Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 25 September 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	**1.**	**Employee of the Month (August and September 2024)** *Purpose: To **note** the Employee of the Month presentations for August and September 2024*	Film	Chair *(15 mins)*
10.15	**2.**	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.30	**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.	**TB24/060 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 31 July 2024*	Report	
	6.	**TB24/061 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				
10.40	**7.**	**TB24/062 Integrated 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*	Report	P Williams L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.10	**8.**	**TB24/063 Committee Assurance Reports** 8.1. Executive Committee 8.2. Extraordinary Audit Committee (30/07 report) 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	A Marr I Clayton G Brown L Knight S Connor *(40 mins)*
Other Board Reports				
11.50	**9.**	**TB24/064 Medical Revalidation Annual Declaration 2023/24** *Purpose: To **approve** the Medical Revalidation Annual Declaration*	Report	P Williams *(20 mins)*
12.10	**10.**	**TB24/065 Learning from Deaths Annual Report 2023/24** *Purpose: To **note** the Learning from Deaths Annual Report*	Report	P Williams *(10 mins)*
12.20	**11.**	**TB24/066 Emergency Planning Response and Resilience (EPRR)** 11.1. Annual Report 2023/24 11.2. Statement of Compliance with National Core Standards 2024/25 *Purpose: To **approve** the EPRR Annual Report 2023/24 and the EPPR Statement of Compliance with National Core Standards*	Report	L Neary *(10 mins)*
12.30	**12.**	**TB24/067 Statutory Pay Gap Report 2023/24** *Purpose: To **approve** the Statutory Pay Gap Report*	Report	M Szpakowska *(15 mins)*
12.45	**13.**	**TB24/068 Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common refresh** 13.1. Refresh of Joint Working Agreement 13.2. Committees-in-Common Terms of Reference *Purpose: To **approve** the Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common refresh*	Report	A Marr *(10 mins)*

Concluding Business				
12.55	**14.**	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.00	**15.**	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 30 October 2024 at 09:30		**13.05 close**
15 minutes lunch break				

Chair: Richard Fraser

The Board meeting is held in public and can be attended by members of the public to observe but is not a public meeting. Any questions for the Board may be submitted to Juanita.wallace@merseywestlancs.nhs.uk 48 hrs in advance of the meeting.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 September 2024
Agenda Item	**TB24/000**			
Report Title	Patient Story			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To receive the Patient Story

Executive Summary

This story is shared by Yvonne, who describes the initial concerns she had regarding the care her mum received specific to her Parkinson's disease when she was admitted to Southport Hospital in June 2023.

Yvonne discusses how she discussed her concerns with the Director of Nursing regarding the lack of staff knowledge on how to deliver Parkinson's medication via an Apomorphine pump. The direct consequence of this was that she had to take daily time off work to ensure her mums pump was managed safely.

As a result of this, some immediate actions were implemented closely followed by the recruitment of a Parkinson's Specialist nurse. Yvonne describes the positive impact of this role on her mum and her end-of-life care and also her experience as a family member.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Patient Story.

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
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 31 July 2024
(Approved at Trust Board on Wednesday 25 September 2024)

Name	Initials	Title
Gill Brown	GB	Non-Executive Director & Deputy Chair (Chair)
Ann Marr	AM	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Lynne Barnes	LB	Acting Director of Nursing, Midwifery & Governance
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director (via MS Teams)
Steve Connor	SC	Non-Executive Director
Rob Cooper	RC	Managing Director
Malcolm Gandy	MG	Director of Informatics
Paul Growney	PG	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Carole Spencer	CS	Associate Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Rani Thind	RT	Associate Non-Executive Director (via Teams)
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative)
Yvonne Mahambrey	YM	Quality Matron, Patient Experience (Agenda Item 2) (via MS Teams)
Jacqui McElhinney	JM	Account Director, Transformation Services, Ergea Group (Observer via Teams)
Anuj Sharma	AS	Account Director, Transformation Services, Ergea Group (Observer via Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Richard Fraser	RF	Chair
Hazel Scott	HS	Non-Executive Director
Sue Redfern	SR	Director of Nursing, Midwifery and Governance

Agenda Item	Description
	The Chair made the following statement on behalf of the Trust Board:

On behalf of everyone at the Trust, I would like to offer my sincere condolences to all of those affected by the tragic incident in Southport earlier this week.

