances in May, compared to 4,527 in April with 94% of UTC patients were seen and treated within 4 hours. 6.2.7. The average daily number of super stranded patients in June 2023 was 137 compared with 142 in May. Going forward the IPR will report 'no criteria to reside' which should give a more accurate occupancy position. There is work ongoing with each Place to map trajectories and formulate a system response to improve the discharge of super stranded patients. 6.2.8. RC explained that to achieve the occupancy target of 95%, the equivalent of an additional 88 beds would be required, an occupancy target of 92% would require an additional 115 beds. T These numbers are not just physical beds but could also include virtual wards and discharge for evaluation patients. Currently across the Trust there were approximately 60 patients that had been identified as ready for discharge, with a further 20-30 patients awaiting social care assessment; this equated to 15-20% of patients not meeting the criteria to reside. Southport and Whiston both benchmark well compared to other organisations within Cheshire & Merseyside (C&M), however, this does mean the Trust has more acute in-patients. 6.2.9. The 18 week RTT target was not achieved in May with 63.7% compliance (YTD=63.7%) against a target of 92%. There were 1,783 52+ week waiters. 6.2.10. The 6 week diagnostic target was not achieved at 65.3%; this is being impacted by the volume of referrals. 6.2.11. There were no 104+ week waiters or 78+ week waiters; there is now focus on clearing all 65+ week waiters by the end of March 2024. 6.2.12. Referrals to the District Nursing Service remain within acceptable limits.	

	6.3. Workforce Indicators 6.3.1. AMS presented the STHK workforce report. 6.3.2. Overall sickness rate in June 2023 was 5.6% (YTD=5.7%) which is in line with pre-Covid levels. The national average for staff sickness is 5.3% and for the northwest is 6.1%. 6.3.3. There had been a slight fall in appraisals compliance at 76.6%, however, this is likely to be a scheduling issue and should improve as the appraisals window progresses. 6.3.4. Mandatory training compliance had seen a slight improvement in June at 83.0%. 6.4. Finance Indicators 6.4.1. GL presented the finance report. 6.4.2. The approved financial plan for 2023/24 was submitted to NHSE on 4th May, with a forecast surplus of £5.6m. To deliver this plan, the Trust must deliver elective recovery activity of 107%, all Trust CQUIN targets and CIP of £28.4m, underpinned by PBR income. 6.4.3. GL reported good progress is being made against PBR income plans, apart from the impact of the continuing industrial action; a 2% reduction in activity because of the industrial action during April has been acknowledged by NHSE, and more industrial action has occurred since April with more planned over the summer period. 6.4.4. Month 3 I&E position was in line with plan. 6.4.5. £16m of CIP schemes had been delivered to date. 6.4.6. Due to high interest rates, the current strong cash position is helping to off-set some of the cost pressures relating to inflation, pay award expenses and industrial action costs. 6.4.7. RF asked if the industrial action was causing harm to patients. PW advised that urgent and emergency cover had been maintained throughout and that the recent junior doctors' strike had not significantly affected cancer MDTs, or other planned activity however, the upcoming Consultants' industrial action was expected to have a wider impact; strike action by radiographers was also expected to impact patients requiring diagnostic tests to confirm their diagnosis. 6.5. The IPR was noted.	
7.	**S&O Integrated Performance Report – MWLTB (23)002** GL introduced the S&O performance report for June and noted that this would be the final IPR for S&O. 7.1. Quality Indicators 7.1.1. LN presented the quality report. 7.1.2. There had been no Never Events reported in June 2023 (YTD=0). 7.1.3. There were no cases of MRSA reported in June 2023	

(YTD=0).

7.1.4. There were 4 C.Diff positive cases in June 2023 (YTD=6) against a target of 39.

7.1.5. Overall Safe Staffing fill rates for June 2023 for RN/Ms 95.3% and HCAs 91.69%.

7.1.6. There were no category 3 hospital acquired pressure ulcers reported, however, there was 1 deep tissue injury reported, which is being closely monitored.

7.1.7. There were 77 patient falls reported in June, 2 of which resulted in moderate harm or above.

7.1.8. The Friends and Family test recommendation rates remained stable; 90.8% for June compared to 90.6% for May.

7.1.9. Complaints response times were achieved in 71.4% of cases during the month against a target of 80%; this is a significant improvement from 52.4% in May.

7.1.10. The number of patient safety incidents resulting in moderate harm or above continues to perform below tolerance.

7.1.11. There had been 2 cases of C.Diff reported on one ward; the Patient Safety Panel are monitoring this on a weekly basis.

7.2. Operational Indicators

7.2.1. LN presented the operational report.

7.2.2. The 14-day cancer performance for May was 84.7% compared to 77.2% in April; this is above the national and northwest averages.

7.2.3. The 62-day performance was reported as 59.4% in May against a target of 85%; this is improved from 45.1% April.

7.2.4. A&E 4 hour performance was 77.7% against the 2023/24 target of 76%. There were challenges relating to the length of stay within the A&E Department whilst patients are awaiting beds; bed occupancy in June was 108% and escalation within CDU and Ward 1 had resulted in some corridor care.

7.2.5. Chase Heys and ward 11a schemes continue and have resulted in improvement in patient pathways and flow. A financial evaluation of the projects is being undertaken..

7.2.6. 18 week RTT was reported at 59.5% and remains below target.

7.2.7. There were 271, 52 plus waiters at the end of June, with 6 patients waiting longer than 65 weeks. There were no 78 or 104 week waiters.
Diagnostics results continued to improve in June achieving 84.7% seen within 6 weeks.

7.3. Financial Indicators

7.3.1. GL presented the S&O financial month 3 position (subject to audit).

7.3.2. Month 3 was in line with plan, showing a £2m deficit.

7.3.3. Cash balance at the end of June was £10.4m.

	7.3.4. In June the Trust received an agreed £9m cash advance from C&M ICB which will need to be repaid over the course of the year, and an additional £5.9m from NHSE for the 2022/23 non-consolidated pay award. 7.3.5. CIP in Q1 is on target to be fully delivered. 7.4. <u>Workforce Indicators</u> 7.4.1. AMS presented the workforce report. 7.4.2. Overall sickness rate for S&O increased slightly to 5.8% in June, compared to 5.4% in May (YTD=6.4%). 7.4.3. The top 3 reasons for absence were gastroenteritis, coughs & colds, and stress & anxiety. 7.4.4. There was a small decrease in mandatory training compliance to 90% (May=90.5%), however it was noted that S&O continue to achieve the 90% stretch target. 7.5. The IPR was noted.	
STHK Committee Assurance Reports		
8.	**Committee Report – Executive MWLTB (23)003** 8.1. AM presented the Executive Committee Chair's Report for June and highlighted the following: 8.1.1. New investments approved were the Attend Anywhere virtual clinic software, the Southport and Whiston Operational Site Management model and ICU Advanced Clinical practitioner role expansion. 8.1.2. Discussions had continued regarding the Agreement for Long Term Collaboration (ALTC) in preparation of the proposed transaction with Southport & Ormskirk. 8.1.3. The Acute Kidney Injury (AKI) improvement plan had been discussed, including the possibility of adding fluid balance training to the mandatory training requirements for clinical staff. It had been agreed that alternative actions would be investigated, and the mandatory training matrix further reviewed if necessary. 8.1.4. Progress continued to be made against the Maternity improvement plan which had been drawn up following disappointing staff survey and patient survey results. 8.2. The report was noted.	**AM**
9.	**Committee Report – Finance, Performance and Investment – MWLTB (23)004** 9.1. JK presented the report and highlighted the following. 9.2. The committee had reviewed the STHK IPR and noted that although the 31 day performance target was achieved in May (98% against a target of 96%) the 62 day target and the 2 weeks wait cancer targets were not achieved. 9.3. The ambulance turnaround time target had not been achieved in June at 51 minutes. 9.4. Capital expenditure to June was £2.6m.	**JK**

	9.5. The Trust had reported a good cash balance at the end of month 3, the interest from which is helping to off-set some cost pressures. 9.6. Agency expenditure remained high. This had been impacted by industrial action, however, work continued within Care Groups to control spend. 9.7. STHK and S&O had submitted a combined 2023/24 plan with an overall surplus of £5.6m, however, this may need to be revised as C&M have posted a system deficit plan. 9.8. The Trust continued to make good progress against CIP with £16.2m delivered (target £28.4m). 9.9. The committee had received a presentation and discussed the plans for improving urgent care performance. 9.10. It was noted that E-Discharge target continued to under achieve, and it had been reported that this was being investigated and a detailed report would be presented to a future committee on the actions being taken. 9.11. The report was noted	
10.	**Committee Report – Quality – MWLTB (23)005** 10.1. GB presented the report and highlighted the following: 10.2. The CQC Outstanding rating awarded to STHK had transferred to MWL. 10.3. There had been 2 MRSA positive cases reported in June; action plans are now in place. 10.4. An infection prevention seminar has been planned for September to coincide with patient safety week. 10.5. There had been a significant decrease in the number of patients held in ambulances due to the reconfiguration of ED. 10.6. S&O ED performance had improved with more patients seen within 4 hours and a reduction in the number of complaints. 10.7. High bed occupancy had been reported across the Trust; the lack of decant space at Southport Hospital had been noted. 10.8. Work continued to improve the patient experience for STHK maternity patients. Key improvements included the introduction of a central referral line for bookings, single point of contact for triage and an advice line for early pregnancy advice. All 10 indicators for the maternity incentive scheme were being delivered. 10.9. The Clinical Effectiveness Council reported a sustained lower rate of admissions for cardiac arrests, below the national average; this has been attributed to improved compliance with recording observations and work on the deteriorating patient project. The committee had been assured that there were plans to roll out the deteriorating patient principles to the S&O sites. 10.10. The Research, Development, and Innovation (RD&I) team had been awarded the Covid-19 Research & Innovation award alongside the Liverpool School of Tropical Medicine and had been congratulated by the Committee. 10.11. The report was noted.	**GB**

11.	**Committee Report – Strategic People – MWLTB (23)006** 11.1. LK presented the report and highlighted the following: 11.2. Staff sickness levels remain in line with previous months. HWWB have introduced an updated process to ensure staff are sign-posted for support earlier in the absence pathway. 11.3. The NHS Long-term Workforce plan had been presented and discussed. This focuses on increasing training provision over the next 6 years, increasing apprenticeships through the apprenticeship levy and development of associate roles. 11.4. The report was noted.	**LK**
	S&O Committee Assurance Reports	
12.	**Committee Report – Executive Committee – MWL TB(23)007** 12.1. AMS presented the report and highlighted the following: 12.2. Discussions had continued regarding the transaction with STHK. The transaction received ministerial approval on 22nd June and TUPE letters were sent to staff on 26th June confirming the establishment of the new organisation on 1st July 2023. 12.3. Updates on industrial action were received at each meeting; operation planning for which was overseen by Gold Command. 12.4. Mandatory training compliance as at 31st May was reported as 90.47%. 12.5. The MIAA final S&O reports for the DSPT and Review of the Safety Culture had both received significant assurance. 12.6. The report was noted.	**AMS**
13.	**Committee Report – Finance, Performance, and Investment – MWLTB (23)008** 13.1. JK presented the report and highlighted the following: 13.2. The 62-day cancer performance had remained challenging. Performance in April was 45.1%, this is lower than both the national average (60.9%) and the Northwest average (61.9%). 13.3. The Trust had received £9m temporary cash support from the ICB. 13.4. Trust A&E 4-hour performance for May was 75.5%; The is slightly below the national average of 76%. 13.5. The Trust reported a £1.3m deficient in month 2 which is broadly in line with plan. 13.6. The Executive Committee agreed a programme of works to apply safety film to high risk windows. 13.7. The report was noted.	**JK**
14.	**Committee Report – Quality & Safety – MWLTB (23)009** 14.1. GB presented the report and highlighted the following: 14.2. The Committee was assured that options for creating decant wards to complete the ward refurbishment programme were being considered by the Executive. 14.3. Proposals to staff a second out of hours maternity theatre for simultaneous emergencies were being developed.	**GB**

	14.4. A review was being undertaken on the information that could or should be recorded in the notes about transgender patients. 14.5. The committee had reviewed the quality indicators in the IPR and noted the increased activity and reduction in long waiters. Committee had also noted the complaints response time improvements. 14.6. Lack of facilities for ablution and prayer at Ormskirk Hospital had been identified. Options were being explored. 14.7. The report was noted.	
15.	**Committee Report – Workforce – MWLTB (23)010** 15.1. LK presented the reported and highlighted the following: 15.2. There was a slight decrease in PDR compliance in May 2023 (78.4%). 15.3. Staff sickness had been 5.4%. 15.4. Time to Hire increased slightly to 46 days, this is due to overseas recruitment which takes longer because of the complexity. 15.5. The report was noted.	**LK**

Other Board Reports		
16.	**STHK – June Corporate Risk Register – MWLTB (23)011** 16.1. NB presented the STHK closing report and noted that the next quarterly report would summarise the CRR risks for MWL. 16.2. There were 796 risks on the risk register, 30 of which had been escalated to the Corporate Risk Register. 16.3. All CRR risks have been reviewed since the previous report and remained broadly unchanged. 16.4. The report was noted.	**NB**
17.	**S&O – June Corporate Risk Register – MWLTB (23)012** 17.1. NB presented the S&O closing report. 17.2. There were 11 risks on the Corporate Risk Register, all of which were within the 30 day review period, all action plans were in place. 17.3. NB clarified that following completion of the transaction there would be a need to align risks to the new organisational structure, but in the interim, there may continue to be some duplicate legacy risks. The critical issue was that staff could continue to report risks and they would be reviewed and escalated as appropriate. 17.4. The report was noted.	**NB**
18.	**STHK – Board Assurance Framework – MWLTB (23)013** 18.1. NB presented the STHK closing report. 18.2. All risks had been reviewed by Directors and the BAF had been approved by the Executive Committee. 18.3. Several actions had been deferred pending the transaction, but no actions were overdue. 18.4. No changes to risk scores were proposed.	**NB**

	18.5. The BAF was approved. 18.6. NB explained that the new MWL BAF would be presented in October, reflecting quarter 2.	
19.	**S&O – Board Assurance Framework – MWLTB (23)014** 19.1. NB presented the S&O closing report. 19.2. The report had been reviewed at the S&O assurance committees and by the Lead Director. 19.3. The BAF was approved.	**NB**
20.	**STHK – Learning from Deaths Quarterly Report – Q4 2022/23 – MWLTB (23)015** 20.1. PW presented the report and highlighted that there were still outstanding reviews from quarter 3 2022/23 and work continues to clear the backlog. 20.2. Of the reviews carried out in Q3, one was reported as amber and had been discussed at the Mortality Surveillance Group because, although unavoidable, there were lessons that could be learnt. 20.3. There were no amber or red ratings identified from the reviews completed in Q4. 20.4. The two learning themes had related to managing end of life care and the management of the delirious patient. 20.5. RT queried the action taken where lessons learnt are outside the Trust's scope of responsibility, such as for care homes. PW advised that lessons learnt are not routinely shared with external organisations, however, feedback would be given if there were any significant findings. 20.6. RT sought assurance that staff can appropriately manage patients at the end of life. PW confirmed that the Palliative Care Team now provide a 7-day service and can support staff caring for patients with complex needs. 20.7. RT discussed the impact of dementia and delirium, noting that S&O had a 3-person team, but the STHK team was currently reduced to 1 person. PW confirmed that dementia training is mandatory for all staff and is also included in training for junior doctors. 20.8. PW advised that when the mortality reviews had highlighted delays in identifying deteriorating patients, the Deteriorating Patient Team was established in December 2020. Significant improvements had been reported since then. 20.9. The Deteriorating Patient Team have been nominated for the HSJ Team of the Year award. 20.10. The report was noted.	**PW**
21.	**S&O – Learning from Deaths Quarterly Report – Q4 2022/23 – MWLTB (23)016** 21.1. PW presented the report, advising that S&O had followed a slightly different process because the Medical Examiners and Learning from Deaths are a single team. All deaths are scrutinised and any that meet the criteria are automatically escalated for a structured	**PW**

	judgement review, along with any deaths identified by the medical examiner; this results in a higher number of Learning from Deaths reviews and the Learning from Deaths report gives a wider overview of mortality across the organisation. 21.2. There had been 16 structured judgement reviews in Q4; 13 unexpected death reviews, 1 Medical Examiner referral and 2 learning disability death reviews but no care related contributory factors had been identified. The reviews had also highlighted that the SMR for patients presenting with a primary diagnosis of renal failure had increased and this had triggered a condition review. 21.3. There was 1 death where the documentation had not been completed correctly, however, this had not been a contributing factor. 21.4. The Q3 detailed analysis had identified the following learning themes around end of life care: 21.4.1. Early discussions with relatives hadn't taken place and the family had been unprepared for the death. 21.4.2. Deteriorating patient had not been identified. PW is currently reviewing the Deteriorating Patients Policy and will share any lessons learnt with the wider organisation. 21.5. The report was noted.	
22.	**STHK 6-monthly Workforce Strategy & HR Indicators Report – MWLTB (23)017**	**AMS**
	22.1. AMS presented the STHK HR indicators report for Jan-Jun 2023. 22.2. Health Work & Wellbeing had been reaccredited for SEQOHS in Occupational Health for the next 5 years reflecting the high standards and comprehensiveness of service provision. 22.3. The Trust has been nominated for a HPMA Excellence in People award for the Reasonable Adjustment Policy and disability passport. 22.4. There has been some improvement in HWWB DNA rates, however, further work is required to achieve the target of 9%. 22.5. The recruitment process for HCAs has been streamlined and some good on-boarding support has been introduced through the HC Academy. 22.6. The Wellbeing Hub for staff has received a 99% satisfaction rate. 22.7. The Improving Attendance programme has resulted in a consistent reduction in overall staff absence due to sickness, 6.48% in January 2023 compared to 5.57% in June 2023. 22.8. The flu vaccination rate 2022/23 was 74.4%; national uptake was 49.9%. 22.9. The Trust continued to offer a good number of apprenticeships, however, the numbers taking up nursing apprenticeships was lower than expected. Contributing factors were discussed including, not having the minimum English and Maths qualifications, operational pressures preventing release of staff and backfill costs. Apprenticeship success rates remain high among those staff who do start an apprenticeship.	

	22.10. Within STHK 3.3% of staff have declared a disability, compared to 25% on the staff survey; work continues to encourage disability disclosure to ensure staff receive the appropriate support. GB queried whether there were any disability support officers within the HR Department that staff could speak to in confidence. AMS advised that there are support officers in a variety of settings as well as a dedicated Equality Team. HR advisors and business partners are available and line managers have also been trained to have disability discussions. 22.11. RF commented that the reported provided an excellent overview of the key metrics and trends for the Trust workforce. 22.12. The report was noted.	
23.	**Information Governance & Freedom of Information Annual Reports 2022/23** 23.1. CW presented the reports. 23.2. The reports detail progress made against the Information Governance Work Programme for 2022/23 and a programme of work for the year ahead to achieve IG compliance and embed IG within the new Trust going forward. <u>MWLTB (23)018a - STHK</u> 23.3. STHK had 1 reportable incident with the ICO. This related to community staff when the IT solution was changed. This caused a problem with e-mailboxes for community staff and led to GP referrals not being received. No patient harm was reported because of the incident and action plans have been put in place to prevent a recurrence. 23.4. In October 2021 STHK had received an infringement order from the ICO although no financial penalty had been applied. This related to inappropriate release of personal data following a Subject Access Request (SAR) and had been flagged by the affected individuals. Controls have been strengthened to prevent a recurrence and responsibility for SARs has now moved from the Legal Department to the Information Governance Team. 23.5. Work will continue in embedding best practice, policies and procedures and delivering the IG training targets. 23.6. AMS will continue as the Freedom of Information (FOI) Lead for the Trust. 23.7. There was a considerable increase in the number of FOI requests in 2022/23, 98% of which were compliant with the 20 working day turnaround target. Complexity of requests has impacted on compliance. <u>MWLTB (23)018B – S&O</u> 23.8. S&O had 1 reportable incident with the ICO. 23.9. No fines had been issued by the ICO to S&O in 2022/23 and the ICO had directed the Trust to manage the incident locally.	**CW**

	23.10. Following the transaction with STHK work will continue to develop the shared team, adopting best practice for MWL and embedding policies and procedures within the new organisation. 23.11. S&O had received 605 FOI requests in 2022/23 and completed 95% of FOI responses within target (20 working days). 23.12. The Board approved both the reports.	
24.	**Data Security & Protection Toolkit (DSPT) Final Submission Reports – MWLTB (23)019a (STHK) and MWLTB (23)019b (S&O)** 24.1. CW presented the reports which provide evidence of self-assessment against the 10 national data guardian standards; both organisations met all the standards. 24.2. MIAA have conducted an annual audit and reported a 'substantial assurance' grade for both trusts. 24.3. The Board approved the DSPT reports.	**CW**
25.	**S&O EPRR Annual Self-Assessment and Declaration – MWLTB (23)020**	**LN**
	25.1. LN presented the S&O EPRR Annual Report. 25.2. The report covers 2022/23 and demonstrated how S&O had delivered its statutory responsibilities as a category 1 responder during this period, achieving full compliance against 62 standards in the EPRR self-assessment and 2 partially compliant standards. 25.3. Additional core standards for 2023/24 had been published and the single MWL assessment had to be completed by end of September 2023. 25.4. Baby Abduction and Lock Down plans have been successfully tested using table-top exercises. 25.5. **The Board approved the Self-Assessment and Declaration.**	
	Closing Business	
26.	**Effectiveness of Meeting** 26.1. RF asked RW to comment on the effectiveness of the meeting. 26.2. RW commented that the meeting had gone very well, particularly considering the complex business reflecting the two legacy trusts. There had been a good level of questioning and challenge among Board members.	**ALL**
27.	**Any Other Business** 27.1. RF thanked the Communications and Media Team for the wonderful job they had done in arranging the STHK awards event in July. The S&O Time to Shine awards evening for 2022/23 will be held on 20th October 2023 and urged all board members to attend, if they were able. From 2023/24 there would be a single MWL staff awards 27.2. RF conveyed the Trust Board's thanks to Everton Football Club for supporting the STHK awards evening and to Liverpool Football Club for their visit during the NHS 75th Anniversary celebrations. 27.3. RF welcomed Juanita Wallace (JW) who would be undertaking Trust Board Administration role going forward and thanked Denise	**ALL**

	Baker who had been supporting the STHK Board and would be taking on other responsibilities from September.	

Date of Next Meeting: Wednesday 27th September 2023

Trust Board Attendance Record 2023/24

Member	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total /10	%
Richard Fraser														
Gill Brown														
Jeff Kozer														
Ian Clayton														
Paul Growney				x										
Lisa Knight		x												
Rani Thind														
Geoffrey Appleton														
Ann Marr		x	x											
Anne-Marie Stretch	x													
Gareth Lawrence														
Peter Williams														
Sue Redfern														
Rob Cooper		x												
Christine Walters														
Nicola Bunce														

Trust Board (Public)

Matters Arising Action Log

Action Log updated 22 September 2023

Mersey and West Lancashire Teaching Hospitals NHS Trust

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
There are no open actions for review							

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
SO056/23	05/04/2023	**Board Assurance Framework**	The controls section for Maternity Services (Strategic Objective 1) to be updated	NB	Jul-23	26/07/2023 - The relevant amendments were made to the Board Assurance Framework. **Action closed**	**Completed**
SO057/23	05/04/2023	**Integrated Performance Report** b) Operational Performance Report	A summary of the financial savings linked to Chase Heys to be presented	LN / JMcL	Jul-23	26/07/2023 - Financial savings linked to Chase Heys will be discussed at the Finance and Performance Committee in September 2023. **Action closed**	**Completed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/030**			
Report Title	**Corporate Performance Report**			
Executive Lead	Gareth Lawrence, Director of Finance and Information			
Presenting Officer	Gareth Lawrence, Director of Finance and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) across four key areas:
1. Quality
2. Operations
3. Workforce
4. Finance

Executive Summary

Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

The forecast for 2023/24 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 10 metrics for Quality provide an overview for summary across MWL.

Recommendations

The Trust Board is asked to note Corporate Performance Report for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

Mersey and West Lancashire 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.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-23	82.5	100	87.2	Top 30%
FFT - Inpatients % recommended	Aug-23	95.5%	90.0%	95.2%	Bottom 50%
Nurse Fill Rates	Jul-23	96.6%	90.0%	97.0%	
C.difficile	Aug-23	8	85	40	Top 50%
E.coli	Aug-23	15	121	87	Top 40%
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0		0.1	
Falls ≥ moderate harm per 1000 bed days	Jul-23	0.2		0.2	
Stillbirths (intrapartum)	Aug-23	0	0	0	
Never Events	Aug-23	0	0	0	
Complaints Responded In Agreed Timescale %	Aug-23	68.2%	90.0%	67.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-23	72.7%	75.0%	69.2%	Bottom 30%
Cancer 62 Days	Jul-23	72.8%	85.0%	70.4%	Top 30%
% Ambulance Handovers within 30 minutes	Aug-23	67.2%	95.0%	70.0%	
A&E Standard (Mapped)	Aug-23	76.8%	76.0%	76.3%	Top 30%
Average NEL LoS (excl Well Babies)	Aug-23	4.6		4.6	Top 30%
% of Patients With No Criteria to Reside	Aug-23	26.4%		25.7%	
Discharges Before Noon	Aug-23	16.5%	20.0%	18.0%	
G&A Bed Occupancy	Aug-23	88.2%	92.0%	89.4%	Bottom 50%
Patients Whose Operation Was Cancelled	Aug-23	0.8%	0.8%	0.9%	
RTT % less than 18 weeks	Aug-23	60.3%	92.0%	61.9%	Top 40%
RTT 65+	Aug-23	397	0	397	
% of E-discharge Summaries Sent Within 24 Hours	Aug-23	65.7%		64.2%	
OP Letters to GP Within 7 Days	Jul-23	39.7%		39.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-23	75.9%	85.0%	75.9%	
Mandatory Training	Aug-23	86.2%	85.0%	86.2%	
Sickness: All Staff Sickness Rate	Aug-23	5.6%		5.6%	
Staffing: Turnover rate	Aug-23	1.6%		1.1%	

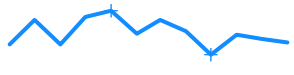
Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Aug-23		3,588	4,840	
Cash Balances - Days to Cover Operating Expenses	Aug-23	3	10		
Reported Surplus/Deficit (000's)	Aug-23		843	-1,357	

Board Summary - Quality

Quality

Complaints - Operational pressures continue to impact on capacity to respond to requests for statements, drafting and quality checking responses.
Measures to support teams include training and guidance on getting statement right first time and ensuring a high quality response is drafted at the initial stages.
Mortality - The latest available Hospital Standardised Mortality Ratio (HSMR) data is for May-23. The YTD position (87.2) shows the Trust has less deaths than expected given the age, comorbidities etc of our patients.
Infection - The Trust is within the tollerance levels for C. Difficile. In Aug the Trust had a total of 8 cases, giving a YTD total of 40.
FFT - Recommendation rates were above 90% for all areas in August, other than ED, where long waiting times features frequently in the comments for patients who wouldn't recommend the service. Work continues to improve flow throughout the hospital and to ensure that patients who are in ED for longer periods are cared for appropriately.
Falls - There were 6 falls (moderate or greater) in July there 2 Severe harm falls reported, one for Ward 1A and the other in ward 14A. There were 2 Moderate harm falls reported from Ward 3B , 1 moderate harm fall from Ward 2C and A&E. Improvement works in progress as part of Trust Strategic Falls Improvement work as well as bespoke programmes for the wards.
Pressure Ulcer - YTD 6 Patients with Category 2+ Pressure Ulcers with lapse in care. Improvement and awareness work in progress. Significant education and monitoring are place. Trust wide prevalence audit completed. RCA for Category 2 and above pressure ulcers being reviewed and validated including for May.

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	May-23	82.5	100	87.2	Top 30%	
FFT - Inpatients % recommended	Aug-23	95.5%	90.0%	95.2%	Bottom 50%	
Nurse Fill Rates	Jul-23	96.6%	90.0%	97.0%		
C.difficile	Aug-23	8	85	40	Bottom 50%	
E.coli	Aug-23	15	121	87	Top 50%	
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0		0.1		
Falls ≥ moderate harm per 1000 bed days	Jul-23	0.2		0.2		
Stillbirths (intrapartum)	Aug-23	0	0	0		
Never Events	Aug-23	0	0	0		
Complaints Responded In Agreed Timescale %	Aug-23	68.2%	90.0%	67.8%		

Board Summary - Operations

Operations

Bed occupancy across MWL averaged 102.6% in August 2023 equating to 40.3 patients, there was a peak of 88 patients (46 at S&O, 42 at STHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. There is an increased number of admissions sustaining this high occupancy level, with 1+ day admissions 6% higher than last August 2022. Average length of stay for emergency admissions is similar across both main sites with an overall average of 8.3 days, the impact of non-Criteria to reside (NC2R) patients being 26% at overall trust level. 4-hour A&E performance improved over the summer with August 2023 achieving 71.3% (all types), national performance at 74% and Cheshire & Merseyside overall position at 73.8%.

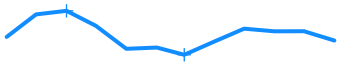
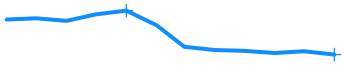
The Trust had 2,353 x 52+ week waiters at the end of August 2023 with 5 x 78+ week waiters. The 52-week position is an increase on plan and 34 more than July 2023. Industrial action and annual leave have affected activity. In the week ending 27th August 2023 Cheshire and Merseyside had 5% of open pathways waiting 52 weeks or longer, for MWL this is 3%. MWL represents 11.8% of C&M long waiters.

Cancer performance for MWL in July 2023 was 80.3% for the 14-day standard (target 93%) and 72.8% for the 62-Day standard (target 85%). STHK performance being 71.2% for 14-day and 81.5% for 62 Day. S&O achieved 92.6% for the 14 -day standard and 58.7% for the 62-day standard.

In July 2023 there were 9 days (7 working days) of industrial action. This included 5 days (3 working days) for Junior Doctors, 2 working days for consultants and 2 working days for radiographers. MWL reported a total of 134 inpatient cancellations and 749 outpatient cancellations.

There were a further 7 days (5 working days) of industrial action in August 2023 for Junior Doctors (5 days, 3 working days) and Consultants (2 working days), MWL declaring 27 cancellations of elective or day case admissions and 396 outpatients' appointments on national returns. 75 out of 252 consultants and junior doctors chose to strike when due on shift in August 2023 (29.76%).

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Jul-23	72.7%	75.0%	69.2%	Bottom 40%	
Cancer 62 Days	Jul-23	72.8%	85.0%	70.4%	Top 30%	
% Ambulance Handovers within 30 minutes	Aug-23	67.2%	95.0%	70.0%		
A&E Standard (Mapped)	Aug-23	76.8%	76.0%	76.3%	Bottom 50%	
Average NEL LoS (excl Well Babies)	Aug-23	4.6		4.6	Top 30%	
% of Patients With No Criteria to Reside	Aug-23	26.4%		25.7%		
Discharges Before Noon	Aug-23	16.5%	20.0%	18.0%		
G&A Bed Occupancy	Aug-23	88.2%	92.0%	89.4%	Bottom 40%	
Patients Whose Operation Was Cancelled	Aug-23	0.8%	0.8%	0.9%		
RTT % less than 18 weeks	Aug-23	60.3%	92.0%	61.9%	Top 50%	
RTT 65+	Aug-23	397	0	397		
% of E-discharge Summaries Sent Within 24 Hours	Aug-23	65.7%		64.2%		
OP Letters to GP Within 7 Days	Jul-23	39.7%		39.7%		

Board Summary - Workforce

Workforce

Stress and Anxiety remains the highest cause for sickness although we have seen an increase in gastro illnesses. Long term sickness is higher than short term. HCA sickness has increased in month.
There is a bi-weekly review of Trust absences by the HR Team and the Health, Work and Wellbeing Clinical Lead. Trends are monitored and management referrals analysed to provide targeted support to areas and for absence reasons as needed. Training is offered to new & existing managers as required.
Meaningful discussions take place between employees and managers during the absence and when employees return to work in the form of welfare, return-to-work, and attendance review meetings. Where applicable, referral to occupational health is undertaken and reasonable adjustments implemented.
The approach to attendance management which includes daily reporting of figures for absences, providing support to staff members who are absent due to sickness, regularly reviewing absence matters, collaborating with the HWWB team, and following the relevant policies, have been maintained.
Operational matters continue to impact on the timely completion of the appraisal documentation. The recording of the appraisal information into ESR is impacted due to missing or incorrect assignment numbers being populated.
Increase in the number of virtual training events regarding appraisals and how to ensure successful completion of paperwork and upload into ESR. Weekly compliance updates identifying staff who do not have a completed appraisal recorded in ESR.
Mandatory Training - Fire Evacuation Training is currently under performing, Face-to-face sessions continue to be offered in Nightingale House and at St Helens Hospital for clinical staff. There is capacity for all staff who need to attend. Walk-ins are accepted and extra courses on the same day are often available. Key issue is staff finding the time to attend/managers to release especially over summer period. Reminders are always being sent to promote these courses. Also Resuscitation L3 Adult & Paeds are having an impact on the overall compliance score.

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Aug-23	75.9%	85.0%	75.9%		
Mandatory Training	Aug-23	86.2%	85.0%	86.2%		
Sickness: All Staff Sickness Rate	Aug-23	5.6%		5.6%		
Staffing: Turnover rate	Aug-23	1.6%		1.1%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 23/24 (combining agreed STHK and S&O plans) gives a surplus of £7.6m, which assumes:
- Full achievement of CQUINs
- Delivery of £31.8m recurrent CIP
- Delivery of £7.0m non-recurrent CIP
- Delivery of the 23/24 activity plan, in order to achieve planned levels of income including ERF/API variable funding

Surplus/Deficit – At Month 5, the Trust is reporting a year to date deficit of £1.4m, which is £2.2m adverse to plan. The £2.2m variance to plan relates to industrial action pressures including activity underperformance and additional pay costs. Due to timing, the ICS has yet to confirm the Trusts allocation of the reported funding to cover months 1 & 2 industrial action (2% of ERF target), once confirmed this will offset against the pressure. As the national team have not yet confirmed the funding route for industrial action in months 3 to 5, this position assumes the pressure will be mitigated by additional income. If unfunded, this would deteriorate the position by £2.1m.

CIP - The Trust's 2023/24 CIP target is £38.8m, of which £31.8m is to be delivered recurrently and £7.0m non-recurrently. As at Month 5, schemes delivered or at finalisation stage totalled £21.9m in year (56%) and £13.3m (42%) recurrently.

Cash - At the end of M5, the cash balance was £6m, with a forecast of £12m at the end of the financial year. The Trust has submitted a request for £10m revenue cash in line with the transaction support agreed with NHS England and C&M ICS. The year end forecast assumes this application is successful.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £5m. No PDC funding (provided by Department of Health & Social Care) has been used.

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Aug-23		3,588	4,840		
Cash Balances - Days to Cover Operating Expenses	Aug-23	3	10			
Reported Surplus/Deficit (000's)	Aug-23		843	-1,357		

Board Summary

Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-23	84.7	100	91.8	Top 30%
FFT - Inpatients % recommended	Aug-23	94.8%	90.0%	95.1%	Bottom 50%
Nurse Fill Rates	Aug-23	96.6%	90.0%	95.3%	
C.difficile	Aug-23	5	39	13	Bottom 30%
E.coli	Aug-23	5	48	37	Bottom 30%
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0		0.0	
Falls ≥ moderate harm per 1000 bed days	Aug-23	0.1		0.1	
Stillbirths (intrapartum)	Aug-23	0	0	0	
Never Events	Aug-23	0	0	0	
Complaints Responded In Agreed Timescale %	Aug-23	72.7%	90.0%	66.7%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-23	75.8%	75.0%	68.2%	Bottom 20%
Cancer 62 Days	Jul-23	58.7%	85.0%	57.2%	Bottom 40%
% Ambulance Handovers within 30 minutes	Aug-23	76.7%	95.0%	78.2%	
A&E Standard (Mapped)	N/A				
Average NEL LoS (excl Well Babies)	Aug-23	8.3		8.4	Bottom 20%
% of Patients With No Criteria to Reside	Aug-23	16.4%		17.5%	
Discharges Before Noon	Aug-23	18.4%	20.0%	19.6%	
G&A Bed Occupancy	Aug-23	78.1%	92.0%	79.5%	Top 10%
Patients Whose Operation Was Cancelled	Aug-23	0.6%	0.8%	0.6%	
RTT % less than 18 weeks	Aug-23	59.4%	92.0%	60.5%	Top 50%
RTT 65+	Aug-23	14	0	14	
% of E-discharge Summaries Sent Within 24 Hours	Aug-23	84.7%		82.1%	
OP Letters to GP Within 7 Days	Jul-23	67.9%		69.6%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-23	73.2%	85.0%	73.2%	
Mandatory Training	Aug-23	91.4%	85.0%	91.4%	
Sickness: All Staff Sickness Rate	Aug-23	5.6%	6.0%	5.5%	
Staffing: Turnover rate	Aug-23	0.9%		1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's					
Cash Balances - Days to Cover Operating Expenses					
Reported Surplus/Deficit (000's)					

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-23	82.0	100	85.8	Top 30%
FFT - Inpatients % recommended	Aug-23	95.7%	90.0%	95.2%	Bottom 50%
Nurse Fill Rates	Jul-23	98.6%	90.0%	99.2%	
C.difficile	Aug-23	3	46	27	Top 40%
E.coli	Aug-23	10	73	50	Top 20%
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0		0.1	
Falls ≥ moderate harm per 1000 bed days	Jul-23	0.2		0.2	
Stillbirths (intrapartum)	Aug-23	0	0	0	
Never Events	Aug-23	0	0	0	
Complaints Responded In Agreed Timescale %	Aug-23	63.6%	90.0%	68.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-23	70.5%	75.0%	69.8%	Bottom 40%
Cancer 62 Days	Jul-23	81.5%	85.0%	78.9%	Top 10%
% Ambulance Handovers within 30 minutes	Aug-23	60.0%	95.0%	63.4%	
A&E Standard (Mapped)	N/A				
Average NEL LoS (excl Well Babies)	Aug-23	3.8		3.7	Top 10%
% of Patients With No Criteria to Reside	Aug-23	31.7%		30.1%	
Discharges Before Noon	Aug-23	14.6%	20.0%	16.4%	
G&A Bed Occupancy	Aug-23	95.6%	92.0%	96.7%	Bottom 10%
Patients Whose Operation Was Cancelled	Aug-23	0.9%	0.8%	1.0%	
RTT % less than 18 weeks	Aug-23	60.6%	92.0%	62.4%	Top 40%
RTT 65+	Aug-23	383	0	383	
% of E-discharge Summaries Sent Within 24 Hours	Aug-23	61.8%	90.0%	60.4%	
OP Letters to GP Within 7 Days	Jul-23	23.4%		22.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-23	75.9%	85.0%	75.9%	
Mandatory Training	Aug-23	84.0%	85.0%	84.0%	
Sickness: All Staff Sickness Rate	Aug-23	5.8%	4.5%	5.7%	
Staffing: Turnover rate	Aug-23	2.0%		1.1%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's					
Cash Balances - Days to Cover Operating Expenses					
Reported Surplus/Deficit (000's)					

Committee/Council/Group Assurance Report			
Title of Meeting	Trust Board	**Date**	27 September 2023
Agenda Item	MWL TB23/031 (8.1)		
Committee being reported	Executive Committee		
Date of Meeting	06, 13, 20 & 27 July 2023		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during July 2023. At every meeting bank or agency staff requests that breach the NHSE/I cost thresholds are reviewed and the Chief Executive's authorisation recorded.		
06 July 2023		
Update on procedural documents	• The Director of Nursing, Midwifery and Governance introduced the report. • At the end of June STHK had 81.8% of procedural documents and policies in date with 18.2% (N132) being reviewed and a further 12 coming due for review in the following month. • S&O had 218 procedural documents and policies, 45% (N98) were in date the remainder required review. • Work continues to create MWL policies, with priority being focused on key clinical safety policies and guidance.	Assurance
Biennial Urgent and Emergency Care Survey Results (STHK)	• The Director of Nursing, Midwifery and Governance introduced the briefing setting out the trust level results of the patient survey. It was noted that the results were embargoed until the national findings were published by the CQC at the end of July, when the trust results could be benchmarked. • It was noted that there had been a deterioration in some questions, particularly relating to waiting times in the department. A full action plan would be developed, and it was noted that some of these actions required wider system support to achieve a 92% bed occupancy rate, which would facilitate efficient patient flow.	Assurance
July Trust Board Agenda	• The Director of Corporate Services presented the draft Trust Board agendas for review. • The nominations for Employee of the Month received in June were also discussed.	Assurance