Our thoughts are with all of the families who tragically lost loved ones, taken far too soon, our community who are understandably still trying to come to terms with the shock of what happened, and of course we are thinking of our staff at Southport and Ormskirk hospitals who responded immediately to the most devastating situation and worked incredibly hard to care for the victims and their family members.

I would like to pay tribute to them today and share our heartfelt appreciation for their care, compassion and kindness.

Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for July 2024 was Victoria Sumner, Clinical Nurse Specialist (Whiston Hospital), and GB advised that due to technical issues the film could unfortunately not be shown at the meeting but would be available on the Trust intranet. **RESOLVED:** The Board **noted** Employee of the Month for July 2024 and congratulated the winner.
2.	**Patient Story**
	2.1. GB welcomed YM to the meeting. 2.2. YM introduced the Patient Story video which shared the experience of a young neuro rehabilitation patient, the things that had helped her through her treatment journey and how her feedback was being used to improve the experience of other younger patients in this environment. 2.3. LK reflected on the comments about the importance of outside space, both dedicated gardens and the wider hospital grounds, for longer stay patients for their mental wellbeing. 2.4. GB thanked YM for this inspirational patient story and asked that YM pass on the Board's thanks to the patient and her family for sharing their experiences. GB asked whether the patient had returned to university or was planning to do so. YM advised that this was the patient's eventual goal but her road to full recovery was going to be quite lengthy. GB also felt that Seddon Ward should be commended for the individualised care they provide to patients with brain injuries. 2.5. The Board reflected on the many valuable roles that could be undertaken by volunteers to support patients of all ages and circumstances, to improve their experience of being in hospital.

	(YM left the meeting) **RESOLVED:** The Board **noted** the Patient Story
3.	**Chair's Welcome and Note of Apologies**
	3.1. GB welcomed all to the meeting including AB and AS who were attending as observers. 3.2. GB reflected on a recent announcement of AM's retirement after 44 years with the NHS and commented that this was a momentous decision for her and for the Trust. It was noted that AM would remain with the Trust until a new Chief Executive Officer (CEO) had been appointed. GB recorded the Board's thanks to AM for her leadership of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) and its predecessor St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) for over 20 years. 3.3. GB noted that it was PG's last Board meeting as his term of office was ending in August and thanked him on behalf of the Board for his commitment and support during his tenure. 3.4. GB advised that AM would be leaving the meeting between 11:00 and 12:00 to attend an important NHS England meeting and the order of the agenda had been amended to accommodate this. 3.5. GB noted the apologies of RF, SR and HS. 3.6. GB acknowledged the following awards and recognition that the Trust had recently received: 3.6.1. Anne Potter, HR Business Partner, was shortlisted for the 'KPMG Star Award' at the HPMA Excellence in People Awards. 3.6.2. Lucy Unsworth, Diabetes Transition Specialist Nurse, Southport and Ormskirk Hospitals, was one of only 15 people worldwide to be awarded a fully funded scholarship to attend the International Society for Paediatric and Adolescent Diabetes (ISPAD) Science School. 3.6.3. The Trust was awarded the T-Level Partner of the Year 2024 at the Southport College Employer Partnership Awards. 3.6.4. The Urgent Community Response Frailty Team have been shortlisted for a Nursing Times Awards in the Care of Older People category. 3.6.5. Lynne Barnes, Acting Director of Nursing, Midwifery and Governance was honoured with the Cavell Charity Nurse's Star Award for her exceptional leadership 3.6.6. Congratulations to the Urology Team at Ormskirk Hospital who successfully performed their very first HoLEP procedure, an operation for patients with enlarged prostates with urinary symptoms. It required no incisions and used

	a laser which meant that patients were usually discharged home the following day. 3.6.7. Whiston Hospital was recognised as 'Orthopaedic Training Hospital of the Year'. The award was voted for by orthopaedic trainees across Cheshire and Merseyside. 3.6.8. The Respiratory Team at Whiston Hospital successfully performed their first ever Medical Thoracoscopy, an innovative diagnostic procedure offered to patients who have fluid between their lungs and chest wall. Previously patients would have been referred to Liverpool Heart and Chest Hospital for this type of procedure, but clinicians have worked extremely hard to implement it at MWL Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no declarations of interests in relation to the agenda items.
5.	**TB24/049 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 26 June 2024 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 26 June 2024
6.	**TB24/050 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following action was closed: 6.2.1. Agenda Ref 12 (MWL TB24/010 Learning from Deaths Quarterly Report) – a summary of the themes and action plans for the Quarterly Learning from Deaths report had been complied into an annual report and this was presented under Agenda Item 14 (TB24/058). **Action closed** **RESOLVED:** The Board **approved** the action log.
Executive Committee Assurance Report	
7.	**TB24/051 Executive Committee Assurance Report**
	7.1. AM presented the Executive Committee Assurance report covering the meetings held in June 2024. AM highlighted the following: 7.1.1. Further work was being undertaken to understand the impact of the hospital environment on patient falls, particularly for those falls which had taken

	place in a side room compared to a bay, as well as the physical differences between the MWL inpatient hospital sites. 7.1.2. The Committee had received a review of Locum Consultants and Speciality and Specialist Doctors (SAS) doctors, and it had been noted that several of the fragile services at the legacy Southport and Ormskirk Hospital NHS Trust (S&O) sites relied on locum staff due to the national shortages in some of the specialities and the solutions to resolve these staff shortages would not be immediate. AM advised that quarterly progress reports would be presented to the Executive Committee to provide assurance that the planned actions were effective. 7.1.3. The Committee had approved the new format for the MWL Quality Ward Rounds (QWR). 7.1.4. The Committee had received an update on the Carbapenemase-producing Enterobacteriaceae (CPE) outbreak and the plans to close and deep clean the ward once the current patients had been discharged. AM noted that the Committee had supported this approach despite the operational difficulties it would cause for patient flow. RC advised that the ward had recently been reopened following the deep clean and that all measures had been taken to prevent a further outbreak. 7.1.5. The Committee had received an update on the Patient Engagement Portal (PEP) and AM noted that whilst, the Committee welcomed this development which would make it easier for patients who were able to engage with technology, the meeting had also been assured that all patients would still have a choice of how they communicated with the Trust and anyone without access to technology would not be excluded. 7.1.6. The Committee had received the Cannular Care Improvement Plan which detailed the actions being taken to improve cannular care and to reduce hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) infections. It was noted that there was a focus on Aseptic Non Touch Technique (ANTT) training to ensure that all staff had the fundamental knowledge and skills required. 7.1.7. The Committee had approved a Business Case for substantive medical staffing for Ward 1a with the recruitment of three WTE respiratory consultants to support the ward. 7.2. RT reflected on the importance of the ward visit as part of the QWR and was pleased these were still being included in the new format. LB undertook to share the proposal for the new QWR format with NEDs, but assured RT that there would be briefings about each ward and a guide to the 15-step challenge process. The QWRs would continue to be a key part of the Board to Ward engagement for MWL, and NED involvement was essential to this, although the challenges of more wards across five different sites were also acknowledged and accounted for in the new proposals. **Action** LB to share the new QWR proposal report with Board members. The remainder of the report was noted.

	RESOLVED: The Board **received** the Executive Committee Assurance Report
Performance Reports	
8.	**TB24/052 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for June 2024 was presented.
8.1.	**Quality Indicators**
	8.1.1. LB and PW presented the Quality Indicators. 8.1.2. LB highlighted the following: 8.1.2.1. There had been no never events reported in June and the investigation of the never event reported in May was being completed to identify any lessons. 8.1.2.2. There had been 12 reported cases of Escherichia coli (E.coli) in June and 38 year to date (YTD). The hydration project continued to reduce the number of cases. 8.1.2.3. The latest data for both falls and pressure ulcers per 1,000 bed days was for March 2024 but LB reported that the improvement programmes to reduce these rates continued to be delivered and the review of the processes for validating the information was also due to be completed in the near future, which would facilitate more timely reporting. 8.1.2.4. The inpatient Friends and Family Test (FFT) recommendation rate in June 2024 was 94.6% against a target of 90.0%, despite lower recommendation rates from the maternity areas. LB advised that a deep dive into maternity response and recommendation rates had been completed and the findings reported to the Executive Committee and shared with the Quality Committee. The MWL maternity services had scored above local peers on all four maternity touch points. LB advised that feedback from the inpatient surveys and real time feedback via compliments, complaints and the Maternity and Neonatal Voices Partnership (MNVP) was also taken into account to get a balanced view of patients experiences of the services. 8.1.2.5. The number of complaints responded to within 60 days was 74.5% in June against the target of 80%, compared to 65.8% in May 2024. Complaints remained an area of focused attention and LB noted that the complaints that had breached the timescale had been responded to. LB noted that the Medicine and Urgent Care Division had the most complaints and the greatest challenge to improve response times and would receive targeted support in the next three months. 8.1.2.6. The backlog of outstanding Patient Advise and Liaison Service (PALS) responses at Whiston Hospital had now been resolved, which should help reduce the number of queries that became formal complaints. 8.1.2.7. There had been a slight decrease in the nurse fill rate in month from 99.1% in May 2024 to 94.2% in June, against the target of 90%. It was noted that the two legacy trusts had reported nursing staff fill rates slightly differently