Limited Liability Partnership (LLP) Update	• The Director of Finance and Information presented an update on how the LLP might operate in MWL to support increased capacity for elective recovery and the procurement issues relating to this. It was agreed that a procurement exercise be initiated.	Approval
Bed moves	• The Managing Director presented analysis of the patient bed moves at STHK in 2022/23 compared to the three proceeding years, including bed moves after 10 pm. • The average numbers of moves had remained relatively constant over this period, but it was identified that additional information was required to better understand the full picture. • It was agreed that the S&O dashboard should be adopted across MWL, which shows the number of times a patient has been moved and allows the allocation of "keep me here" flags, although it was acknowledged that at times of severe bed pressures this could be difficult to achieve. • Quarterly reports on bed moves would be presented to the Committee to track the impact of these changes.	Assurance
2022/23 Audit (S&O)	• The Director of Finance presented the outcome of discussions with Mazara (External Auditors) about the treatment of transaction reconfiguration funding in the 2022/23 S&O accounts.	Assurance
13 July 2023		
Band 2 – 5 Nursing review	• The Director of Nursing Midwifery and Governance introduced the report which detailed the background to the Unison claim for band 2 HCAs to be regraded to band 3. • The paper detailed the current roles of HCAs across the Trust and the Agenda for Change role definitions and requirements. • Options to move the situation forward based on the skill mix needed to provide high quality patient care in different wards and departments were discussed but additional information was required to support the approval of which option would deliver the greatest benefits, and the team were requested to review these additional requirements and bring a revised report when this work had been completed.	Approval
Nursing and Midwifery Strategy 2022-2025 Review of year 1	• The Director of Nursing, Midwifery and Governance introduced the paper which reviewed progress in delivering the STHK Nursing and Midwifery Strategy year one priorities. • The committee noted the progress that had been made in many areas and those priorities that would be carried forward to year 2.	Assurance

	• The strategy would be reviewed, and consultation was planned to create a single strategy for MWL. • The update was being presented to the Quality Committee.	
Maternity CNST Claims Score card, Incidents and Complaints Report	• The Director of Nursing, Midwifery and Governance introduced the report, which forms part of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme and safety actions for STHK. • The aim of the report was to highlight any persistent themes that would require targeted interventions to improve patient safety. • The maternity CNST score card showed that the STHK maternity service had received 40 claims since 2012/13. A small number (2.44%) of these are high value claims with most claims being of low value (97.56%). 25 claims had been resolved/settled and 15 were still in progress. These claims reflected 7% of total claims made against the Trust but 20% of the value of the claims awarded. • Incidents relating to the loss of a baby, stillbirth, cerebral palsy and severe perineal trauma or obstetric complications are scrutinised locally, regionally, and nationally. • The service had received 10 complaints in 2022/23. • The report also detailed how PSIRF would be adopted to support the maternity incident reviews. • Committee discussed the maternity performance dashboard and the KPIs to be included on the monthly performance report to Board. • A similar report had been produced for S&O, however this was noted to contain some errors so the report was withdrawn for further review. • In summary S&O had received 40 claims between 2012/13 and 2021/22, 10 of which were still in process. The settled claims accounted for 11% of the claims received by the Trust but 59% of the value of settled claims.	Assurance
Risk Report and Corporate Risk Register (CRR)	• The Director of Corporate Services presented the first chairs assurance report STHK Risk Management Council for the risks reported in June 2023. • There were 796 risks reported to the Trust risk register of which 37 had been escalated to the CRR. • It was noted that from August there would be a single MWL Risk Management Council. Because the risk management systems remained aligned to the legacy organisations there would continue to be two sets of reports until the new organisational structure was in place.	Assurance

Integrated Performance Reports – STHK and S&O	• The Committee reviewed the IPRs for each legacy Trust reporting performance in June 2023. • Changes to the commentary were agreed and the reports were approved for circulation to the July Committee meetings.	Assurance
Industrial Action	• Committee discussed the preparations for the planned industrial action by consultant medical staff and radiographers.	Assurance
20 July 2023		
Deteriorating Patient Project - update	• The Medical Director introduced the report which provided an update on the project's progress. • The project had been established to ensure the early detection and appropriate care of deteriorating patients. • The project had explored the barriers to digital recording of observations and how these could be overcome. Many wards had now exceeded the improvement target of less than 15% per month missed observations and the team were working with the Quality Matrons and Service Improvement Team to develop improvement plans for the areas which had not yet achieved the target. • The use of the ESR system to track and flag missed observations was being developed with the informatics team. • It was agreed that the principles of the project should be expanded to the Southport and Ormskirk sites, when work had been completed to standardise the escalation protocols. • The committee commended the project team on their excellent work and continued enthusiasm.	Assurance
Electronic Patient Record (EPR) Business Case	• The Director of Informatics presented the EPR outline business case to achieve a single EPR for MWL and access the national digital maturity funds. • The committee supported the business case for presentation to the July Trust Board for approval.	Assurance
Data Security & Protection Toolkits (DSPT)/ Information Governance and FOI Annual Reports 2022/23 – STHK and S&O	• The Director of Informatics presented draft reports to the committee on the outcomes of the DSPT audits and the IG and FOI annual reports for both legacy Trusts, ahead of presentation to the July Trust Board for approval.	Assurance
STHK Appraisal and Mandatory Training Compliance – June	• Appraisal compliance at the end of June was 77% and it was noted the annual appraisal window closed at the end of September. • Mandatory training compliance continued to gradually improve and was 83%	Assurance

Patient Safety Incident Response Plan 2023/24	• The Director of Nursing Midwifery and Governance introduced the report proposing the local priorities for patient safety investigations for 2023/24, which every Trust was required to publish on its website in September. • The committee made some suggestions to amend the categories and it was agreed the paper would be revised and presented to the Trust Board for approval in September.	Approval
STHK Board Assurance Framework (BAF)	• The Director of Corporate Services presented the STHK BAF for quarter 1, for agreement to present to the July Board. • The single BAF for MWL would be produced for quarter 2.	Approval
Patient Safety Incident notification	• The Director of Nursing, Midwifery and Governance notified the committee that an avoidable grade 3 pressure ulcer had been reported for a patient who had been cared for on ward 2B and was being investigated. • Committee discussed the further actions that would need to be taken to establish what had gone wrong and the lessons that could be learnt.	Assurance
27 July 2023		
Sterile Services Provision	• The Director of Corporate Services introduced a paper detailing the options for the provision of the STHK sterile services when the current contract ended in 2025. • The committee supported the recommendation to use the new NHS Shared Business Services approved procurement framework to engage with selected suppliers. • It was noted that this route would enable a collaborative approach with other C&M Trusts who also needed to secure this service from a commercial provider. • It was also agreed to review the in-house capacity and service provision at Southport.	Approval
STHK Safer Staffing Report – June 2023	• The Director of Nursing, Midwifery and Governance introduced the June safer staffing report for STHK. • The RN/M overall fill rate was 97.24% and the HCA fill rate was 118.45% • The report also included the deep dive into the May staffing position which confirmed that there had been no patient safety incidents linked to staffing levels. • The recent internal audit review of the process for allocating shifts had reported significant assurance. • Committee welcomed the continued improvement in fill rates to establishment and the progress that had been	Assurance

	made in recruitment and reducing time to hire to 39.6 days. • From month 4 a single MWL safer staffing report was being developed	
Society of Radiographers (SoR) Industrial Action	• The report detailed the position in relation to the S&O branch of the SoR who had "adopted" the STHK strike mandate following the TUPE of staff when the transaction was completed. The SoR members at the Southport and Ormskirk Hospital sites had therefore taken part in the SoR industrial action on 25th and 26th of July. • Advice had been sought from NHSE. • The current SoR mandate is valid until December 2023	Assurance

Alerts:

None

Decisions and Recommendation(s):

Investment decisions taken by the committee during July were:

- **Butterfly (End of Life) Volunteer Business Case (06/07/23)**
  The Director of HR/Deputy CEO presented the business case on behalf of the End of Life service to recruit, train and manage a cohort of specialist volunteers dedicated to visiting patients at the end of their life and supporting their families. The business case was for 2 years of funding for a volunteer coordinator to manage the programme at Whiston Hospital. 1 year of funding had been provided by the Anne Robson Trust. If successful, the programme would be expanded to other MWL sites. The business case was approved.
- **Electronic Patient Record (EPR) Business Manager Business Case (13/07/23)**
  The Director of Informatics presented a business case to appoint a dedicated EPR Business Manager to support the EPR replacement programme. The business case was approved.

Committee/Council/Group Assurance Report			
Title of Meeting	Trust Board	**Date**	27 September 2023
Agenda Item	MWL TB23/031 (8.1)		
Committee being reported	Executive Committee		
Date of Meeting	03, 10, 17, 24 and 31 August 2023		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were five Executive Committee meetings held during August 2023. At every meeting bank or agency staff requests that breach the NHSE/I cost thresholds are reviewed and the Chief Executive's authorisation recorded.		
03 August 2023		
Chairs Assurance Report for the HR Commercial Services Finance & Performance Group	• The Director of Corporate Services presented the report which provided assurance on the activities of the HR commercial services and the contract pipeline. • It was noted that the intention was to make this meeting a formal council reporting to the Strategic People Committee, following a review of the workforce governance arrangements for MWL.	Assurance
Strategic Issues, Spinal Unit Swimming Pool	• The Committee discussed the recent request that had been received to open the spinal unit swimming pool for staff and public use, which had happened in the past. It was noted that health and safety and infection prevention control reviews would need to be undertaken to assess the risk and any operational requirements to meet the current regulatory environment.	Assurance
10 August 2023		
S&O Decant Options CMO Occupancy	• The Director of Corporate Services presented a report detailing the staff who would need to be relocated if the Southport CMO was converted to wards for decant capacity. The cost of conversion for a temporary building was noted to be high and a value for money assessment would be necessary if this option was to be pursued as part of the strategic site development plan. Off-site accommodation would also need to be secured for those staff displaced who could work from another location.	Assurance

	• Capacity issues at Southport Hospital and the option to transfer step-down patients to Ormskirk Hospital as an alternative strategy were also discussed. • It was agreed that capacity across all MWL sites from a 2023/24 winter planning needed to be considered.	
Electronic Prescribing and Medicines Administration (EPMA) Status Report	• The EPMA rollout at the Whiston, St Helen's and Newton sites had gone well. An issue had been identified with the recording of NHS numbers at the Southport and Ormskirk Hospital sites in the legacy S&O Electronic Patient Record (EPR), which meant that the roll out to these sites was temporarily paused while a solution was implemented. • The Trust had submitted a bid for national technology funding to facilitate validation of NHS numbers in the master patient index to eliminate duplicate records.	Assurance
HR Governance Arrangements	• The Director of HR/Deputy CEO presented the proposed HR governance arrangements which created three HR councils reporting into the Strategic People Committee (SPC). The proposals had been discussed and agreed with the SPC chair. • The Committee confirmed its support for this change.	Approval
17 August 2023		
2023 Staff Survey Bespoke Questions	• The Director of HR/Deputy CEO presented proposals for the Trust's bespoke questions to be included in this year's staff survey. The proposed questions reflected themes from the 2022 action plans and the culture of the organisation post transaction; flexible working, equipment availability, and culture. It was also noted that additional questions about sickness absence were being included in the national survey.	Approval
New Pension Flexibilities and Pension Recycling	• The Director of HR/Deputy CEO presented the briefing following the completion of the Department of Health and Social Care consultation on introducing more flexible retirement options to allow for partial retirement without a break in service. • The national guidance was also that trusts should offer pension recycling as an option for staff impacted by pension taxation, although acknowledging the recent changes to the annual allowances announced in the budget would reduce the numbers impacted. The Trust policy would be reviewed and presented to a future Remuneration Committee.	Assurance
Horatio's Garden	• The Director of HR/Deputy CEO presented a proposal from the Horatio's Garden charity. The Charity aims to create a specialist garden at all spinal units across the	Assurance

	country, and wanted to identify a suitable site at Southport Hospital • It was noted that the garden needed to be adjacent to the spinal unit and the Trust was required to identify a suitable space and part fund the garden. • The charity would fundraise for the garden and would also cover ongoing running costs. • Because of the constraints of the site and the location of the spinal unit, identifying a suitable site for the Southport Horatio's Garden was challenging, however the Committee were very supportive of working with the charity to explore options for creating a facility to help the recovery of patients at the spinal unit.	
Risk Report and Corporate Risk Register (CRR)	• The Director of Corporate Services presented the first Chair's Assurance report from the MWL Risk Management Council. Because the risk management systems remained aligned to the legacy organisations there had been two sets of reports, which resulted in 47 high or extreme risks being escalated to the CRR. • The risk management system would be aligned with the new organisational structure over the coming months, and work had started on services aligning their risk registers. The format of reporting was also being reviewed to create a uniform approach; however, it was noted that the key assurance at this stage was that staff continued to report new risks and they were visible across the organisation. • The new MWL Business Continuity Policy and Generic Business Continuity plan template was approved.	Assurance
MWL Corporate Meeting Templates	• The Director of Corporate Services presented the proposed MWL corporate templates for consideration. These had been developed with reference to the STHK and S&O templates and referencing best practice from other organisations rated as outstanding for Well Led by the CQC. • The Committee approved the adoption of the new templates for use at all governance meetings across MWL from September.	Approval
24 August 2023		
Safe Staffing Reports	• The Director of Nursing, Midwifery and Governance introduced the legacy reports for month 3 for STHK and S&O. The reports detailed fill rates, bank and agency use, and recruitment. • The overall fill rate at Whiston and St Helens for registered nurses (RN) was 98.61% and for health care assistants (HCAs) was 124.86%. The fill rate for the S&O sites for RN was 97.97% and for HCAs it was 92.07%.	Assurance

	• The STHK workforce update was presented. • A draft format for the new combined report reflecting the three sections (Right Staff, Right Skills, and Right Place) was presented and agreed. • The role of NHS Professionals was discussed, and an options appraisal for MWL will be presented at a future Executive Committee.	
Integrated Performance Report (IPR)	• The Director of Finance and Information presented the first combined MWL IPR report, for performance in July. • The Director of Finance and Information presented the Trust response to the Integrated Care Board (ICB) request (letter dated 5th July 2023) for all organisations to review their expenditure controls, because the ICB had not submitted a balanced budget for 2023/24. The response was required by 31 August and therefore would be approved by the CEO, as there was no Board meeting in August.	Assurance
Embedding a Culture of Continuous Improvement	• The Managing Director presented a progress report of the Delivery and Continuous improvement Review that was being undertaken with NHS Impact to help develop proposals for a single MWL approach. It was noted that this would link into the work of the wider post transaction culture and staff engagement agenda.	Assurance
Shaping Care Together	• The Managing Director presented a report on the progress in re-starting the Shaping Care Together programme and an outline timetable for the development of the pre-consultation business case. The Managing Director was confirmed as the Senior Responsible Officer (SRO) for the programme.	Assurance
Update from Place Partnerships	• The Director of Integration presented the regular update report on the activities at the five places and the ICBs. • A concern was raised that the work being undertaken at place level had not resulted in the required impact on bed occupancy in the Trust. It was noted that the Halton Place Leadership team have now identified SROs for their top five priorities and produced a dashboard with associated trajectories for improvement against each priority. It was agreed that the Trust should continue to monitor the place plans and escalate to the ICB if progress was not timely, or the impact not as predicted.	Assurance
Any Other Business	• The verdict of the Lucy Letby trial was discussed with reflection of the learning for all organisations.	Assurance
31 August 2023		

Any Other Business	• The Committee received a briefing on the upcoming joint consultants and junior doctors' industrial action on 20 September 2023.	

Alerts:

None

Decisions and Recommendation(s):

Investment decisions taken by the committee during August were:

Nurse Staffing Establishment Business Cases - Wards 3E and 4A (10/08/2023)

- Following the last nurse establishment review two areas had been identified as needing additional staffing. The business cases proposed consolidating staffing arrangements that had informally been in place since the review, to respond to the pressures faced on the wards.
- The specific pressures on ward 3E with 19 beds, two treatment rooms and four assessment chairs to increase the establishment from three to four RNs on days.
- For ward 4A the request was to consolidate to five RNs on during the day and an additional HCA at night.
- The Committee approved the business cases.

Electronic Patient Records (EPR) Outline Business Case (10/08/2023)

- The Committee approved the revised EPR Outline Business Case which had been amended to reflect feedback from the Cheshire & Mersey (C&M) ICB and NSHE. It was noted that the Trust Board had delegated approval authority to the Executive Committee to ensure that the Trust complied with the national timescales for submission.

Pennine Payroll Tender (17/08/2203

- The meeting received a proposal to bid for the Pennine Acute Trust payroll service and approved the bid parameters.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	27 September 2023
Agenda Item	TB MWL23/031 (8.2)		
Committee being reported	Audit Committee		
Date of Meeting	20 September 2023		
Committee Chair	Ian Clayton, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items (Part 1)		
Title	**Description**	**Purpose**
S&O Financial Statements 2022/23	The amended financial statements were reviewed with a recommendation to the Board to approve the annual report and accounts. The adjustment to the financial statements since the June audit committee meeting (£26m capital assets under construction moved to capital prepayments) was discussed and accepted.	Approval
S&O External Audit Year End Reports	The External Audit Report was presented by Mazars. The only material issue identified had been the treatment of assets under construction in the accounts. The Value for Money (VFM) element of the 2023/24 audit remained on going. The report was noted.	Assurance

Agenda items (Part 2)		
Title	**Description**	**Purpose**
STHK Financial Statements 2022/23	The amended financial statements were reviewed with a recommendation to the Board to approve the annual report and accounts. The adjustments to the financial statements since the June Audit Committee meeting (prior period adjustment from capital assets under construction to capital prepayments of £6.4m and an in-year capital to prepayment adjustment of £15.4m) were discussed and accepted.	Approval
STHK External Audit Year End Reports	The External Audit Report was presented by Grant Thornton. The only material issue identified had been the treatment of assets under construction in the accounts. The VFM element of the 2023/24 audit remained on going. The report was noted.	Assurance
MIAA - Internal Audit Reports	All outstanding planned audits from 2022/23 for both legacy organisations had been concluded.	Assurance

	Both Trusts had submitted the audited Data Security and Protection toolkits (DSPT) which had achieved substantial assurance. MIAA will be required to provide an internal audit opinion in respect of the part-year audit for S&O, for Quarter 1 2023/24.	
MWL Audit Action Logs	There are 13 outstanding internal audit actions currently being managed. Eight outstanding actions had been signed off by MIAA as complete since the last Audit Committee, with two further actions being completed by the Trust and waiting on sign off. There were two limited assurance reports on the log, one from STHK where the management action plan has been agreed and one from S&O currently being reviewed by MIAA.	Assurance
MIAA - Local Counter Fraud Progress Report	The Committee received the update from the Trust counter fraud specialist in compliance with the Government Functional Standard GovS 013: Counter Fraud, and the agreed counter fraud workplan. There were two referrals to counter fraud brought forward from the previous period with four new referrals this month. Two have been closed in the reporting period, leaving four to carry forward.	Assurance
Post Transaction Arrangements - Scheme of Delegation	The Standing Financial Instructions (SFIs) and Corporate Governance Manual (CGM) are being reviewed and the Scheme of Reservation & Delegation (SORD) will be aligned to the new organisational structure. There was also a proposal to revise the limit for waivers to £30k to align with national guidance, with immediate effect. There have been some differences between approval limits across the two legacy organisations which are being reviewed on a case-by-case basis, to ensure compliance ahead of the formal review of the SFIs.	Assurance
Audit Committee Terms of Reference and Annual Workplan	The Terms of Reference and Annual Workplan for the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Audit Committee had been reviewed with reference to HFMA guidance and NHS Corporate Governance Code to ensure that all relevant business has been included. The Committee reviewed the Terms of Reference and agreed to recommend them to the Trust Board for approval.	Approval
S&O Declarations of Interest Update	The process for S&O staff making annual Declaration of Interests (DoI) via ESR was introduced prior to the transaction. The percentage of S&O staff identified as decision makers who	Assurance

	made a DoI has increased from 14% to 30% - with actions outlined on improving compliance across MWL. The Committee asked for a more detailed report on DoI at staff group level, and the actions that were being taken to increase compliance further.	
NHS Shared Business Services (SBS) Audit Report	The Committee was informed that PwC's audit of Shared Business Services (SBS) had provided an unqualified audit report for SBS Finance, Accounting & Procurement for the financial year 2022/23. The Committee was also informed that there had been a national audit of the ESR system, which had resulted in a qualified audit report. The payroll team were reviewing the recommendations to assess the actions that could be taken locally to mitigate the risk that had been identified.	Assurance
Financial Reports - Losses and Special Payments	For the financial year to date (Month 5), £171k losses and special payments have been recorded, which is below the 2022/23 run rate (STHK £222k / S&O £390k).	Assurance
Financial Reports - Aged Debt Analysis	For the period to 31 August 2023, total NHS debt overdue is £19.9m of which £6.4m has been due for more than 90 days. Total Non-NHS debt overdue is £7.1m of which £4.9m has been due for more than 90 days. It was clarified that debt relating to NHS Wales was not classified as NHS debt and accounted for a significant % of the non-NHS debt.	Assurance
Financial Reports - Tenders and Quotation Waivers	19 waivers have been registered for the period June 2023 – August 2023, with a value of £2.1m The amended quotation and tender waiver threshold for MWL from £10k to £30k (inclusive of VAT) is being applied.	Assurance
Any other business	MIAA proposed fees for 2023/24 were raised. The Committee noted the proposed inflationary increase being consistent with expectations, and satisfaction with the services received.	Assurance

Alerts:

Although the single material issue with the STHK 2022/23 audit had now been resolved, the audit had still not been concluded with the audit letter to be issued and the VFM review work to be finalised.

Although the single material issue with the S&O 2022/23 audit had now been resolved, the audit had still not been concluded with the audit letter to be issued and the VFM review work to be finalised.

Decisions and Recommendation(s):

1. The Board approves the STHK 2022/23 Annual Report and Accounts.
2. The Board approves the S&O 2022/23 Annual Report and Accounts.
3. The Board approves the limit for waivers to be increased to £30k.
4. The Board approves the Audit Committee Terms of Reference.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee/Council/Group Assurance Report			
Title of Meeting	Trust Board	**Date**	27 September 2023
Agenda Item	MWL TB23/031 (8.3)		
Committee being reported	Quality Committee		
Date of Meeting	19 September 2023		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Matters Discussed	• The action logs from former StHK and S&O Quality Committee/Quality and Safety Committee were discussed. • Three actions were closed which included project Shakespeare which will be reported via CEC, IPC summit actions, IPR quality targets: recognition that this is working in progress and one action related to fluid balance monitoring is due in October.	Assurance
Quarter 1 update on delivery of Trust objectives aligned to the Quality Committee	• Update five Trust objectives aligned to the Quality Committee, with progress made in the delivery of most of the specific areas. • The quarter one position highlights the challenges in achieving some of the areas, including timely assessment of patients in Emergency department, the full completion of fluid balance charts and improving the effectiveness of the discharge process. • Detailed review of partially achieved objectives, including actions being taken to address areas needing improvement	Assurance

Corporate Performance Report (CPR)	• MWL Performance report with information on Quality and Safety including Patient Experience and Maternity from STHK and SO was reviewed and discussed with the following points highlighted in particular:
	  • CQC outstanding rating was transferred to the new organisation on 1st July 2023
	  • Continued high levels of bed occupancy.
	  • Comprehensive action developed and implemented following two incidents of lapse in care pressure ulcers.
	• Operational and Financial performance metrics noted
		Assurance

Patient Safety Council report STHK	• A number of papers were received in September council meeting, with the following highlighted at the meeting:	Assurance

	• Sustained high levels of safeguarding activity and improvement in Training compliance. • Implementation of Learning from Patient Safety Events (LFPSE) replacing NRLS in accordance with the plan. • Assurance of actions taken as a result of two Category 3 and above Pressure Ulcers with lapse in care. Action plan developed.	
Patient Safety update S&O	• Report highlighted key information on incidents reported for the period July and August 2023. • Four new patient safety incidents were reported to StEIS, with immediate actions identified and implemented. • Incident reporting remains high and within expected and historical trends. • Update on falls reduction and improvement activities.	Assurance
Incidents, Never Events and Serious Incidents Thematic Review (STHK)	• Report detailed information on incidents reported in Q1, with further information on Serious Incidents identified. • Incident reporting for the Quarter remains high and within expected and historical trends. • No Never event identified in Q1. • Assurance of improvements, lessons learnt, and actions taken as a result of incident noted.	Assurance
Maternity Services Update (Ormskirk Maternity)	• Paper detailing and providing assurance of the progress of the Maternity Service to key priorities including Ockenden, Maternity staffing, workforce planning and the three-year single delivery plan. • Report covered Maternity Services update elements during Q1 and YTD Q2 2023/24. • Compliance to all 10 Safety Actions in the MIS Year 4 was declared and submitted to NHSR following Board approval. MIS Year 5 has now been received, monitoring compliance and preparing evidence for submission on 1 February 2024 have commenced. • First internationally recruited Midwife commenced in the maternity service in April 2023 and a further one is expected early in 2024. • • Achieved 100% compliance of providing one to one care to women in established labour and the availability of a supernumerary Shift Coordinator.	Assurance
Patient Experience Council	• A number of papers were received in August and September Council meeting, with the following highlighted: progression with QCAT assessment plans, establishment of five workstreams to drive continuous improvement as part of nutrition and hydration steering group. • Funding secured for two years for butterfly volunteer service lead to support end of life patients and their loved ones.	Assurance

	• Update provided on the improvements being made across Southport and Ormskirk sites, including making non-clinical areas safer for patients with dementia and those at risk of falling. • Carers Poster to Support John's Campaign – Dementia & Delirium poster approved.	

Clinical Effectiveness Council	• A number of papers and assurances were received in September Council meeting, with the following:
	  • NICE Annual report shows 92% compliance, leads actively working with specialities to get compliance.
	  • Integration of clinical services progressing slowly while clinical staff continue to deliver services.
	• In Medical Care Group, Cardiac arrest rate per 1,000 hospital admissions 0.54 despite increase in hospital admissions
		Assurance

Presentation on NHSE letter on the Verdict on the Trial of Lucy Letby – Assurance of Trust processes and next steps.	Director of Nursing and Midwifery presented Trust assessment to the recommendations made in the letter from NHSE. This was discussed in detail regarding the current processes and place and the required actions to ensure assurance this will also include soft intelligence in combined with triangulated data. Review of Freedom to Speak Up process and culture, as well as plans for further improvement were detailed and discussed.	*Assurance*
Quality Committee - Terms of Reference	Committee reviewed amendments made on the Terms of Reference	*Decision*
Alerts:		
• Nothing to escalate to Trust Board as the NHSE letter on the Verdict on the Trial of Lucy Letby – Assurance of Trust processes and next steps is included on the public Board agenda for 27 September 2023		
Decisions and Recommendation(s):		
Not applicable		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	27 September 2023
Agenda Item	MWL TB23/031 (8.4)		
Committee being reported	Strategic People Committee		
Date of Meeting	18 September 2023		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes of the last meeting – July 2023	The meeting reviewed the minutes of the meeting held on 17 July 2023 and approved them as a correct and accurate record of proceedings.	Approval
Action Log – July 2023	There were no outstanding action from the previous SPC meeting on the 17 July 2023. There are two legacy actions from the S&O Strategic Operations Committee on the 03 May 2023 which have been noted and will be picked up by the new councils and monitored accordingly.	Assurance
New HR Governance arrangements	A paper setting out the new proposed HR Governance arrangements was presented which detailed the Council structure reporting to the Strategic People Committee. The terms of reference (ToR) for the MWL Strategic People Committee were discussed and a number of suggestions made for recommendation to the Board. The ToRs for the councils will be discussed at the meetings taking place in the next two months and then will be presented to the Committee for approval. A formal effectiveness review will be scheduled for the end of the financial year to feed into the annual governance statement and recognising that some adjustments may need to be made as the governance for MWL matures.	Assurance
SPC Annual Work plan	The MWL SPC Annual Work Plan based on the draft ToRs was presented and endorsed.	Assurance
Workforce Dashboard	The new format MWL IPR dashboard now referred to as the Committee Performance Report, focusing on the key indicators for the SPC was presented. It was noted that vacancy rates Allied Health Professionals (AHP's) had increased and were significantly higher than for other staff groups since February 2023. Committee requested a detailed analysis of the reasons for the increased vacancies and the actions required to improve retention.	Assurance

Fit & Proper Person (FPPT) Framework and Freedom to Speak up (FTSU)	The Committee received a briefing on the new Fit and Proper Persons Test framework. An overview of the changes was discussed which included the requirement to record FPPT evidence in ESR and use a mandatory reference for Directors. The FPPT framework will be supported by a new Leadership Competency Framework for directors which would be used to inform appraisals from 2024/25. The Committee was also briefed on the work the Trust was undertaking to review its FTSU arrangements following the verdict in the case of Lucy Letby and the guidance received from NHSE. This work included the plans to integrate and standardise the FTSU approach and processes across MWL. Assurance was provided that the Trust regularly remind staff of how to speak up if they have a concern.	Assurance

Alerts:

Decisions and Recommendation(s):

- Approval of the MWL SPC Annual Work Plan.
- Amendments to be made the SPC TORs to recommend to the Trust Board for approval.
- The HR risks were being reviewed to create a single HR risk register for MWL.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	Trust Board Meeting	**Date**	27 September 2023
Agenda Item	MWL TB23/031 (8.5)		
Committee being reported	Finance and Performance Committee		
Date of Meeting	21 September 2023		
Committee Chair	Jeff Kozer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
MWL FC23/053 – Integrated Performance Report Month 5 2023/24	• Bed occupancy across MWL averaged 102.6% in August 2023. There is an increased number of 1+ day admissions, 6% higher than last August 2022. • Average length of stay for emergency admissions is an average of 8.3 days, the impact of non-Criteria to reside (NC2R) patients being 26% at overall trust level. • 4-hour A&E performance improved over the summer with August 2023 achieving 71.3% (all types). National performance is at 74% and Cheshire & Merseyside overall position at 73.8%. • The Trust had 2,353 x 52+ week waiters at the end of August 2023 with 5 x 78+ week waiters. The 52-week position is an increase on plan and 34 more than July 2023. • Cancer performance for MWL in July 2023 was 80.3% for the 14-day standard (target 93%) and 72.8% for the 62-Day standard (target 85%). • Industrial action and annual leave have impacted activity in month.	Assurance
MWL FC23/054 – Finance Report Month 5 2023/24	• At the end of Month 5, the Trust is reporting a year-to-date deficit of £1.4m (£2.2m adverse variance to plan) • This includes £1.5m underperformance on PbR income and a £0.7m pressure relating to unfunded industrial action costs. • Forecast outturn for 23/24 remains in line with plan at £7.6m surplus as conversations with C&M ICB ongoing regarding adjusted financial allocations which are expected to be reflected in Month 6 reporting. • Agency costs £7.8m year to date. This equates to 4.1% of total pay spend, against a target of 3.7%. Mitigating actions are being taken to address this.	Assurance

	• CIP is on track to be delivered in line with target by the end of the year • Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £4.8m • At the end of M5, the cash balance was £6m, with a forecast of £12m at the end of the financial year. The Trust has submitted requests for cash in line with the transaction support. • The Better Payment Practice Code (BPPC) compliance has reduced in line with expectations post ledger merge, plan in place to achieve target.	
MWL FC23/055 – Month 5 2023/24 CIP Programme Update	• Total targets for 23/24 (including £2.8m recurrent CIP delivered by S&O during M1-M3) are £41.6m in year and £34.6m recurrently. • Schemes identified totalling £48.4m in year and £32.6m recurrently • Delivered/low risk schemes currently total £24.7m in year (59% of target) and £16.1m recurrently (47% of target) • Trust remains on track to deliver full CIP target by end of year • Committee noted the update	Assurance
MWL FC23/056 – Elective Recovery Update	• Committee noted the update and reviewed the self - assessment against the declaration required by every Trust. • The committee noted the compliance against seven out of 11 key areas and the actions being taken to support further compliance against the four areas rated as partially compliant. Two requests for additional funding had been submitted to support this activity. £125k to support the IT and c£300k for workforce to support validation.	Assurance
MWL FC23/057 – Expenditure Controls	• Committee approved the contents of the review.	Approval
MWL FC23/058 – 2022/23 National Cost Collection (NCC) Pre-submission Update	• Committee approved the proposed costing processes at STHK and S&O sites, to support the NCC submission of 2022/23 financial data	Approval
MWL FC23/059 – Benefits Realisation Update	• 93% of benefits are on track to deliver in line with target • Committee noted the update	Assurance
MWL FC23/060 – Finance, Performance & Investment Committee Workplan	• Proposed 23/24 workplan approved by Committee	Approval
MWL FC23/061 – Finance, Performance & Investment	• Proposed Terms of Reference approved by Committee, subject to minor amendment to reflect	Approval

Committee Terms of Reference	Estates & Facilities and IT Councils now reporting into FP&I Committee following transaction	
MWL FC23/062 – Medical Care CIP Presentation	• Committee noted the update	Assurance
MWL FC23/063 – Community CIP Presentation	• Committee noted the update	Assurance
Assurance Reports from Subgroups:	• MWL FC23/064 - CIP Council Update • MWL FC23/065 - Capital Planning Council Update • MWL FC23/066 - Procurement Steering Council Update • Committee noted the updates	Assurance

Alerts:

Not applicable

Decisions and Recommendation(s):

MWL FC23/058 – Expenditure Controls
Committee approved the contents of the review and recommend approval by Board.

MWL FC23/058 – 2022/23 National Cost Collection (NCC) Pre-submission Update
Committee approved the proposed costing processes at STHK and S&O sites, to support the NCC submission of 2022/23 financial data, and recommend approval by Board.

MWL FC23/060 – Finance, Performance & Investment Committee Workplan
Proposed 23/24 workplan approved by Committee. Recommend approval by Board.

MWL FC23/061 – Finance, Performance & Investment Committee Terms of Reference
Proposed Terms of Reference approved by Committee, subject to minor amendment to update to reflect Estates & Facilities and IT Councils now reporting into FP&I Committee following transaction. Recommend approval by Board.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**	**Date**	27 September 2023
Agenda Item	**MWL TB23/032 (9.1)**		
Report Title	**2022/23 Medical Revalidation Annual Declaration (STHK)**		
Executive Lead	Dr Peter Williams, Medical Director and Responsible Officer		
Presenting Officer	Dr Peter Williams, Medical Director and Responsible Officer		
Action Required		**To Approve**		**To Note**

Purpose

The purpose of this report is to provide assurance to the Trust Board that St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) are compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

All responsible officers are required to submit an Annual Report to their Trust's Board and a statement of compliance to the Higher Level Responsible Officer at NHS England.

Executive Summary

The report covers the period of 01 April 2022 to 31 March 2023.

As of 31 March 2023, 528 doctors had St Helens & Knowsley Teaching Hospitals NHS Trust as their registered Designated Body and the Trust has 109 trained medical appraisers. In 2022/23 a total of 474 doctors completed medical appraisal in line with GMC guidance. Of the 54 doctors who did not complete appraisals, 45 were approved Missed appraisals (e.g. due to sickness) and nine were unapproved. The Medical Appraisal and Revalidation Team work closely these doctors to ensure that they engage with the appraisal process.

During this time, a total of 38 revalidation recommendations were made to the GMC with 32 doctors being positively recommended for revalidation. All doctors who were recommended for revalidation were deemed to be engaging with the revalidation process and had provided the appropriate evidence of this.

In 2022/23 one doctor was referred to the GMC for further action and one was referred to the Practitioner Performance Advice Service for support. Zero doctors were excluded from practice in this period.

In March 2023, Dr Peter Williams became the Responsible Officer to cover the unexpected long-term absence of Dr Jacqui Bussin (previous Responsible Officer). In July 2023, St Helens & Knowsley Teaching Hospitals NHS Trust came together with Southport & Ormskirk Hospital Trust to form a new designate body, Mersey and West Lancashire Teaching Hospitals NHS Trust, of which Dr Williams is currently the Responsible Officer.

Following the approval of a business case in early 2022, the Medical Appraisal and Revalidation team has expanded and consists of a full time Medical Appraisal, Revalidation and Governance Lead, and a full time Medical Workforce Administrator. The full time Medical Appraisal and Revalidation Officer's role will be filled in mid-2023. The expansion of the team has helped to increase appraisal compliance and provide more support to doctors during the appraisal and revalidation processes.

The organisation will continue to work towards complying with Medical Professional Regulations. During the coming year, we anticipate closer, collaborative working between the Medical Revalidation and Medical HR teams, and a review of the appraisal system and processes across the new organisation.

Financial Implications

Not applicable

Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Trust Board is asked to approve the 2022/23 Medical Revalidation Annual Declaration (STHK).	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

NHS England North West
Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West: St Helens & Knowsley Teaching Hospitals NHS Trust

Appraisal and Revalidation and Medical Governance

Contents

Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

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

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

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**St Helens & Knowsley Teaching Hospitals NHS Trust**
What type of services does your organisation provide?	Acute hospital care

	Name	**Contact Information**
Responsible Officer	Dr Peter Williams	0151 430 1134
Medical Director	Dr Peter Williams	0151 430 1134
Medical Appraisal Lead	Dr Stephen Allsup	0151 430 2419
Appraisal and Revalidation Manager	Michelle Langton	0151 430 1650
Additional Useful Contacts	Cameron McCall	0151 290 5720

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: N/A **Please describe arrangements for Responsible Officer to report to the Board:** This report will be presented to the Board on 27th September 2023. **Date of last RO report to the Board:** 28th September 2022

Section 2a: Appraisal Data

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

Total number of doctors with a prescribed connection as at 31 March 2023?	528
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	474
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	45
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	9
Total number of appraisers as at 31 March 2023?	109

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

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

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	38
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	32
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	4
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	2

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	0
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	1
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	Formally, 1 doctor, though advice is sought on several doctors
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	0

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Medical Appraisal & Revalidation Policy	March 2020	March 2024

List your policies to support MHPS and managing concerns	Implementation date	Review date
Maintaining High Professional Standards		
Handling Medical Concerns	01 December 2018	30 November 2021
Disciplinary Policy	05 August 2021	31 August 2024
Remediation Policy	01 June 2018	30 September 2021

Other relevant policies	Implementation date	Review date
Grievance Policy	06 May 2022	30 November 2024

How do you socialise your policies?
All policies are available on the Trust intranet pages. When a doctor is overdue their appraisal, the Medical Appraisal and Revalidation Team will include a copy of the Medical Appraisal and Revalidation policy with all escalation/non-compliance emails.

Section 4: General Information

The board can confirm that:

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

Yes, Dr Peter Williams, Medical Director for St Helens & Knowsley, became Responsible Officer in March 2023 to cover an unexpected long-term absence of Dr Jacqui Bussin (previous Responsible Officer). Dr Williams has completed the appropriate Responsible Officer Training.

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

Yes

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? We review the GMC Connect list of connected doctors daily. Every month this list is cross checked with doctors on the Trust Appraisal system and with ESR full staff reports.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024). For the next appraisal year, we plan to strengthen the communication with the recruitment team and to be included in new starter and leavers update reports.

4.4 Do you have a peer review process arranged with another organisation?

We do not currently have a peer review process arranged, due to the current plans to join with another organisation in mid-2023. However, this is something we would consider from 2025, once processes have been confirmed and we have implemented any necessary changes from the 2023 transaction with the other organisation.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes, the Trust continues to provide support with appraisal and revalidation for all doctors including those on short term contracts and those doctors working solely on the Trust's medical bank. For any doctors with a prescribed connection to another organisation, the Trust will provide information to the doctor and their Responsible Officer to assist their revalidation when requested.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

All doctors, working only or mostly for St Helens & Knowsley Teaching Hospitals NHS Trust will be registered for a PReP appraisal account and will be assigned an appraiser. We do not currently have a process in place to provide information to doctors who work mostly for another organisation, but we do provide a letter of no concerns on request. In the next year we plan to provide doctors who work in the Trust but are not connected with governance reports which would include details on any incidents, complaints and SUI's. All doctors can request their individual information regarding complaints and significant events from the Quality and Risk Department.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

Dr Bussin (Responsible Officer until March 2023) was successful with her business case, and we were able to recruit additional team members - a full time Medical Workforce

Administrator in August 2022 and a full time Medical Appraisal, Revalidation and Governance Lead in January 2023. The remaining post will be filled in April 2023.

Whilst there have been some challenges over recent months, the additional resources within the Team have allowed us to follow up on overdue appraisals which has seen the appraisal compliance stay at around 90%. We have capacity to arrange for doctors to complete their MSF in the third year of their revalidation cycle, send regular reminders to doctors regarding their appraisal and offer more face-to-face support and reassurance.

We have undertaken an audit of appraisal supporting information regarding Educational Appraisals. This has prompted closer working with the Director of Medical Education and revised communication to doctors working as Clinical and or Educational Supervisors. Over a short period, we have noticed a significant increase in doctors including supporting information linking to the domains for Educational Appraisal.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

From April 2023, the Medical Appraisal and Revalidation Team will be fully staffed, and we plan to offer more support to our doctors.

In July 2023, the Trust will merge with another organisation (Southport and Ormskirk), to become one new organisation. This will require close and collaborative working with our colleagues in the Medical Appraisal and Revalidation Team at Southport and Ormskirk sites. Dr Peter Williams will remain as the Responsible Officer until further notice.

We will be restarting the Appraiser Support Groups (suspended during COVID) and will be working with the Trust's International Medical Graduate Lead to offer support to doctors that are new to the UK and new to the appraisal and revalidation process.

We will undertake a further audit relating to Educational Appraisal and will also focus on auditing appraisal input and output forms.

We will routinely provide medical governance information to doctors and plan to implement an SOP for doctors working at other organisations.

We will build working relations with recruitment colleagues, to ensure we capture all new starters.

5.5 How do you train your appraisers?

All doctors wanting to become an appraiser are required to attend the New Appraiser Training webinar facilitated by MIAD.

5.6 How do you Quality Assure your appraisers?

The Trust's Clinical Appraisal Lead facilitates a bi-monthly appraiser support group. All appraisers are expected to attend one support group per year, and this is monitored by the Medical Appraisal and Revalidation Team.

At the end of each appraisal, the doctor must complete a feedback questionnaire. The results are compiled anonymously, and a report is sent to the appraiser at the end of the appraisal year. If anything flags up on the system such as or low/poor scores, the Clinical Appraisal Lead will look at this in more detail and will discuss with the appraiser.