	and this was in the process of being harmonised, with a single methodology planned to be in place from July. 8.1.2.8. LB stated that she would not comment in detail on the maternity and neonatal metrics as these would be covered by the more detailed report later on the agenda. 8.1.3. PW noted the following: 8.1.3.1. The Hospital Standardised Mortality Ratio (HSMR) data reported was still from December 2023. 8.1.3.2. Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation for the period April 2023 to March 2024 had been released and remained consistent for MWL at 1.06 which was within the confidence interval giving assurance that the Trust had the expected levels of mortality. 8.1.3.3. PW advised that the Clinical Coding and Clinical Information Teams were working together to submit the HSMR information, and it was anticipated there would be an update by September.
8.2.	**Operational Indicators**
	8.2.1. LN, presented the operational indicators and highlighted the following: 8.2.1.1. Urgent Care performance remained pressured, but the 4-hour performance (mapped) had increased from 74.1% in May 2024 to 77.6% in June. The Trust remained in escalation in a number of areas on both the Whiston and Southport Hospital sites. Bed occupancy remained high and there were long waits in the Emergency Departments (ED) and additional staff had been required for corridor care and escalation areas. 8.2.1.2. The Trust (all-types) 4-hour ED performance had increased from 68.2% in May 2024 to 72.7% in June 2024, national performance was 74.6% and Cheshire and Merseyside (C&M) was 72.7%. 8.2.1.3. The number of Non-Criteria to Reside (NCTR) patients had increased to 22.3% (0.3% increase from May 2024). In comparison Liverpool University Hospitals NHS Foundation Trust (LUHFT) were at 24% and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) at 22%. 8.2.1.4. Bed occupancy across all sites was 105% in June 2024 (93 additional patients) compared to 05.8% in May 2024. 8.2.1.5. LN noted that the C&M Integrated Care Board (ICB) Urgent and Emergency Care (UEC) Recovery Programme had been discussed in detail at the Finance and Performance (F&P) Committee meeting, which had recorded limited tangible improvement to date that had impacted on the numbers of NCTR patients. LN advised that the Programme Director had been invited to attend an Executive Committee to discuss the plans for winter 2024/25. 8.2.1.6. The elective recovery programme was on track to achieve zero 65+week waiters by the end of August 2024, ahead of the national deadline of September 2024. LN noted that it was anticipated that activity would increase towards the end of August 2024 once the two new theatres were completed and operational.

	8.2.1.7. The Trust had achieved the overall diagnostics 6-week performance target at 96.1% in June 2024 and it was noted that this was ahead of national performance of 77.9% (latest month May 2024) and C&M of 90%. LN reported that the C&M ICB was the top performing ICB nationally and MWL was the top performing Trust. This was a testament to the huge amount of work undertaken by the teams to achieve the improvement plans. 8.2.1.8. The cancer faster diagnosis standard performance had increased to 73.5% in May 2024 from 70.3% in April 2024 against the 2024/25 target of 77%, and LN advised that she anticipated the improvement trajectory to continue. The 2024/25 target for the 62-day cancer performance has been reduced from 85% to 70% for all trusts excluding MWL which was set at 82%, however, MWL had made a decision to continue to plan for the 85% target and all improvement plans had been based on this target. The 62-day cancer pathway performance was 80.2% in May (C&M performance was 71.8% and national was 65.8%). LN noted that each tumour site had its own improvement plan to achieve both the 28 and 62-day targets. 8.2.1.9. Production of GP letters following an outpatient appointment within seven days, had decreased slightly to 71.5% in June 2024, however, the Trust remained on track to deliver the standard of 90%, with plans in place to achieve this. 84.3% of urgent discharge summaries were being sent within 48 hours. 8.2.2. CS asked whether there was a system plan for the UEC Recovery Programme that could be shared, and LN confirmed that the slides that had been presented at F&P had included some of this detail and would be circulated, however some of the workstreams did not yet have detail of the key measures of success and timetables for delivery. **Action** LN to share the UEC Recovery Programme slides with Board members. 8.2.3. CS asked whether do not attends (DNAs) were still an important feature of the elective recovery challenge. LN confirmed that DNAs remained a concern in some specialties , however, with the use of technology, for example text messages, was resulting in improvement. Healthwatch had agreed to support the Trust with a piece of work relating DNAs for endoscopy patients to better understand the reasons why patients did not attend appointments. However, LN noted the primary focus remained in achieving activity plans and improving productivity, so patients did not have to wait so long. 8.2.4. RT noted that the non-elective length of stay (LOS) of 4.2 (against a target of 4.0) for MWL and the differences in performance between the legacy S&O sites (5.7) and legacy STHK sites (3.7) and asked if there was an understanding of the reasons for this difference. LN confirmed that the reasons for this were known and included the use of elective beds to accommodate escalation pressures. Protocols had now been changed and