During the next appraisal year, we will be undertaking an audit of appraisal input and output forms. Following this, we plan to review the findings and implement any workstreams as necessary.

Several of the Trusts appraisers are due to complete the appraiser refresher training, which will be implemented during the coming appraisal year.

5.7 How are your Quality Assurance findings reported to the board?

Medical Workforce updates are provided to the Strategic People Committee.

5.8 What was the most common reason for deferral of revalidation?

The most common reason for deferral of revalidation was due to outstanding multi-source feedback exercises and incomplete appraisals. We have struggled this year with the reallocation of doctors to new appraisers, mostly due to workload and capacity of existing appraisers. We are now actively registering doctors for a new multi-source feedback exercise in year 3 of their revalidation cycle which has had a positive response.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

Included within the appraisal policy, is a flowchart for non-engagement. This policy is sent to all doctors that are overdue their appraisal.

All doctors are sent an email from the Trust's inbox, 3 months, 2 months, 1 month, and the month of their appraisal. The doctor's appraiser is also copied into the email for

information. The electronic appraisal system sends the doctor a generic email with similar reminders during the same timescale.

If a doctor fails to engage with the appraisal process, we will proceed through the non-engagement flow chart, and they would be required to meet with the Responsible Officer.

All emails are kept for auditing and time-line purposes, should we need to take additional action and refer the doctor to the GMC revalidation team.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

There are a number of policies and processes in place that include -

- Whistleblowing
- Speaking out safely
- Datix
- Serious Untoward Incident's
- Respect and Dignity at work
- Medical Appraisal Revalidation policy

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

This would depend on the process the concern has been raised through, e.g., disciplinary/respect at work process would be discussed at the ER scrutiny committee which is then fed through to the Board.

6.3 How do you ensure that any concerns are managed with compassion?

Managers are coached on the handling of situations and difficult conversation. The Trust has launched a 'Just Culture' across the organisation and pastoral and wellbeing support is offered as per policies and processes.

During 2023-2024, the Trust will take part in the Compassionate Conversation pilot scheme.

6.4 How do you Quality Assure your system for responding to concerns?

Regular case review meetings take place alongside the ER Scrutiny Committee and Strategy Group. We always adhere to policy and process.

From September 2023, the introduction of a Strategic Case Review Meeting and a Medical Case Review Meeting will allow us to discuss and review our ongoing cases, with senior colleagues and counterparts from Southport and Ormskirk.

6.5 How is this Quality Assurance information reported to the board?

Information is reported to the ER Scrutiny Committee which includes a Non-Executive Director.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

When a doctor joins our Trust, we request completion of a Responsible Officer to Responsible Officer form. Should any comments be included in the transfer form, they are escalated to the Medical Appraisal and Revalidation Governance Lead and to the Responsible Officer.

If a doctor reconnects to a new organisation, we will send the new Responsible Officer a transfer form.

If a doctor leaves the Trust but has not yet connected to a new Designated Body, we will wait for the transfer form to be requested.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The Medical Director and Responsible Officer of St Helens & Knowsley, meets with the GMC ELA quarterly to discuss any concerns about our doctors.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

A total of three additional roles were created within the Medical Workforce Team – Medical Workforce Professional Standards and Governance Lead, Medical Appraisal, Revalidation and Governance Lead and Medical Workforce Administrator. The roles are currently being embedded into the team and allowing us to expand the services we offer.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

From mid-late 2023, there will be an introduction of two new meetings – Strategic Case Review and Medical Case Review Meetings. Also in attendance at these meetings, will be counterparts and colleagues from Southport and Ormskirk.

The new governance roles will be fully embedded into the team and all vacancies within the team will be filled by mid-2023.

We will be undertaking a number of audits to identify any patterns and trends to help us with our communication and to further develop and enhance the support we offer to our doctors.

Section 7: Employment Checks

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

St Helens & Knowsley Teaching Hospitals adhere to the NHS Safer Recruitment Standards.

Do you collate EDI data around recruitment and /or concerns information?

Yes
Initial data is reviewed and reported as part of the MWRES process. Internally, EDI data is locally analysed for trends and action plans would be devised accordingly. During 2023 – 2024, we plan to further evaluate the EDI data and use this to create new workstreams and to build working relationships with the Trust EDI team.

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

The Trust has a Service Level Agreement with Willowbrook Hospice which will be reviewed during 2023-2024.
St Helens & Knowsley Teaching Hospitals NHS Trust will merge with Southport and Ormskirk Trust to create a new Trust.
We will being working collaboratively with colleagues and counterparts from Southport and Ormskirk with immediate effect so will need to review workflows, roles and responsibilities.
St Helens & Knowsley are currently using an electronic appraisal system, which was extended for 1 year, until July 2024. This will need to be reviewed in late 2023, early 2024. Southport and Ormskirk currently use an inhouse system, and a decision will need to be made on how both legacy organisations move forward to a new system.

Section 9: Statement of Compliance:
The Board of St Helens & Knowsley Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body -
Deputy Chief Executive

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

Name: ……. Anne-Marie Stretch ……

Role: …….Deputy Chief Executive……..

Date: …… September 2023…….……..

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	27 September 2023
Agenda Item	**MWL TB23/032 (9.2)**				
Report Title	**S&O Medical Appraisal and Revalidation Annual Report 2022/23**				
Executive Lead	Dr Peter Williams, Executive Medical Director /Responsible Officer				
Presenting Officer	Dr Kate Clark, Director of Strategic Clinical Reconfiguration				
Action Required	X	**To Approve**		**To Note**	

Purpose

The purpose of this paper is to assure the Board that appropriate processes are in place to ensure that the Trust is compliant with its legal obligations as per **'The Medical Profession (Responsible Officers) Regulations 2010'** (amended 2013) and continues to provide a robust medical appraisal and revalidation system.

All responsible officers have been requested to present an annual report to their Board, using '**The Framework of Quality Assurance for Responsible Officers and Revalidation**' (FQA) template and submit a '**Statement of Compliance**' to the Higher-Level Responsible Officer at NHS England.

Executive Summary

As of 31 March 2023, Southport and Ormskirk NHS Trust was the 'designated body' for 245 doctors. During the appraisal cycle 83.3% of doctors completed a medical appraisal in line with GMC requirements. The reasons for incomplete or missed appraisals are as below:

APPRAISAL CYCLE		**2019/20**	**2020/21**	**2021/22**	**2022/23**
Number of doctors at 31.03.2023		**199**	**222**	**235**	**245**
Appraisals completed		190 (95.5%)	146 (65.77%)	205 (87.23%)	**204 (83.3%)**
Approved missed	sickness/mat/other	9 (4.5%)	47 (21.17%)	9 (3.83%)	**12 (4.9%)**
	new starters	0	28 (12.61%)	21 (8.94%)	**28 (11.4%)**
Unapproved missed/late appraisal (i.e., Not authorised by RO)		0 (0%)	1 (0.45%)	0 (0%)	**1 (0.4%)**
Total		**199**	**222**	**235**	**245**

Financial Implications

None

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to approve the contents of the report and sign off the 'Statement of Compliance' for submission to NHSE.

Strategic Objectives

	SO1 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety

	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

NHS England North West
Medical Directorate
Professional Standards Team

Southport and Ormskirk Hospitals

2022-2023 Annual Submission to NHS England Northwest:

Appraisal and Revalidation and Medical Governance

Contents

Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

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

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

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Please note: This report is in relation to Southport and Ormskirk NHS Trust for the period covering April 2022 to Mar 2023. From 1st July 2023 the Trust merged with St Helens and Knowsley NHS Teaching Hospitals to become Mersey and West Lancashire Teaching Hospitals NHS Trust.

2022-2023 Annual Submission to NHS England Northwest:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Section 1: General

Name of Organisation:	**Southport and Ormskirk NHS Trust**
What type of services does your organisation provide?	**Acute Provider**

	Name	Contact Information
Responsible Officer	Dr Peter Williams	peter.williams3@sthk.nhs.uk
Medical Director	Dr Peter Williams	peter.williams3@sthk.nhs.uk
Medical Appraisal Lead	Mr Kevin Thomas	kevin.thomas@nhs.net
Appraisal and Revalidation Manager	Ann Higgin	ann.higgin@nhs.net
Additional Useful Contacts	Dr Kate Clark (RO for reporting period)	kate.clark11@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: Queenscourt Hospice

Although Queenscourt Hospice is a separate designated body, the Trust provides a responsible officer for the hospice given the small number of doctors employed (7). The hospice is provided with a separate board report and the Trust provides appraisal support for the hospice under a formal Service Level Agreement.

Please describe arrangements for Responsible Officer to report to the Board:

The Responsible Officer presents the annual report at the Queenscourt Council Meeting in September and then the signed Report and Statement of Compliance are forwarded to NHS England.

Date of last RO report to the Board: 20th September 2022

Action for next year: Continue the same process.

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below. *(GMC registered doctors only).*

Total number of doctors with a prescribed connection as of 31 March 2023?	**245**	
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	204	
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	12	Sick/Mat/other
	28	Recently joined
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	1	
Total number of appraisers as of 31 March 2023?	48	

*A missed appraisal is an appraisal that is not completed, and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

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

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	**52**
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	49
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	2
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	1
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	**1**
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	**1**
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**0**
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	**0**

Organisational Policies

List your policies to support medical appraisal and revalidation	**Implementation date**	**Review date**
'Medical Appraisal and Revalidation Policy' MED STAFF 14	July 19	Current
'Maintaining High Professional Standards in the Modern NHS' (MHPS) MED STAFF 01	July 19	Current

List your policies to support MHPS and managing concerns	**Implementation date**	**Review date**
Maintaining High Professional Standards in the Modern NHS' (MHPS) MED STAFF 01	July 19	Current

Other relevant policies	**Implementation date**	**Review date**

How do you socialise your policies?
Internal intranet
Referenced on relevant documents (e.g., appraisal form)
Medical Leadership Team Meeting
Appraiser Support Forum

Section 4: General Information

The board / executive management team can confirm that:

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

Yes
During the reporting period Dr Kate Clark was the Responsible Officer (RO) for Southport and Ormskirk NHS Trust. Following the merger on 1st July 2023, Dr Peter Williams was appointed Responsible Officer for the new trust (Mersey and West Lancashire Teaching Hospitals NHS Trust). Dr Williams has undertaken the required RO training programme and as per other Responsible Officers will undertake an annual appraisal by an external appraiser appointed by NHSE (NHS England).
Action for next year (1 April 2023 – 31 March 2024) Continue as above.

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

Yes - this will be reviewed following the merger of the two trusts.
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? Revalidation dates are issued to individual doctors by the GMC. The Appraisal & Revalidation Manager receives a monthly report from the HR department, which is cross referenced with the GMC electronic system 'GMC Connect' and any anomalies investigated and amended as necessary. There are also a small number of doctors who are not subject to revalidation as they are governed by the General Dental Council (GDC) which does not yet have a revalidation process in place. These doctors still undergo the same annual appraisal process as those governed by the GMC.

If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024). Not applicable

4.4 Do you have a peer review process arranged with another organisation?

No
If yes, when was the last review? Not applicable

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

All non-training grade doctors holding a contract of employment are supported by the Trust and given the resources to undertake an annual appraisal regardless of whether they are employed as a locum or a permanent doctor. The Risk Department provide the Appraisal and Revalidation Manger with information in relation to complaints, claims, incidents suis etc. for all doctors to enable reflection. Any relevant request for supporting information by a doctor with a prescribed connection to another organisation is provided accordingly.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes partially
The Trust adopted the Appraisal 2020 model which had an increased focus on the health and wellbeing of doctors and continue to review in line with NHSE recommendations. **If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).** Future appraisal models will obviously be dependent on combining the systems for both previous trusts into one system.

5.2 Do you use MAG 4.2?

No
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024). Not applicable

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

- Encouraging more SAS (Specialty and Associate Specialist) doctors to take up the role of appraiser.
- Providing a platform to enable Physician Associates and Anaesthetics Associates to undertake annual appraisal in preparation for GMC regulation in the future.
- Reintroduced Appraiser Support Group meetings following break 20/21
- Upgraded appraisal system on Teams/share point following system issues

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Following the merger of the two hospitals there will be the necessity to review all systems and integrate processes.

5.5 How do you train your appraisers?

As at 31.3.23 there were 48 trained appraisers *(36 consultants / 3 specialty doctors/ 4 Associate Specialists and 5 Locum consultants).* All appraisers need to undertake appraisal training which is currently provided through an external company called MIAD Healthcare Training which are used by several other NHS trusts for such training.

Appraisers are also invited to attend Appraiser Support Groups held twice a year to keep up to date with NHSE/GMC guidance and discuss any difficult cases or scenarios.

5.6 How do you Quality Assure your appraisers?

Quality assurance measures including a process for review of appraisal portfolios are in place.

Following completion of their appraisal, doctors are requested to complete an appraisal feedback form, which includes feedback on their appraisal meeting, resources provided and how the appraiser conducted the meeting. This information is anonymised, and collated for each appraiser who is then provided with an individual '*Appraiser Quality Assurance and Feedback Report'* for them to reflect upon in their own appraisal. Any concerns highlighted are discussed with the RO and any relevant action taken e.g., discussion with appraiser re. retraining etc.

Appendix 1 *contains a summary of the appraisal feedback received.*

Appraisers are required to participate in relevant continuous professional development to maintain their appraisal skills. The trust provides support to appraisers through the '*Appraiser Support Groups'* held twice per year. Group attendance is monitored and recorded on each appraiser's individual annual appraisal summary.

5.7 How are your Quality Assurance findings reported to the board?

The '*Annual Organisation Audit'* (AOA) and '*Annual Board Report'* and *'Statement of Compliance'* form the basis of reporting to the '*Workforce Committee'* before being presented to the Board and then submitted to NHSE. Appraisal completion rates are published monthly.

5.8 What was the most common reason for deferral of revalidation?

Delay in finalising patient feedback. There were two deferrals made during the reporting period. The reasons were discussed with the doctors prior to any deferral recommendation being forwarded to the GMC and supportive plans put in place.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

The Appraisal and Revalidation Manager communicates with the doctor to understand the reasons for delay/non engagement and to provide any assistance. Should there still be concern, the Responsible Officer will communicate with the doctor and arrange to meet to agree an action plan. Any further non-engagement would then follow the GMC process for reporting of non-engagement.

If a doctor is unable to complete an appraisal for whatever reason and can demonstrate engagement with the process, the RO can agree to an '*approved missed appraisal'.* This is confirmed in writing and a signed copy uploaded to the doctor's portfolio to provide an accurate ongoing record of the reason for any appraisal gaps due to non-completion and to ensure no detriment to a doctor's revalidation in the future. Reasons may include ill-health, maternity leave, personal circumstances etc.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS" (MHPS) and other relevant Trust policy are followed.

There is a monthly meeting to review any concerns or performance issues involving the RO, Medical Appraisal Lead, A & R Manager, HRD, and HRBP's. Actions are tracked via this forum.

The RO attends a Serious Incident Review Group on a weekly basis to monitor overall response to serious incidents in the organisation. Actions identified in this group are monitored through the Scrutiny and Assurance Group and can be escalated for further review. Doctors are required to include a reflection on any incidents within their next appraisal.

Quarterly meetings are held between the RO and the GMC's employment Liaison Advisor and A & R Manager to discuss any performance or revalidation issues.

The RO meets with the PPA advisor 4-6 times per year to review ongoing concerns and ensure appropriate support is in place.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

The RO in the organisation is responsible for managing any concerns raised regarding doctors and would involve HR/senior medical management in the organisation as per policy. There are systems in place for reporting and reviewing significant events, complaints, and clinical performance. Openness and reporting of incidents are encouraged. This process is managed through the CBU (CLINICAL BUSINESS UNIT) governance, reporting to a Serious Incident Review Group and a Clinical Effectiveness Committee.

The Board also receives Workforce Racial Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), and gender pay gap reports.

6.3 How do you ensure that any concerns are managed with compassion?

The Trust has a 'Just and Learning' Policy which ensures staff are supported through any concern or investigation.

6.4 How do you Quality Assure your system for responding to concerns?

Concerns relating to doctors are monitored via a monthly MHPS meeting. Reports regarding active investigations are reported via Workforce Committee to Board. Actions from complaints, incidents and claims are monitored via Scrutiny and Assurance Group.

6.5 How is this Quality Assurance information reported to the board?

Workforce Committee reports to Board. MHPS reports by exception to the Executive Management Group. Scrutiny and Assurance via Clinical Effectiveness Committee to Quality and Safety Committee who report to Board.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

RO to RO references are issued and requested as appropriate and RO's communicate between each other if there are any immediate concerns.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The Trust policy MED STAFF 01' Maintaining High Professional Standards in the Modern NHS (MPHS) and other relevant Trust policy are followed e.g. Just & Learning Policy.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

Expanded agenda for MHPS meeting to incorporate all aspects of concerns. Re-instated Appraiser Support Groups and QA process for appraisals.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Sharing good practice within the new merged organisation to develop a single appraisal and revalidation policy which includes a QA process and feedback for appraisers and reporting structure within new governance arrangements.

Section 7: Employment Checks

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

The Trust has an appropriate procedure in place operated by the medical staffing department, for obtaining relevant information when entering a contract of employment with doctors for the provision of services.

Do you collate EDI data around recruitment and /or concerns information?

Yes
If yes, how do you use this information? Information is reported through the WDES & WRES. The Trust has self-assessed against EDS2022 standards. Domain 2; Workforce health & well-being rated 6 'Developing Activity.

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

The engagement of doctors and the support from appraisers at Southport and Ormskirk hospitals remains very positive towards appraisal and revalidation, despite some challenges with the internal appraisal system over the past couple of years, which have now been rectified. This is evidenced in the appraisal feedback received. With the trust merger and pending progression to a new appraisal system this will hopefully continue to reduce the administrative burden on doctors and enhance the positive medical appraisal culture that has developed over the years.

Section 9: Statement of Compliance: ***(Southport and Ormskirk Hospitals)***

The Board / executive management team –of **Mersey and West Lancashire Teaching Hospitals NHS Trust** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body [(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Mersey and West Lancashire Teaching Hospitals NHS Trust**

Name:
……

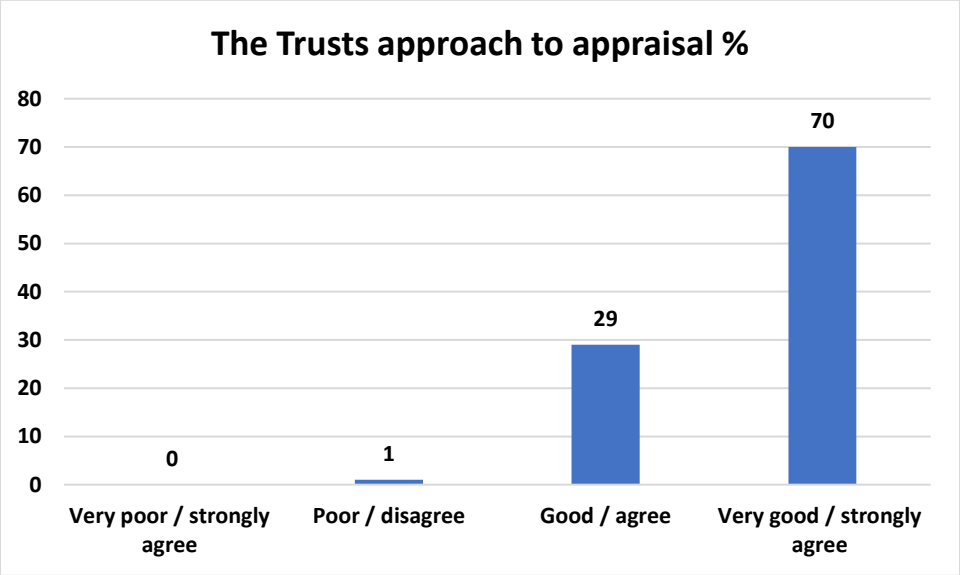
Role:
……..

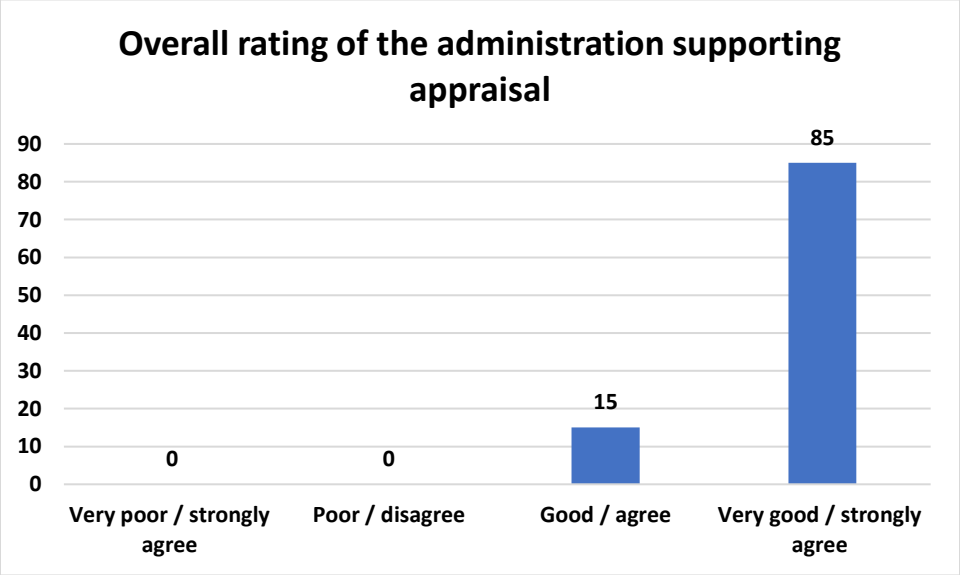
Date:
……..

APPENDIX 1 Medical Appraisal and Revalidation Annual Report 2022/2023

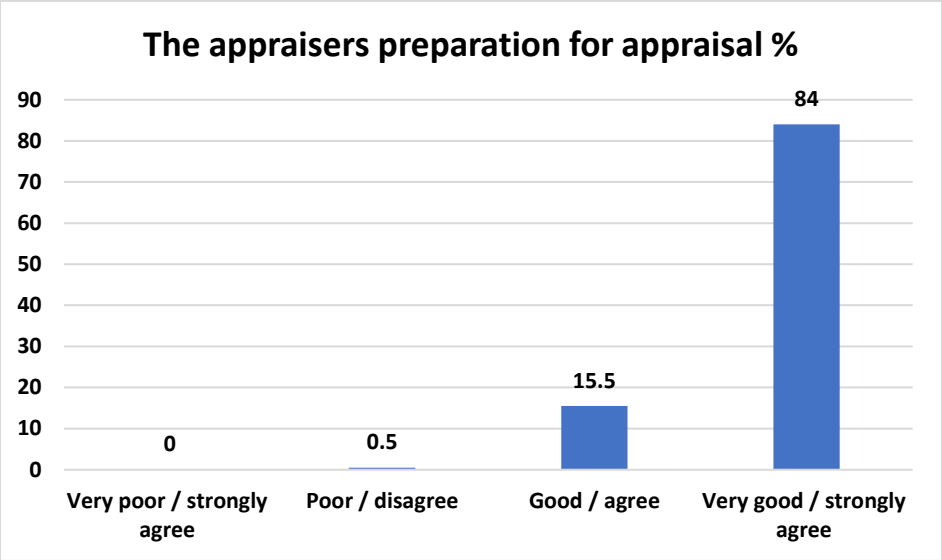
APPRAISEE FEEDBACK SUMMARY - SOUTHPORT AND ORMSKIRK HOSPITALS

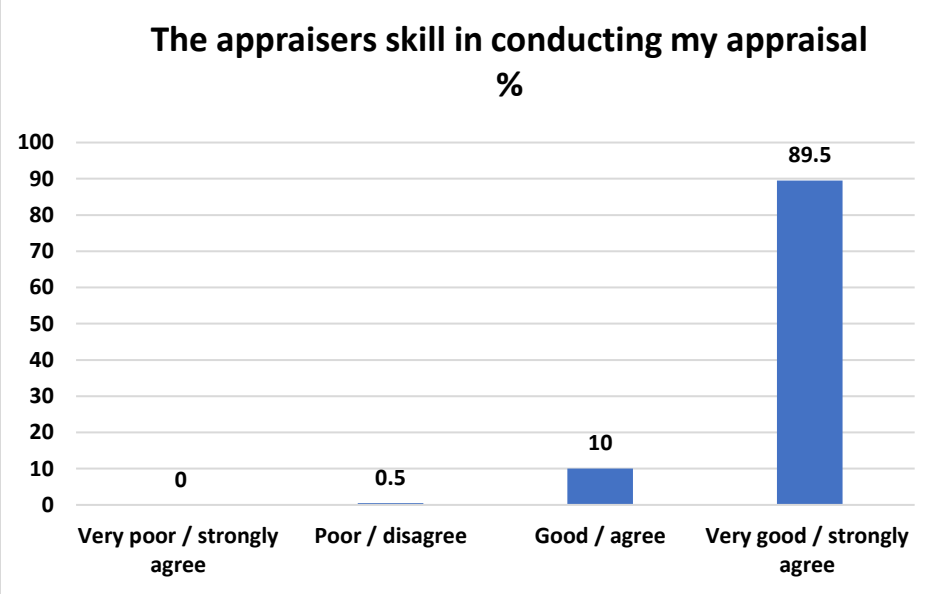
1. Overall Summary

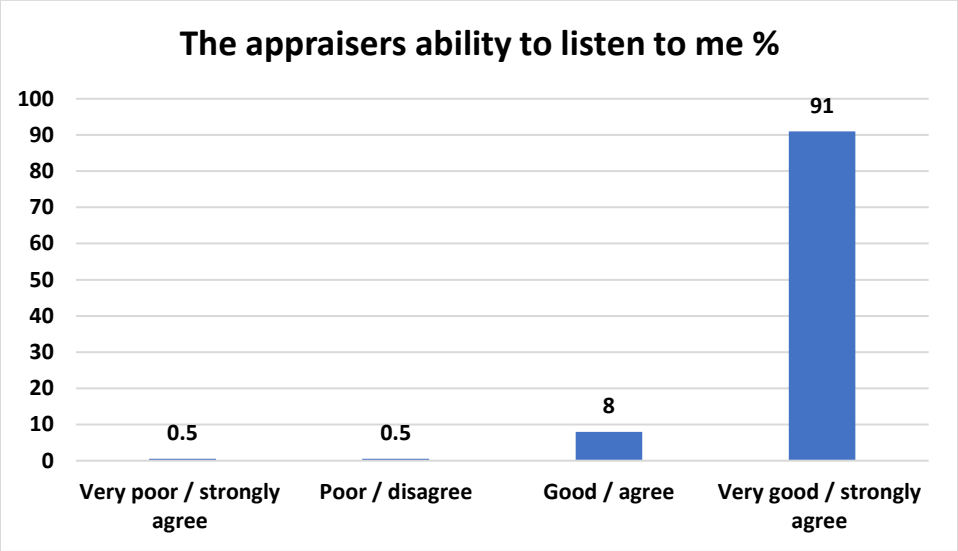


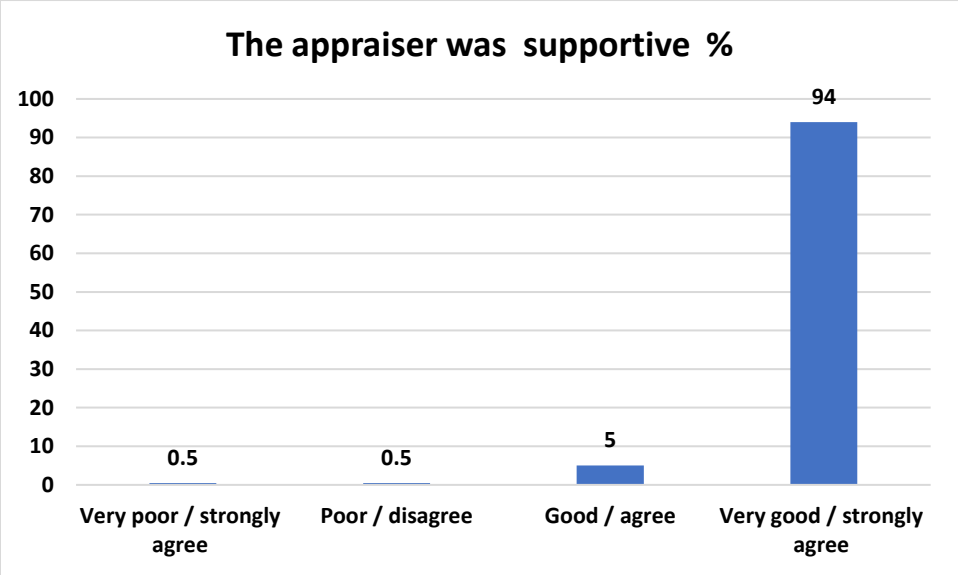


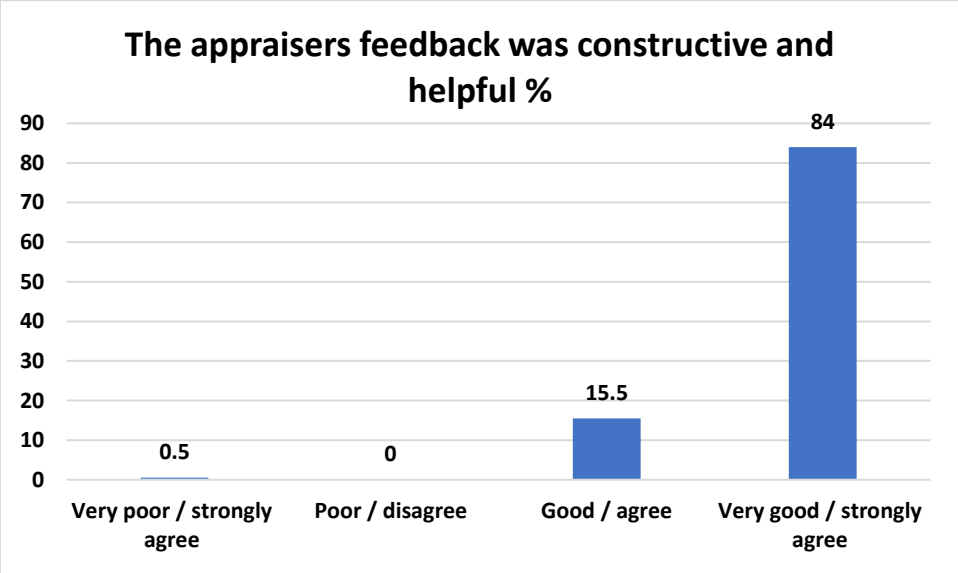
1.1 Appraisers

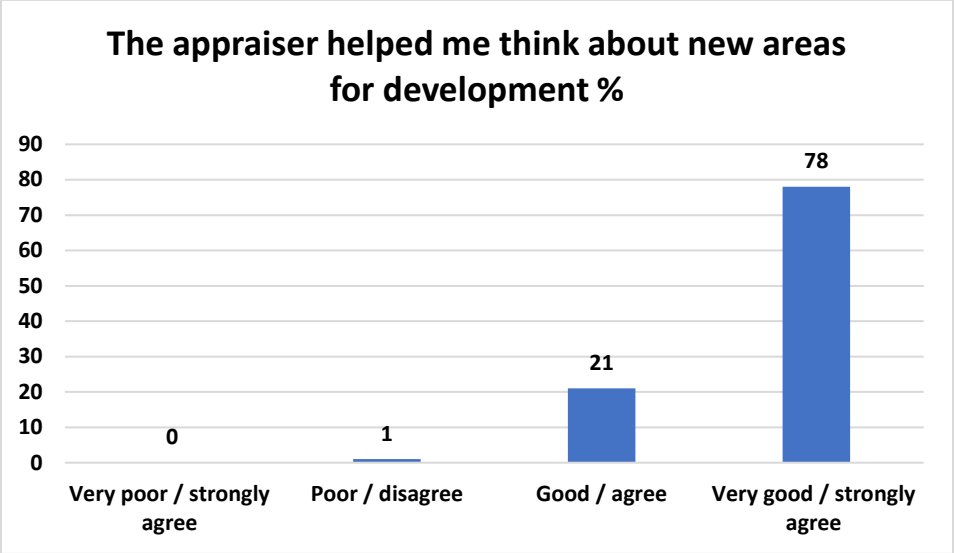


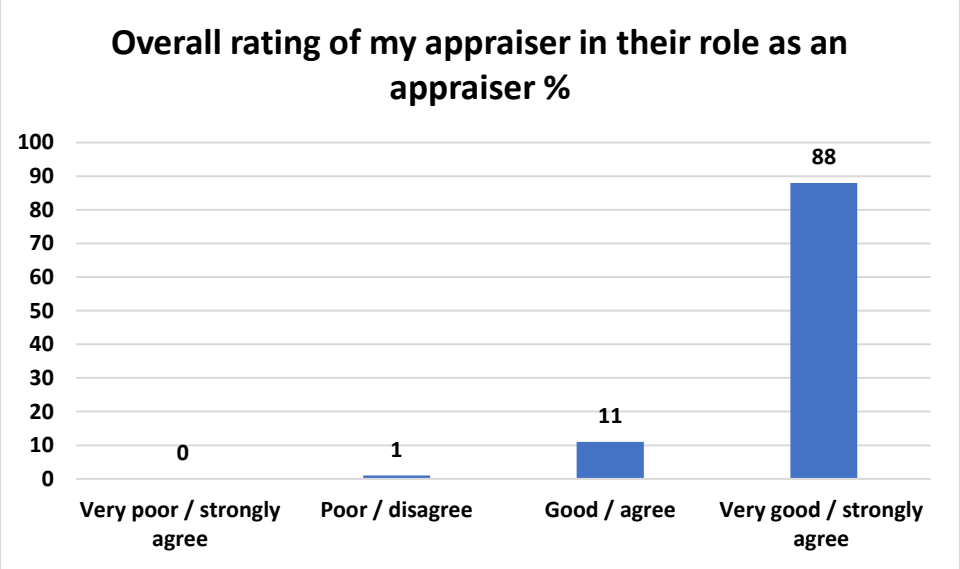



The appraisers ability to listen to me %
100
90
80
70
60
50
40
30
20
10
0
0.5
0.5
8
91
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree

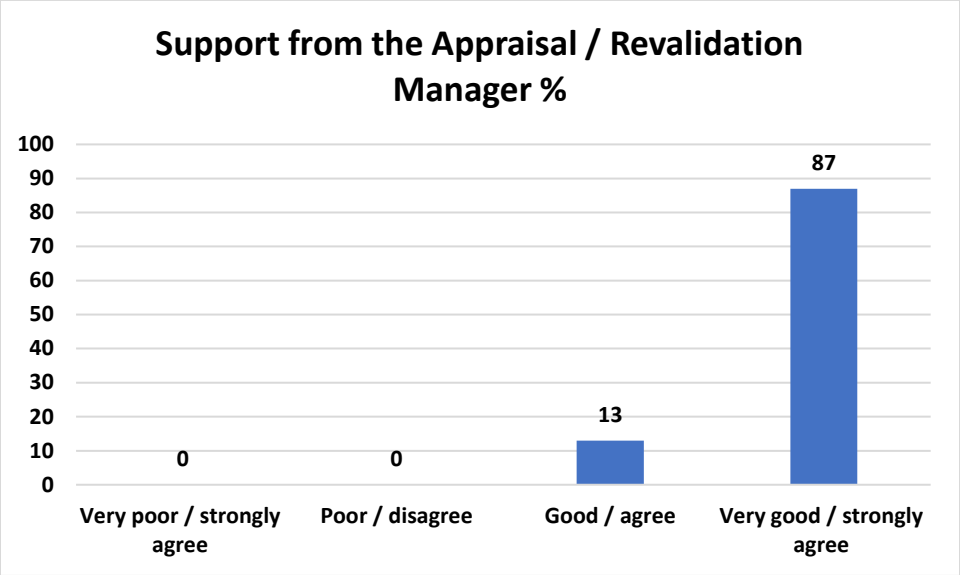

The appraiser was supportive %
100
90
80
70
60
50
40
30
20
10
0
0.5
0.5
5
94
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree

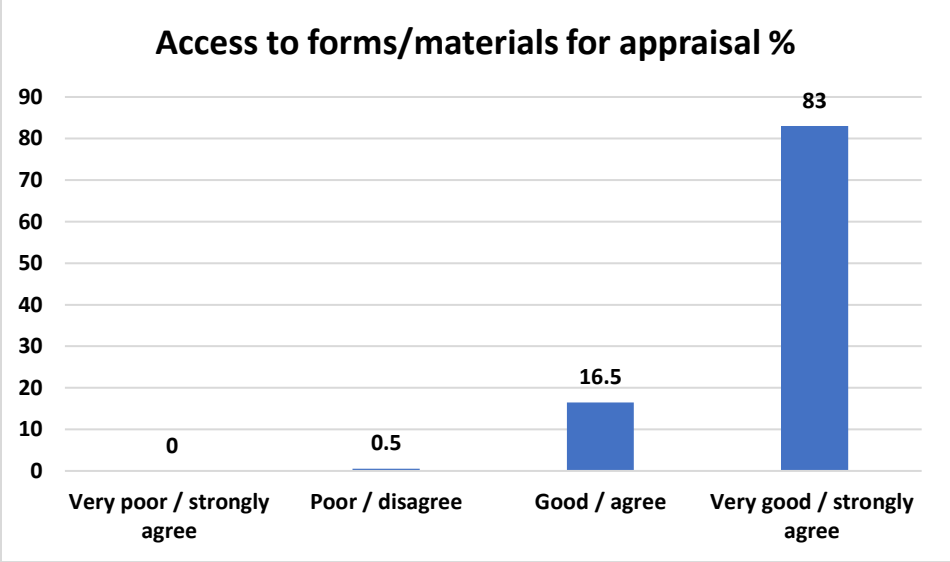

The appraisers feedback was constructive and helpful %
90
80
70
60
50
40
30
20
10
0
0.5
0
15.5
84
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree

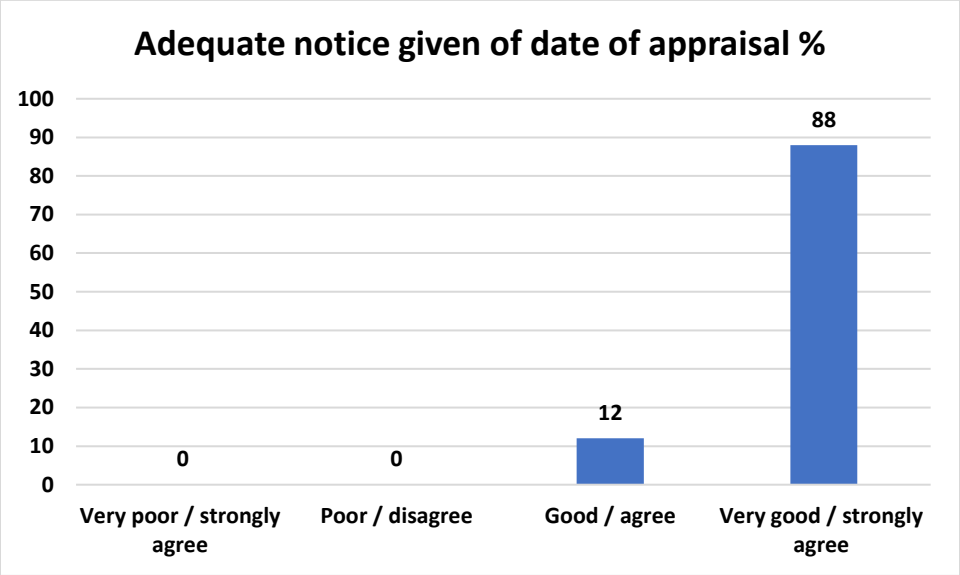

The appraiser helped me think about new areas for development %
90
80
70
60
50
40
30
20
10
0
0
1
21
78
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree

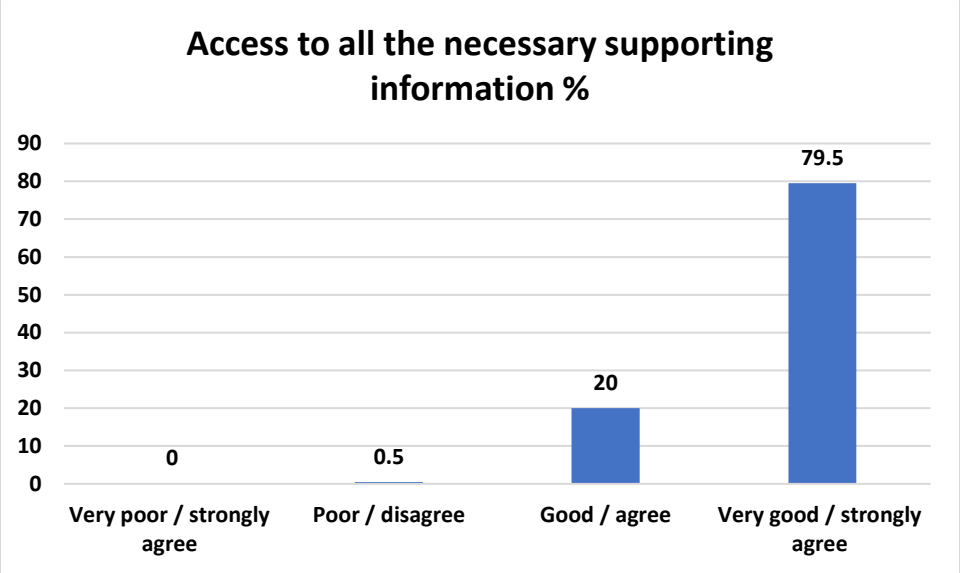

Overall rating of my appraiser in their role as an appraiser %
100
90
80
70
60
50
40
30
20
10
0
0
1
11
88
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree

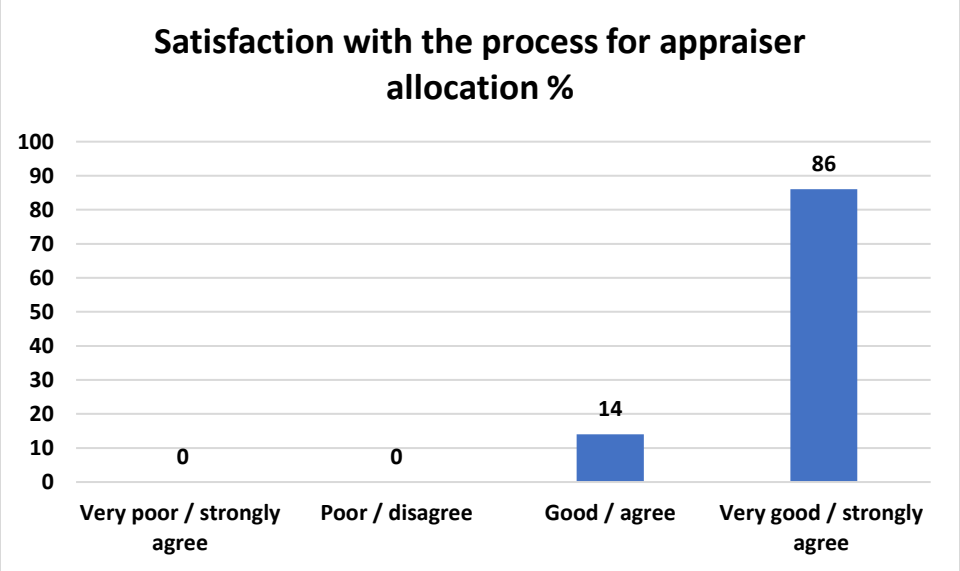
1.2 Administration of Appraisal






Adequate notice given of date of appraisal %
100
90
80
70
60
50
40
30
20
10
0
0
0
12
88
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree


Access to all the necessary supporting information %
90
80
70
60
50
40
30
20
10
0
0
0.5
20
79.5
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree


Satisfaction with the process for appraiser allocation %
100
90
80
70
60
50
40
30
20
10
0
0
0
14
86
Very poor / strongly agree
Poor / disagree
Good / agree
Very good / strongly agree

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/033 (10.1)**			
Report Title	**STHK Emergency Preparedness, Resilience and Response (EPRR) Annual Report (April 2022 to March 2023)**			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Lesley Neary, Chief Operating Officer (obo Sue Redfern)			
Action Required	X	**To Approve**		**To Note**

Purpose

To approve legacy STHK Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022-23

Executive Summary

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be presented to the governing committee which will ultimately report to Trust Board.