	it was anticipated the difference in the LoS between the legacy sites would reduce. *(AM left the meeting)*
8.3.	**Workforce Indicators**
	8.3.1. MS presented the Workforce Indicators and highlighted the following: 8.3.1.1. The Trust appraisal window was from April to September 2024 across MWL and the compliance rate had increased to 74.4% in June 2024, against a trajectory of 85%. MS advised that the compliance rate compared favourably to the same period in the preceding year and the Trust remained on trajectory to achieve 85% by the end of September. 8.3.1.2. Core mandatory training compliance was at 88.5% against a target of 85%. It was noted that there was a continued focus on the priority compulsory training subjects at the Quality Committee and there was detailed monthly reporting to the Executive Committee. 8.3.1.3. In June sickness absence was 5.7% (an increase of 0.1% from May) against the target of 5% and MS noted that this was comparable to the rest of the C&M region. There had been a slight reduction within nursing and Healthcare Assistant (HCA) sickness compared to the same period in 2023/24 and this would be an area of renewed focus at the Strategic People Committee (SPC). A Task and Finish Group had been established to review HCA sickness and a deep dive had been undertaken and an action plan presented at the Executive Committee.
8.4.	**Financial Indicators**
	8.4.1. GL presented the Financial Indicators and highlighted the following: 8.4.1.1. The final approved MWL financial plan for 2024/25 had a deficit of £26.7m which had assumed: • Payment of £12m funds in line with the transaction business case • A Cost Improvement Programme (CIP) target of £47m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 activity plan 8.4.1.2. At month 3 the Trust had reported a deficit of £14.7m which was a £1m negative variance from plan due to the impact in month from the junior doctors industrial action and this included additional costs to ensure that services remained safe during the week-long period of industrial action. 8.4.1.3. The Trust had achieved £27.4m (over 50%) of the overall CIP target and this included £24.8m which was recurrent and there was a further £1.1m of recurrent CIP that was about to be transacted. 8.4.1.4. The cash balance at month 3 was £3.5m and the Trust would require cash support from NHSE throughout the year, which had been highlighted in the plan. The application for cash support had been submitted in line with NHSE processes, however the usual processes had been amended mid-month and the application would now need to be resubmitted. 8.4.1.5. Capital expenditure was currently below plan due to the timing of projects and GL assured that this would be fully utilised by the end of the year.

	8.4.2. GL highlighted the following risks: 8.4.2.1. There had been an increase in the run rate, and this was being monitored through the Executive Committee. 8.4.2.2. The addition of the new theatres at the end of August would increase activity and income. 8.4.2.3. The £12m transaction support was being discussed with regional colleagues as this had formed part of the transaction agreement to recognise the underlying financial position of S&O. 8.4.2.4. The whole ICB remained financially challenged as did the wider NHS and this might result in additional pressure on the Trust. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
9.	**TB24/053 Committee Assurance Reports**
9.1.	**Audit Committee (24/06/2024)**
	9.1.1. SC, on behalf of IC, presented the Audit Committee Assurance report from the meeting held on 24 June 2024 and noted that a verbal update had been provided at the Board meeting on 26 June 2024. SC highlighted the following: 9.1.1.1. The meeting consisted of two parts and part one covered the part year accounts for S&O for the period April to June 2023 and the following was highlighted: • The Head of Internal Audit Opinion had provided substantial assurance. • The Committee had reviewed and approved the annual accounts for the part year April to June 2024. • Mazars provided an overview of their external audit findings and completion report and noted that it was an excellent set of accounts and a credit to the finance team. • The Committee reviewed and approved the Annual Governance Statement 9.1.1.2. The second part of the meeting covered 2023/24 for STHK (April to June 2023) and then MWL from 01 July 2023 and SC highlighted the following: • The External Auditors (Grant Thornton) provided a verbal update which included the key field work undertaken to date as well as the regular meetings with the finance team. It was noted that the External Audit timetable had been issued and approved outside of the meeting. • The Head of Internal Audit Opinion was confirmed as substantial assurance. • The Committee had received the Annual Meeting Effectiveness Review. • The Committee reviewed and approved the MWL draft Annual Governance Statement and Annual Report and SC noted that this had also been presented at the Extraordinary Audit Committee held on 30 July 2024.