Once approved, the EPRR Annual Report be retained as evidence for the Core Standards Self-assessment process.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to approve the 2022/23 STHK Emergency Preparedness, Resilience and Response (EPRR) Annual Report.

Strategic Objectives

	SO1 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) STHK ANNUAL REPORT 2022/2023.

1. Executive Summary

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be produced for the Trust Board to assure them that the organisation is meeting its obligations.

This report will cover the period 1 April 2022 to 31 March 2023.

Responsibility for Resilience within the UK sits with the Civil Secretariat. Failure to meet the set-out obligations can lead to prosecution via relevant Government agency. NHS England oversees the arrangements within NHS England organisations and provides assurance to the Local Resilience Forum via the Local Health Resilience Partnership. This body of work is known as Emergency Preparedness, Resilience and Response (EPRR).

The role of NHS England relates to potentially disruptive threats and the need to take command of the NHS, as required, during emergency situations. These are wide ranging and may be anything from extreme weather conditions to outbreak of an infectious disease, a major transport accident or a terrorist incident. There continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing risk and hazard landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the trust must be prepared for. It is essential that there is a continued focus on the Trust's EPRR and business continuity arrangements and that the Trust maintains and continues to contribute towards the region's preparedness.

The Trust must be able to continue to deliver key services during times of disruption as part of the wider health economy. In doing so it must ensure patient and staff safety and consider stakeholder considerations.

This report aims to update the Board on progress in this matter and sets out how the Trust meets its obligations. The Trust is required to have an up-to-date Major Incident Plan and Business Continuity Plan. These must be updated following a major incident, exercises and/or other learning**.**
The Trust has a mature suite of plans to deal with major incidents and business continuity issues. These conform to the civil contingencies act (2004) and current NHS-wide guidance. All plans have been developed in consultation with local and regional stakeholders to ensure cohesion with their plans. Throughout the year the plans have been reviewed, any changes to plans must be tested / exercised to ensure they are fit for purpose.

The responsibility for EPRR sits within the portfolio of the Director of Nursing, Midwifery and Governance. The work is managed on a daily basis by the EPRR Manager and supported by a designated Consultant in the Emergency Department. The work programme is managed through the EPRR Group, which is chaired by the Director of Nursing. The group meets monthly with representatives from across the organisation and reports directly into the Risk Management Council. During 2022-23 a new EPRR Manager post was successfully appointed to.

2. LEGAL OBLIGATIONS

As a Category 1 responder, the Trust has the following legal obligations:

a) Co-operation with other responders
b) Risk Assessment
c) Emergency Planning
d) Communicating with the public
e) Sharing information
f) Business Continuity Management

Ways that the Trust is meeting these obligations are listed below:

a) Co-operation with other responders

The Trust is represented by the DoNM&G and EPRR Manager at the Local Health Resilience Partnership (LHRP) Strategic and Tactical meetings and relevant subgroups.

The Trust has participated in various exercises and meetings with multi agency partners, including NHS England, provider Trusts, commissioners and other partners including the Police, Fire Service and NWAS.

On 29 November 2022, the ICB arranged a Tabletop exercise - Exercise Arctic Willow. This involved all Trusts in the Cheshire & Mersey region. The aim of the exercise was to explore the health response to multiple concurrent operational and winter pressures in England and the interdependencies with Local Resilience Forum partners in responding to these pressures. The pressures consisted of:

- Potential medical supply disruption.
- Energy supply disruption.
- Adverse winter weather
- Prolonged and significant industrial relations action including strikes.
- Reduced staffing numbers resulting from multiples concurrent operational issues and winter pressures.

As part of the exercise, EPRR arrangements were reviewed which included the practicalities of mutual aid from resilience partners, business continuity arrangements and options available to maintain patient flow.

Key Managers from the Trust participated in the preparation for Arctic Willow and the EPRR Manager was in attendance on the day.

b) Risk Assessment

Under the CCA 2004 the Trust has a statutory obligation as a Category 1 responder “from time to time to assess the risk of an emergency occurring” (CCA 2004 Part 1, Section 2).

EPRR risk assessments are completed in line with the National Risk Register (NRR) and Community Risk Registers (CRR) and apply to any risk to our patients, staff and premises or at-risk areas. EPRR is included in the Trusts Board assurance framework (BAF).

Pandemic Influenza remains the top national risk, followed by Cyber Attack, Climate Change (ie, Flooding, Heatwave, etc) and Loss of Critical Infrastructure (ie, national power loss, water, and bleep outage).

There is also a Local Resilience Forum (LRF) Community Risk Register which shows that the highest risks are the same as those on the National Risk Register.

Any items of concern or risk to the Trust will be received at the EPRR meeting and added to the Trust Risk Register if required. This is discussed at RMC.

c) Emergency Planning

The Major Incident Plan and the Business Continuity Management Plan require Board approval. Emergency Plans are reviewed three yearly as a minimum and shared with multi agency partners. Once developed, plans are exercised to ensure they are fit for purpose.

With effect from 29 March 2023 the UK Covid-19 alert level system was suspended. The suspension of the system reflects the transition to Living with Covid-19 and this has been achieved due to the success of the vaccination programme and availability of treatments for those who need them.

The UK Health Security Agency (UKHSA) continues to track the latest Covid-19 epidemiology through numerous surveillance systems.

The Trust's Vaccination Centre at St Helens Rugby grounds and Nightingale House sites were dismantled on 23 April 2022.

d) Communicating with the public

The Trust continues to explore ways of communicating with the public. Social media has enormous potential to help the NHS reach patients and service users who do not use traditional communications and engagement channels. During the year, the Trust has used a range of methods to communicate with the public, including local radio, local TV, local press, Facebook, Twitter, and a public facing Trust website.

e) Sharing information

Under the CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of co-operation.

The Trust receives alerts from an online private network called Resilience Direct, which is run by the Cabinet Office and enables civil protection practitioners to work together, across geographical and organisational boundaries, during the preparation, response and recovery phases of an event or emergency. The network helps organisations fulfil their obligations under the Civil Contingencies Act to co-operate and share information to ensure that action is co-ordinated.

f) Business Continuity Management

The Trust Business Continuity Management Plan is updated as a minimum every three years. This is due to be updated in April 2023 following the transaction with Southport and Ormskirk Hospitals. The plan sets out the framework that the Trust should follow when responding to disruption in line with legal obligations and EPRR guidance. Wards and Departments are responsible for developing their own plans and updating them annually as a minimum and immediately post incident or if there is a change of service. If support is required, this will be provided by the EPRR Manager.

The Trust experienced disruption to its business continuity through various incidents such as bleep outages, communications, and IT downtime. The Trust is continually looking at ways to minimise the impact these incidents have. Debriefs are held to ensure valuable learning and information to help improve performance. Action plans are drawn up following the debrief to address the issues raised. Incidents are discussed and recorded at the EPRR Group meetings and actions taken as appropriate.

The Trust implemented its Business Continuity Plans (BCPs) on several occasions when planned downtimes were requested and agreed via the EPRR group or the Senior Operational meeting. Additionally, unplanned outages affected a number of areas on occasions across

the hospital sites requiring Wards/Departments to revert to BCPs (see Appendix A).

3.0. Assurance

In accordance with the requirements laid out in the EPRR 2021-2022 Assurance Process Letter (29th July 2022), the overall level of compliance is based on the total percentage of standards that the Trust is fully compliant with against the rating thresholds, The Trusts self-assessment 49 out of 64 Core Standards were declared as 'fully compliant', resulting in STHK receiving an overall EPRR assurance rating of 'Partial' for 2022/2023. STHK receiving a rating of 'Partial' prompted mitigating actions to be implemented in order to address areas of concern, and this has been included in the EPRR Workplan 2022/23. The three main reasons were related to:

1. The number of EPRR Core Standards applicable to Acute Trust is increased this year to 64 (last year they were only 46).

2. Operational pressures and lack of external training related to HAZMAT/CBRN training trainers – previously trained staff were required to attend the National Ambulance Resilience Unit (NARU) 'train the trainer' training. This training is provided by NWAS and has limited places. The Trust has requested places on the next available course and has secured support from the Cheshire and Merseyside EPRR lead to be able to deliver this training in- house.
3. CBRN exercising of the policy.

4.TRAINING

Training and awareness sessions have been held with various groups across the Trust including staff who cover on call at Tactical and Operational levels. Training held within the Trust during the period 1 April 2022 – 31 March 2023 are listed at Appendix A.

5.EXERCISES

A requirement of NHS England Emergency Preparedness, Resilience and Response Core Standards requires Acute Trusts to participate in planned exercises with external partner organisations. Exercises held are listed in Appendix A.

Following the transaction of St Helens & Knowsley (StHK) and Southport and Ormskirk hospitals (now MWL) on 1 July 2023, the EPRR Training and Exercise Plan was produced based on future exercises potentially needing to be aligned with StHK.

In this reporting period a Trust-wide Mass Casualty Tabletop Exercise - Exercise Florence took place (28 September 2022). STHK EPRR lead attended this exercise with External partners from NHS England, Cheshire & Merseyside ICB, NWAS and Merseyside Fire & Rescue Service. The exercise was successful and the feedback from all that attended was extremely positive.

A tabletop evacuation Exercise was held in January 2022 focusing on the Whiston site.
Debriefing from Live Events and Exercises

Following live events and exercises, debriefs are undertaken to capture learning points. Lessons identified from live events and exercises are subsequently incorporated into major incident and business continuity plans and are shared with partner organisations.

6.COMMUNICATIONS

Communication is critical in dealing with any adverse incident. The Trust holds a

communications exercise" Dr M Majax" twice yearly to test communication, this simulates a major incident communications cascade.

7.GOVERNANCE AND OVERSIGHT

The workplan for EPRR is managed through the EPRR Group which reports on progress to the Risk management Council. The workplan and actions are managed within that meeting.

As a Category 1 responder the Trust must report progress and provide assurance with regard to emergency planning to Trust Board.

8.PARTHERSHIP WORKING Partnership

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Local Health Resilience Partnership

RECOMMENDATIONS

In line with our legal obligations as a Category 1 responder to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place, the Trust Board is asked to acknowledge this Annual Report on Emergency Preparedness, Resilience and Response (EPRR).

The arrangements the Trust has in place as outlined in this Annual Report are in line with our legal obligations as set out in the Civil Contingencies Act 2004 and NHS England EPRR guidance.

ENDS

APPENDIX A

Incidents, Exercises and Training between 1 April 2022-31 March 2023.

	Incidents
04.04.22	St Helens Hospital Bleep voice messages not going out
06.06.22	MRF Interagency Communications Capabilities & Guidance update and submission
13.07.22	Bleep outage at St Helens Hospital
19.07.22	EPMA down time
10.08.22	Aintree Hospital incident – electric fire in Plant room impacting their ED and Crit care
17.09.22	Request for mutual aid regarding increase in CAHMS patients and impact on bed availability at Whiston paediatric wards
17.09.22	Electric supply test
17.09.22	Exercise black start generator test
11.10.22	EPMA planned down time
13.10.22	PRPS audit
Oct 2022-March 2023	Cyber security alerts (monthly)
15.11.22	Regional EPRR Energy Resilience Working Group: BCPs and Fuel Shortage Plans
20.11.22	Core switch upgrade
05.12.22	Start of increase in Group A Strep (GAS) attendances at Pead's ED
27.12.22 02.01.23	Trust and regional full capacity Opel 4 declared
26.01.23	Chartered Society of Physiotherapist Industrial Action.
18-19. 01.23	RCN IA
6-7.02.23	RCN IA
14-16. .03.23	Junior Doctors Industrial Action.

Exercises

Date	
28.01.22	Tabletop evacuation exercise
28.04.22	Loggist Train the trainer delivered by NHSE
June 22	Multiple session re CBRN and decontamination (Tent)
Sept 22	GM on call training
Sept 22	Multiple session re CBRN and decontamination
Sept 22-March 2023	External Strategic and tactical EPRR training (PHE) monthly session for on call staff
28.09.22	Major Incident Tabletop exercise at Bliss Southport
0ctober 22	PRPs Training
20.11.22	Loggist Training
27.11.22	Exec and GM EPRR legal training
22 .11.22	LHRF Strategic exercise
18-19.23	RCN IA: Loggist and ICC Command and Control Live exercise
6-7.02.23	RCN IA: Loggist and ICC Command and control Live Exercise
12.02.23	PRPs and decontamination
14-16.03.23	Junior Doctors Industrial Action: Loggist and ICC command and control Live Exercise

APPENDIX B

Summary of 2022/23 Self-Assessment

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

Acute Trusts	Compliance Level	Fully compliant standards	Partially compliant standards	Non-compliant Standards	Overall compliance percentage
STHK	Partial	49	14	1	77%

Title of Meeting	**Trust Board**	**Date**	27 September 2023
Agenda Item	**MWL TB23/033 (10.2)**		
Report Title	**Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2022/23**		
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance		
Presenting Officer	Lesley Neary, Chief Operating Officer (obo Sue Redfern)		
Action Required		**To Approve**	X **To Note**

Purpose

The Trust's annual statement of compliance with EPRR national core standards to be approved by Trust Board, prior to submission to the Integrated Care Board (ICB).

Executive Summary

Under the Civil Contingencies Act 2004 NHS Acute Providers are Category 1 responders, subject to the full set of civil protection duties. To demonstrate compliance with these duties, Acute Providers must meet the NHSE Core Standards for EPRR and, in line with contractual requirements, the Trust is required to provide to NHS England (by submission to the Integrated Care Board) an annual assurance of compliance with the Core Standards, with a 2023-24 submission deadline of 29/09/2023 comprising key documents of:

a) Statement of compliance.
b) EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.
c) Actions taken

The NHS core standards for EPRR are the basis of the assurance process. This year Domain 10 (CBRN) of the core standards have been reviewed and will also incorporate updated interoperable capabilities standards.

Amongst the backdrop of several concurrent issues, not least the ongoing industrial action, whilst delivering a major recovery plan for urgent and emergency care service, the ability of the NHS to remain resilient and responsive over a sustained period is due to our collective commitment to emergency preparedness, resilience, and response (EPRR).

All NHS organisations must undertake a self-assessment against the 2023/24 updated 62 core standards relevant to their organisation. The outcome is required to be taken and discussed at a public board.

MWL's self-assessment against the 62 EPRR core standards indicates compliance with 49 out of 62 Core Standards, 52 are fully compliant, 6 partial compliant and 4 non-compliant which is an 84% partial compliance rating.

ICBs are required to work with their commissioned organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice.

NHS England regional heads of EPRR and their teams are to work with ICBs to agree a process to obtain organisation-level assurance ratings and provide an environment that promotes the sharing of learning and good practice across their region.

All evidence to support the trust self-assessment must be uploaded to the EPPR portal and this will be discussed at the check and challenge meeting to confirm compliance rating. A new requirement for this year is that staff who are Executive or General managers on the on-call rota are required to complete the NHSE strategic / tactical command training and provide a portfolio of reflection and evidence that they meet the Minimum Occupational Standards document identifies the following National Occupational

Standards/Skills for Justice (NOS/SFJ) competencies.

NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

The full statement of compliance has been provided in Appendix A.
A summary of the Trust position against each standard is attached in Appendix B.

A comprehensive EPRR workplan for the period 2023/24 has been developed to address and mitigate all the Core Standards which are currently marked as "non or partially compliant" and to maintain the status of full compliance where this has been achieved.

Financial Implications

None directly as a result of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to approve the Trust's statement of compliance with EPRR national core standards.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

2023-24 STHK EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE CORE STANDARDS SELF-ASSESSMENT

1. INTRODUCTION

The purpose of this report is to provide the MWL self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2023-24.

2. CONTEXT

The Civil Contingencies Act 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2022 underpin EPRR within health. Both Acts place EPRR duties on NHS England. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with NHS England EPRR guidance.

Under the CCA 2004 Acute Providers are Category 1 responders, which are recognised as being at the core of emergency response and are subject to the full set of civil protection duties including: risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

The minimum requirements Acute Providers must meet are set out in the NHSE Core Standards for EPRR, which are in accordance with the above-mentioned Acts. In line with contractual requirements the Trust is required to provide an annual assurance of compliance with the Core Standards, with a 2023-24 submission deadline of 29/09/23 comprising key documents of:

a) Statement of compliance.
b) EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.

This year, following the publication of new guidance relating to EPRR in July 2023, there are a total of 64 standards applicable to Acute Providers, and additionally a ‘deep dive’ is to be conducted to gain additional assurance into a specific area, which is, and a deep dive was undertaken against the 13 core standards although these do not contribute towards the overall Trust compliance level.

The core standards cover 10 domains:

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing
- Cooperation
- Business Continuity
- Chemical biological radiological nuclear and hazardous material

3. COMPLIANCE

In 2022-23 Southport and Ormskirk self-assessment with the core standards declared that out of 64 areas applicable to acute trusts, the Trust were complaint with 62. This provided a substantial compliance rating.
STHK for the same period declared partial compliance based on 49 out of 64 Core Standards were declared as 'fully compliant', resulting in STHK receiving an overall EPRR assurance rating of 'Partial' for 2022/2023

UKHSA have indicated due to the change in standards and requirement for training, Trust are not expected to be fully compliant against the standards.

As a new organisation MWL have undertaken a self-assessment of the revised EPRR core standards. Based on MWL self-assessment; 49 out of 62 Core Standards, 52 are fully compliant, 6 partial compliant and 4 non-compliant which is an 84% partial compliance rating the 4 area of non-compliance are:

1. Standard 14: Need to create Mass Countermeasures Plan following lessons identified from Mass Vaccination Centres
2. Standard 16: In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site. This is in progress.
3. Standard 18**:** Business continuity pans have been audited externally with Post Audit Reports, audit programme is reported to board showing oversight of issues raised.
4. Standard 51: Hazmat/CBRN risk assessments and impact assessments are in progress and not yet completed and tested.

The areas of partial compliance relate to:

- Standard 6: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered. All relevant staff are booked to attend however some sessions have been cancelled due to the impact of a number of industrial actions.
- Standard 16: Evacuation and shelter plans, S&O site plans in date and tested regularly (last exercise 11/09/2023). Draft MWL Plan currently under review.
- Standard 25: Staff Awareness & Training, Training Booklet in place, exercising and % compliance need to be reported to Trust board.
- Standard 39: Mutual aid arrangements. Following MWL transaction need to review mutual aid arrangements.
- Standard 40: " Documented and signed information sharing protocol includes sharing of information during an incident.
- Standards 65 and 66 relate to CRBNe exercising and training.

On going actions are in place to achieve compliance in all standards

It is to be noted that most of the areas of improvement are linked to the staffing issues that have impacted the EPRR function in the course of the last year in terms of review, update and test of plans and policies currently in use. A process of harmonizing polices across sites has been conducted.

The full statement of compliance has been provided in Appendixes A and B.

Actions to address all the partially compliant standards are in place overseen and will be monitored via the MWL EPRR Working Group to ensure delivery, with assurance to the Risk Management Council being provided regularly by the Head of EPRR. Cascade of actions will be undertaken through the EPRR governance structure reporting into the risk management Council.

4. RECOMMENDATIONS

The Trust Board are asked to note and approve MWL EPRR statement of compliance for 2023-24 stating partial compliance noting the actions that will be taken to address the area of partial compliance .

End

Appendix A

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

- Mersey and West Lancashire Teaching Hospitals NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.
-
- Where areas require further action, Mersey and West Lancashire Teaching Hospitals NHS Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

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

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

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

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

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

Appendix B

Version Control
2.1 28/07/23

Please choose your organisation type

Acute Providers

Generate Action Plan

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	8	1	2	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	2	2	0	3
Business continuity	10	9	0	1	1
Hazmat/CBRN	12	9	2	1	7
Total	**62**	**52**	**6**	**4**	**11**

Compliance	84%
Overall Assessment	**Partially Compliant**

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	9	1	0	0
Total	**10**	**9**	**1**	**0**	**0**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/034**			
Report Title	**Protecting and Expanding Elective Capacity Declaration**			
Executive Lead	Lesley Neary, Chief Operating Officer			
Presenting Officer	Lesley Neary, Chief Operating Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

The purpose of this paper is to seek approval from the Board to submit the Trust's response in relation to protecting and expanding elective capacity declaration request from NHS England.

This declaration has been considered in detail and approved at Executive Committee and Finance and Performance Committee in September 2023.

Executive Summary

In May 2023 NHS England wrote to NHS acute trusts outlining the priorities for elective and cancer recovery for the year ahead.

This was further reiterated in July 2023 in a letter in relation to winter planning with an ask for NHS acute trusts to maintain as far as possible ring fenced elective and cancer capacity through winter.

In August 2023, NHS England wrote again to NHS acute trusts outlining the requirement to further consider the protecting and expansion of elective capacity, specifically in relation to outpatient capacity and transformation.

The letter set out 3 key priorities for NHS acute trusts:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that Referral to Treatment (RTT) rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

NHS acute trusts are asked to provide assurance against a key set of activities and undertake a self-certification process signed off by Board that will drive outpatient recovery at pace. A draft was requested to be submitted by 14 September 2023 with a final sign off from Board by the end of September 2023.

This paper sets out our external response to the board checklist which has been approved at Executive Committee and Finance and Performance Committee and it is recommended to Board that this is approved for submission.

Financial Implications

Request to NHS England to validation and communication.

£301k (including onboarding costs) for data validation and £125k for roll out of the interim IT solution to communicate with patients.

Quality and/or Equality Impact
No impact

Recommendations
The Board is asked to approve the final submission in relation to protecting and expanding elective capacity declaration.

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

PROTECTING AND EXPANDING ELECTIVE CAPACITY

27th September 2023

Lesley Neary
Chief Operating Officer

Summary

Key Area		Assurance Level
1a.	Data Quality Reports and the use of LUNA/RAIDR Systems (national systems) to address data quality Issues	**Yes**
1b.	Plans in place to communicate & validate 90% patients waiting over 12 weeks.	**Partial**
1c.	Ensures that the RTT rules and guidance and local access policies are applied, and actions are properly recorded.	**Yes**
1d.	Report received on non-RTT patients and has built the necessary clinical capacity into operational plans.	**Partial**
2a.	Signed off the ambition that no patient in the 65 week 'cohort' will breach 65+ weeks wait will be waiting for a first outpatient appointment after 31st October 2023.	**Yes**
2b.	Signed off the trust's plan to ensure that Independent Sector capacity is being used here necessary to support recovery plans.	**Yes**

Key Area		Assurance Level
3a.	Report on current performance against submitted planning return trajectory for outpatient follow-up reduction.	**Yes**
3b.	Plans to increase the use of PIFU to achieve a minimum of 5%.	**Partial**
3c.	Plan to reduce the rate of missed appointments (DNAs) by March 2024.	**Yes**
3d.	Plan in place to increase the use of specialist advice (advice and guidance).	**Partial**
3e.	Identified outpatient transformation priorities focussed on maximising clinical value and minimising unnecessary touchpoints for patients.	**Yes**

Support Required?

Support Required from NHS England
There are some key risks to delivery of this ambition including any further impact of industrial action, any further potential Covid admissions and an increase in non-elective demand as we head into winter. The delivery of the ambition, the risks and the mitigations are discussed at a CBU/Care Group level with escalation through to the CBU/Care Group Finance and Performance Committee (F&P) then to the appropriate committees (Trust F&P and Quality) and then received at Board. Support the 2 financial requests for validation & communication £301k (including onboarding costs) for 17.4 x WTE data validators (across validation and communication) £125k for roll out of the interim IT solution to communicate with patients

APPENDICES

(1) Validation

Key Area		Assurance Level	Narrative
1a.	Data Quality Reports and the use of LUNA/RAIDR Systems (national systems) to address data quality Issues	**Yes**	From October 2023 the IPR will include a suite of data quality metrics in line with those reported in the LUNA system. Whilst the Trust transitions to the new clinical divisional structure appropriate governance remains in place to ensure the delivery of safe clinical services across the CBU's/Care Group's across the two legacy Trusts. PTL management remains a key area of focus for each of the legacy Trust's CBU's/care groups. There is also two key forums that review data quality across the CBU's/Care Group – Information Stands Group/Data Quality Group.
1b.	Plans in place to communicate & validate 90% patients waiting over 12 weeks by 31st October 2023	**Partial**	The Trust is in the process of aligning key digital systems. This includes how we communicate with patients. Both sites are working together to ensure processes are in line with the digital validation toolkit. The Trust will continue to communicate with our longest waiting patients first. Current resource will deliver this ambition by March 2024. However, with additional resource requested of c£300k, the Trust will aim for full compliance ahead of March 2024. With additional resource of c£125k the solution used at STHK could be rolled out across S&O until the implementation of the Patient Engagement Portal (PEP).
1c.	Ensures that the RTT rules and guidance and local access policies are applied, and actions are properly recorded.	**Yes**	Both legacy trusts have a robust set of Standard Operating Procedures (SOPs) and policies in place to ensure the effective and consistent management of clinical pathways which includes communicating with patients. These SOPs and policies are in place to ensure the appropriate oversight and management of processes and workflows, including the management of data quality. Across both legacy trusts, weekly PTL meetings are held which provide an appropriate structure for the management of patient pathways. Involved in the work across C&M in alignment of patient access policies, led by the C&M COO group.
1d.	Report received on non-RTT patients and has built the necessary clinical capacity into operational plans.	**Partial**	The clinical risk for non-RTT patients is managed at an individual specialty meeting level and discussed at the monthly specialty meetings and then through CBU/Care Group governance meetings to Clinical Effectiveness and Quality Committee. Standard Operating Procedures are in place describing the risk stratification process. Chair reports are then received at the monthly CBU/Care Group Clinical Governance meetings which are then reported through Clinical Effectiveness Committee, Quality Committee and then Board.

(2) First Appointments

Key Area		Assurance Level	Narrative
2a.	Signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' will be waiting for a first outpatient appointment after 31st October 2023	**Yes**	Both legacy Boards approved the Trust activity plans for 2023/24 which signed up to the ambition of having no patients waiting over 65 weeks by 31st March 2024 and have an ambition to ensure that all patients with the potential to breach 65+ weeks have had a first outpatient appointment by 31 October 2023. There are some key risks to delivery of this ambition including any further impact of industrial action, any further potential Covid admissions and an increase in non-elective demand as we head into winter.
2b.	Signed off the trust's plan to ensure that Independent Sector capacity is being used here necessary to support recovery plans.	**Yes**	Both legacy Boards approved the Trust activity plans for 2023/24 which included the use of independent sector (IS), insourcing, outsourcing or mutual aid (where relevant) to support the delivery of these activity plans. There are a number of specialties across sites utilising insourcing and completing work through local IS hospitals. The Trust has digital mutual aid system (DMAS) representatives who engage with the regional and national teams as needed.

(3) Outpatient Follow Ups

Key Area		Assurance Level	Narrative
3a.	Report on current performance against submitted planning return trajectory for outpatient follow-up reduction.	**Yes**	Both legacy Boards approved the Trust activity plans for 2023/24 which included the activity for outpatient follow-ups in 2023/24. Performance against plan is monitored through Financial and Planning Committee (F&P) which is presented to Board monthly.
3b.	Plans to increase the use of PIFU to achieve a minimum of 5%.	**Partial**	Both legacy Boards approved the Trust activity plans for 2023/24 which included the ambition of increasing the use of PIFU to a minimum of 5% within 2023/24 across all specialties. Both sites have Outpatient Transformation groups which have plans in place. At STHK, a PIFU working group has been implemented which reports into its Outpatient Transformation Group with the ambition of increasing the use of PIFU.
3c.	Plan to reduce the rate of missed appointments (DNAs) by March 2024.	**Yes**	To support a reduction in DNAs the Trust is completing a review of its text messaging service to ensure that all patient details are accurate to ensure that reminder texts are sent prior to appointments. The increasing use of PIFU will also support a reduction in DNA rates by offering alternative pathways to regular attenders. Health Inequalities data is being reviewed to try and determine the root causes of DNAs to plan mitigations and support attendance. SOPs and processes will ensure that patient DNAs are managed in line with the Trust's local Access policies which will be aligned across C&M when the C&M COO group have approved the collective policy.
3d.	Plan in place to increase the use of specialist advice (advice and guidance).	**Partial**	Both legacy Boards approved the Trust activity plans for 2023/24 which included the ambition of increasing specialist guidance. The Trust utilises Specialist Advice via eRS and implementation across all areas will be completed in Q3. Further to this, the Trust utilises RAS systems in some areas which allows triage and returning the referral to GP with advice. Model Hospital data is used as a benchmarking tool across all specialties.
3e.	Identified outpatient transformation priorities focussed on maximising clinical value and minimising unnecessary touchpoints for patients.	**Yes**	The Outpatient Transformation group monitors progress against the outpatient improvement plans. Previous work completed includes the redesign of rheumatology and haematology clinic services ensuring patients were seen quicker, and the pathways were streamlined. Current work includes the implementation of Best Practice Timed Pathways within prostate, bladder, colorectal. Future schemes include tele-dermatology pilot, using A&G and CDC pathways.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/035**			
Report Title	**Patient Safety Incident Response Plan 2023/24**			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Peter Williams, Medical Director (on behalf of Sue Redfern, Director of Nursing, Midwifery and Governance)			
Action Required	X	**To Approve**		**To Note**

Purpose

To provide the Trust Board, a draft of Trust's Patient Safety Incident Response Plan for review and approval, the plan will be supporting implementation of Patient Safety Incident Response Framework (PSIRF).

Executive Summary

Patient Safety Incident Response Framework (PSIRF) replaces current Serious Incident Framework and makes no distinction between "patients safety incidents" and "serious incidents". The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work. All NHS organisations are required to confirm plans and commence transition to PSIRF by 01 October 2023 .

The purpose of this paper is to seek approval of the Patient Safety Incident Response Plan by the Trust Board.

This patient safety incident response plan sets out how Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) intends to respond to patient safety incidents over a period of 2023/24. The plan is made up of two elements – national guidance which sets priorities which safety incidents must be investigated in-depth, and a local plan, which has been developed by our Trust and details additional patient safety incidents for investigation. Our plan details how we will respond to patient safety incidents and how and when investigations will be carried out, in a proportionate manner.

The plan was developed in collaboration with a wide range of stakeholders across the Trust. The patient safety incident risks for this organisation have been profiled using organisational data on safety and existing improvement projects. The plan will be supported by patient safety incident response framework and policy.

Financial Implications

No direct financial implication expected.

Quality and/or Equality Impact

No impact on quality or equality expected as a direct consequence.

Recommendations

The Trust Board is asked to review the contents of the report and supporting information and approve Patient Safety Incident Response Framework Response Plan.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and process for responding to patient safety incidents, for the purpose of learning and improving patient safety. PSIRF will replace the Serious Incident Framework, with all organisations expected to transition to PSIRF by Autumn 2023.

The purpose of this paper is to seek approval of the Patient Safety Incident Response Plan by the Trust Board.

2. Background

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.

Its intention is to support the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

While some events and issues will arise which will require a special type of response as dictated by policies or regulations (such as the Never Events or learning from deaths criteria), the PSIRF helps organisations conduct investigations relevant to their context and the populations they serve. Investigation into incidents will not be based on the harm caused in the event, but by the potential for learning and improvement. Requirement to report incidents on StEIS will cease with adoption of PSIRF.

3. Priorities

The PSIRF approach is designed to be flexible and adapt as organisation to learn and improve, so they explore patient safety incidents relevant to organisation and risk identified. As part of this change, organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes.

A key part of developing the new national approach is to understand the amount of patient safety activity the trust has undertaken over the last 5 years. Trust PSIRF plan (Appendix-1) was drawn using data and triangulation from a variety of sources including incidents, complaints, claims, patient experience, Freedom to Speak, staff consultation exercise and through insight and involvement of Patient Safety Specialists. This information gathered was shared and discussed with the PSIRF Implementation Team. As part of this a review of all incidents reported between April 2018 and March 2023 were carried out, along with a review of all Serious Incidents reported as per the Serious Incident Framework, to identify recurrent theme, improvement plans in place and continued risk.

MWL plan details how we will respond to patient safety incidents and how and when investigations will be carried out, in a proportionate manner. The plan is made up of two elements – national

guidance which sets priorities which safety incidents must be investigated in-depth e.g. Never events/ HSIB and other nationally mandated safety incidents, and a local plan, which has been developed by the Trust which details additional patient safety incidents for detailed investigation.

It is estimated that approximately 50 -70 incidents per year will require comprehensive Patient Safety Incident Investigation (PSII) across NWL, comprising of 30-50 incidents identified as local priorities requiring PSII include issues with care of deteriorating patients, unsafe discharges, misdiagnosis, cancer pathway gaps, unexpected deaths, medication incidents with significant learning, falls with significant learning, category 3 pressure ulcers with significant learning and areas of emerging themes of risk. Additionally, 20 nationally mandated PSII is estimated, this incudes category red mortality reviews, never events, screening program incidents, maternal and child death etc.

4. Changes

4.1. Framework

Under the current Serous Incident Framework (SIF), level and indepthness of investigation into patient safety incidents are determined by level of harm caused. Serious harm or death caused as a result or contributed by the incident are required to be reported on StEIS and required to undergo a Level 2 investigation using Root Cause Analysis methodologies.

PSIRF represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. Unlike the current Serous Incident Framework (SIF), the PSIRF is not an investigation framework that prescribes what to investigate. There is no distinction made between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Incidents of any nature are no longer required to report incidents on StEIS (Appendix 2).

Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to investigating and learning are balanced with those needed to deliver improvement. This means that organisations can choose which incidents they prioritise for a full investigation, with detailed Patient Safety Incident Investigation (PSII) and learning response based on system review, and those incidents which they will respond to differently – for example, by conducting a multidisciplinary review, patient safety reviews (PSR) or facilitated debrief.

4.2. Investigation methodology

In the current SIF Framework, methodology of investigation used is predominantly based on Root Cause Analysis.

PSIRF will utilise detailed exploratory review of the incident using approaches similar to currently used by Health Service Investigation Bureau (HSIB) to demonstrate a system-based approach utilising tools like SEIPS framework (Systems Engineering Initiative for Patient Safety). That is, an approach which includes consideration of all the factors that influence including impact of systems on the causation of incidents.

4.3. Team

Under current SIF framework, incidents reported on StEIS were investigated by various clinical and non-clinical members with expertise with Root Cause Analysis. The process relies heavily on senior clinicians and nurses, undertaking reviews in their allotted management time.

Implementation of PSIRF is proposed to be operationalised by centralising a new investigation team under the Trust Patient Safety Team structure. The team of independent highly trained investigators will lead and support PSII (Level 2) investigations. The investigators will have received training on Human Factors, National Patient Safety Syllabus Level 1 and 2, HSIB Investigation Training at appropriate levels, training on interview techniques and on patient liaison role.

Divisions and Directorates will continue lead, conduct, and support all Patient Safety Responses – Concise Investigation (Level1), After Action Reviews, Debrief sessions and other forms of learning responses. (Appendix 3)

4.4. Duty of Candour

Duty of Candour will continue to be provided as per current process and requirement. Trust will continue to provide and comply with Duty of Candour procedures in the event of any harm identified, meeting Duty of Candour threshold.

4.5. Patient and Family involvement

Under SIF, the Trust actively engage with patient and family in understanding their concerns, however the scope of involvement with investigation is comparatively limited to the opportunities described in PSIRF.

Engagement and involvement of those affected by patient safety incidents is key to PSIRF. Patients and family will be involved with Patient Safety Incident Investigation (PSII) at the very early onset, supported by a nominated Patient Safety Liaison officer. Patient and family will influence Terms of Reference of the investigation. PSIRF would support patients and families to inform of their perspective of the incident – both from a causal point of view, as well as from how/ what improvements can be brought about in the future. Interviews with patients and family members will be conducted by trained investigators.

A key role of investigation team and Patient Liaison Officer is to support patients and families with questions, queries, and emotional support.

An information leaflet has been developed to support and inform patients and families through PSIRF, setting out expectations, support they will receive through the course of investigation and contact details (Appendix 4).
In the current SIF process, families will receive approved investigation reports. However, in PSIRF process, patients and families may be invited to review investigation reports in draft format, before finalisation.

4.6. Time for investigation

Under the current SIF, StEIS reported incident investigation are completed within 60 working days, unless agreed with Commissioners if any additional time is required to complete complex investigation.

In the PSIRF framework, due to indepthness, time frame for investigations is negotiated with patient or family members and aimed to be completed at the earliest possible. All investigations are to be expected to be completed in 3 months, to a maximum of 6 months at the latest.

4.7. Staff involvement

Under SIF, staff members are required to provide statements to support investigation procedures.

In PSIRF, staff members involved in the incident will have greater involvement in the review, by provision of detailed written statements, as well as being able to describe in documented structured interviews. Staff members will be able to elaborate on aspects of human factors, which may have influenced their practice.

4.8. Governance

Under the current SIF framework, all incident investigation report concluded for incidents reported on StEIS system, are approved by designated Trust Executive Lead (DoN). The report and action plans are then scrutinised by the commissioners. Upon receipt of satisfactory assurance from the Trust, commissioners close the incident on StEIS.

Governance for PSIRF is delegated to PSIRF executive lead, with an overarching responsibility for quality or patient safety. This framework places the responsibility for the sign-off of locally led PSIIs with the Executive Lead or appropriate panel. MWL has established weekly Patient Safety Panel chaired by MD and DoN, supported by Patient Safety Specialists as part of sign-off process of learning response and appropriate assurances. A governance process for managing incidents and investigations has been developed in a Divisional structure (Appendix 3).

Reports about incidents, trends and investigations carried out will be continued to be provided to Trust Governance Committees i.e., Quality Committee and The Trust Board.

4.9. Reporting

Under current serious incident framework, incidents resulting in severe harm and death and those meeting SIF criteria are reported on National StEIS system, providing alerts and information to NHSE and CQC.

Under PSIRF, there will not be a requirement to report any incidents on StEIS. NHSE will be able to review all patient safety incidents reported on the new incident reporting platform, Learning from Patient Safety Events (LFPSE) which will replace NRLS system in October 2023. One notable exception is the death of a patient detained under the Mental Health Act, which must be reported directly to CQC.

4.10. Infection Prevention incidents

Under the current SIF, all IPC incidents are investigated using a standardised RCA / PIR template.

However, in accordance with NHSE guidance issued, once an organisation transitions to the PSIRF the current rules governing responses to healthcare acquired infection (HCAI), i.e., to conduct a PIR and/or RCA, will no longer apply.
Instead, responses to a suspected HCAI will be guided by the organisation's patient safety incident response plan. Trust IPC and Patient Safety team have already commenced codesign of Patient Safety Response process for HCAI.

5. Recommendation

Trust Board is requested to review and approve MWL Patient Safety Incident Response Plan 2023-24. The plan identifies key areas where detailed exploration of patient safety incidents which will allow potential learning and improvement. Implementing the PSIRF will allow for deeper understanding of patient safety incidents to better understand the system-factors that contributed to the infection; thus, helping organisation identify and make meaningful improvements in its objective of delivering 5 Star Patient Care.

Mersey and West Lancashire
Teaching Hospitals
NHS Trust

Patient Safety Incident Response Plan 2023-2024

Foreword

The Patient Safety Incident Response Framework (PSIRF) is a new approach to how the NHS will respond and learn from Patient Safety Incidents. This is a new process to investigate incidents and learn from them when they occur; a marked cultural shift in our approach to systems, protocols, and thinking. Working closely with families, patients, and staff this new framework will support us to make changes to ensure incidents that have occurred may be prevented from happening again.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patients Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at Mersey and West Lancashire Teaching Hospitals NHS Trust to prepare for "go live" with PSIRF.

PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents. PSIRF promotes a proportionate approach to responding to patient safety incidents.

Under the new PSIRF framework, each organisation internally determines the type of incidents to be investigated, based upon local risks, trends and priorities for highest impact.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better, means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how Mersey and West Lancashire Teaching Hospitals NHS Trust will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve patient safety incident investigations (PSIIs) by:

- Refocusing Patient safety incident investigation (PSII) towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents.

Aidan Fowler, National Director of Patient Safety, NHS England – "The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. "

A note from Mersey and West Lancashire Teaching Hospitals Executive Director of Nursing, Midwifery and Governance and Trust PSIRF Executive

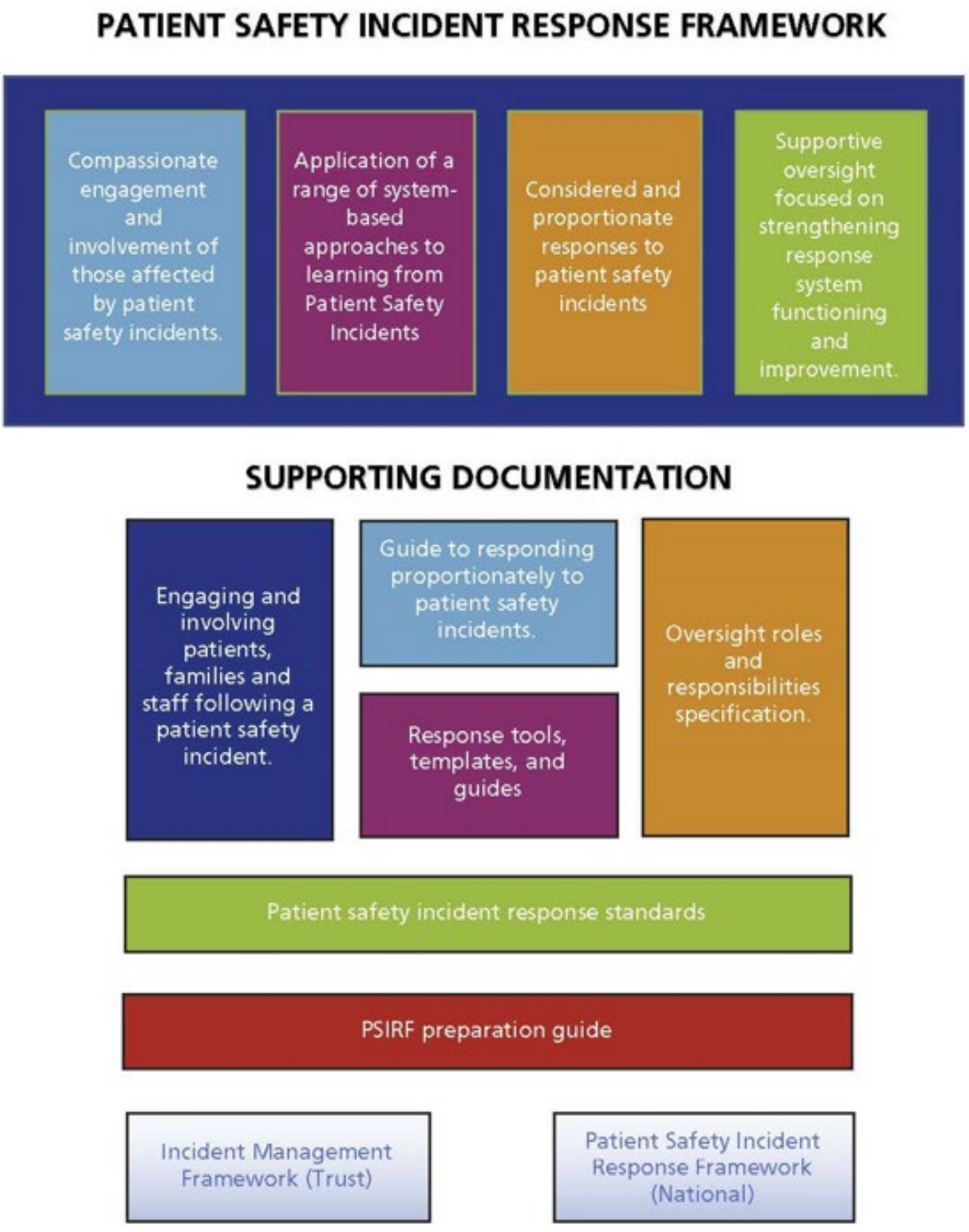
I am proud to introduce our plan for the management of investigations under the new Patient Safety Incident Response Framework. The Trust has worked hard to develop this plan. We will embed this new framework into our existing safety processes and ensure we have developed the right team, tools, and response to managing these investigations.

As part of the review, we have undertaken in the Trust, we have consulted with staff, patients, specialists, and our data to create our 'local priorities' which will be the indicators to when we will conduct a Patient Safety Incident Investigation. This investigation will be done, using methodology which we have adopted to support incident investigation and ultimately support us in learning from that event, putting things right and ensuring that there are mechanisms and risk management to stop it from happening again.

I hope this plan provides you an insight into how we will conduct these investigations in the future and evidence the care for our patients, our staff, and delivering 5-star care across Mersey and West Lancashire Teaching Hospitals NHS Trust.

Sue Redfern

Overview of the Patient Safety Incident Response Framework



Who we are?

Mersey and West Lancashire Teaching Hospitals NHS Trust provides healthcare in hospital and the community to people across St Helens, Knowsley, Halton, Liverpool Southport, Formby and West Lancashire.

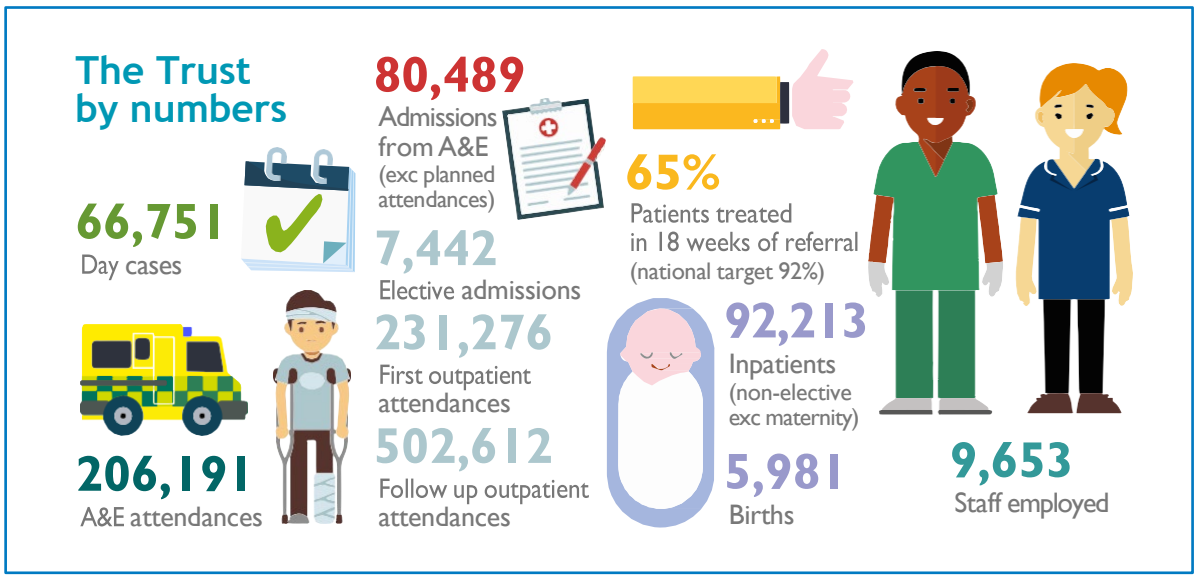
Acute care is provided at Southport and Formby District General Hospital, Ormskirk District General Hospital, Whiston Hospital, St Helens Hospital and Newton Hospital.

This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities.

In addition, the Trust hosts the Mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital. The Trust provides the Mid-Mersey Hyper-Acute Stroke Unit (HASU) and the Mersey Regional Burns and Plastic Surgery Unit, Northwest Regional Spinal Injuries Centre at Southport Hospital and provides specialist care for patients from across the North West of England, North Wales and the Isle of Man.

Women's and children's services, including maternity, are provided at both Whiston Hospital and Ormskirk Hospital.

The Trust also provides an Urgent Treatment Centre (UTC) at the Millennium Centre in St Helens, and Marshalls Cross Medical Centre (primary care services) and intermediate care and community services at Newton Hospital. In addition, the Trust delivers a range of community services, including adult community nursing (for St Helens), Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy, plus outpatient and diagnostic services from a range of other community premises.



This plan intends to be delivered with the existing Trust shared vision, which is:

''To provide 5-star patient care to all of our patients across Merseyside and West Lancashire.''

What PSIRF will mean?

PSIRF will replace the Serious Incidents process. This means our incident response will change but PSIRF will allow us further learning and opportunity to make improvements on the back of future incident investigations.

We will respond to Patient Safety incidents using a systems-based approach, removing a 'person focused' approach where the actions or inactions of people or 'human error', are stated as the cause of an incident.

Our Trust Board will have increased accountability and oversight of Patient Safety Incident Investigations.

Our investigations team will be specially trained and have the right skills and knowledge to conduct a Patient Safety Investigation with PSIRF methodology.

We will support Patients, families, and our staff through the process.

How PSIRF is different

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'.

As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate.

PSIRF will:

- Advocate a coordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by the patient safety incidents.
- Embed patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programs. To do so, information is collected from a wide variety of sources, including wider stakeholder engagement.

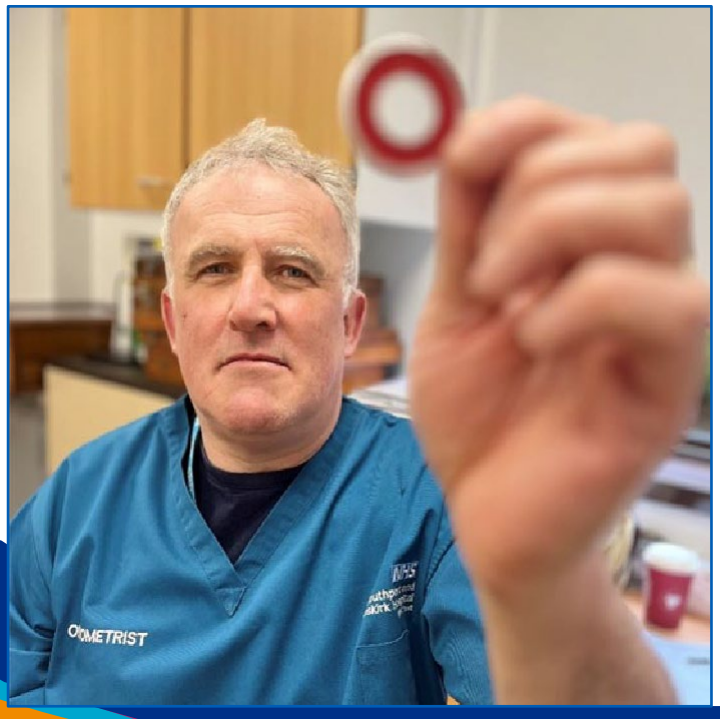
How we have prioritised our incidents and our investigation resource

Mersey and West Lancashire Teaching Hospitals NHS Trust has a developed quality and safety assurance process to ensuring services are safe and effective.

A key part of developing the new approach is to understand the amount of patient safety activity the trust has undertaken over the last 5 years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

A review of the activity associated with patient safety incident investigation for the period 2018-2023, claims, inquests and complaints has been undertaken to determine key priorities. This review has been undertaken by the Trust's Patient Safety Specialists with support and involvement from colleagues, committees, and groups to identify the Trusts local priorities.

A new framework for investigation of patient safety incidents will be established, supported by a team, which will include specialists, investigators and subject matter experts as appropriate. Support will be provided by clinical staff within specialties to ensure patient/family/carers are involved and kept informed of progress.



To improve our ability to deliver against PSII standards, the Trust plan to:

- Assign a team of appropriately trained Patient Safety Incident investigators who have received system-based training on incident investigation methodologies.
- Assign an Executive Team/Board member to oversee delivery of PSII standards and support the sign off, of all PSIIs.
- Develop an incident investigation toolkit to support other Trust staff so they can review patient safety incidents where a PSII is not indicated but learning can still be identified.
- Ensure that the Trust has a Patient Safety Partner to be part of the PSIRF implementation and sub-committees as a patient voice and help shape investigations and learnings.
- Support and provide training to staff to develop and implement tools for Patient Safety Reviews (PSRs) to ensure they reflect current practice and analytical tools for the identification of all causal factors.

How we have prioritised our incidents and our investigation resource (continued)

The Trust used a thematic analysis approach to determine which areas of patient safety activity it should focus on, to establish the local priorities.

Our analysis used several data sources and safety insights from key stakeholders.

The patient safety risk process was a collaborative process to enable us to define the top patient safety risks from incident reporting and then cross reference these from several other data sources including key stakeholders.

The key priorities were defined from this list based on number of Serious Incident investigations conducted and areas where the Trust had existing quality priorities or initiatives in place.

Key stakeholders included:

- Staff from all levels and areas
- Senior Managers within the Trust.
- Patient Safety Specialists.
- Staff from all levels and areas.
- Commissioners.
- Patient Safety Partners.
- Patient Safety teams.
- Healthwatch.
- Cheshire and Mersey ICB

The Trust reviewed five years of data, the sources included:

- Patient safety incident reports.
- Complaints.
- Mortality reviews.
- Claims and outcomes of inquests.
- Trust Risk Register
- Staff survey on patient safety key priorities
- Feedback from Safety groups.

National Priorities for PSIRF

Listed below are the national priorities which will either require a full Patient Safety Incident Investigation (PSII) or the use of an appropriate Patient Safety Tool.

		Event	Approach	Improvement
Patient Safety Incident Investigation	National Priorities	Incidents meeting each baby counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency / organisation as required. Potentially local led PSII.
		Incidents meeting maternal death criteria		
		Child Death	Initiate child death review process	
		Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) programme	
		Safeguarding incidents meeting criteria	Reported to named safeguarding Lead	
		Incidents in screening programmes	Reported to Public Health England (PHE)	
		Deaths of patients in custody, in prison or on probation	Reported to Prison and Probation Ombudsman (PPO)	
		Incidents meeting the Never Event criteria	Patient Safety Incident Investigation Team	Create local organisational recommendations and safety improvement plans. Patient safety investigation will be undertaken.
		Incidents resulting in death (incidents meeting the learning from deaths criteria for PSII)	Patient Safety Incident Investigation Team	
	Trust Priorities	Local organisation PSIRF priorities	Patient Safety Incident Investigation Team	
Patient Safety Review	Local Level	No / Low Harm Patient Safety Incidents	Validation of facts at local level recorded on DATIX	Inform thematic analysis of ongoing patient safety risks at teams, speciality, directorate, division, and trust level. Relevant patient safety tool will be used to investigate incident.
		Moderate and Severe Harm incidents	Statutory duty of candour and appropriate PSR tool	

Our Trust priorities

Listed below are the Trust priorities which will either require a full Patient Safety Incident Investigation (PSII) to learn and improve, these will be conducted by the PSIRF team. Whilst other types of priorities will be investigated by a separate resource or governing body or locally in the Trust by the specialist area the incident occurred in.

INCIDENT TYPE	DESCRIPTION	ACTION
Care of the deteriorating patient	Incidents where the identification of a deteriorating patient has been delay leading to significant impact on patient outcome	**FULL PSII**
Unsafe discharges	Discharges from hospital that have been deemed unsafe and impacted on the patient outcome	**FULL PSII**
Misdiagnosis	Missed or delayed diagnosis that has impacted on patient outcomes, with potential for significant learning	**FULL PSII**
Medication	Medication incident that has significantly impacted on patient outcomes	**FULL PSII**
Pressure ulcers	Hospital Acquired Category 3 pressure ulcers and above, with potential for significant learning	**FULL PSII**
Slips, trips, and falls	Inpatient fall leading to fracture of hip bone, with potential for significant learning	**FULL PSII**
Areas of emerging risk	Based on trend or analysis from the patient safety group, PSII will be conducted on specific areas of risk that have been identified	**FULL PSII**

How we will respond to a patient safety incident under PSIRF

Aside from the national requirements that have been set out, PSIRF sets no further threshold to determine what method of response is required for any patient safety incident.

We have created our local priorities as a Trust with collective data and input from committees, patient safety groups, staff and patients.

When incidents arise, this does not mean that we will routinely investigate all incidents through PSIRF. This could lead to us recreating the old process of the Serious Incident Framework (SIF). Therefore, we have explored other toolkits and methods suggested for reviewing incidents outside of PSIRF and will use these tools in principle for Patient Safety Reviews (PSR).

We may undertake:

- Swarm reviews or team huddles (Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.)
- Rapid reviews
- After action reviews
- Audits
- Structured Judgement Reviews (SJR's)
- Thematic Analysis

Staff that undertake these reviews will be trained and supported to conduct the method of review and set processes/frameworks will be in place to oversee this.

We will have 'ward to board' governance mechanisms in place and subsequent reporting structures to ensure that patient safety incidents and improvement is overseen effectively, and we learn from incidents and ensure the learning is placed back into the organisation.

Involvement of patients, service users, families, carers, and staff during incident investigations

We recognise and acknowledge the impact that patient safety investigations may have on our patients, service users, families, carers, and staff.

The Patient Safety Incident Response Framework has been put in place to ensure that those affected by an incident are engaged with in a meaningful way, shown compassion and ensure they are involved and for those affected to have the ability to understand or ask any questions in relation to an incident.

To ensure that this happens, our organisation will appoint Family Liaison Officers (FLO) who will be trained and supported in giving advice and information during the investigation and supporting those affected.

This will aid our learning and improvements, but it will also allow us to support those affected and ensure that they are kept up to date with the investigation and can contribute towards it.

As a Trust we have worked hard to ensure we move away from a culture of blaming individuals in response to incidents to establishing a well embedded Just Culture. The Trust is committed to ensuring that Patient Safety Incident Investigations are conducted for learning and improvement purposes only.

For staff that are involved in incidents we will ensure that support is at hand when needed. We offer in house training on Human Factors which supports staff around psychological safety at work and offer other forms of patient safety training to ensure we embed a good Patient Safety Culture.

We value our staff and offer additional support from our excellent Health and Wellbeing services and Freedom to speak up services, should they have concerns.

Duty of Candour

Our Trust will ensure we are open, honest, and transparent about a patient safety incident investigation.

This means explaining when something has gone wrong and apologising for it, ensuring there are steps in place to put it right and keeping a secure record of the events. All our staff are accountable to ensure we comply with this, and this is part of their clinical registration.

We will ensure that we maintain the Statutory Duty of Candour for any incident that meets the national threshold, to do this we must:

- Tell the person/people involved (including the family, where appropriate) that an incident has taken place.
- Apologise and say that we are sorry.
- Provide a true account of what has happened, explaining and being clear about what we know at that point.
- Explain and be clear about what we are going to do to understand the events (for example if we conduct a PSII or PSR).
- Follow up by providing this information and the apology, in writing.
- Keeping secure written records of any meetings, or communications given.

Duty of Candour will also allow us to take insight and learning from incidents and we can provide this information back to those affected.

Roles and responsibilities

Our staff will have key roles to play in this new framework and we have listed some of the key roles that will help support this change to patient safety investigations.

Executive Directors and Non-Executive Directors

All Executive Directors have responsibility for ensuring incidents are investigated in a timely manner and responded to in accordance with this plan and appropriately signed off.

Patient Safety Specialists

The Trusts PSS team supports the Executive and Non-Executive Directors in carrying out their responsibilities for the management of PSII investigations within the trust and the presentation of learning and assurance back to system partners.

Patient Safety Partner

The PSP will support the Patient Safety Specialists and be actively involved in the design of safer healthcare at all levels in the organisation, this will be a voluntary role and represent ‘the patient’.

Trust Lead for PSIRF

The Trust Lead for PSIRF will provide assurance on Patient Safety incident management processes and overseeing the functionality of the Trust’s Patient Safety Incident panels. PSIRF Lead will work closely with system partners to ensure that PSII’s are shared with the board and learning is distributed across the wide ICS and is shared in collaboration with other Trusts.

Patient Safety Incident Investigation Leads

The Patient Safety Incident Investigation Lead is responsible for undertaking a full investigation into patient safety incidents that meet the criteria within the plan, that they are conducted in accordance with the plan and for working closely with the family liaison officer to ensure patient/family/carers are given an opportunity to provide relevant information that will support the investigation, that they are kept informed of the process and outcome of the investigation.

Family Liaison Officer

Family Liaison Officer are responsible for ensuring appropriate support is offered to the patient/family/carers and confirming any questions of concern the family/patient/carer would like to include as part of the key lines of enquiry of an investigation being the link person for patient/carer/family and ensuring that they are given the opportunity to provide relevant information that may inform the outcome of the investigation and linking in with the Patient Safety Incident Investigation Lead.

Divisional/Directorate Managers, Clinical Leads, Lead Matrons/Matrons/Senior Nurses and Service Managers

Ensure that appropriate experts are available to support the Patient Safety Incident Investigation Leads to carry out investigations within the relevant division and departments. They ensure that all investigations are completed in a timely manner by releasing all staff involved within an incident to attend any investigation discussions. They will also conduct Patient Safety Reviews using the appropriate toolkits.

Patient Safety Leads

The Patient Safety Teams support the Trust's governance teams in ensuring that the review, manage, investigate, and monitor learning from incidents. They work closely with the Patient Safety Incident Reporting and Investigation Teams in supporting the timely and appropriate reporting, recording, investigating and coordination of all incidents. The Patient Safety Leads are responsible for ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is included within the Patient Safety and reported to the Governance Meetings so learning can be cascaded through the Quality and Safety processes within the and wider throughout the Trust.

Patient Safety & Governance Team

The Patient Safety and Governance Team are responsible for reviewing all incidents reported on the incident management system, obtaining additional information and amending incident details as necessary. They will manage and co-ordinate the triage of all incidents assigning the correct level of investigation in conjunction with the Divisional Patient Safety Leads. The Team is required to report incidents to relevant external stakeholders in accordance with their reporting requirements.

All Staff

All staff are required to provide information either/both verbal or written reports for any investigation for an unexpected event or incident in a culture of being open and honest, supporting colleagues with a view to learning lessons in a just culture. Line managers have a responsibility to ensure staff are released from duty to attend debriefings, round table discussions, interviews regarding any incident.

Contact us:

Whiston Hospital (Trust Head Office)

Patient Safety Team, Nightingale House
Warrington Road
Prescot
L35 5DR

Southport Hospital

Integrated Governance Team, Trust Management Offices
Southport Hospital
Town Lane, Kew
Southport
PR8 6PN

Telephone: 0151 426 1600

Website: https://www.merseywestlancs.nhs.uk

Twitter: @MWLNHS

Facebook: www.facebook.com/


WHISTON HOSPITAL
NHS


ST HELENS HOSPITAL

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/037**			
Report Title	**Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case (OBC) for a Laboratory Management Information System (LIMS)**			
Executive Lead	Christine Walters, Director of Informatics			
Presenting Officer	Christine Walters, Director of Informatics			
Action Required	X	**To Approve**		**To Note**

Purpose

To obtain support and approval for the direction of travel as outlined in the attached outline business case and accompanying slide pack – LIMS market testing and engagement.

Executive Summary

Attached is an Outline Business Case (OBC) for a system wide Pathology Network LIMS for Cheshire & Merseyside. Alongside the business case, there is a presentation which covers the salient points for consideration.

The OBC is to enable the project to move to procurement, no decision or final agreement has been confirmed.

The Trust Board is asked to:

1. Support and enact system approval for this direction of travel – LIMS market testing and engagement.
2. Note the LIMS Outline Business Case as presented endorsing the aims and objectives of the approach.
   - Acknowledging the 'system' wide benefit of these proposals and the need to develop system responses on risk and gain share alongside this process to support the management of risk and opportunities.
3. Support the next step in the development of options for a consolidated Cheshire & Merseyside (C&M) approach to LIMS DELEGATE decision making and oversight for the process of market testing and engagement to Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) Leadership Board (who in turn will report to Trust Boards).

On the basis the recommendations are agreed, a full business case will be produced to include firm costing information, system financial interactions and implementation requirements secured through the supplier engagement process.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to:

- Support and enact system approval for this direction of travel – LIMS market testing and engagement.
- Note the LIMS Outline Business Case as presented endorsing the aims and objectives of the approach.
- Acknowledge the 'system' wide benefit of these proposals and the need to develop system responses on risk and gain share alongside this process to support the management of risk and opportunities.
- Support the next step in the development of options for a consolidated C&M approach to LIMS DELEGATE decision making and oversight for the process of market testing and engagement to CMAST Leadership Board (who in turn will report to Trust Boards).

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Cheshire & Merseyside Pathology Network (CMPN)

Laboratory Information Management System (LIMS)

Outline Business Case (OBC)

NHS
Cheshire and Merseyside

Title	**Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case for a Laboratory Management Information System**
Author(s)	NHS Transformation Unit
Contributors	CMPN and Integrated Care Board Stakeholders
Version	V0.4
Target Audience	ICB and Trust Boards
Date of Issue	12/09/2023
Document Status (Draft/Final)	Final
Purpose	For decision to instigate procurement activity

Document Version Control

Version	Date	Author	Change
0.1	04/07/23	S Maynard Walker	Initial draft
0.2	26/07/23	C Griffiths	Updates across all sections
0.3	01/09/23	C Griffiths	Including finalised assumptions
0.4	08/09/23	C Griffiths	Following agreement of risk and gain share

1. Purpose of this Document

The core aim for this project is to procure a LIMS designed to work for a pathology network to support the transformation of pathology services in the CMPN, which in turn will support improvements in clinical services and outcomes for patients.

This document sets out the outline business case to procure the preferred Laboratory Management Information System (LIMS) option for the Cheshire & Merseyside Pathology Network (CMPN). It is intended to provide sufficient information for Cheshire and Merseyside Integrated Care Board (ICB) and Trust Boards to support their decision making to support the recommendations presented, which are:

- To accept this Business Case.
- To take forward the procurement for the preferred option.
- On approval by Trust Boards, to issue an Invitation to Tender to initiate the procurement stage.

On the basis the recommendations are agreed, a **full** business case will be produced to include the firm costing information and implementation requirements secured through the supplier engagement process.

2. Strategic Case

Strategic Context

Pathology is at the core of the NHS. Around 95% of clinical pathways rely on patients having access to pathology service[1]. The opportunity to do more of the right tests in the right place at the right time, to diagnose earlier and ensure greater efficiency in the correct care pathway being followed and entered, is one that will have a far greater impact on our ability to sustain services across specialties. Therefore, improvements in pathology services have a direct impact on the quality, effectiveness and safety of the majority of patient care.

Easy access to test requests, timely results reporting and access to discipline specific expert advice from the pathology service, all have an impact on the quality of clinical services delivered to patients, patient flow, admission avoidance and complications.

The development of point of care testing and self-testing (as accelerated in the recent pandemic), improves timely services to patients and widens the scope for personalised care, an aim for each of the partner Trusts.

As demand for health care grows, together with the drive to service recovery after the pandemic, pathology services also need to respond.

Part of that response is the agreement by the Five partner Trusts and laboratory services to work together towards the formation of the Cheshire & Merseyside Pathology Network (CMPN), one of the 29 such networks identified by NHSE.

LIMS is a vital enabler for the network's efficient and effective operation and is part of a wider digital and IT workstream which includes inter-related system implementation plans for Primary Care Order Comms and Digital Pathology.

[1] Pathology Facts and Figures (rcpath.org)

The core aim for this project is to procure a LIMS designed to work for a pathology network to support the transformation of pathology services in the CMPN, which in turn will support improvements in clinical services and outcomes for patients.

This project is intended to respond to this aim by: -

- Improving the connectivity with the network to allow requests, tests and results to flow across the CMPN geographic area.
- Supporting seamless care pathways for patients crossing traditional boundaries.
- Increasing the system capacity and resilience of pathology diagnostics.
- Supporting a continued pandemic response.
- Aid the recovery of clinical services from the pandemic's effects.
- Enhancing the ability to respond to increased complexity and demand.
- Selecting a solution flexible enough to accommodate a CMPN Target Operating Model (TOM).
- Enabling opportunities for improved system and local level efficiencies
- Enabling the CMPN to reach maturity.

Business Needs

In 2016, Lord Carter published a review, '*Operational productivity and performance in English NHS acute hospitals: Unwarranted variation'*, evaluating whether the NHS gets the best value from its annual budget. The review concluded that the NHS could save £5 billion per year if the significant and unwarranted variations in costs and clinical practice were addressed. Of this, up to £2 billion could be accrued through better use of clinical, scientific, and technical staff; reducing agency spend and absenteeism; and adopting good people management practices.[2] Through this review, it was estimated that pathology services alone cost the NHS between £2.5 to £3.0 billion annually.[3] Lord Carter's 2016 report confirmed that the consolidation of pathology services within the NHS would make them most efficient in both service quality and cost effectiveness.

Moreover, to combat unwarranted variation in NHS pathology services, in 2019 NHS England wrote to Trusts calling for 29 pathology networks. By combining pathology services and bringing together clinical expertise, these services would provide a higher quality of patient care, making them more efficient. Additionally, reducing the service costs of the labs, could increase productivity and enhance career prospects of pathology staff.[4]

In 2019, The NHS Long Term Plan also highlighted the need to re-organise pathology services, the need for better connectivity between LIMS and the need to digitise pathology workflows.

The Get It Right First Time (GIRFT) National Programme identified the need to improve the quality of health care by addressing unwarranted variation in care in all diagnostic services and followed this up with a report specifically for pathology services (2021). Specifically for the digital agenda, it highlighted the need for: -

- The ability to integrate results from any source, including point of care testing and Community diagnostic hubs.
- Data to support patent focused pathology and support for innovations such as wearables.
- Systems to flag minimum test intervals at the request stage and in clinical decision support
- Facilitate remote reporting, better decision support and artificial intelligence assistance

[2] https://www.england.nhs.uk/wp-content/uploads/2020/08/Pathology_business_case_template_final_v1.pdf
[3] Operational productivity and performance in English NHS acute hospitals: Unwarranted variations: An independent report for the Department of Health by Lord Carter, 36.
[4] https://www.england.nhs.uk/pathology-networks/

In 2020, Professor Sir Mike Richard published The *Independent Review of Diagnostic Services* that revealed that the Covid-19 pandemic had 'exacerbated the pre-existing problems in diagnostics'. Investment and reform in equipment, facilities and workforce would be needed to combat the growing breaches in diagnostics.[5]

The review offered a series of recommendations for pathology including a number of specific recommendations regarding the use of technology:

- **Pathology and genomics equipment and facilities should be upgraded to facilitate the introduction of new technologies, to support Covid-19 testing and drive efficiency.**
- **Improving connectivity and digitisation across all aspects of diagnostics should be prioritised to drive efficiency, deliver seamless care across traditional boundaries and facilitate remote reporting.** Across all diagnostic disciplines the coding of tests needs to be standardised to compare like with like. The current lack of standardisation is seen particularly across pathology. Standardisation through the introduction of a universal test list will support patient safety, delivery of services across networks and more accurate collection of diagnostic data and reduce the need for repeat testing. Which leads to the next recommendation:
- **NHS Digital's work on developing and implementing a standardised universal test list across all diagnostic disciplines (pathology, imaging, endoscopy and cardiorespiratory services) should be accelerated as has been done for the National Genomic Test Directory.**

Added to this are the positive contributions arising from the recent pandemic response, which offer the opportunity to reduce health inequalities by using point of care testing in more accessible locations and the wider use of techniques, such as direct viral detection and antibody testing. Research from GIRFT showed the scale at which pathology labs were able to accelerate their responses: in just one month some labs were able to meet 100% of tests within 24 hours; 15 out of the 29 labs that responded to the GIRFT questionnaire were getting more than 90% of results from their Emergency Departments back to clinicians within 24 hours.[6] The requirement to continue and develop these techniques in the future implies a greater laboratory throughput. Also, the further use of genomics in health care will certainly have an impact on histopathology services, if, as expected, the number of samples taken increases because of such a development.

Other Relevant Strategies

- National Pathology Programme Digital First: Clinical Transformation through Pathology Innovation (2014).
  The strategy sets out the opportunities presented by greater use of digital services in the support of Pathology services.
- NHS Architecture Principles (October 2020).
  Setting out modern web browser interfaces, internet first and public cloud first principles for NHS systems.
- NHSE What Good Looks Like (October 2021).
  Its key requirements are for better connectivity between EPR and diagnostic services,

[5] https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf

[6] Pathology GIRFT Programme National Specialty Report, September 2021, 147.

better cyber security and a data platform to support AI as well as data driven service improvement.
- A plan for digital health and social care (June 2022).
- Local Trust IT strategies.

The Case for Change

In 2021, NHS England published the Network Maturity Matrix tools for both imaging and pathology networks. The tool identified seven domains that characterise a networks formation, as networks develop through implementation to maturing and eventually thriving. Digital and IT have a specific set of criteria for the network, showing the importance of digital innovation within a network. The criteria look at maturity across three main domains:

- ***Laboratory Information Management System***
- ***Order Comms***
- ***Digital Pathology***

LIMS is one of the three areas which the network should develop in order to prove it is a 'maturing network'. The four stages include: emerging, developing, maturity and eventually thriving. At one of the earlier stages 'Developing' the aim for LIMS is to achieve 'Shared LIMS within networks which meet data, interoperability and technical standards, enabling sharing of data across ICS's (not necessarily single LIMS)' showing at even the developing stage of a network, LIMS connectivity is vital. However, as the network reaches 'thriving' the criteria states 'LIMS provided connectivity to regional and national data layers and are driving improvement to the UTL'. At this stage, not only are networks required to be connected locally, but also regionally, showing the important to establish a connected LIMS system across the network.

In addition, as the network is currently also implementing a single GP Order Communications, the network, through the introduction of an integrated LIMS system will ensure a fully integrated an end to end workflow for ordering and conducting tests, enabling clinicians to access the results from any hospital or GP practice.

	Emerging	Developing	Maturing	Thriving
Laboratory Information Management Systems	Plans for integration of technology and systems across care & pathology settings within ICS *and* Start of adoption of data standardisation within ICS and some networks i.e., Universal Test List (UTL) *and* Limited to no visibility of laboratory testing capacity & demand beyond ad-hoc manual reporting at an ICS level.	Some visibility of lab testing capacity and demand based on regular reporting via an electronic platform within ICS and network *and* *Shared LIMS within* networks which meet data, interoperability and technical standards, enabling sharing of data across ICSs' (not necessarily single LIMS) *and* Digitally enabled POCT equipment is all connected to the LIMS and/or patient record.	LIMS provide connectivity to regional and national data layers and support public health analysis of all notifiable diseases *and* Sample flow tracking is in place *and* Connectivity across all pathology and care settings within network (including POCT, CDCs and genomics).	Network Business Intelligence (BI) is utilised to ensure service response matches population requirements and improved clinical outcomes *and* LIMS provided connectivity to regional and national data layers and are driving improvements to the UTL *and* Adopt national data standardisation across pathology, including Units of Measure (UoM) and agreed list of result test codes.
Ordercomms and Results interoperability	Digital orders are created in a structured format and held as part of the patients' and service users' digital care record. *and* Plans for visibility of ordering and results between Trusts / care settings within ICS, some settings allow interoperability outside of ICS *and* Limited ability to integrate, report & view results to other Trusts / care settings within network.	> 50% of order communications processes are electronic, in most care settings with minimal manual reliance and Clear visibility of results between member network trust care settings within ICS.	> 80% End to end order communications in structured, electronic format from request to result and Health and care professionals across the region have direct digital access to all relevant diagnostic test results for those under their care and Full Integration of order comms and electronic patient records.	> 95% End to End order communications are electronic, from request to result, in all care settings and consistent for all diagnostics within an ICS *and* Clinical decision support at the point of request to ensure appropriate tests, reduce duplication and avoid patient harm as per minimum requesting intervals document or equivalent *and* Systems integrated with interoperability layer across care settings within & between ICS.
Digital pathology	Low use of Whole Slide Imaging (WSI) with a majority use of standard microscopy for primary diagnosis for specific services or subspeciality in each service provider location.	WSI used for primary diagnosis for specific services or subspeciality in each network service provider. *and* Enterprise-wide digital image acquisition and communication workflows implemented.	WSI used for primary diagnosis at least 50% of services or investigations in each network *and* A proportion of WSI are being analysed using computerised analysis.	WSI used for 70%+ of primary diagnosis of service or investigation in each network leading to evidenced improvement in health outcomes *and* Capability for WSI analysis with AI and machine learning.

17 | Progressing Network Maturity 2022/23

Figure 1

In May/ June 2022 PUBLIC were commissioned by CMPN to complete user research regarding current LIMs system and the programmes approach. This research found:

- That current systems were laborious and produced multiple points where error / patient safety incidents could occur
- Services at LUHFT and COCH had the least LIMS capability to mitigate against clinical safety issues
- Telepath sites (LUHFT & STHK) have the least technical capability and most user difficulty
- The multi-specialty approach could potentially lead to an overly complex implementation strategy, though, acknowledges the need for “quick wins” to ensure safety
- It was noted that there were hardware insufficiencies at LUHFT for current Telepath solution; these issues considered acceptable for current operation
- It was noted that there would be business, quality and contractual considerations that would need to be thoroughly explored at each Hub – this includes current contract lengths, current functionality, current dependent systems, and appraisal of supplier performance.

It is clear that the current LIMs system across the network do not offer the flexibility or the capabilities to support the transformation required or needed from the network. The network needs LIMS system that can:

- Effectively support improvements in productivity and the quality of diagnostic workflows.
  - The flow of samples, tests and results are not seamless and there is no unified test list that might assist with such transfers. Whilst NPEX is used across the system, the new cost per test model also includes significant charges should the network want to reallocate work
- Offer sufficient opportunity to reduce manual data entry processes and there is limited opportunity to support flexible and remote working, or from any site in the SMPN
  - There are currently five different LIMS system across Cheshire and Merseyside, all of which do not speak to one another and have differing workflows etc.

- Improve the resilience of pathology services due to their longevity, which also increases the risk of service disruption as time passes:
  - Some of the current LIMS systems have been with the Trusts for a number of years are reaching the end of their life cycle. LIMS solutions are needed that adapt rapidly to the changing of technology (AI, Digital Pathology) when the older systems are obsolete
  - A number of the current systems are Electronic Patient Record systems with embedded LIMs solution. These solutions are often not fit for purpose and are slow to the adoption of change or technological advances.
- Offer sufficient support to increase the capacity or resilience of pathology services
- Provide the capability required to enable new technologies
  - The current LIMS are outdated across most Trusts. Whilst some investment in Pathology IT provision has been made over the years, investment has been lacking in the LIMS in most Trusts, resulting in not only old hardware and software but technology that does not provide modern functionality. There are several LIMS that are already considered legacy, whereby support is limited, and the underlying hardware is beyond their age.

Existing Arrangements

CMPN laboratories perform **53 million** pathology tests every year, with pathology diagnostic testing being necessary **in 95% of patient journeys. This covers the 2.7million patients in the region and as a service, pathology employs c. 2000staff.**

The test numbers that we will manage through the new LIMS each year are shown below:

Total Test In the Network	Chemistry	Haematology	Immunology	Combined Blood Sciences	Microbiology	Cellular Pathology	Region Total
Region Total	40,440,774	6,504,697	2,753,928	49,622,430	3,278,329	253,986	53,154,745

Figure 2

In CMPN there are currently seven different Laboratory Information Management systems (LIMS) being used across the main Pathology providers in Cheshire and Merseyside. Whilst there is some consolidation (Chester and Wirral Microbiology Service) each of the seven Trusts currently operate different LIMS solutions with very little interoperability between systems (see Figure 3).

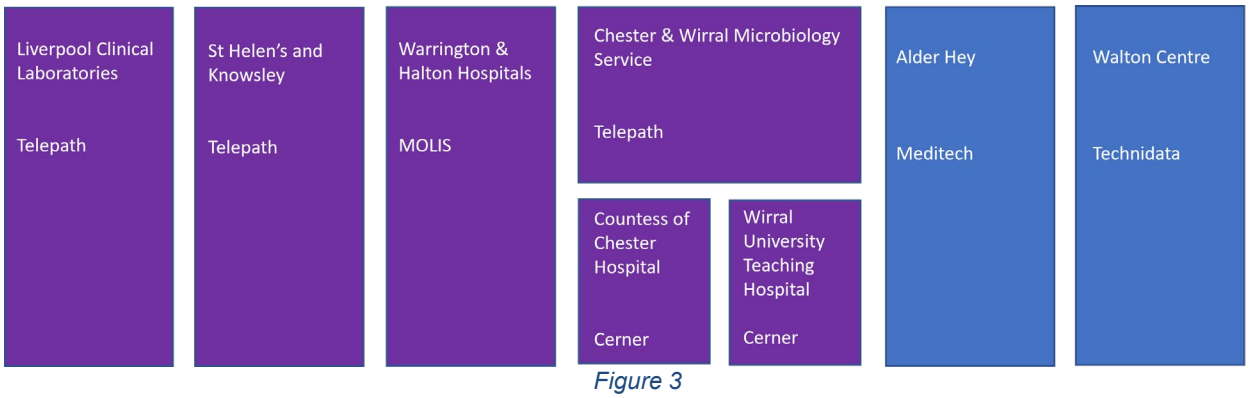


Figure 3

Fig X: LIMS type by Trust

LIMS solutions communicate with a GP Order Communications Solution (how GPs request tests), laboratory analysers and Digital Pathology solutions. Pathology Services within Cheshire and Merseyside currently use different LIMS solutions, hosted at local Trusts.