	The remainder of the report was **noted.**
	Extraordinary Audit Committee (30/07/2024)
	9.1.2. IC presented a verbal assurance report following the Extraordinary Audit Committee that had been held on 30 July 2024 and noted the following: 9.1.2.1. Grant Thornton (GT) provided an overview of the external audit findings and shared the draft External Auditors Findings Report and the draft Annual Auditors Report which included the Value for Money report. The Value for Money report contained five recommendations with the associated management responses. The draft Annual Auditors Report noted that there were no material errors or areas of significant weakness found in the accounts. Additionally, the area of significant weakness which had been identified in the 2022/23 accounts, relating to the treatment of assets under construction had been resolved. There was one non-material misstatement in the accounts which related to the treatment of an asset under construction and IC advised that as this was non material the Audit Committee had not required an adjustment to the accounts. 9.1.2.2. IC noted that there were still a number of outstanding items that the audit team were working through before the audit could be completed, and it was anticipated that a final opinion would be shared in August 2024 which was in line with the Audit Plan. However, these items were not expected to materially alter the accounts, at this stage. 9.1.2.3. The Committee had therefore reviewed and approved the following items: • the 2023/24 MWL annual accounts • the draft MWL Annual Governance Statement • the revised MWL Standards of Business Conduct Policy 9.1.2.4. GL advised that the Audit Committee had delegated authority for approval of the final audit opinion to himself and IC, in his role as Chair of the Audit Committee. The remainder of the report was **noted.**
9.2.	**Quality Committee**
	9.2.1. GB presented the Quality Committee Assurance Report for the meeting held on 23 July 2024 and highlighted the following: 9.2.1.1. An action plan following the Quality Committee Effectiveness Review 2023/24 would be drafted and shared with the Committee in September 2024. GB noted that this had been suggested by the Audit Committee based on feedback received via the annual committee effectiveness review. 9.2.1.2. There had been an update on the review of the Sepsis metrics with AQUA, and alignment to the National Institute for Health and Care Excellence (NICE) guidelines and once the updated data started to be reported it would be included in the Committee Performance Report (CPR).

	9.2.2. The following points were highlighted from the specific reports reviewed by the Committee: Clinical Strategy Annual Review: 9.2.2.1. The draft Clinical Strategy was developed in 2023 and would be formally launched in the next few weeks. Maternity and Neonatal Services Quarterly Report (Quarter 1) 9.2.2.2. The report had been reviewed and discussed in-depth at the meeting, but the same issues would be picked up at the Board under Agenda Item 15 (TB24/059). 9.2.2.3. The mandatory training for Safety Action 8 would include additional governance processes for this year's submission to provide additional assurance. Patient Experience Council Report 9.2.2.4. The Dementia and Delirium Steering Strategy Group had now been relaunched as a MWL group. 9.2.2.5. Following feedback from the Council, the Committee had suggested a review of weekend opening times for the coffee shop at Southport Hospital and a review of the reception service which was currently manned by volunteers. Clinical Effectiveness Committee 9.2.2.6. Whiston Hospital's Stroke services were the highest performing nationally Complaints, PALs, Claims and FFT Quarter 1 Report 9.2.3. A deep dive into claims regarding Orthopaedics to ensure that there were no emerging themes was being undertaken 9.2.3.1. The Committee had noted that the PALs enquiry backlog at the Whiston site had been cleared. Patient Safety Council Report 9.2.3.2. The Committee was assured on the work being undertaken to reduce the number of outstanding policies and procedures. GB noted the enormity of the task and was assured by the progress being made which included future divisional reporting. Safeguarding Quarterly Report 9.2.3.3. The Committee had received the first combined MWL safeguarding report Infection, Prevention Control Quarterly Report 9.2.3.4. One case of MRSA bacteraemia had been reported and the Committee had received an update on the Cannula Improvement Plan. 9.2.3.5. The Committee noted that the MWL ANTT mandatory training harmonisation plan would be presented to the Mandatory Training Steering Group in August 2024, to improve ANTT compliance

	9.2.3.6. The controlled re-opening of the ward following the Carbapenemase-producing Enterobacteriaceae (CPE) outbreak on the Whiston site was discussed. <u>Care Quality Commission (CQC) Quarterly Report</u> 9.2.3.7. The Committee noted that draft reports following the CQC inspections of the Emergency Departments at Southport and Whiston Hospitals had not yet been received for factual accuracy checking. 9.2.3.8. The 2024/25 programme of Quality Ward Rounds (QWR) would commence at the end of August. <u>Mandatory Training Compliance Report and Action Plans</u> 9.2.3.9. The Committee had been assured by the systems and processes in place to monitor compliance and noted the project to review mandatory and compulsory training requirements. 9.2.3.10. Further improvement was required for some key compulsory training subjects and would remain an area of focus and close oversight by the Executive Committee. 9.2.4. LB advised that as part of the Quality Committee action plan LB and GB would meet regularly to plan and review the meetings, which would include reviewing the annual workplan. GB agreed with LB and felt that the additional scrutiny of maternity services expected following recent national reports, had added to the agenda. The remainder of the report was **noted**.
9.3.	**Strategic People Committee**
	9.3.1. LK presented the Strategic People Committee Assurance report and highlighted the following: 9.3.1.1. The Committee received the Sickness Absence Deep Dive presentation which included an action plan. LK noted that additional analysis was required of the exit interview data for band 2 staff, 21 to 25 and 60 to 62 age groups as well as disabled staff to gain a better understanding of increased or continued sickness absence. 9.3.1.2. The Committee had received the following updates: • Trust Objectives 2024/25 Q1 • People Plan Update Q1 (Trust) • People Plan Update Q1 (Lead Employer) • Workforce Operational Plan (Provider Workforce Return 2024/25) • Staff Survey Action Plan Update Q1 9.3.1.3. The Committee had received the Volunteers Operational Plan Annual Assurance Update and LK noted that there was still work to be done to align the volunteer teams from the legacy organisations. The Volunteer Services would be delivered as part of the Workforce Development Team going forward. The Committee had recognised the Trust's volunteers and

	had highlighted their amazing contributions which included the positive feedback which had been received about Jack the Therapy Dog. 9.3.2. The Committee received the Assurance report from the Employee Relations Oversight Group and the complexity of employee relations cases that the Team were involved in, particularly those involving safeguarding matters, had been discussed. LK had raised a query in relation to the wellbeing support available to the team. There was already considerable support in place including from the Trust Safeguarding Team, but this was kept under constant review. 9.3.3. RT reflected on a Team Talk that she had recently attended at Ormskirk Hospital where a medical secretary had commented on the difficulty in recruiting and retaining medical secretaries. LN agreed that there were challenges nationally with vacancies for medical secretaries and acknowledged that the role was changing with technology. A review of the operational administration services across MWL, which included medical secretaries, was being undertaken and this would lead to a report recommending the future direction of these roles and how the Trust could support them. LN noted that the legacy organisations had completed a re-banding process with the medical secretaries. 9.3.4. RT reflected on the young volunteers that had been mentioned in the patient story and asked how well developed this volunteer group was and whether volunteering was used as a way of teaching young people about NHS careers. RT also asked if the Trust provided support to the young volunteers to develop their Curriculum Vitae (CV) to assist with their applications to healthcare courses and universities. MS advised that the Volunteer Services at the legacy organisations had been set up slightly differently, however, going forward this would form part of the Workforce Development Team and work was ongoing to finalise the Trust's strategy for the Volunteers Service. MS noted that there had been a discussion at the Strategic People Committee (SPC) about the reasons for why people volunteered and the different workstreams and advised that as the service was part of workforce development, support would be provided to develop CVs and careers in healthcare, and this would be included in the development plan. LK commented that this would support the increasing links with schools and colleges in the area. MS commented that the Trust had developed a good relationship with the local schools and colleges and promoted different careers within healthcare, and that this would continue to be an area of focus. The remainder of the report was **noted**.
9.4.	**Finance and Performance Committee**
	9.4.1. SC presented the Committee Assurance report for the meeting held on 25 July 2024 and noted that the Committee had reviewed the CPR and monthly