The lack of interoperability between current systems and organisations is a barrier to collaborative working and reconfiguration of pathology services.

Every Pathology provider has a current individual contract with their existing LIMS supplier. Table 1 details the contract expiry by Trust.

Table 1

Organisation	LIMS Supplier	Contract Expiry
Mersey and West Lancashire Hospital	Dedalus/ Telepath	March 2024
Warrington & Halton Hospitals	CGM Molis	March 2024
Liverpool University Hospitals	Dedalus/ Telepath	March 2026
Countess of Chester Hospital	Cerner	May 2031
Wirral University Teaching Hospitals	Cerner	December 2031

Resilience

- Two of the providers are on existing long-term contracts which renew yearly (Mersey and West Lancashire, Warrington and Halton). By continuing to renew yearly the providers may be paying above standard rates.
- Two of the Trusts are at the greatest risk of resilience due to the age of their technology (Mersey and West Lancashire, Liverpool University Hospitals) prioritising these providers will be required during implementation.

In addition, other providers have LIMS contract wrapped up in the contract of their Electronic Patient Record System (EPR). Although, to remove LIMS from this contract would not cost the providers, ensuring patient records.

Performance and Activity

Service demands are increasing year on year because of changing demographics and long-term conditions. Demand for Pathology testing in Cheshire and Merseyside is rising each year. In addition, there are also pressures to maintain and reduce turnaround times to support patient flow and earlier cancer diagnosis. Increasing productivity will enable Pathology services to meet rising demand without increasing costs. Managing demand by implementing consistent, clinically agreed protocols for requesting tests will also help and will be more robust if done by all Pathology services in Cheshire and Merseyside.

Having the same LIMS will reduce duplication if all results can be viewed at any site, thereby helping to manage the capacity and demand of the services across Cheshire and Merseyside and work can be redirected/ tracked more efficiently. Samples will also be able to be repatriated from outside of the geography, which will lead to financial savings through reduction in carrier costs. It

will also support the benefits digital pathology, genomics and AI with the availability of patient reports across the whole region.

The service resilience across Cheshire and Merseyside will increase as, if one site is down due to analyser failure, the work can be processed at one site and validated at another site. This would the region to have a better business continuity plan and allow the seamless running of the Pathology service regardless of any technical, staff or major incidents.

Potential Scope and Service Requirements

In line Digital Diagnostic Capability Programme (DDCP) scope agreed, organisations included in the scope of the project are the main providers of Pathology services in Cheshire & Merseyside:

- Liverpool University Hospitals (LUHFT)
- Merseyside & West Lancashire Trust (MWL)
- Warrington & Halton Hospitals (WHH)
- Countess of Chester Hospital (COCH)
- Wirral University Teaching Hospital (WUTH)

Within this project they will be called the 'Core 5 Providers'.

Whilst the following Trusts are included in the scope of the project, they will be considered as an extension of the providers that host their Pathology services:

- Clatterbridge Cancer Centre (CCC)
- Liverpool Women's Hospital (LWH)
- Liverpool Heart and Chest (LHC)

The full extent of interoperability will be explored through the procurement process and competitive dialogue with market vendor/supplier in keeping with NHS security and information governance requirements.

Spending Objectives

The objectives for the proposed investment required for the LIMS project were agreed through th approval of the evaluation criteria as explained in Economic Case.

They are listed below along with those additional factors that will allow a judgement to be made as to whether they have been met. They are: -

Table 2

1	**Patient Experience and Outcomes**	Maintains or improves outcomes for patients Maintains or improves experience for patients Maintains or improves equity of access/care Maintains or improves equity of access/care to patient records across Pathology teams
2	**Stakeholder Experience and Outcomes**	Maintains or improves outcomes/experience for internal stakeholders (e.g., clinical departments, clinicians) Maintains or improves outcomes/experience for external stakeholders (e.g., Primary Care practitioners, external organisations accessing services) Promote the use of systems and tools to enable frictionless movement of staff across the ICS - allowing staff from different organisations to work flexibly and remotely where appropriate
3	**Quality and Productivity**	Consider evidence of best practice within Digital and IT services Maintains requirements of on-site services where required

4	**Resources and Efficiency**	Maximizes use of existing resources Affordable in terms of capital requirements Affordable in terms of revenue requirements
5	**Reduction in variation**	Harmonises ways of working, policies and procedures and SOPs Harmonises equipment and kit Avoid duplicating effort and unnecessary costs be collaborating across system, sharing and reusing technology, data and services (AKI) Supports demand management across the system Support business continuity/ Resilience

Main Benefits

The benefits from the implementation of a new LIMS system were considered in a workshop held on 26 July 2023 where 35 individual benefits were identified by 19 stakeholders. These have all been recorded in a benefits register that will be updated with new benefits as they are identified and with details regarding the measurements, baselines and responsible staff as they are agreed.

The copy of the full benefits register can be found here: Appendix: Benefits Register.

NHS England have identified the main 3 categories of benefits as **non-cash releasing benefits**. Full information is included here: Appendix: Diagnostics Digital Capability (DDC) Programme.

The non-cash releasing benefits focus on the 'time-saved' and efficiencies which can be recognised at a provider level. It is important to recognise that this will be significant, however will be highlight dependent on the LIMS option which is chosen.

Table 3

Benefit Title
Referring samples to other laboratories within the same network (lab to lab referrals**)**
Access to pathology results and reports generated by any laboratory in the network
Reduced LIMS systems maintenance burden

After review and analysis, three cash releasing benefits have been identified and they are: -

Table 4

Benefit Title
Potential to eliminate a number of interfaces and eliminate costly third-party middleware.
Smaller digital footprint - save rackspace/energy.
Could reduce licensing Costs.

There are also qualitative and societal benefits that are also recorded in the Appendix: Benefits Register.

The proposed approach to achieving these benefits is explained in the Management Case. Both the benefits and the approach are subject to detailed discussion with the chosen supplier and will be confirmed in the Full Business Case prior to contract award.

Main Risks

A risk register for the project has been created and all the identified risks have been recorded, together with an assessment of their impact and likelihood. The risks have been developed through engagement with variety of governance meetings across the system. The risk rating used is the standard NHS risk matrix. Mitigating actions for each risk have been identified and the risks scores adjusted in the light of these actions. The register will be kept updated as new risks are identified and others recede, following the same review process. Those risks and issues with the highest residual score and mitigating actions are as follows:

Table 5

Risk/Issue	Mitigation	RAG
RISK Operational – Local Trusts may not be able to commit sufficient IT/Lab resources to support implementation of solution	Proactive communication with Trust IT and Pathology Teams to ensure resource requirements are clearly understood and any potential issues are identified and dealt with at the earliest opportunity.	
RISK Operational – Additional regional resources will be required to implement the solution. If such resources are not available, the implementation will not progress as planned.	Identify required resources as early as possible and recruit suitably skilled and experienced personnel.	
ISSUE Deployment - Liverpool University Hospitals Foundation Trust (LUHFT) signed a contract for Cellular Pathology LIMS. The Trust is currently exploring how to end the contract. This could impact procurement as the provider is a market leader in LIMS.	LUHFT are currently working with the NHS England Procurement Team to understand mitigation and get advice regarding the contract.	
ISSUE Operational - Two sites need to replace their Telepath (LIMS) hardware systems this year (Mersey and West Lancashire, Liverpool Clinical Laboratories)	Both providers have currently developed sufficient workaround to make the system feasible for the next few years. The LIMs implementation should ensure that all systems are replaced. Implementation plans currently being developed.	
ISSUE Operational - a number of Trusts are implementing Electronic Patient Record (EPR) systems which could adversely impact the resource deployment and implementation timescales while the complexities are resolved	The network will be planning to schedule providers in line with their requirements including lack of resourcing or risk regarding current systems.	

Dependencies

- Local Trust & ICB level IT, finance and lab capacity to engage and support implementation
- Funding decisions at national level
- NHSE procurement directives
- The parallel development of the CMPN Target Operating Model (TOM). Any changes to the proposed TOM (3 hub model) may affect the number of provider organisations included in the proposal. However, it is clear that the procurement approach and implementation of the LIMs solution will enable a TOM to be fully implemented.
- The agreement between the Trust partners on risk/gain sharing and project governance.
- The ability to support the revenue costs in future years.

Each of these dependencies, issues and risks could impact deliverability and timescales of the programme.

Constraints

- Timelines and external funding allocation conditions.
    - DDCP funding for LIMS was allocated to Liverpool University Hospitals, Mersey and West Lancashire and Wirral University Teaching Hospitals on behalf of the system across 2022-25. Whilst funding was not drawn down in 22/23, proposed funding in 23/24 and 24/25 will be available.
    - Although the programme has funding until 2025, subsequent funding years have not been agreed and additional funding may be required

3. Economic Case

The economic case is used to understand the value for money considerations across the project. The case will consider costs at provider and system level, versus system wide benefits and risks.

The case is based on the Delivery Diagnostic Capability Programme (DDCP) capital allocation of £17.69m from 2022 to 2025.

The case recommends the preferred option, considering the options appraisal workshop, scoring and economic modelling. The most recent NHS Economic Model 58.2 process has been applied to ensure complete transparency.

Critical Success Factors

Table 6 sets out the critical success factors that have been agreed for the LIMS project:

Table 6

6	**Strategic Fit – Local, Regional and National**	Aligns with Trust strategy around collaboration and partnership Aligns with ICS-wide digital and data strategy Aligns with national vision around pathology collaboration/networks
7	**Sustainability and Modernisation**	Alignment with modern and innovative digital pathology initiatives Harmonises IT systems across both organisations Ensures progress towards net zero carbon, sustainability, and resilience ambitions Aligns with regional/national visions around pathology digitalisation
8	**Achievability**	Feasible to deliver in timely and effective way
9	**Interoperability**	Makes use of open standards to ensure the technology works and communicates with other technology and can be easily upgraded and expanded Improves the access to external systems including primary care, community, specialist providers
10	**Financial**	Drive organisations towards ‘simplification of the infrastructure’ by sharing and considering consolidation of spending, strategies and contracts

Evaluation Criteria

In a structured project requiring an option analysis, an evaluation criterion provides an agreed and normative framework that can be used to determine the merit or worth of options.

The evaluation criteria establish the high-level considerations, in line with the aims and objectives of the project to assess an option against. For this project. tThe criteria were developed considering the What Good Looks Like Framework and The Technology Code of Practice. The evaluation criteria combine the spending objectives and critical success factors of the business case, this is detailed in Appendix: Evaluation Criteria.

Options

The economic case determined the preferred way forward considering the shortlist of options. The shortlist of options were developed considering historical engagement between 2021- 2022 as part of the Delivery Diagnostic Capability Programme and more recently through the engagement of an updated LIMSLIMS Project Initiation Document engagement across June 2023 which covered various governance groups including:

- Digital Diagnostic Steering Group
- Directors of Finance
- Heads of Procurement
- Chief Operating Officers
- Chief Information Officers
- CMPN Management Group
- Senior Responsible Officers Group
- CMAST Operational Group
- CMAST Leadership Board

The options which were agreed through this process for appraisal were:

1. Do nothing
2. Integrate existing LIMS solutions
3. Implement discipline-specific network-wide LIMS solutions
4. Implement network-wide LIMS solution for all pathology disciplines (Convergent Plan over several years with sites coming on line at appropriate point in line with current contract)
5. Implement network LIMS solution for all pathology disciplines, integrated with EPR-embedded LIMS solutions as required

Option Appraisal

The LIMS options were appraised at a system wide workshop on 24 July 2023.

The spending objectives and critical success factors were used as the evaluation criteria to objectively identify the best option to take forward for CMPN and the ICB overall.

To appraise each of the options Strengths, Weakness, Opportunities, Threats (SWOTS) of each of the options were presented.

Table 7

Option One: Do Nothing	
Strength • The project is highly complex. Providers currently have different LIMS contracts, with different end dates. If the 'do nothing' option was explored,	**Weakness** • The current LIMS system across Cheshire and Merseyside do not integrate and therefore transformation at a system level is not possible.

providers would be able to upgrade their current systems in time with contract end dates. • This is business as usual, and no organisational change or process change. • Each LIMS system is bespoke and custom to each provider. For example, some providers have bespoke interface per each connection (EPR, PAS etc). • Some providers have integration with current EPR systems, which means information streamlined and easily accessible across the provider.	• PUBLIC identified a number of issues with the current LIMS systems including: a lack of functionality and inability to integrate with new systems, to name just a few. • Providers will not be able to receive the efficiency benefits that are associated with a more integrated system wide LIMS if they keep the do nothing option • The financial savings which can be achieved by a more integrated system wide LIMs will not be realised • Bespoke interface solutions – may come with multiple costs • Financial implications for multiple middleware, NPEX
Opportunity • Some systems are not only UK driven, but European driven which gives you areas of innovation.	**Threats** • The network will be unable to meet Digital Maturity as implementing integrated LIMS system is a core requirement from NHS England • The network will be unable to achieve a successful Target Operating Model • Patient safety issues as clinicians and workforce are unable to see records across the system • Huge inefficiencies around staffing and sample referrals • Inability to flex the workforce as they only train on their current system- lack of movement

Table 8

Option Two: Integrate Existing LIMS	
Strength • No provider needs to implement a new LIMs solution. • Implementation of the solution will be agnostic to current LIMS solutions and contracts • A standardised approach to data management accelerating and facilitating network strategic design and data driven operational, workforce and quality improvements • Infinite scalability with extended interoperability capability between	**Weakness** • Technical complexity – will require significant specialist integration resources to achieve integration across all providers. • Change management resource would be huge • Risk around sample management – sample accessioning • Resource and financial implications for integrating across 9 providers • Loss of single reception • Decreased benefits

pathology networks and other regional or national services e.g. genomics	• Clinicians may need to log on to various systems • Financial implications for multiple middleware, NPEX
Opportunity • This will create an opportunity to maximise efficiency and improve standard practice • Simplify referral workflows – removing the need for NPEX- costs savings associated	**Threat** • There may not be a suitable solution for this option- as solution providers have not yet been explored • This solution is currently being explored by other networks, but we do not know if successful • Risks around patient records, including multiple patient references could lead to a patient safety risk

Table 9

Option Three: Discipline specific LIMS	
Strength • The solution could be more bespoke to the disciplines meeting clinical requirements • Giving lab clinicians a lot more clinical information, at system level, to make informed decisions • Could implement gradually and have a staged approach- causing less clinical impact • Could allow providers to share workforce across sites- in disciplines • Business continuity between disciplines across providers	**Weakness** • PUBLIC found the multi-specialty approach could potentially lead to an overly complex implementation strategy • You need to integrate the different LIMs solution • You need to integrate the Primary Care Order Comms Solution with a number of LIMS providers- extra resource and time associated • No central reception- would need to centralise which will come with additional resource and time needs • Additional cost for integration for multiple digital products • There would no access to a central clinical reporting workspace to enable collaboration and system wide working • Hosting complexity with multiple LIMS providers • Financial implications for multiple middleware, NPEX

Opportunity	Threat
• Greater stakeholder engagement, as you engage discipline specific and create more bespoke solutions • Could get a better product for each of the disciplines – system leader for speciality • Opportunity to standardise working practices across network	• Different providers could be chosen for different disciplines, resulting in various integration requirements/ contracts • Different LIMS provider may have different costs associated, difficulty in determining split and need across providers • Unable to manage shared samples (duplication of booking, information and integration requirements) • Providers with EPR-embedded LIMS solutions may be unable to move to a network-wide LIMS

Table 10

Option Four: Network Wide LIMS for all disciplines	
Strength	**Weakness**
• Includes the strength from options 2 and 3 • Common foundation for all services; Remote-working cross-site supported • Supports ICS & Trust-level drivers around safe, responsive services • Resource requirements to manage the solution after implementation will be simplified • Improving patient safety with having one clinical record on one LIMS • Supporting patient choice • Supporting system wide working – movement of services • Linking one phlebotomy service across Cheshire and Merseyside • Financial savings with single middleware solutions, single NPEX etc, savings with smaller consumables	• Change management burden for all providers as changes required across all the providers • Significant resourcing requirement to implement LIMS effectively • Some workflows & clinicians may claim “step backward” from current system • Providers currently under contracts across the network. A number of Trusts in long term contracts- implementation will be longer (option 3 too) • Implementation testing will be huge • One Trust will need frontrunner • A single externally hosted LIMS solution would always be inferior to the utopia of one Cheshire and Merseyside wide EPR system with LIMS across all providers • Removing integration requirements across Cheshire and Merseyside is a huge benefit in terms of resource and complexity
Opportunity	**Threats**
• Financial benefits & Long-term benefits with AI/Digital Pathology	• Providers with EPR-embedded LIMS solutions may be unable to move to a network-wide LIMS

• Opportunity to define and execute needed change across the network • Opportunity to standardise working practices across network • Minimum amount of IT resource to maintain and support as business as usual in the long term	• Possibility of providers choosing new EPR systems • Once a solution provider is chosen, it will be difficult for Cheshire and Merseyside to move off that provider

Table 11

Option Five: Network Wide integrated with EPR-embedded LIMS	
Strength • Common foundation for all services; Remote-working cross-site supported • Supports Trust-level drivers around safe, responsive service for patients • Allows provider organisations to retain EPR-embedded LIMS solutions • Simplify digital maturity at a provider level	**Weakness** • BAU burden for all services • Significant resourcing requirement to implement LIMS effectively. • Some workflows & clinicians may claim "step backward" inherent lack of functionality with embedded LIMs • Lack of integration capabilities • Inability to innovate in timely manner • Upgrading the EPRs is incredibly difficult • Providers currently under contracts across the network. A number of Trusts in long term contracts. • Complexity around patient management – different patient codes • Supplier engagement is known for being poor • Does not support system wide working • Resource requirements around breaking EPR/ LIM solutions • Duplication of patient records • Difficulty to maintain the system, needs to IT developed and supports not Lab IT supported
Opportunity • Some financial benefits & Long-term benefits with AI/Digital Pathology • Opportunity to define and execute needed change across the network	**Threat** • Encourages providers to think independently of the network solution • Providers may be encouraged to explore embedded EPR systems rather than network wide solutions

• Opportunity to standardise working practices across network • Opportunity to have regional LIMS integration	• Resources to maintain a network wide solution and independent solutions • Potentially would not have local integration

Scoring

Only the 'Core 5 Providers', were able to score:

- Liverpool University Hospitals (LUHFT)
- Merseyside & West Lancashire Trust (MWL)
- Warrington & Halton Hospitals (WHH)
- Countess of Chester Hospital (COCH)
- Wirral University Teaching Hospital (WUTH

Scoring was not completed on an individual role basis. One scoring sheet was completed by each provider, with a score of 0-5 across the 10 criterion.

To score the evaluation criteria, a score of 0 to 5 was given using the following rating scale:

A score of:

0. Does not deliver this criterion

1. Delivers criteria at a very basic level

2. Delivers some aspects of the criteria

3. Delivers at least half the expectations of the criteria at an acceptable level

4. Delivers most of the criteria

5. Delivers all expectations at a high level

To ensure that the system perspective was included in the scoring, the design of the workshop was such that each provider had to take account of the wider stakeholders views in their scoring.

Once each of the 5 providers had scored, the scoring of each criterion was totalled, and a weighting was applied as detailed in Appendix: Evaluation scoring.

Preferred Way Forward

Based on the options appraisal and scoring completed by the providers, the option with the preferred option was Option 4, **Network Wide LIMS for all disciplines** with a score of 3.89. This was universally the preferred option was all providers.

As a result, the preferred option is for the Cheshire and Merseyside Pathology Network to procure a pan pathology instance of LIMS. This will be a convergent Plan over several years with sites coming on line at appropriate point in line with current contract.

	Option 1	Option 2	Option 3	Option 4	Option 5
	Do nothing	Integrate existing LIMS solutions	Integrate discipline specific network-wide LIMS solutions	Integrate network-wide LIMS solution for all pathology solutions	Integrate network-wide LIMS solution for all pathology solutions with integrated EPR-embedded LIMS solutions as required
Overall Outcome	**1.67**	**1.66**	**2.27**	**3.89**	**2.72**
Rank	**4**	**5**	**3**	**1**	**2**

Figure 4

Value for Money

The Green Book requires us to acknowledge the full costs associated with each option, therefore the financial models don't move incrementally. The risks and benefits are then overlaid to show running costs and a weighted probability.

Overview economic analysis

The tables below are taken from 58.2 of NHS England economic modelling template. An economic analysis has been provided across each of the options. This analysis allows us to explain the option development and the main costs, benefits, and risks for the business case options. This has been completed subsequent to the options appraisal, in order to provide a more thorough analysis of the options included.

The analysis has been conducted over 10 years. The incremental analysis provides a true comparison between the benefits and costs and risks.

Costs

Costs of each option have been calculated based on information on the current spend for LIMS across Cheshire and Merseyside, the expected costs of changing the LIMS as is, estimates for the project support required to deliver each option and using two LIMS Outline Business Case from different pathology networks as indicative costings.

It is important to recognise here that two key providers in Cheshire and Merseyside do not pay for separate LIMS systems. It is also important to acknowledge that we did not receive all costs from each provider, which means that the do-nothing costs are slightly lower.

A number of assumptions have been made across the costings and a list of the assumptions have been included in the Financial Case.

The results of the costings are detailed below:

Costs (£000 exc VAT)		2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	Total	% of highes cost
Option 1 - Option 1 long name	Capital	£0	£705	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£705**	
	Revenue	£1,714	£1,742	£1,742	£1,742	£1,742	£1,742	£1,742	£1,742	£1,742	£1,742	£1,742	**£19,136**	26%
	Total	**£1,714**	**£2,447**	**£1,742**	**£1,742**	**£1,742**	**£1,742**	**£1,742**	**£1,742**	**£1,742**	**£1,742**	**£1,742**	**£19,841**	
Option 2 - Option 2 long name	Capital	£284	£1,805	£850	£0	£0	£0	£0	£0	£0	£0	£0	**£2,939**	
	Revenue	£1,714	£2,125	£2,105	£2,955	£2,955	£2,955	£2,775	£2,775	£2,775	£2,775	£2,775	**£28,685**	41%
	Total	**£1,998**	**£3,930**	**£2,955**	**£2,955**	**£2,955**	**£2,955**	**£2,775**	**£2,775**	**£2,775**	**£2,775**	**£2,775**	**£31,624**	
Option 3 - Option 3 long name	Capital	£36,000	£3,184	£2,450	£1,400	£900	£900	£900	£900	£900	£900	£900	**£49,334**	
	Revenue	£1,714	£2,516	£3,112	£2,588	£2,588	£2,588	£2,588	£2,588	£2,588	£2,588	£2,588	**£28,045**	100%
	Total	**£37,714**	**£5,700**	**£5,562**	**£3,988**	**£3,488**	**£3,488**	**£3,488**	**£3,488**	**£3,488**	**£3,488**	**£3,488**	**£77,379**	
Option 4 - Option 4 long name	Capital	£12,500	£1,784	£1,500	£0	£0	£0	£0	£0	£0	£0	£0	**£15,784**	
	Revenue	£1,714	£1,640	£1,786	£1,212	£1,212	£1,212	£1,212	£1,212	£1,212	£1,212	£1,212	**£14,835**	40%
	Total	**£14,214**	**£3,424**	**£3,286**	**£1,212**	**£1,212**	**£1,212**	**£1,212**	**£1,212**	**£1,212**	**£1,212**	**£1,212**	**£30,619**	
Option 5 - Option 5 long name	Capital	£13,714	£3,058	£2,774	£0	£0	£0	£0	£0	£0	£0	£0	**£19,546**	
	Revenue	£0	£283	£429	£1,729	£1,729	£1,729	£1,729	£1,729	£1,729	£1,729	£1,729	**£14,543**	44%
	Total	**£13,714**	**£3,341**	**£3,203**	**£1,729**	**£1,729**	**£1,729**	**£1,729**	**£1,729**	**£1,729**	**£1,729**	**£1,729**	**£34,089**	

The lowest cost option for the project is option do-nothing. However, this option does not meet the objectives of this project. In addition, this does not consider risks such as the loss of £17.69m capital and the potential cash-releasing benefits of £15m~. The next lowest cost option is option 4, at £30,619m (across 10 years) of both capital and revenue, which is the preferred option as identified by the options appraisal workshop.

LIMs Benefits

Benefits have been assessed within each of the following categories:

- Cash Releasing (Financial)

- Non-Cash Releasing (Financial)
- Societal (Financial)
- Quality (Non-financial)

For each expected benefit confidence been factored into the calculations.

The project has many benefits across the four categories. The project also has a benefit logic diagram included in Purpose of this Document Appendix: Benefits workshop overview. The extent to which these benefits are realised will be dependent on collaboration with individual Trusts across the life cycle of the project.

In addition, LIMS is one of the single biggest enablers to CMPN achieving its overarching aims as a network. This is not only a key strategic objective of Cheshire and Merseyside but of NHS England who set the direction to; supports the standardisation of working practices; reduced duplication of testing and service resilience. In the CMPN OBC published in 2019 it was estimated that the target operating model could lead to 100% and 117% of the £10,074,493m annual target saving set in the revised 2018 'state of the nation' report. This is in line with NHSI expectations, although, slightly lower than what has been achieved elsewhere in terms of actual vs NHS Improvement predicted savings. The TOM aims and potential to achieve these savings is limited by progress of a unified LIMS system. It is assumed, that LIMS will be the single biggest contributor to the delivery of that annual target and could be assumed, proportionally 50% of the cash-realising benefits i.e. £50m could be attributed to this LIMS project across 10 years.

The CMPN OBC financial benefits were calculated based on:

- The financial model produced in the OBC was based on a cost model for the evaluation of savings on the "As Is" declared cost base;
- Review of most recent Pay and Non-Pay data submission for any errors or omissions on costs and test volumes;
- Development of a 11-year financial baseline based on most recent Pay and Non-Pay data submission;
- Staffing savings were calculated based on the level of activity for each option that would remain at the Essential Service Laboratories (ESL) and the additional needs of staff at the centralised testing centres;
- ESL laboratory staffing levels were based on a fixed benchmark. Centralised services staffing levels were calculated based on the productivity of high performing sites within the network, validated against benchmarks, at a department level. As described in detail above, these productivity gains are likely to stem from a range of enabling works related to estates, IT, automation and shared best practices. Better use of lower band staff have also been considered as part of the workforce and pay-cost analysis;
- Material & Equipment savings calculated based on the current cost of equipment and the expected additional volume discount that would be available from suppliers (as indicated by savings achieved within C&M as well as similar networks);
- Calculation of savings against the baseline for each of the options over 11 years; and Comparison of savings for each option.

However, the project has taken a conservative estimate of benefits, using recent stakeholder engagement and assumptions to develop benefits across the four different categories.

For the cash releasing benefits, the project has assumed savings when reducing duplicate software, maintenance and resourcing requirements across LIMS. There are further cash

releasing benefits through; reduction in duplicate testing which would be experienced when implementing a network wide LIMS. For the purpose of this business case, however this has not been calculated.

The table below sets out the Cash Releasing Benefits:

Cash releasing benefits (£000)	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	Total	% of highest benefit
Option 1 - Option 1 long name	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**	0%
Option 2 - Option 2 long name	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**	0%
Option 3 - Option 3 long name	£0	£0	£0	£863	£863	£863	£863	£863	£863	£863	£863	**£6,905**	45%
Option 4 - Option 4 long name	£0	£0	£0	£1,906	£1,906	£1,906	£1,906	£1,906	£1,906	£1,906	£1,906	**£15,250**	100%
Option 5 - Option 5 long name	£0	£0	£0	£673	£673	£673	£673	£673	£673	£673	£673	**£5,386**	35%

The option with the highest cash-releasing benefits, is Option 4 with £15,250.

In the business case was to take into consideration proportioned benefits from the CMPN OBC, £40,298m savings could be attributed to the project.

The table below sets out the Non- Cash Releasing Benefits. The non-cash releasing benefits have been worked out based on stakeholder engagement. For more information, please see the benefits workings sheet in Appendix: Benefits workings

Non-cash releasing benefits (£000)	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	Total	% of highest benefit	Rank
Option 1 - Option 1 long name	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**	0%	
Option 2 - Option 2 long name	£0	£0	£0	£1,674	£2,092	£2,510	£4,184	£4,184	£4,184	£4,184	£4,184	**£27,197**	18%	3
Option 3 - Option 3 long name	£0	£0	£0	£0	£2,705	£5,410	£8,115	£9,017	£9,017	£9,017	£9,017	**£52,300**	35%	2
Option 4 - Option 4 long name	£0	£0	£0	£0	£10,388	£15,582	£20,776	£25,970	£25,970	£25,970	£25,970	**£150,626**	100%	0
Option 5 - Option 5 long name	£0	£0	£0	£0	£3,499	£6,997	£10,496	£13,995	£13,995	£13,995	£13,995	**£76,972**	51%	1

The option with the highest cash-releasing benefits, is Option 4 with £150,626. This is a conservative assessment with a confidence of 30%.

There are no quantifiable qualitative benefits or societal benefits. For more information please see Appendix: Benefits workings.

Risks

The full list of risks are included in the Risk Register in Appendix: CMPN LIMS Programme Plan (including risk register). However, for the purpose of the economic model, the specific risks which have quantifiable mitigations are listed below:

Table 12

Risk	Risk impact	Mitigation	Explanation of value
Current LIMS system across C&M do not integrate	This will mean that the Target Operating Model of the network will not be achievable.	Ongoing work through the network to support standardisation, reduction in variation etc.	The total amount cash-releasing benefits of the preferred option not being realised.
Providers will not be able to receive	Benefits not realised		Loss of the total amount Non-cash

efficiency benefits that are associated with a more integrated system-wide LIMS		Time spent sending referrals, time spent accessing referrals	releasing benefits (from the preferred option)
LIMS is a core requirement from NHS England	The network will be unable to meet Digital Maturity	Continued working with providers to improve connectivity	Loss of capital from NHS
Change management burden for all providers as changes required across all the providers	Huge financial/resource implications	Network team to work across each of the providers	Cost of additional project management in year 25/26 and 26/27 which are not covered in the costs currently.
One Trust will need frontrunner	Significant risk/ time resource required for host Trust	Additional implementation costs to support the first provider	Recruitment of an integration project manager band 8A. Bottom of the band to support the first provider to go live.

Value for Money

The table below details the value for money across each of the options, considering the total costs, cash releasing benefits, non- cash releasing benefits and risks.
Table 13 provides a summary position, considering discounted figures, across capital expenditure, revenue, risk retained, cash releasing and non-cash releasing benefits.

Table 13

Summary - undiscounted (all financial figures £000 exc VAT)	Option 1 - Option 1 long name	Option 2 - Option 2 long name	Option 3 - Option 3 long name	Option 4 - Option 4 long name	Option 5 - Option 5 long name
Capital expenditure exc VAT	-705	-2,939	-49,334	-15,784	-20,587
Capital expenditure optimism bias uplift	0	-676	-21,707	-2,210	-6,794
Revenue expenditure exc VAT	-19,136	-29,585	-29,087	-14,812	-14,543
Revenue expenditure optimism bias uplift	0	-6,805	-12,798	-2,074	-4,799
Total expenditure exc VAT	**-19,841**	**-40,005**	**-112,926**	**-34,879**	**-46,724**
Plus cost of risk retained	-181,788	-250	-1,291,070	-87	0
Less cash releasing benefits	0	0	7,625	15,250	6,034
Less non-cash releasing benefits	0	27,197	52,300	150,626	76,972
Less societal benefits @ 1.5%	0	0	0	0	0
Less societal benefits @ 3.5%	0	0	0	0	0

Conclusion of the economic model

A single LIMS is the single biggest enabler to securing wider system benefits across the network. To ensure value for money, option 4: Integrate network-wide LIMS solution for all pathology solutions is the preferred way forward.

4. Commercial Case

Procurement Strategy

The Digital Diagnostic Capability Fund (NHS England) has provided capital funding to Cheshire and Merseyside Pathology Network (CMPN) for a LIMS project from 2022-2025.

All NHS England (NHSE) centrally funded projects must comply with the NHSE endorsed routes to market. For clinical software, these are the London Procurement Partnership (LPP) Clinical Digital Solutions (CDS) framework, the Enterprise-wide Electronic Patient Records framework provided by NHS England Health Systems Support and NHS Supply Chain Medical IT Departmental Software and Hardware Solutions. Lot 1 - Medical IT Software Solutions – LIMS. There are only three NHS England endorsed routes to market. Not all our current suppliers are listed on all the frameworks. In order to determine the best framework to use, CMPN have decided to take a two phased approach on the advice of NHSE.

Countess of Chester (COCH) Commercial Procurement Services have been commissioned to lead the procurement of the LIMS solution. The process will be carried out via the Countess of Chester Hospital NHS Foundation Trust eTendering Portal (Bravo system).

Procurement Process

A procurement plan has been drafted. The approach includes a two phased early market engagement approach followed by the Invitation to Tender (ITT).

1) Early Market Engagement – Stage 1:

There are only three NHS England endorsed routes to market. Not all our current suppliers are listed on all the frameworks. At this stage, it is difficult to do an options appraisal of the framework providers without further information from the Laboratory Information Management System market. The first phase will be early market engagement.

Early market engagement (EME), also known as soft market testing, is the process of engaging with potential suppliers before you begin buying goods or services for your organisation. It gives suppliers the opportunity to both inform the specification and to get ready to meet the demand.

The first stage will include sending out to all current suppliers and all suppliers on the three available frameworks detailing the CMPN network, chosen requirement and timescales to use as a fact finding exercise to inform the specification and to see which suppliers are interested in bidding. This will determine a number of suppliers who only want to provide a LIMS system as part of an EPR system.

Taking the time to carry out EME and gather market intelligence is regarded as ‘best practice’ and recommended as part of the preparation process for any future contract, especially where procurements are complex or of significant value. You can engage with the market at any time as long as you comply with the Public Contracts Regulations 2015, specifically Regulation 40 which states that ‘preliminary market consultation may be used in the planning and conduct of the procurement procedure, provided that it does not have the effect of distorting competition’. CMPN is opting to follow the regulations to ensure a more effective and efficient procurement process and aims to engage early and widely with the market to allow the latter an opportunity to shape the requirement.

The initial aim of the early market engagement is to make suppliers aware of the upcoming procurement needs for the provision of a Laboratory Information Management System at CMPN. Further to this, we are keen to engage in early market engagement to understand what supplier

LIMS solutions are available, how such solutions compare, and the maturity of the supplier and product in delivering the requirements.

2) Early Market Engagement – Stage 2:

The second stage includes selecting a framework, liaising with suppliers on our chosen framework, sending them our draft specification, pricing document and terms and conditions for comment prior to finalising our tender documentation.

CMPN reserve the right to abandon stage two of the early-market engagement due to time constraints.

Table 14

Process Timetable	
Publication of Supplier Pre-Market Engagement Process	15th August 2023
Supplier Pre-Market Engagement Initial Response Deadline	25th August 2023
Supplier Pre-Market Engagement Questionnaire Response Deadline	15th September 2023

Please note that all timescales and information included are indicative.

The aim is to conduct a tender procedure starting in October 2023, but CMPN reserves the right to make changes to this intention following the early-market engagement.

CMPN understands that timelines are extremely tight however capital funding needs to be committed by the end of March 2024.

3) Tender Process:

Invitation to Tender (ITT)

The ITT will be open to all suppliers in the chosen framework.

All tender documents will be available for download on the portal and will contain all or some of the following:

- Instructions to tenderers
- Specification
- Pricing schedule
- Contract conditions – defining the relationship between the public body and the supplier/contractor. These will be the framework terms and conditions.
- Tender evaluation model. Bidding suppliers will be asked to complete a questionnaire and provide supporting documentation. We intend to evaluate the submission
- Supporting documentation – depending on the contract requirements

The ITT assesses the offer and the requirements as set out in the specification.

An outline Specification for the LIMS is being produced and will be issued to suppliers with initial invitation to tender, along with pricing schedule and a tender evaluation model which will contain questions for tenderers to complete and be evaluated on.

Evaluation of the tender submissions

This is completed by an evaluation panel.

Award of contract

- All suppliers that submitted a tender will be informed of the decision to award the contract via the portal. Decision letters should give details of the successful supplier/s and score achieved in the evaluation of tender submissions.
- a Contract Award Notice will be published.

Hosting Arrangement

To facilitate the project, one Trust must agree to host the contract with the solution provider and or the solution (depending on what solution is chosen). To do this, the project team issued an expression of interests to the core five providers in scope of the project. Through this process, Mersey and West Lancashire Hospitals Foundation Trust was agreed to host the contract and or solution.

Although the project will be unable to confirm the arrangement regarding the solution until later procurement stages, the specifics of how the contract will be hosted will be confirmed through a specification document. This specification document will include costings, assumptions and overall responsibilities of the host Trust.

Key Contractual Issues

The contractual approach is to have a single LIMS contract, with an identified Trust acting on behalf of all partners, handling payments, change management and contract performance. The necessary governance structure to support this arrangement, outlining decision making, reporting and risk sharing are to be detailed in a specification that is being drafted. This approach supports some of the conditions to access central NHSE funding, as set out in the NHSE Local Organisation Agreement document.

The contract period has yet to be confirmed and will be dependent on the supplier chosen and costs associated.

The contract will have a single cap for supplier liability and also a separate cap for the Trust's liabilities in relation to the supplier.

Implementation timescales will form part of the contract. This is in line with the implementation milestones outlined in the management case of this document. A detailed implementation plan will be agreed with the chosen supplier.

After contract signature, material amendments to the milestones will be managed through a formal change control process.

5. Financial Case

Overview

The purpose of this section is to set out the forecast financial implications of the preferred way forward (as set out in the economic case) and the proposed solution and its procurement route (as set out in the commercial case). It describes the impact on the main financial statements – the Statement of Comprehensive Income (I&E statement) and Statement of Financial Position (Balance Sheet) – and forms a conclusion on the overall affordability of the preferred option.

Sources of Capital Funding

The programme has been allocated funding under the Diagnostic Digital Capability programme by NHS England. The funding covers a variety of Digital and IT project across Pathology and Radiology projects.

In 2021, a Letter of Agreement was signed by Directors of Finance across Cheshire and Merseyside to draw down a total of £17.497m as detailed in Appendix: Letter of Agreement 2022 across all Digital and IT projects (GP Order Comms, Digital Pathology AND LIMS). In March 2023, Director of Finance agreed they would be unable to draw down a total of £2.468m funding in regards to LIMS. In August 2023, due increased engagement and thorough plans with LIMS, NHSE agree to reallocate the 22/23 funding on £2.468m back to the network, with the agreement of an additional £2.34m in 24/25 with a total now of £17.69m. The network has agreed a change notice which is currently working its way through governance.

	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	
	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	Total
Funding Source	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
DDCP Pathology LIMS 2023/24	7,440	0	0	0	0	0	0	0	0	0	0	7,440
DDCP Pathology LIMS 2024/25	0	5,100	0	0	0	0	0	0	0	0	0	5,100
DDCP Pathology CWMS Migration 2022/23	341	0	0	0	0	0	0	0	0	0	0	341
DDCP Pathology LIMS 2022/23	2,468	0	0	0	0	0	0	0	0	0	0	2,468
DDCP Pathology Additional 2024/25	0	2,340	0	0	0	0	0	0	0	0	0	2,340
Total Capital	**10,249**	**7,440**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17,689**

Figure 5

Current LIMS Contract Costs

THIS INFORMATION HAS NOT BEEN INCLUDED IN THIS TABLE.

Other Costs

Financial analysis and Impact on Income & Expenditure

Overview of Option 4 Income and Expenditure impact:

Total Costs

Financial Summary for preferred option	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000	2029/30 £000	2030/31 £000	2031/32 £000	2032/33 £000	2033/34 £000	Total £000
Capital Expenditure												
Cost of New Lims	12,000	0	0	0	0	0	0	0	0	0	0	12,000
Hosting Arrangements	0	300	300	0	0	0	0	0	0	0	0	600
3rd Party Support	0	150	150	0	0	0	0	0	0	0	0	300
Product Support	0	350	350	0	0	0	0	0	0	0	0	700
Managed Service	0	200	200	0	0	0	0	0	0	0	0	400
Project Team	500	500	500	0	0	0	0	0	0	0	0	1,500
Mirth Costs	0	284	0	0	0	0	0	0	0	0	0	284
Optimum bias and Risk	1,750	250	210									2,210
Total Capital Requirements	**14,250**	**2,034**	**1,710**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17,994**
Income & Expenditure Account (I&E):												
Hosting Arrangements	0	0	0	300	300	300	300	300	300	300	300	2,400
NPEX	0	66	66	66	66	66	66	66	66	66	66	660
3rd Party Support	0	0	0	150	150	150	150	150	150	150	150	1,200
Product Support	0	0	0	350	350	350	350	350	350	350	350	2,800
Managed Service	0	0	0	200	200	200	200	200	200	200	200	1,600
Mirth Costs	0	0	146	146	146	146	146	146	146	146	146	1,313
Non Recurrent & Dual Running Costs	1,714	1,562	1,562	0	0	0	0	0	0	0	0	4,838
Cash Releasing Savings	0	0	0	(1,221)	(1,221)	(1,221)	(1,221)	(1,221)	(1,221)	(1,221)	(1,221)	(9,770)
Total I&E Impact	1,714	1,628	1,774	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	5,042
Assumed Funding:												
Existing budgets (current contracts)	0	0	0	(685)	(685)	(685)	(685)	(685)	(685)	(685)	(685)	(5,480)
Incremental I&E Impact	1,714	1,628	1,774	(694)	(694)	(694)	(694)	(694)	(694)	(694)	(694)	(438)

Overview of Options to Procure a New LIMS with savings impact

The table above articulates that across option 4, there will be a total capital cost of £17.994m, this includes optimism bias (14%) and risk costs.

In terms of revenue costs, the income and expenditure overview shows a total system saving over 10 years of £438,000.

A detailed 10-year view of all the options can be found at Appendix: Economic modelling. The Financial Case also details the underlying assumptions of each option and detailed costing of each element.

It should be noted that the supplier costs are indicative at this point. This is based on two separate network OBCs and Do-Nothing costs which include current costs with hardware and software suppliers.

Costs will be revised once the market has been tested and a preferred supplier identified with clarity on the level of implementation resource support from the supplier.

Individual provider financial impact have been projected but remain DRAFT at this stage of the process – market testing and engagement are subject to committed system working by DOFs to support development of an overarching financial approach to this sort of activity. It is recognised this is contingent on future decision making in this area.

Provider Income and Expenditure

Provider income and expenditure in detailed below. Total costs are dependent on current Trust spend. Cash releasing benefits have been proportioned based on the current activity numbers. The tables in this section have been removed as they are commercially sensitive.

Incremental analysis (discounted)

The image below shows the incremental analysis including a discounted rate. The table shows that there will be a capital spend of £17.130 (included optimism bias, but no risk cost), there would also be an incremental benefit total of £274,242m across 10 years, including non-cash releasing benefits. This is a benefit- cost ratio of 16.

Incremental Analysis (Discounted)	BAU	Option 1 - Option 1 long name	Option 2 - Option 2 long name	Option 3 - Option 3 long name	Option 4 - Option 4 long name	Option 5 - Option 5 long name
Incremental Cost - Capital (inc opt bias)	-681	0	-2,789	-67,848	-17,130	-26,263
Incremental Cost - Revenue (inc opt bias)	-16,203	0	-14,172	-19,303	0	0
Incremental Cost - Risks	-143,714	0	0	-961,117	0	0
Incremental Cost - Total	**-160,599**	**0**	**-16,961**	**-1,048,267**	**-17,130**	**-26,263**
Incremental Benefit - Cash Releasing	0	0	0	6,116	12,232	4,840
Incremental Benefit - Non-Cash Releasing	0	0	21,353	40,459	116,673	59,297
Incremental Benefit - Societal	0	0	0	0	0	0
Incremental Cost Reduction - Capital (inc opt bias)		0	0	0	0	0
Incremental Cost Reduction - Revenue (inc opt bias)		0	0	0	1,702	552
Incremental Cost Reduction - Risks		0	143,493	0	143,635	143,714
Incremental Benefit - Total	**0**	**0**	**164,845**	**46,575**	**274,242**	**208,402**
Risk-Adjusted Net Present Social Value (NPSV)		0	147,884	-1,001,693	257,112	182,139
Benefit-Cost Ratio		0.00	9.72	0.04	16.01	7.94

Preferred Option

As a result of the local options appraisal, plus additional benefits assessment and financial analysis supports this, **Option 4: a Single Pan Pathology LIMS system** has been chosen as the preferred option for LIMS procurement.

Option 4 supports the strategic direction for the network and its aspiration to deliver service improvements through standardisation and consolidation. Additionally, following implementation, Option 4 offers the lowest steady-state revenue costs of the four options (£1,211.92 per annum), offering a reduction from the current 'do nothing' position of £1,742 (year 3 onwards) per year to £1,246 per year. This figure will, however, will be split across a greater number of providers. It is therefore assumed, that as a system there will be savings, but there may be individual providers who have a greater savings than others.

Table 15

Revenue implications	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000	2029/30 £000	2030/31 £000	2031/32 £000	2032/33 £000	2033/34 £000	Total £000
Current revenue spend	1,714.01	2,447.21	1,742.21	1,742.21	1,742.21	1,742.21	1,742.21	1,742.21	1,742.21	1,742.21	1,742.21	
Option 4 revenue spend	1,780.01	1,640.00	1,640.00	1,211.92	1,211.92	1,211.92	1,211.92	1,211.92	1,211.92	1,211.92	1,211.92	
Variance	66.00	(807.21)	(102.21)	(530.29)	(530.29)	(530.29)	(530.29)	(530.29)	(530.29)	(530.29)	(530.29)	
Equal split	13.20	(161.44)	(20.44)	(106.06)	(106.06)	(106.06)	(106.06)	(106.06)	(106.06)	(106.06)	(106.06)	
	INCREASE	SAVING	SAVING	SAVING	SAVING	SAVING	SAVING	SAVING	SAVING	SAVING	SAVING	

Assumptions

Detailed assumptions included in the economic model are detailed in Table 22.

Table 16

Assumption	Risk	Mitigation
Current running costs of running LIMS separately - estimates from Trust teams	Additional resources may be required, requiring further investment.	Continuing to work with Trust teams to estimate resource requirements & digital contract spend.
Existing maintenance costs will not cease until the solution has been implemented	Additional double-running costs required to fund current and new maintenance cost during deployment	
Hosting, Support & Managed Service costs will be capitalised during the implementation phase	Potential for differing views on what can be capitalised. Potential that the cost of the solution may not allow for sufficient capital funding	

	to capitalise implementation costs	
Confirm solution is VAT reclaimable	Potential for differing views on VAT.	Expert opinion will need to be sought on VAT.
No assumptions have been made on asset impairment.	Detailed review of capitalised costs and asset impairment may reduce capital charges.	Detailed review of capital costs and asset impairment to be undertaken before contract signature.
Project Team will be needed to implement the solution. Costs have been estimated.	Additional resource may be required which required further investment. Potential that the cost of the solution may not allow for sufficient capital funding to capitalise implementation costs	
In the income and expenditure tables, cash releasing benefits have been split based on where savings will be realised	There is a risk that cash-releasing benefits are not shared equally across the system	Risk and Gain share to explore the key principles of this
In the income and expenditure tables, costs have been proportioned based on activity levels	There is a risk that this may differ dependent on the supplier chosen and principles agreed in risk and gain share.	Risk and Gain share to explore the key principles of this

6. Management Case

Overview

The LIMS project is one of several that make up the programme of work to create the CMPN as an entity. One of the crucial enablers for the programme is a modern, flexible and resilient LIMS to support the operation of the network and to ensure that the participating organisations have an open, transparent view of the results of their investment.

The integration of the LIMS project within the CMPN programme's governance structure is shown in the following diagram: -

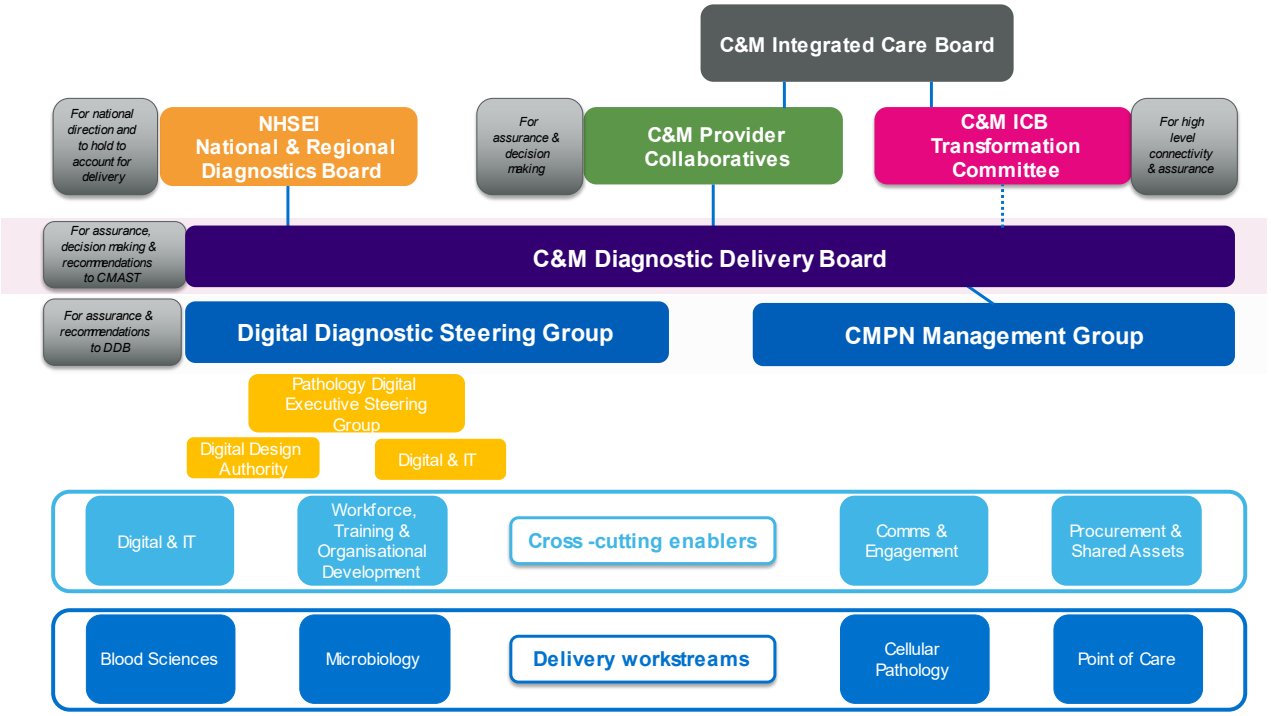


Figure 6

The implementation will be overseen by the Pathology Digital Executive Steering Group that will be accountable to the Digital Diagnostics Steering Group (DDSG), which represents members from all of the individual Trusts, both clinical and other staff groups. The Pathology Digital Executive Steering Group will be made up of the core 5 executive leads, ICB representatives and CMPN representatives.

To support the Pathology Digital Executive Steering Group, will be supported by two separate groups, including:

1) Pathology Digital and IT Group

- This group will be made up on clinical and operational leads to support the LIMS project. This group is already established as part of the CMPN governance. It does however have the best individuals on the meeting to ensure communications and engagement.

2) Digital Design Authority

- This group will be made up on technical expert to support integration requirements across the system. This is an already established group which has overseen system wide projects such as Picture Arching Communication system (PACS)

Follow on approval, decisions and communication will flow up to Diagnostic Delivery Board and wider ICB and NHSEI governance. Reporting will be via the agreed ICB highlight report template.

The task and finish group membership will be drawn from the relevant Trusts, to ensure appropriate representation. Members are responsible for contributing to the successful delivery of the project and for communicating key messages and issues to their respective organisation and feeding back any responses in return.

Project Milestones

The current planned milestones for the project are summarised in Table 23.

Table 17

Ref:	Name of Milestone/ Deliverable	Owner	Estimated Start Date	Estimated Delivery Date
1	Development of cost and funding proposal	Programme Lead	24th July 2023	30th August 2023
2	Development of LIMS Pathology Business Case	Programme Lead	24th July 2023	30th August 2023
3	Benefits workshop	Benefits Lead	26th July 2023	26th July 2023
4	Approval of LIMs Business Case	Programme Lead	30th August 2023	30th September 2023
5	Development of procurement strategy	COCH Procurement lead	1st August 2023	16th August 2023
6	Development of LIMS requirements/ specification for all pathology disciplines	Operational Leads	1st May 2023	30th September 2023
7	Develop procurement documentation	COCH Procurement lead	3rd July 2023	8th September 2023
8	Approve LIMS specification	Programme Lead	8th September 2023	22nd September 2023
9	Stakeholder engagement sessions	Programme Lead	19th June 2023	December 2024
10	Supplier Engagement	COCH Procurement lead	8th September 2023	30th September 2023
11	Confirm programme team and roles and responsibilities	Diagnostic Delivery Director	16th August 2023	30th September 2023
12	Recruit project management and other technical roles	Diagnostic Delivery Director	30th September 2023	30th October 2023
13	Pre market engagement	COCH Procurement lead		
14	Issue invitation to tender		8th September 2023	29th September 2023
15	Evaluation of supplier responses	COCH Procurement lead	2nd October 2023	31rd January 2024
16	Identify preferred supplier	COCH Procurement lead	18th December 2023	29th January 2024
17	Update business case	Programme Lead	18th December 2023	29th January 2024

18	Approval of preferred supplier at Trust boards		29th January	February 29th 2024
19	Review and finalise contract schedules	COCH Procurement lead	5th February 2024	22nd March 2024
20	Implementation planning	Programme Lead	5th February 2024	22nd March 2024
21	Agree standardisation of coding structures	Operational Leads	1st October 2023	15th January 2024
22	Trusts to amend coding structures	Trusts	15th January 2024	15th February 2024
23	Review current processes	Pathology Digital Operational Task and Finish Group	1st October 2023	15th January 2024
24	Agree future state processes	Pathology Digital Operational Task and Finish Group	15th January 2024	15th February 2024
25	Develop standard operating procedures	Pathology Digital Operational Task and Finish Group	3rd January 2024	15th February 2024
26	Data cleansing at all Trusts	Trusts	15th February 2024	15th March 2024
27	Installation of network infrastructure	Digital Integration Task and Finish Group	3rd January 2024	15th February 2024
28	Build, configuration, testing of LIMS	Digital Integration Task and Finish Group	3rd January 2024	15th February 2024
29	Trial loads for data migration	Digital Integration Task and Finish Group	3rd January 2024	15th February 2024
30	Creation of data archive	Digital Integration Task and Finish Group	3rd January 2024	15th February 2024
31	Confirmation of implementation schedule	Programme Lead	29th February 2024	30th March 2024
32	Contract signature	COCH Procurement lead	29th February 2024	22nd March 2024
33	Benefits planning	Benefits manager	3rd January 2024	15th February 2024
34	Implementation agreed	Programme Lead	3rd January 2024	15th February 2024
35	User training	Training Lead	3rd January 2024	15th February 2024
36	Go live planning	Programme Lead	3rd January 2024	15th February 2024
37	Trust 1 interface development and testing	Trust 1	April 2024	June 2024
38	Trust 1 final data migration	Trust 1	June 2024	Sept 2024
39	Trust 1 archive data	Trust 1	Sept 2024	Dec 2024
40	Trust 1 training	Trust 1	Dec 2024	Feb 2025

41	Trust 1 hardware installation (if required)	Trust 1	Dec 2024	Feb 2025
42	Trust 1 go live	Trust 1	Mar 2025	May 2025
43	Trust 1 support and optimisation	Trust 1	May 2025	June 2025
44	Trust 1 evaluation and lessons review	Trust 1	TBC	TBC
45	Trust 1 contingency	Trust 1	TBC	TBC
4659	Trust 2 interface development and testing	Trust 2	TBC	TBC
47	Trust 2 final data migration	Trust 2	TBC	TBC
48	Trust 2 archive data	Trust 2	TBC	TBC
49	Trust 2 training	Trust 2	TBC	TBC
50	Trust 2 hardware installation (if required)	Trust 2	TBC	TBC
51	Trust 2 go live	Trust 2	TBC	TBC
52	Trust 2 support and optimisation	Trust 2	TBC	TBC
53	Trust 2 evaluation and lessons review	Trust 2	TBC	TBC
54	Trust 2 contingency	Trust 2	TBC	TBC
55	Trust 3 interface development and testing	Trust 3	TBC	TBC
56	Trust 3 final data migration	Trust 3	TBC	TBC
57	Trust 3 archive data	Trust 3	TBC	TBC
58	Trust 3 training	Trust 3	TBC	TBC
59	Trust 3 hardware installation (if required)	Trust 3	TBC	TBC
60	Trust 3 go live	Trust 3	TBC	TBC
61	Trust 3 support and optimisation	Trust 3	TBC	TBC
62	Trust 3 evaluation and lessons review	Trust 3	TBC	TBC
63	Trust 3 contingency	Trust 3	TBC	TBC
64	Trust 4 interface development and testing	Trust 4	TBC	TBC

65	Trust 4 final data migration	Trust 4	TBC	TBC
66	Trust 4 archive data	Trust 4	TBC	TBC
67	Trust 4 training	Trust 4	TBC	TBC
68	Trust 4 hardware installation (if required)	Trust 4	TBC	TBC
69	Trust 4 go live	Trust 4	TBC	TBC
70	Trust 4 support and optimisation	Trust 4	TBC	TBC
71	Trust 4 evaluation and lessons review	Trust 4	TBC	TBC
72	Trust 4 contingency	Trust 4	TBC	TBC
73	Trust 5 interface development and testing	Trust 5	TBC	TBC
74	Trust 5 final data migration	Trust 5	TBC	TBC
75	Trust 5 archive data	Trust 5	TBC	TBC
76	Trust 5 training	Trust 5	TBC	TBC
77	Trust 5 hardware installation (if required)	Trust 5	TBC	TBC
78	Trust 5 go live	Trust 5	TBC	TBC
79	Trust 5 support and optimisation	Trust 5	TBC	TBC
80	Trust 5 evaluation and lessons review	Trust 5	TBC	TBC
81	Trust 5 contingency	Trust 5	TBC	TBC
82	Handover to BAU	Programme Lead	TBC	TBC
83	Benefits management	Benefits Manager	TBC	TBC

The implementation timeframes detailed above are, at this point, indicative only. A detailed project plan will be produced through an engagement with the chosen supplier after the contract has been awarded.

The detailed milestones are based on the initial 12 month implementation, however, whilst it will proceed on a site-by-site basis, implementation may run concurrently, and take longer than 12 months. The details may change through negotiations with the preferred supplier and therefore the delivery plan will confirmed in the full business case.

Further adjustments may need to be made as further clarity is received on the CMPN TOM and the other projects on which the LIMS project has some dependency.

Resource Deployment

The implementation of LIMS will take significant resource at both a regional and local level. Detailed below is an indicative central team to support implementation. This team will need to be recruited.

Table 18

Title	Individual	Responsibility
Senior Responsible Officer	Dr Liz Bishop Diagnostic Delivery SRO	To provide senior oversight to the project
Project Lead	Charlotte Griffiths Programme Manager – Mar 24	To provide leadership to the project
Clinical Lead	TBC	To provide clinical input into the project
Technical Lead	TBC WTE	To provide technical input to the project
Integration expert	TBC WTE	To support integration requirements
Finance lead	Andrew Atkinson Cheshire and Merseyside Diagnostic Finance lead	To support and oversee the capital and revenue expenditure
Operational Lead (LIMS)	Neil Gaskell (LIMS) Pathology Manager – WHH	To provide operational input into the project
Primary Care Lead	Dr Sangeetha Steevart	To provide clinical input
Patient representative	TBC	To provide a patient perspective to the project
Project Manager(s)	Nick Evans (TBC) IT Programme Manager – CMPN Dedicated LIMS Project Manager to be recruited (TBC) Dedicated Order Comms Project Manager to be recruited. (TBC)	To provide the project management resource
Benefits Lead	Jae Richardson- ICB	To provide benefits realisation resource.
Procurement Lead	Jim Flood	To provide procurement advice and support to the project

Whilst the central team will provide oversight and ensure coordination across the sites, there will be an expectation that local teams will be needed to support implementation.

The project will however require local team expertise and capacity, which will not be funded centrally.

Change Management

The project team will be using a combination of Managing Success Programmes (MSP), Prince 2 and other methodologies as necessary.

Communication and engagement are recognised as an important part of the change management process and vital for the LIMS Project. The project will ensure regular communication through the CMPN governance including, clinical and enabling workstreams but

also through wider system governance included the Digital Diagnostic Steering Group and attendance at other CMAST governance groups as and when needed.

The Pathology Digital Executive Steering Group will have a clear terms of reference, and provide regular milestone updates through highlight reports. The roles and responsibilities of the members included in the workstream will include the dissemination of the information to their own individual Trusts.

As the programme moves into implementation, the programme will work with the providers to develop training materials.

Benefits Realisation

Benefits realisation is crucial to understand whether a project has reached its full potential. The project will be following the benefits realisation approach as outlined in the Digital Diagnostics Capability Programme Benefits Realisation Management Strategy included in Appendix: Benefits strategy. As LIMS has been funded under the Digital Diagnostics Capability Programme, this strategy covers LIMs and other digital projects across the ICB. The strategy provides the framework for enabling and realising benefits. It sets out the approach to identify, monitor, and review benefits in the benefits realisation.

Key principles of benefits realisation are included below:

Table 19

BM Principles	Rationale	Tactics
Start with the end in mind	DDCP is driven by the benefits it will deliver, informing the scope of products and services	• Use existing reporting of metrics wherever possible • Establish mechanisms for benefits realisation reporting over the full product lifecycle
Align benefits with strategy	Develop a clear line of sight DDCP clearly aligns to strategic and spending objectives of national and local commissioning bodies	• Timely review of strategic drivers, spending objectives and indicators • Benefits Dependency Network maps for DDCP, showing value chains from outputs, outcomes, and benefits to strategic objectives
Manage benefits from a portfolio perspective	Manage benefits at portfolio (the CAMRIN (Cheshire and Merseyside Radiology Imaging Network), CMPN and all other consumers to the service) and programme levels (DDCP) across all the partner organisations, bringing increased coherence to Benefits Realisation Management activities and artefacts/products	• Manage and share Benefits plans and tools across all DDCP organisations to avoid duplication/double counting and ensure apportionment is agreed • Map interdependencies between programmes • Prioritise benefits to optimise delivery
Utilise successful delivery methods	Embed Benefits Realisation Management across the DDCP Programme incorporating standardised benefits management activities	• Develop a simple, efficient, supported Benefits Realisation Management model that is easy to use, using tools and templates developed locally and nationally • Follow standard benefits activities which best fit with local requirements • Manage benefits realisation over the full product lifecycle
Apply effective governance	Derive full benefits from DDCP, increasing the value gain from its delivery and use	• Establish clear roles and responsibilities • Arrange regular review and progress reporting of benefits to the DDCP Oversight Group and Diagnostics Delivery

		Group and the relevant ICB Diagnostic Network Groups as appropriate • Submit for independent assurance
Integrate benefits with performance management	Use of existing performance management mechanisms will ensure accountability for realisation becomes embedded within roles	• Use existing reporting of metrics wherever possible • Embed benefits ownership/reporting activities within job descriptions
Develop a value culture	Develops and evolve a culture where benefits realisation leads spending/investment decisions	• Support the programme and other stakeholders in understanding the purpose of benefits management • Work with Business Change colleagues to use benefits to demonstrate the value of the change

Benefits Monitoring and Reporting

In order to realise and continuously monitor and report the benefits a number of key activities will be undertaken. These include:

- Actively managing the anticipated benefits through to realisation
- Tracking and reporting on benefits realisation
- Liaising with beneficiaries to evidence the scale of improvements they've realised
- Keeping track of metrics, including from Thrive and Solus
- Developing case studies to evidence benefits, as appropriate, including endoscopy user stories
- Continuously liaising with the operational teams to ensure benefits are optimised
- Identifying and leveraging emergent benefits
- Mitigating against dis-benefits
- Engaging with stakeholders, including clinical feedback groups

Specific reporting of data/ metrics to evidence impact benefit is outlined in Appendix: Benefits Register. This is a wider system tracker and consider other projects as well as LIMS.

Risk & Issue Management

A Risk & Issues Register has been created for the project and is actively being managed. This is included in the Appendix: CMPN LIMS Programme Plan (including risk register).

New risks are added to the register as they are identified and assigned to the relevant owner for review by the Project Team. Once assessed, these new risks are presented to the LIMS Delivery Group and escalated as required. Red risks will be escalated to the Digital Diagnostic Steering Group.

Once the LIMS passes into business-as-usual operation, the responsibility for risk monitoring will pass to the business-as-usual governance structure.

Post Project Evaluation

Post project evaluation is planned to take place 6 months after LIMS is live on all sites. This is to ensure that any residual issues arising from the implementation can be resolved and there is a period within which benefits can be properly assessed. The process is planned to last 3 months.

The exercise will be carried out by a specific team, who, ideally, were not involved in the implementation exercise.

The evaluation will look to produce a lessons learned report so that any good practice can be adopted by future projects, which can also benefit from understanding those areas that can be improved.

The report is intended to be shared with all the LIMS Project stakeholders.

7. Recommendations

The core aim for this project is to procure a LIMS designed to work for a pathology network to support the transformation of pathology services in the CMPN, which in turn will support improvements in clinical services and outcomes for patients.

This document has set out the outline business case to procure the preferred Laboratory Management Information System (LIMS) option for the Cheshire & Merseyside Pathology Network (CMPN). It is intended to provide sufficient information for Cheshire and Merseyside Integrated Care Board (ICB) and Trust Boards to support their decision making to support the recommendations presented, which are:

- To accept this Business Case.
- To take forward the procurement for the preferred option.
- On approval by Trust Boards, to issue an Invitation to Tender to initiate the procurement stage.

On the basis the recommendations are agreed, a **full** business case will be produced to include the firm costing information and implementation requirements secured through the supplier engagement process.

Appendices

1. Appendix: Benefits Register

DDCP Benefits Toolkit Economic Sum

2. Appendix: Diagnostics Digital Capability (DDC) Programme

Diagnostics Digital Capability Programm

3. Appendix: Evaluation Criteria

Evaluation Criteria v3.docx

4. Appendix: Evaluation scoring

Options Appraisal scoring workbook.xlsx

5. Appendix: Benefits workshop overview

LIMS Benefits Workshop 260723 Su

6. Appendix: CMPN LIMS Programme Plan (including risk register)

Project Plan Risk Register Procurement

7. Appendix: C&M Pathology Network OBC

C&M Pathology OBC.pdf

8. Appendix: Benefits strategy

DDCP Benefits Management Strategy

9. Appendix: Benefits workings

This has been removed as the information is commercially sensitive.

10. Appendix: Letter of Agreement 2022

LOA22 Diagnostics
Digital Capability Lett

11. Appendix: Economic modelling

This has been removed as the information is commercially sensitive.

NHS
Cheshire and Merseyside

C&M Pathology Network Laboratory Information Management System (LIMS) overview

Purpose

NHS
Cheshire and Merseyside

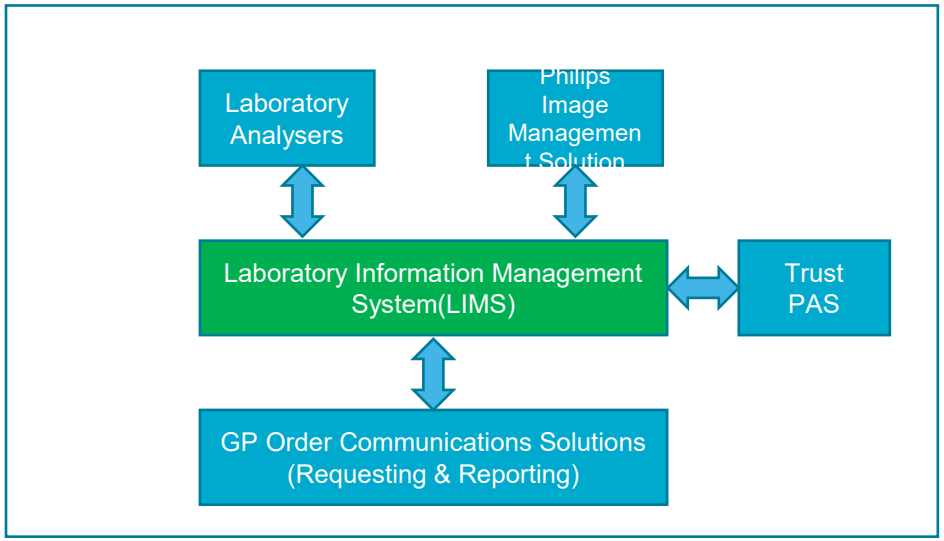
1. SUPPORT and enact system approval for this direction of travel – LIMS market testing and engagement
2. NOTE the LIMS Outline Business Case as presented to Trust Boards endorsing the aims and objectives of the approach
    - Acknowledging the ‘system’ wide benefit of these proposals and the need to develop system responses on risk and gain share alongside this process to support the management of risk and opportunities
3. Supporting the next step in development of options for a consolidated C&M approach to LIMS DELEGATE decision making and oversight for the process of market testing and engagement to CMAST Leadership Board (who in turn will report to Trust Boards).

On the basis the recommendations are agreed, a full business case will be produced to include the firm costing information, system financial interactions and implementation requirements secured through the supplier engagement process.

Background

NHS
Cheshire and Merseyside

- A Laboratory Information Management System (LIMS) is a software solution which manages data associated with samples being processed by a laboratory.
- LIMS solutions communicate with a GP order communications solutions (how GPs request tests), laboratory analysers and Digital Pathology solutions.
- Pathology Services within Cheshire and Merseyside currently use different LIMS solutions, hosted at local Trusts. There are a number of different systems in use with very little interoperability between systems.
- The lack of interoperability between current systems and organisations is a barrier to collaborative working and reconfiguration of pathology services.



Why

NHS
Cheshire and Merseyside

LIMS is the biggest enabler to achieving the Target Operating Model for the Pathology Network	By combining pathology services and clinical expertise, these services would provide a higher quality of patient care, making them more efficient. Additionally, reducing the service costs of the labs, could increase productivity and enhance career prospects of pathology staff.
Efficiency and time saved through standardisation, reduction in variation.	Time saved across the system amounts to around £150m of non cash releasing benefits. This can be used to improve the service for patients including supporting better turn around times.
Access to pathology results and reports generated by any laboratory in the network- reduction in retests, patient quality	This allows the movement of staff ensuring greater staff resilience, as well as supporting flexibility of staff.
A reduction of LIMS systems will see savings	Reducing the number of LIMS systems will see savings across maintenance fee's, supplier fee's and resourcing costs
Current LIMs system are laborious and some lack the technological capabilities needed for future ways of working	In May/ June 2022 PUBLIC were commissioned to complete user research regarding current LIMs system. They found multiple problems with current system including multiple points where error / patient safety incidents could occur

NHS England requirements

Cheshire and Merseyside

In 2021, NHS England published network maturity matrix tools both imaging and pathology networks.

The tool identifies seven domains that characterise a networks formation, as networks develop through implementation to maturing and eventually thriving. Digital and IT have a specific set of criteria for the network, showing the importance of digital innovation within a network.

The network is currently identified as ‘Developing’ across all domains.

LIMS is one of the three areas which networks should look to implement to achieve a status of either ‘Maturing’ and ‘Thriving’.

In Digital and IT there are three domains;

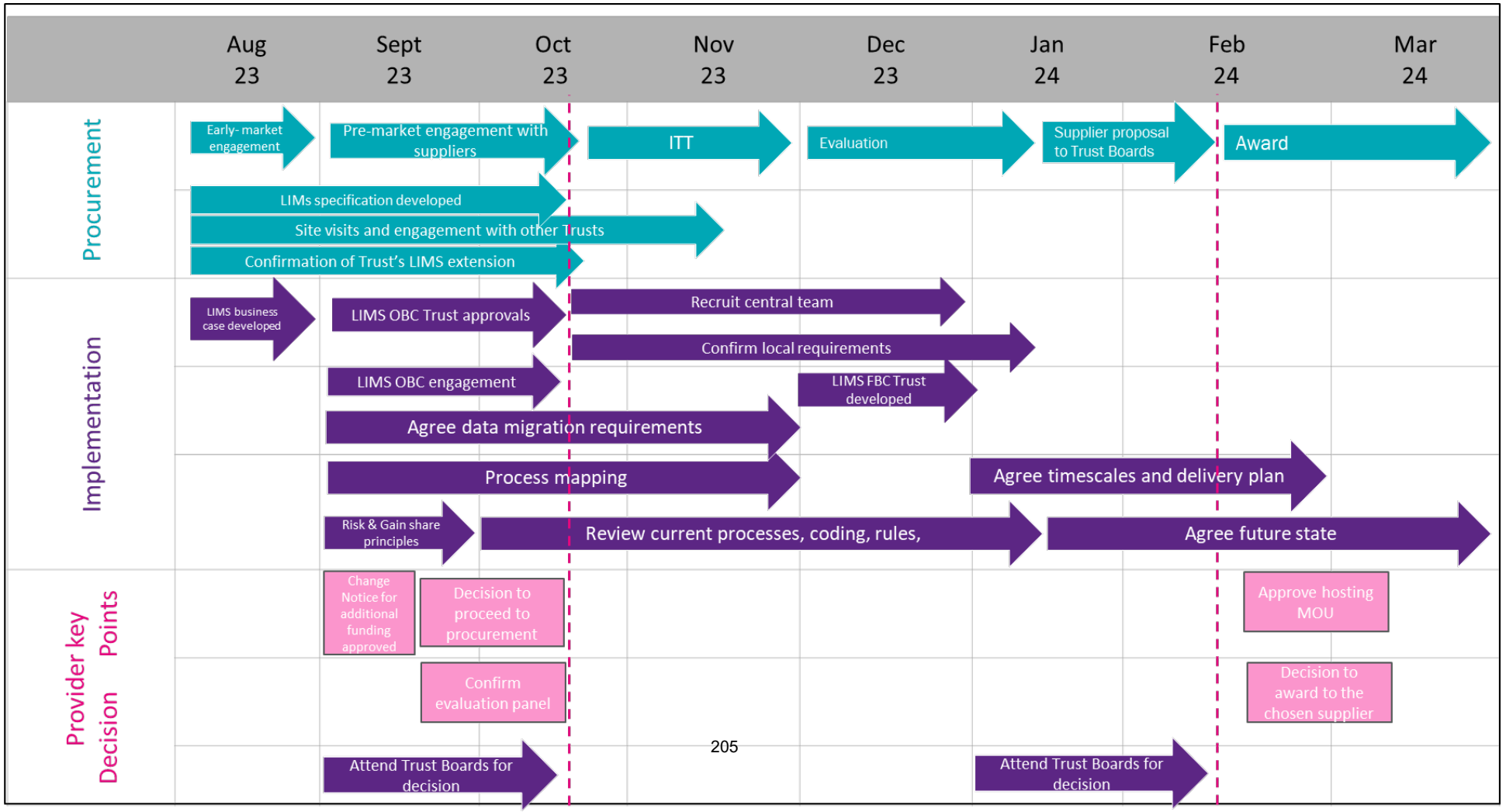
- ***Laboratory Information Management System***
- ***Order Comms***
- ***Digital Pathology***

CMPN is currently at ‘Developing’ stage and significantly delayed compared to other systems that are already at Maturing and even Thriving. Many of whom are currently procuring or implementing system wide LIMs system.

Programme Timeline

NHS
Cheshire and Merseyside

- The programme timeline is incredibly tight to ensure that we are able to spend the allocated capital by March 24.



Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/037**			
Report Title	**Gender Pay Gap 2023**			
Executive Lead	Anne-Marie Stretch, Deputy Chief Executive Officer and Director of Human Resources			
Presenting Officer	Anne-Marie Stretch, Deputy Chief Executive Officer and Director of Human Resources			
Action Required	X	**To Approve**		**To Note**

Purpose

To update the Trust Board on the annual Gender Pay Gap Report for 2023 in accordance with the legal regulations.

Executive Summary

In accordance with *The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017* this report details the Trusts Gender Pay Gap for the March 2023 snapshot date for STHK, S&O and a theoretical MWL calculation based on the merger of both data sets.

The key headlines are:

STHK

- Mean Gender Pay Gap is **30.4%**
- Median Gender Pay Gap is **13.7%**
- Mean Bonus Pay Gap is **17.8%**
- Median Bonus Pay Gap is **0.0%**

S&O

- Mean Gender Pay Gap is **20.6%**
- Median Gender Pay Gap is **5.9%**
- Mean Bonus Pay Gap is **8.5%**
- Median Bonus Pay Gap is **0.0%**

MWL

Based on the merging of 2 data sets, a theoretical MWL pay gap would be:

- Mean Gender Pay Gap is **27.0%**
- Median Gender Pay Gap is **11.7%**
- Mean Bonus Pay Gap is **14.8%**
- Median Bonus Pay Gap is **10.6%**

Key causes of the gender pay gap are the number of men and women in the workforce, the distribution of men relative to women within the pay structure (vertical segregation), and the proportion of men and women in different career groups (horizontal segregation), which results is a higher proportion of men occupying higher paid roles, in comparison to women.

Financial Implications

None

Quality and/or Equality Impact

This report is a legal requirement under the specific equality duties of the Equality Act 2010.

Recommendations

The Trust Board is asked to approve: 1. Approve the report for publication. 2. Approve the summary actions.

	Strategic Objectives
	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

Gender Pay Gap

Report 2023

Contents

List of Tables

1. Introduction

In accordance with The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Mersey and West Lancashire Teaching Hospital NHS Trust is pleased to report its annual Gender Pay Gap for March 2023, specifically the:

1. mean gender pay gap,
2. median gender pay gap,
3. proportion of males and females in each pay quartile.
4. mean bonus gender pay gap,
5. median bonus gender pay gap,
6. proportion of males and females receiving a bonus payment.

The data reported in relation to the mean and median pay gaps and the population quartiles corresponds to the employee population as of the 31st March 2023; and the mean and median bonus pay gaps correspond to any bonus pay paid in the period of the 1st April 2022 to 31st March 2023.

With the snapshot date preceding the merger of between St Helens and Knowsley Teaching Hospitals NHS Trust (STHK), and Southport and Ormskirk Hospital NHS Trust (S&O), this report includes the pay gaps for both STHK, S&O and a theoretical MWL Trust.

1.1. About Mersey and West Lancashire Teaching Hospital NHS Trust

Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) is the successor organisation of the merger between St Helens and Knowsley Teaching Hospitals NHS Trust (STHK), and Southport and Ormskirk Hospital NHS Trust (S&O).

STHK as a legacy Trust provides acute and community healthcare services at St Helens and Whiston Hospitals, Community Intermediate Care services at Newton Community Hospital in Newton-le-Willows, and an Urgent Treatment Centre, operating from the Millennium Centre, in the centre of St Helens. STHK is also the “Lead Employer” for over 13,000 doctors in training who are employed by the Trust but are in placement across the country.

S&O as a legacy trust provides acute and community healthcare services at Southport and Formby District General Hospital, and Ormskirk and District General Hospital

1.2. What is the Gender Pay Gap

The gender pay gap is the difference between the hourly rate of pay of the female population compared to the male population, expressed as a percentage. Where the pay gap is a **positive black** number, the pay gap is in favour of men; and where the pay gap is a **negative red** number, the pay gap is in favour of women.

The gender pay gap and equal pay audits, although using similar methodologies should not be conflated, as they are looking at different things. Equal Pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value, whereas the

gender pay gap looks at differences between the whole population. It is unlawful to pay people unequally on the basis of their sex.

The gender pay gap reported is for:

- The total population of STHK, S&O and MWL
- The population on Agenda for Change pay banding for STHK, S&O, and MWL
- The population of Medical & Dental staff for STHK, S&O, and MWL.

For the purpose of the gender pay gap calculation, an employee means all posts/assignments that were paid in March and who received 100% of their expected hourly rate of pay (without deductions because they are on leave).

The Hourly rate of pay means the total amount of pay received by a post/assignment in March, including enhancements but excluding overtime. Any salary sacrifice payments are deducted, including pension, childcare vouchers etc; and the final amount is divided by the number of hours worked to provide each post/assignment with an hourly rate of pay.

The closer the pay gap is to 0%, the better the Trusts' performance.

1.3. Note on "Mersey and West Lancashire Teaching Hospital NHS Trust" data

The Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) data is a theoretical calculation of what that Trust Gender Pay Gap would likely be. However, this is based on the merging of the 2 staff data populations into a single theoretical trust, without factoring in future changes to staffing levels, pay or employment practices. Future MWL calculations will be based on a single data set which will account for some of these differenced. Therefore, the MWL data should be used as a guide, and not an absolute.

2. Population Summary

On the snapshot date of the 31st March 2023, the following number of employees were included in the data analysis: STHK: 7,333; S&O 3416; and MWL 10,749.

Table 1: Trust Population

	# Total	# Female	# Male	% Female	% Male
STHK	7333	5981	1352	81.6%	18.4%
S&O	3416	2584	832	75.6%	24.4%
MWL	10,749	8565	2184	79.7%	20.3%

Table 2: Agenda for Change Population

	# Total	# Female	# Male	% Female	% Male
STHK	6714	5692	1022	84.8%	15.2%
S&O	3074	2465	609	80.2%	19.8%
MWL	9788	8157	1631	83.3%	16.7%

Table 3: Medical and Dental Population

	# Total	# Female	# Male	% Female	% Male
STHK	619	289	330	46.7%	53.3%
S&O	342	119	223	34.8%	65.2%
MWL	961	408	553	42.5%	57.5%

3. Mean Gender Pay Gap (1)

The mean gender pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole male population, and the average hourly income of the whole female population expressed as a percentage. Table 4-9 includes the hourly rate of pay, pay difference, and pay gap value.

Table 4: Trust Mean Gender Pay Gap

	STHK	S&O	MWL
Female	£17.39	£17.57	£17.44
Male	£24.96	£22.13	£23.90
Difference	£7.58	£4.56	£6.46
% Pay Gap	**30.35%**	**20.60%**	**27.03%**

Table 5: Agenda for Change Mean Gender Pay Gap

	STHK	S&O	MWL
Female	£16.13	£16.82	£16.34
Male	£16.95	£16.28	£16.70
Difference	£0.82	£0.54	£0.36
% Pay Gap	**4.81%**	**- 3.30%**	**2.15%**

Table 6: Medical & Dental Mean Gender Pay Gap

	STHK	S&O	MWL
Female	£42.08	£33.19	£39.48
Male	£49.78	£38.18	£45.12
Difference	£7.70	£4.99	£5.64
% Pay Gap	**15.48%**	**13.09%**	**12.49%**

4. Median Gender Pay Gap (2)

The median gender pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole male population (from smallest to largest), and the middle value hourly income of the whole female population expressed as a percentage.

Table 7: Trust Median Gender Pay Gap

	STHK	S&O	MWL
Female	£14.87	£16.00	£15.11
Male	£17.24	£17.00	£17.12
Difference	£2.36	£1.00	£2.01
% Pay Gap	**13.71%**	**5.90%**	**11.71%**

Table 8: Agenda for Change Median Gender Pay Gap

	STHK	S&O	MWL
Female	£14.48	£15.55	£14.49
Male	£14.80	£14.23	£14.79
Difference	£0.32	£1.32	£0.30
% Pay Gap	**2.17%**	**- 9.27%**	**-2.05%**

Table 9: Medical & Dental Median Gender Pay Gap

	STHK	S&O	MWL
Female	£43.70	£27.28	£38.21
Male	£50.86	£36.07	£47.48
Difference	£7.10	£8.79	£9.27
% Pay Gap	**14.09%**	**24.37%**	**19.52%**

5. Proportion of males and females in each pay quartile (3)

To allow the trust to compare the distribution of men and women within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher. The total number of men and women are counted in each to produce the quartile populations.

Table 10: Quartile Populations

		STHK	S&O	MWL
Quartile 1	**% Female**	84.8%	77.6%	83.10%
	% Male	15.2%	22.4%	16.9%
Quartile 2	**% Female**	84.7%	77.2%	82.3%
	% Male	15.2%	22.8%	17.7%
Quartile 3	**% Female**	85.2%	79.5%	82.8%
	% Male	14.8%	20.5%	17.2%
Quartile 4	**% Female**	71.5%	68.3%	70.5%
	% Male	28.5%	31.7%	29.5%

6. Bonus Pay Gap (4,5)

6.1. Meaning of Bonus Pay

The meaning of bonus pay for the Trusts gender pay gap is a reference to the local and national clinical excellence awards/clinical impact awards which recognise clinical excellence of consultants (only).

Since COVID, the local clinical excellence awards have been awarded to all qualifying consultants at an equal value of the available funding at STHK and S&O respectively. In addition, STHK allows recipients to select whether the payment is received in March or April. As such the STHK data includes 2 LCEA values, S&O includes 1, and MWL includes 3 LCEA values.

National Clinical Excellence Awards / Clinical Impact Awards are awarded via a competitive application process and where successful are paid via the Trust payroll even though it is not the awarding body. Only consultants still employed on the 31st March 2023 are included in the data.

6.2. Mean and Median Bonus Pay Gap

The mean and median bonus gender pay gaps were as follows:

Table 11: Mean Bonus Gender Pay Gap

Sex	STHK	S&O	MWL
Female	£6,788.93	£7992.24	£7206.75
Male	£8,250.76	£8732.48	£8458.99
Difference	£1461.83	£740.24	£1252.24
% Pay Gap	**17.77%**	**8.48%**	**14.80%**

Table 12: Median Bonus Gender Pay Gap

Sex	STHK	S&O	MWL
Female	£5,268.05	£4709	£4709.00
Male	£5,268.05	£4709	£5268.05
Difference	£0	£0	£559.05
% Pay Gap	**0.00%**	**0.00%**	**10.61%**

8. Proportion of males and females receiving a bonus payment (6)

Table 13 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were male and female.

Table 13: Number of Bonus Pay recipients.

Sex	STHK	S&O	MWL
% Female receive Bonus Pay	0.6%	0.9%	0.7%
% Male receive Bonus Pay	5.5%	7.6%	6.4%
% Bonus Pay recipients Female	32.3%	27.2%	31.7%
% Bonus Pay Recipients Male	67.7%	72.8%	68.3%

9. Commentary

9.1. Cause of the Mean and Median Gender Pay Gap

The key factors that influence the gender pay gap are the number and location of men and women with the pay structure (vertical segregation), and the number of men and women in specific types of roles (horizontal segregation).

Influencing factors include large scale gendered and societal pressures that impact on career choices; access and uptake of training and development; promotion and progression practices; and life decisions relating to family, flexible and part time working.

In healthcare these factors are particularly pronounced where in STHK, 81.6% of the workforce is female, yet a mean pay gap of 30.4% and a median pay gap of 13.7% occur.

This is caused by a larger proportion of women occupying lower pay bands/roles, compared to men: 26% of women are in Quartile 1, compared to 20.6% of men; and 21.9% of women are in Quartile 4, compared to 38.7% of men.

In S&O this is less pronounced as that Trust has a larger proportion of male staff, 24.4% v 18.4% at STHK. A similar comparison shows that at S&O, 25.7% of women are in Quartile 1 v 23% of men; and 22.6% of women are in Quartile 4, compared to 32.6% of men. This has the effect of a reduced pay gap of 20.6% (mean) and 5.9% (median).

A large influencing factor in the pay gap is the number of employees on medical and dental contracts, compared to Agenda for Change pay band spine. When omitting medical and dental pay from the calculation,

- the mean pay gap for STHK reduces from 30.4% to 4.8%; and for S&O from 20.6% to -3.3% (in favour of women);
- the median pay gap for STHK reduces from 13.7% to 2.2%; and for S&O from 5.9% to -9.3% (in favour of women).

Medical and Dental

Compared to the Trust population, women make up a minority of Medical and Dental roles at 46.7%, STHK; 34.8%, S&O; 42.5% MWL. Although the overall proportions are over 40%, a larger proportion of female medics are on the lower graded roles than men. For example, 21% of female medics are on a Foundation 1 / 2 post compared to 8.7% of male medics; whereas 40% of female medics are Consultants, compared to 54.3% of male medics. In addition. A larger proportion of female consultants have been in their current post for a shorter time period than male consultants, with 74% having been in post less than 10 years, compared to 59% of male consultants; and at the upper end, 13% of female consultants have been in post for 15 plus years, compared to 19% of male consultants.

The combination of a higher proportion of women being on lower pay bands, and overall having a lower length of service in senior posts where length of service is linked to pay levels, is resulting in a lower hourly rate of pay, and hence the pay gap for medical and dental posts.

Bonus Pay

The bonus pay values are based on 4 different bonus pay offers, the 2021 and 2022 local clinical excellence awards fixed values at STHK; the 2022 LCEA fixed value at S&O; and the varying national clinical excellence / impact award values which were awarded to a small minority of people based on a competitive application process.

Individually each round of the LCEA should result is a 0% difference in the pay gap, but the combination of these awards; in addition to there being a higher proportion of men in eligible consultant positions, is causing the bonus mean pay gap.

The median bonus pay gap at STHK and S&O are both 0% because of the impact of awarding the same value for the LCEA; however, when these are merged for MWL, a median pay gap of 10.6% occurs because of the differing values awarded by each trust.

10. 2022 Gender Pay Gap Comparators

The publication of all gender pay gap data for the March 2022 GPG was completed by the 30th March 2023. Benchmarking of the 2022 Trust data against this data set is as follows:

Table 14: Rank comparison with NHS Trusts

	STHK	S&O
Mean	199th	122nd
Median	149th	95th
Bonus Mean	84th	57th
Bonus Median	12th (Joint)	12th (Joint)

11. Conclusion and Actions

The analysis of the 2023 data indicates that there remain some differences in pay between the men and women at STHK, S&O and a combined MWL.

Ongoing actions to address the gender pay gap are:

Table 15: Action Plan

Action
1. Review approaches to the recruitment and retention of men in lower pay bands, in particular Admin and Clerical; Nursing and Midwifery with the aim to improve the recruitment and retention of men in lower pay bands.
2. Review promotion/progression process and support for women into higher pay bands.
3. To review the support and development for women to apply for National Clinical Excellence / Impact Awards
4. Review how flexible working and family friendly policies, guidance, advice and support can improve retention, progression, and childcaring stereotypes.
5. Review the “Mend the Gap” report recommendations, and where identified, implement recommendations for NHS Trust on addressing the medical gender pay gap.
6. Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process.
7. Analyse data by race, disability, and other protected characteristics for publication in future years.
8. Implement an effective flexible working policy including advertising flexible working options on organisations’ recruitment campaigns.
9. Create and implement a talent management plan to improve the diversity of executive and senior leadership teams and evidence progress of implementation. Address gender and ethnicity imbalances were identified to aid the reduction of the gender pay gap.
10. Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan.

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/038**			
Report Title	**Freedom to Speak Up – Response to the NHSE Letter**			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Dr Peter Williams, Medical Director (on behalf of Sue Redfern)			
Action Required		**To Approve**	X	**To Note**

Purpose

The purpose of the paper is to provide assurance about the Trust position and response to the recommendations in the letter dated 18 August 2023 issued by NHSE, following the verdict in the Lucy Letby trial.

Executive Summary

NHS England wrote to all NHS Trust on 18 August 2023 asking NHS Leaders and Boards to review their arrangements and ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also, those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.
5. Boards are regularly reporting, reviewing, and acting upon available data.

This paper details the arrangements in place across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) to provide assurance in relation to each of these points and recommendation for future actions.

Financial Implications

No direct financial impact

Quality and/or Equality Impact

Potential to impact quality and equality

Recommendations

The Trust Board is asked review and note the report and to consider if there are any further steps the Trust should take to improve the Freedom to Speak Up (FTSU) and Whistleblowing process.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce

	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Trust response to the NHS England letter sent to Trusts following the Lucy Letby verdict.

1. Introduction

On the 18 August 2023, the verdict of the trial of Lucy Letby was announced, alongside the creation of an independent inquiry by the Department of Health and Social Care into the events at the Countess of Chester Hospital NHSFT. Lucy Letby was convicted of the murder of 7 babies and the attempted murders of 6 others. Crimes she committed while working as a neonatal nurse at the Countess of Chester Hospital NHSFT between June 2015 and June 2016.

First and foremost, our thoughts and sympathies are with the parents and families whose lives have been so terribly impacted.

The evidence at the trial suggested there may have been missed opportunities by the Trust to prevent some of the deaths when concerns were raised by staff on the neonatal unit. These issues will be fully explored by the independent inquiry.

At MWL Teaching hospitals NHS Trust, we aim to provide the highest standard care however, with the best intentions, we don't always get things right and we can always improve. It is vitally important that as an organisation we support our staff to raise concerns and ensure their voice is heard and acted upon at all levels, we must never be complacent. We, along with the rest of the NHS, need to reflect on what lessons we can learn, not only so that something as dreadful as this could never happen in our hospitals but to provide assurance that safe and high-quality care is everyone's priority.

In the most recent letter from the NHS England senior leadership team dated 18 August 2023: Verdict in the trial of Lucy Letby (Appendix 1), Trusts have been compelled to ensure every possible learning from this case is taken and implemented within NHS Organisations across the country. One of the key learnings is to ensure that everyone working in the health service feel safe to speak up and confident that it will be followed by a prompt response. In addition, the letter also provides a reminder of the importance of NHS Leaders listening to the concerns of patients, families, and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level. The letter sets out 5 areas for Trust Boards to review and assure themselves that enough is being done:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up.
4. Boards seek assurance that staff can speak up with confidence and whistle blowers are treated well.
5. Boards are regularly reporting, reviewing, and acting upon available data.

In preparation for the transaction between St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust, which took place on 1st July 2023 a review of the FTSU and Whistleblowing arrangements has been undertaken and these are in the process of being harmonised and integrated. Freedom to Speak Up and Raising Concerns supports our Trust's vision of 5-star care. A combined MWL Trust Freedom to Speak Up Strategy is in development. Further recruitment of additional FTSU Guardian and development of a FTSU Champion is in plan and progressing. As an integrated organisation a unified FTSU policy will be developed and shared. The Trust will be carrying out a Board Self-assessment in the new format as prescribed by the NGO in 2023/24

As a Trust, we are embarking on a significant period of change in how we manage our patient safety incidents as a result of a national patient safety strategy to help provide a safety management system across the NHS. This project is known as the Patient Safety Incident Response Framework (PSIRF). We are due to transition to this new approach from 1 October 2023.

2. National guidance

The Trust is required to meet the following legal/regulatory requirements in relation to raising concerns:

- The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report 'The Freedom to Speak Up' (2015 www.freedomtospeakup.org.uk/the-report/). These recommendations in response to Sir Robert's finding that the culture in the NHS did not always encourage or support workers to raise concerns that they might have about quality and safety of care provided, potentially resulting in poor experiences and outcomes for patients and colleagues.
- The NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian.
- The National NHS Freedom to Speak Up raising concerns (whistleblowing) policy (2016)
- NHS Constitution: The Francis Report emphasises the role of the NHS Constitution in helping to create a more open and transparent reporting culture in the NHS which focuses on driving up the quality and safety of patient care.
- Public Interest Disclosure Act 1998: The Act covers all workers including temporary agency staff, individuals on training courses and self-employed staff who are working for and supervised by the NHS.
- Enterprise and Regulatory Reform Act 2013: The Act introduces a number of key changes to the Public Interest Disclosure Act targeted at strengthening protections for whistleblowers.
- The Bribery Act 2010: This guidance is targeted at helping employers ensure that their local policies and procedures are in line with the legislation and, most importantly, are tied into whistleblowing arrangements.
- Health Service Circular 1999/198 "The Public Interest Disclosure Act 1998: Whistleblowing in the NHS": The Health Service circular requires every NHS trust to have robust policies and procedures in place which enable staff to raise concerns in compliance with the Public Interest Disclosure Act and remains in force.
- PAS 1998 Whistleblowing Arrangements Code of Practice.

- NHS England has recently strengthened the fit and proper person Framework, by bringing in additional background checks for Board members, which needs to be implemented by October 2023. We are currently undertaking an urgent review of our approach locally in line with the new guidance to ensure we implement the changes at pace.

3. Trust Review

A review of current processes at the two legacy trusts has been undertaken against each point in the NHSE Letter, the plans for integrating the FTSU process for MWL are outlined and Assurance evidence has been listed (and in some cases is still being gathered).

4. FTSU Arrangements Assurance Review (Appendix1)

5. Next steps

- The initial self-assessment has indicated that we have established systems and processes in place with evidence that these are affective. However, it is recognised that there is more to do the create a single FTSU and safety culture for MWL.
- A detailed review of services and processes, utilising risk registers, patient and staff feedback, incident reporting supported by triangulation of data at local, regional, and national level needs to be embedded so that the new Trust can be assured issues raised will be reported, escalated, and investigated.
- A review of the staff survey improvement plans will be undertaken with the aim of improving the “confidence to raise concerns” scores to a consistently high level across MWL.
- The Patient Safety Incident Response Framework (PSIRF) will be implemented from 1st October 2023 with ongoing review.
- The Board and integrated FTSU team will be completing the NGO Self review before January 2024, this will identify the organisational and leadership strengths for speaking up and identify any areas for development which will form the basis of an action plan.
- An additional FTSU Guardian role is out to advert to strengthen visibility across the organisation and the network of Champions will be increased.
- The Trust is implementing the new Fit and Proper Person Framework in line with national guidance.
- An integrated organisation a unified FTSU policy will be developed and shared.
- A combined MWL Trust Freedom to Speak Up Strategy is in development.

Recommendations

The Trust Board is asked to:

1.Review and note the report.

2. To consider if there are any further steps and evidence the Trust should take to improve the FTSU, Whistleblowing and maintain patient safety.

ENDS

FTSU Arrangements Assurance Review

Evidence – in red is where we need to collate and check, black text indicates we already have this (or it has been presented to the Board/SOC).

STHK sites current position	S&O sites current position	MWL plans	Sources of assurance
1. All staff have easy access to information on how to speak up.			
The Trust has an Executive Director lead for FTSU. 4 FTSU guardians who consist of 3 board members and the Associate Director of Patients Safety.	The Trust had an Executive Director lead for FTSU. 1 FTSU guardians and a network of FTSU champions, who support and encourage staff in seeking Freedom to Speak Up support.	Consider changing the FTSU guardians to have less board members. Introduce FTSU champions across all MWL sites. Development of a single MWL reporting structure to identify trends. An additional post at band 7 is out to advert, with ring fenced time to undertake engagement and promotion.	Job descriptions S&O 32 FTSU contacts since April 2023 to date and STHK 18 contacts April 2023 to date.
One of the FTSU Guardians is from a BAME background and attends staff network meetings.	There has been a focus on possible underrepresented staff groups like overseas nurse recruits and BAME staff by the FTSU guardian with specific engagement events at the staff networks.	FTSU Guardians will continue to present at the overseas nurse induction programme. FTSU Guardians will continue to support the nurses on the preceptorship programmes	January 2023, a nurse from a BAME background was supported by the FTSU guardian when an investigation was carried out into a clinical incident. The trust achieved NHS pastoral care quality award for providing best practice pastoral support for international nurses and midwives July 2023

FTSU is regularly advertised on the banner on the Trust Intranet site main page and there is a link to a dedicated intranet page. Posters providing details of the FTSU are widely distributed across the Trust and include pictures and contact details of the FTSU Guardians.		The MWL single intranet will have a dedicated FTSU section, which will include a register of the FTSU champions. New MWL FTSU posters are being distributed to all areas.	MWL has already updated the information on the legacy intranet pages ahead of the implementation of a single intranet for all staff.
Regular engagement events were conducted to raise awareness	Quality engagement events were undertaken weekly by senior nurses within the Trust.	Annual programme of MWL engagement events. FTSU Guardians to hold regular meetings to feedback on occurring themes, review trends on 'Open cases' and/or any high-risk cases that the Executive/Board need to be made aware of.	Attendance records at induction and engagement events.
		Use the national FTSU Month in October to launch the MWL approach to FTSU, with a specific focus on reaching out to night/weekend and bank staff.	
Auditing of awareness		Include FTSU in the ward accreditation programme, working with Tendable to include this domain. Maintain records of staff who have completed FTSU training. FTSU to be included in the internal audit programme	

The staff benefits leaflet includes FTSU		Included in staff recruitment letters sent before staff start in post.	Staff Benefits (1).pdf
Information about freedom to speak up and raising concerns regularly and periodically features in Trust Brief sessions		Feature FTSU in Team Brief Live throughout the FTSU month.	Last presented at the MWL team brief live on 07.09.2023 by DONM&G Team Brief Live September 2023 FTS
Speak In Confidence TM system in place. Raising concerns hotline		Speak in Confidence TM System extended to all MWL sites and allows staff to raise concerns or submit ideas anonymously. This can be accessed from a Smart Phone, Tablet or PC, the person receives a personalised response to the concern. Confidential Raising Concerns hotline: 0151 430 1777 has been extended for all MWL staff.	Audits of themes to speak in confidential Raising concerns hotline to be undertaken.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.			
FTSU Guardians and the Human Resources Department aware of the support mechanisms available for staff members within the Trust and through NGO office.	FTSU Guardians and the Human Resources Department aware of the support mechanisms available for staff members within the Trust and through NGO office. S&O contract with NHS Professionals includes responsibilities to share FTSU information.	MWL FTSU Policy is based on the Model FTSU Policy published by NHS England in June 2022. MWL completing a single FTSU self- assessment against the national policy toolkit. Information about National Guardians Office are included as part of information during engagement events and included on the Intranet page.	All FTSU Guardians have completed the national training programme. Information about the National Guardians Office Support Scheme is included in induction information and awareness sessions. Evidence of referrals made, and actions taken.

3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. **Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.**			
Executive and NEDs attendance at Quality ward rounds and team talks with feedback on actions taken. "Ask Ann" the system where staff, patients and members of the public can raise issues directly to the Chief Executive is widely recognised as a means of raising concerns and is used by staff.		The Raising Concerns/FTSU posters, information leaflets and engagement materials are being refreshed with the MWL branding. Ask Ann has been put in place for MWL. In partnership with the ED&I leads developing a programme to raise awareness of the role of the FTSU Champions	Review of policies e.g., safeguarding, NMC referrals and allegations process. Revised NHSE self-assessment framework to be completed by January 20214 to develop objectives for FTSU strategy and forward plan
		PSIRF being introduced from October 2023, which will change the way we respond to patient safety incidents, with a greater understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients. The new framework will require organisations to have a greater involvement of staff involved in incident and patient/relatives in patient safety investigations.	PSIRF agreed priorities for 2023/24
Both Trusts have received FTSU /raising concerns issues from a wide cross section of trust staff, giving assurance that Various staff groups have approached FTSU Guardians in the previous years, indicating confidence of staff in all areas to raising issues.		Identify staff groups who have had limited interface with FTSU such as students, volunteers, and contractors for targeted awareness raising	

4. Boards seek assurance that staff can speak up with confidence and whistle blowers are treated well.			
FTSU reports have detailed the outcomes of the concerns raised and if the individual was satisfied with the outcome.	Have increased the number of FTSU concerns since the last CQC inspection. FTSU reports have detailed the outcomes of the concerns raised and if the individual was satisfied with the outcome.	FTSU concerns are recorded per NGO Guidelines themes of Patient Safety/Well-being, Worker Safety/Well-being, Inappropriate Attitudes and Behaviours and Bullying & Harassment. Staff networks will be encouraged to report any issues.	PALS and complaints contacts by area and themes Staff Survey results and action plans Number of whistle blowers/concerns raised with CQC which have previously been raised internally. Safe recruitment of agency staff either employed directly or via subcontracted services. Review of policies to describe processes to raise safeguarding alerts. LADO Referrals and DBS process Pals contacts
Medical examiners – The Trust has established medical examiners to ensure independent scrutiny of all deaths which are not investigated by a coroner and improving data quality, making it easier to spot potential problems.		Medical examiners reviews can identify any issues with care delivery and escalate any concerns.	% reviews completed and escalated for further investigation via structured judgement review process Learning from Death, LEDER and SUDIC Reviews
5. Boards are regularly reporting, reviewing, and acting upon available data.			
Quality Committee and more latterly the Strategic People Committee received regular Freedom to Speak Up reports with relevant data presented.	Board and under the ALTC arrangements SOC received quarterly FTSU reports	MWL to review reporting arrangements and frequency	Previous FTSU reports Staff Survey results Trust Objectives
The Trust Board/SOC/Quality Committees also received regular reports on incidents, learning from deaths,		STHK was a high reporter of incidents, and this culture is being embedded across MWL.	Staff survey results and action plans

mortality (HSMR/CRAB) and a range of other clinical effectiveness and outcomes measures that can be triangulated with the FTSU reports to identify any areas of concerns. This is an indication of a learning culture.		Clinical Audits National benchmarking data on incident reporting NHS Get It Right First Time (GIRFT) Neonates and maternity. Reviews and recommendations. CNST MIS 10 safety actions NHSR score card -claims. Process mapping of incident reporting in progress, escalation, and triangulation of data. PSRIF – patient safety panel weekly supported by SIRG and incident reviews by divisions. Planned HSIB / PSRIF training for board members .

Title of Meeting	**Trust Board**		**Date**	27 September 2023
Agenda Item	**MWL TB23/039**			
Report Title	**Staff Vaccination Campaign 2023/24**			
Executive Lead	Anne-Marie Stretch, Deputy Chief Executive Officer and Director of Human Resources			
Presenting Officer	Adam Hodkinson, Assistant Director of Health, Work and Wellbeing			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide public assurance, that the Trust Board and senior leadership team for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) are fully committed to the seasonal Healthcare Worker (HCW) vaccination Campaign 2023/2024.

Executive Summary

As laid down in the DHSC, UKHSA and NHS England the National Autumn/Winter (AW) 2023/24 Flu and Covid-19 Seasonal Campaign for frontline healthcare and social care workers should be offered vaccination by their employer. This is an employer's responsibility to help protect their staff, patients, and clients to ensure the overall safe running of services.

Employers should commission or implement a service which makes access to the flu and Covid-19 vaccine easy for all frontline Healthcare workers (with patient contact) and encourages staff to get vaccinated and monitors the delivery of their programme.

One of the quality indicators in the 2023/24 Commissioning for Quality and Innovation (CQUIN) is to vaccinate healthcare workers for seasonal influenza, with a vaccine uptake between 75% to 80% of staff.

The DHSC and NHS England have stipulated that the self-assessment checklist should be published by trusts to ensure public assurance.

To deliver this campaign, the service will need significant support from clinical areas to deliver a comprehensive and proactive vaccination campaign. To meet the anticipated demand, a roving vaccination model will be required in all clinical areas as a minimum service delivery model, which will commence on the 07 October 2023 and a pre-booking service will be available from 26 September 2023 (actual appointment attendance will not start until the 07 October 2023).

Financial Implications

As per Vaccination Business Case, approval. No Direct financial implications as result of this campaign checklist, being approved.

Quality and/or Equality Impact

None.

Recommendations

The Trust Board is asked to note the Staff Vaccination Campaign 2023/24 report.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety

	SO3 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Seasonal Vaccination Campaign – Leadership Checklist Report 2023-2024

1. **Trust Self-Assessment:** Healthcare worker vaccination best practice management checklist

Item	Leadership	BRAG
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers. (Staff who have contact with patients)	Completed
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Completed
A3	Board receives an evaluation of the vaccination programme 2022-2023, including data, successes, challenges, and lessons learnt	Completed
A4	Agree on a board champion for the vaccination campaign	Completed
A5	All board members promote flu and COVID-19 vaccinations and publicise	In-Progress
A6	Vaccination team formed with representatives from all directorates, staff groups and trade unions	Completed
A7	Vaccination team to meet regularly from September 2023	On-Going

Item	Communication Strategy	BRAG
B1	Rationale for the vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	In-Progress
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	In-Progress
B3	Board and senior managers promote having vaccinations and to be publicised	In-Progress
B4	vaccination programme and access to vaccination on induction programmes	In-Progress
B5	Programme to be publicised (screensavers, posters, and social media etc.)	In-Progress
B6	Weekly feedback on percentage uptake for directorates, teams, and professional groups	In-Progress

Item	Service Delivery Model's	BRAG
C1	Schedule for easy access drop-in clinics agreed	On-Going
C2	Schedule for roving vaccinations to be agreed	On-Going
C3	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and/or empower eligible staff to have the vaccinations	In-Progress

Item	Incentives	BRAG
D1	Board to agree on incentives and how to publicise	In-Progress
D2	Success to be celebrated	In-Progress

END

Title of Meeting	**Trust Board**			**Date**	**27 September 2023**
Agenda Item	**MWL TB23/040**				
Report Title	**Board and Committee Terms of Reference**				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required	**X**	**To Approve**		**To Note**	

Purpose

To approve the Terms of Reference (ToR) for the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Board and its committees.

Executive Summary

The Board finalised the prospective corporate governance structure for MWL in June 2023.

The terms of reference (ToR) for the Board and each committee have been reviewed, to ensure the functions align to the new corporate governance framework, the Corporate Governance Manual, and the NHS Code of Governance.

Where there have been committee meetings in September the proposed terms of reference have been reviewed and endorsed for recommendation to the Board.

Following approval of the committee ToR the reporting governance council ToR will also be reviewed to ensure they align to the committee functions.

It is acknowledged that the new ToR may need to be adapted as MWL corporate governance arrangement mature. The annual board effectiveness review will take place at the beginning of 2024/25 and will provide board members with the opportunity to reflect on the new arrangements and make any changes or adaptations.

Financial Implications

None

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the new Terms of Reference to support the MWL corporate governance structure.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems

X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
x	**SO9** Strategic Plans

TRUST BOARD – Terms of Reference (2023/24) Proposed	
Authority	Mersey and West Lancashire 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 1990/2446) amended by SI 1999/632 and SI 2023/711(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 Terms of Reference.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 6 Non-executive Directors (one of which will be appointed Vice Chair) 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 (2023/24) Proposed	
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: - Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); - 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. <u>Internal Audit</u> 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. <u>External Audit</u> 6. Make recommendations to the Trust Board about the appointment and independence of the External Auditor. 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. <u>Financial Reporting and Governance</u> 12. Approve the Annual Report and Accounts on behalf of the Trust Board, when the audit timetable does not allow for the Annual Report and Accounts to be approved at a scheduled Trust Board meeting. When approving the Annual Report and Accounts the Audit Committee should focus 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	<u>Core Members</u> 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, one of whom will be the committee chair (who will be a qualified accountant or have a finance background). <u>In attendance</u> The Director of Finance, the Director of Corporate Services, 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, but usually 4 – 5 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 Corporate Services. Documents submitted to the Committee should be in line with the corporate standard.

CHARITABLE FUNDS COMMITTEE – Terms of Reference (ToR) 2023/24 - Proposed	
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 this ToR.
Purposes	The Charitable Funds Committee ('the Committee') is established to ensure that the Trust's duties as Corporate Trustee of its subsidiary charity ('the Charity') have been discharged. The formal purposes of the Charitable Funds Committee can be summarised as follows. • To agree the purpose, strategy, policies, and controls of the Charity. • To oversee the Charity's financial and treasury management processes. • To control expenditure from the funds. • To control and support fundraising and income initiatives. • To recommend an Annual Report and Accounts to the Corporate Trustee, outlining the Charity's key achievements. The Board of Directors of the Corporate Trustee maintains overall responsibility and legal obligations for these areas. However, the Charitable Funds Committee has delegated authority / responsibility, from the Corporate Trustee, within the limits set out in this ToR.
Authority	The Committee will oversee the administration of the Charity in line with statute and with Charity Commission (and other regulatory) requirements. The Committee has duties and delegated authority from the Board as follows. i) Approve the purpose, strategy, policies, and controls of the Charity, having due regard for propriety, compliance, risk, effectiveness, and efficiency. ii) Approve any significant changes in the Charity's governing document and registration with the Charity Commission, for recommendation to the Board of Directors of the Corporate Trustee.

	iii) Review those aspects of Standing Orders and Standing Financial Instructions that relate to the Charity and its operation, advising the Audit Committee on any such matters which need further attention. iv) Control all charitable expenditure in accordance with the Charity's Objects, Charities Act 2011/2016, *patient benefit criteria*, and best practice, through review and approval of the Charity's *Expenditure Policy.* v) Control income generation / handling mechanisms, including official fundraising, in accordance Charities Act 2016 and best practice, through review and approval of the Charity's *Fundraising and Incomes Policy.* vi) Approve detailed proposals for: appeals, the accumulation of funds for major purchases, delegated fundholder-ship and financial limits, fund structure, closing funds, and/or the establishment of new funds. vii) Oversee the use of investments in line with the Trustee Act 2000 and best practice, restricted to the explicit conditions or purpose of each donation, bequest or grant, through review and approval of *the Charity's Treasury Management Policy* and the *Reserves Policy.* viii) Oversee the appointment of investment advisors when required and monitor the performance of any resultant portfolio. ix) Receive and consider reports addressing the Charity's risks and risk management arrangements. x) Receive regular reports on the performance of the Charity, and steer activity with a view to maintaining acceptable levels of risk and maximising compliance and effectiveness. xi) Appoint the external auditor for the Charity and approve any change from audit to independent examination if the Charity qualifies as below-threshold. xii) Receive the Annual Report and Accounts, consistent with *Charities SoRP* and relevant legislation and accounting standards, for review and recommendation for final approval to the Board of Directors of the Corporate Trustee. The Charitable Funds Committee's duties may be discharged by any sub-committees or working groups that it seeks to establish. It would approve the Terms of Reference, workplans and duration of any such groups. The Committee must respond to any action plans referred to it by the Audit Committee. The Committee is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to co-operate with any request made by the Committee.

	The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. **All decisions on behalf of the Charity must be distinct from Trust decisions, must be in the best interests of the Charity, and must be in accordance with the *duty of prudence*.**

Associated documents	This ToR is to be read in conjunction with the following.
	
	• ***The essential trustee: what you need to know, what you need to do*** – *Charity Commission* (to be interpreted for an NHS Charity context, and a Corporate Trustee context).
	
	• **The Trust's Standing Financial Instructions.**
	
	Additionally, the following governance documents – taken as a set - describe the separate Charity entity**.**
	
	• **The Charity's 5-year Vision and Income Strategy**, as approved by this Committee.
	
	• **The Charity's Annual Report and Accounts,** which outlines the Charity's history, constitution, governance, and management arrangements, as recommended to the Trust Board for approval.
	
	• **The Charity's policies**, as approved by this Committee, including the following.
	  ○ Treasury Management Policy;
	  ○ Reserves Policy;
	  ○ Fundraising and Incomes Policy; and
	  ○ Expenditure Policy, including Mission Statement.
	
	The above documents make direct reference to the following legislation.
	
	• Charities Acts 2011 and 2016
	• Trustee Act 2000
	• General Data Protection Regulation (GDPR) 2018

Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. This process includes review of this ToR, and the setting of the Committee's annual workplan.

Membership	**Core membership** • Nominated Non-Executive Director (Chair) • Additional Non-Executive Director • Director of Finance & Information • Head of Charity In attendance • Charitable Funds Financial Accountant • Charitable Funds Officer • Assistant Director of Communications • Fundraising Team representatives All members should aim to attend all scheduled meetings. Other officers of the Trust may be invited to attend on an ad-hoc basis to present papers or to advise the Committee. Professional advisors and/or auditors may be invited to attend, when deemed necessary. Other members of the Board of the Corporate Trustee may attend meetings of the Committee. As mentioned under *Authority,* the Committee may establish appropriate time-limited working groups to consider specific issues on a project basis. Representation from such groups may be required at Committee meetings.
Attendance	Core Members are expected to attend a minimum of 60% (2 of the 3 meetings) of meetings per year. Members are expected to engage as follows. • Ensure that papers are read 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 progress. Core members, and officers who engage in Charity business, are also expected, from time to time and with appropriate notice, to contribute to Charity events and promotional activities, as requested by the Head of Charity. If a decision is needed between meetings, it can be made via an ad hoc virtual meeting, or a shared email trail, with quoracy as below. It must be ratified at the next full meeting of the Committee.

Quorum	The Committee would be considered quorate with 50% attendance, to include both of the following. • At least one Non-Executive Director. • Either the Director of Finance & Information or the Head of Charity.
Accountability & reporting	The Committee will report to the Board of Directors following each meeting via a Chair's report, covering key decisions, developments and risks, and the basis of any recommendations made to the Board.
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.
Administration	The Director of Finance & Information will be responsible for all administrative arrangements, including the following. • Timely notice of meetings. • Agendas based on the Committee's annual workplan. • Distribution of electronic papers at least 4 working days prior to the Committee, unless there are exceptional circumstances agreed with the Chair. • Minutes and Action Log updates for each meeting.

REMUNERATION COMMITTEE – Terms of Reference (2023/24) Proposed	
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.
Duties	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. <u>In attendance</u> 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.

QUALITY COMMITTEE – Terms of Reference (2023/24) - Proposed	
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 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. The Committee is authorised by the Board to commission independent professional or legal advice within the delegated authority of the Director of Nursing Midwifery and Governance or the Medical Director
Role	The Committee shall review all aspects of clinical quality, including patient experience, patient safety and clinical effectiveness and provide assurance to the Trust Board that the Trust is delivering high quality safe care to patients.
Duties	The Committee's role is to: 1. Provide assurance on clinical quality, including triangulating relevant information and ensuring an effective framework in place for learning lessons and acting on feedback from incidents, complaints, claims, patient, and staff feedback. 2. 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. 3. Provide assurance to the Board on the delivery of the Trust's Clinical Strategy, based on the Trust's vision for 5-star patient care. 4. Provide assurance to the Board of compliance with regulatory standards and guidelines, including compliance with NICE. 5. 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. 6. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes.

<table>
<tr><td></td><td>7. Identify areas for action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board ensure Freedom to Speak Up arrangements are effective.
8. Request assurance of the delivery of the annual trust objectives aligned to the Committee.
9. Review the final draft Annual Quality Account prior to submission to the Board for approval.
10. Gain assurance that the reporting councils are approving the policies and procedures for which they are responsible, in line with the Trust Procedural Documents development and Management Policy.
11. Approve any policies and procedures that are aligned to the Quality Committee and if necessary, make recommendation to the Board, in line with the Trust Procedural Document Development and Management Policy.
12. 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.
13. 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.
14. Receive assurance that effective safeguarding arrangements are in place.
15. Receive assurance that high quality maternity services are delivered,
16. Receive annual reports on behalf of the Board, e.g., complaints, infection prevention control, safeguarding, medicines management, patient engagement strategy, the clinical audit and clinical research programmes.
17. Receive assurance that the appropriate quality and equality impact assessments of proposed service developments or service changes are being undertaken.
18. Undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils.
19. Escalate any issues or concern or newly identified risks relating to quality to the Board.</td></tr>
<tr><td>Review</td><td>Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.</td></tr>
<tr><td>Membership</td><td>Core Members
<table>
<tr><th>No</th><th>Title</th><th>Named Deputy (if app)</th></tr>
<tr><td>1.</td><td>Non-Executive Director (chair)</td><td>n/a</td></tr>
<tr><td>2.</td><td>Non-Executive Directors x 2</td><td>n/a</td></tr>
<tr><td>3.</td><td>Chief Executive*</td><td>n/a</td></tr>
<tr><td>4.</td><td>Director of Human Resources /Deputy Chief Executive</td><td>Deputy Director of HR</td></tr>
</table></td></tr>
</table>

	5.	Director of Finance	Deputy Director of
	6.	Medical Director	Deputy Medical Director
	7.	Director of Nursing, Midwifery and Governance	Deputy Director of Nursing and Quality
	8.	Managing Director	Chief Operating Officer or Divisional Director of Operations
	9.	Chief Operating Officer	Divisional Director of Operations
	10.	Director of Corporate Services	

*Remains a core member but it is recognised that may not attend regularly due to the Trust's additional responsibilities in relation to Cheshire and Merseyside ICS.

Core members should ensure that if they are unable to attend a meeting, a fully briefed deputy is appointed and attends in their place.

Requested attendees
In addition to core members the committee shall be able to require the attendance of any other member of staff, to present reports.

A log of all members and supporting staff names and titles (and where external members, email addresses) are to be recorded on the Group's membership and circulation list. This list is to be reviewed and/or updated every financial year in accordance with the terms of reference review.

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. A record of attendance will be maintained throughout each financial year
Quorum	A quorum shall be 50% of core members including at least two Non-Executive Members (including the Chair).
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 Quality Committee Chair. The committee should undertake regular effectiveness reviews, including reviews of the terms of reference and annual workplan.

	Meeting effectiveness will be a standing agenda item.
Meeting Frequency	The Committee will meet monthly each year, except 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 Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

Finance and Performance Committee Terms of Reference 2023/24 - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance, Performance & Investment 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 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 (CIP) 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, Capital Planning, Estates and Facilities Management and IT 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.
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 & Information Deputy Chief Executive/Director of HR Managing Director Medical Director Chief Operating Officer Director of Corporate Services 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 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 2023/24 Proposed	
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 Trust Board. The Committee shall provide assurance to the Trust 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 Trust 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 Trust Board level significance it is to be reported to the Trust Board for approval before action. The Trust 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 Trust 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 people practices and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on all workforce issues. 2. Identify, prioritise, and monitor risk arising from workforce and people policies and practice. 3. Ensure the effective and efficient use of resources through benchmarking and evidence-based practice. 4. Protect the health and safety and wellbeing of Trust employees. 5. Ensure compliance with legal, regulatory, and other obligations. The Committee has established a Valuing our People Council, People Performance Council and the HR Commercial Services Council and may recommend additional Councils aligned to key areas of its activity as it deems appropriate. Triangulation with other committees of the Board to ensure themes are identified and actions are progressed to support the development of the people agenda and delivery of high-quality services.
Duties	The Committee will undertake the following duties: - 1. Consider and recommend to the Board, the Trust's overarching People Strategy and associated action/implementation plans.

	2. Obtain assurance of the delivery of the People Strategy through the associated action/implementation plans. 3. Consider and recommend to the Board the key people and workforce performance metrics and improvement targets for the Trust. 4. Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. 5. Review the people and workforce risks of the corporate risk register and the Board Assurance Framework, (BAF).. 6. Receive reports in relation to internal and external quality and performance targets relating to people and workforce and associated activity/implementation plans. 7. Conduct reviews and analysis of strategic people and workforce issues and to recommend the Board level response. 8. Review and make recommendations to the Board in respect of regulatory and statutory workforce publications and returns, such as; Annual Gender/BAME/Disability Pay Gap, Freedom to Speak Out declarations, the annual staff survey, WDES/WRES//MWRES/Bank WRES/PSED 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 • Managing Director • Chief Operating Officer • Director of Finance & Information • Director of Corporate Services **Other Members** • Director of Staff Engagement & Inclusion (by invitation as per agenda) • Deputy Director of HR x 2 (by invitation as per agenda) • Corporate Governance Manager 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, other officers of the Trust may be co-opted or requested to attend as considered appropriate may be asked to attend all or part of the meetings to present on specific issues. Members are selected for their specific role or because they are representative of a function of service. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet 10 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 are via the PA to the Deputy Director of HR & Governance. 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 Councils reporting to the Strategic people Committee (and associated groups) will be received by the Committee along with the reports as agreed.

EXECUTIVE COMMITTEE – Terms of Reference (2023/24) Proposed	
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, the Premium Payment Scrutiny Council, the Transition and Transformation Council and other appropriate supporting governance or project 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 - Managing Director - Director of Corporate Services - Chief Operating Officer - Director of Informatics - Director of Integration The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is allowable 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.