	finance report, but the key points had already been discussed in earlier reports so would not be repeated. Other points to highlight were: 9.4.1.1. The Director of Finance report had highlighted that the C&M system was off plan for Q1, which excluded the impact of the industrial action. There had been a detailed discussion about the current financial controls in place at the Trust and the Committee had been assured by the discussion. 9.4.1.2. There would be a focus on the System recovery plan and external financial improvement support which would review financial governance, controls and delivery of efficiencies. It was noted that PricewaterhouseCoopers (PwC) International Limited had been commissioned to undertake a four-week review of the C&M system and the Director of Finance (DoF), the CEO and the Chair would be meeting with them in the coming weeks. SC noted that this would be an opportunity to reiterate the local pressures faced by the Trust and the impact of delayed discharges on the finances of the NHS. 9.4.1.3. The Committee had reviewed the results of the 2022/23 National Cost Collection, which had been the last separate collection for the two legacy organisations. Scores were against a national average of 100 with Trust scores below 100, demonstrating lower than average costs and Trust scores higher than 100 demonstrating above average costs. Legacy STHK had achieved a score of 90 for 2022/23 which was an improvement of 4 from 2021/22 and legacy S&O had achieved a score of 104 which was an improvement of 6 from 2021/22. 9.4.1.4. The CIP target for 2024/25 was £48m and this included £36.2m recurrently. The Trust had delivered £28.7m (60% of target) and £25.9m recurrently (72% of target) of CIP. There was a focus on completing the outstanding Quality Impact Assessments (QIA) and training was being provided to support completion. The Committee had received a progress update from the Medicine and Urgency Care Division which had included examples of CIP identified and the cost controls in place to ensure effective use of existing resources. 9.4.1.5. The Committee had received the Urgent Care Performance Delivery review which provided an overview of the internal UEC improvement projects and how these linked into the C&M UEC Improvement Programme. SC noted that the Committee had been assured by the items in the action plan that were within the Trust's gift to deliver but were less assured by items and action plans that required input from system partners. 9.4.2. The Committee received the assurance reports from the Procurement Council, the CIP Council, the Capital Planning Council, the Estates & Facilities Management Council, and the IM&T Council Update. The remainder of the report was **noted**. **RESOLVED:** The Board **noted** the Committee Assurance Reports

Other Board Reports	
10.	**TB24/054 Corporate Risk Register**
	10.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the MWL CRR and noted that risk management and the reporting mechanisms continued to rely on two separate legacy DATIX systems. It was noted that an integrated system had been approved for MWL, however, it would take several months before the new system was in place. 10.2. The new divisional structures were now in place and work had started on aligning the risks to ensure consistency in scoring of risks and to remove any duplicated risks and NB noted that there would be numerous amendments to the risk register over the next few months. NB noted that there were several risks being reviewed by the Lead Directors. 10.3. NB advised that the total number of risks on the MWL risk register was 1,068 compared to 1,055 in April 2024 of which 39 risks had been escalated to the CRR (compared to 44 in April) and NB noted that these mainly reflected the new CIP risks for the 2024/25 period. Two new escalated risks had been reported on the CRR in July compared to April and eight risks had been closed or de-escalated from the CRR reported in April 2024. 10.4. NB advised that risks highlighted in yellow in Section 4 of the Appendix 1 where those that had specifically been identified by the Executive Committee for review by the divisions and the Lead Director, and changes would be reflected in the next quarterly report. 10.5. GB reflected on the enormity of work required to harmonise the risk register across the sites. 10.6. CS reflected on Risk 2083 (If medical bed occupancy increased above 95% there will be no capacity to admit patients from Emergency Department) and asked about the risk score of 15 as bed occupancy had been reported as 105% in the Operational Indicators report. NB advised that the risk had been included at the time when the Trust was aiming for 95% bed occupancy and had therefore been selected for review, so that the wording could be updated to reflect the current situation facing the organisation. *(PW left meeting)* **RESOLVED:** The Board **noted** the Corporate Risk Register
11.	**TB24/055 Board Assurance Framework**
	11.1. NB presented the quarterly review of the Board Assurance Framework (BAF) and noted that each BAF risk has been reviewed by the lead Executive. The

	Executive Committee had reviewed the BAF, and it was noted that, whilst there were no amendments to the risk score in Q1, there had been minor amendments to the actions and gaps in assurance, to ensure that the document remained current. **RESOLVED:** The Board **approved** the Board Assurance Framework
12.	**TB24/056 Informatics Reports**
12.1.	**Data Security and Protection Toolkit (DSPT)**
	12.1.1. MG presented the Data Security and Protection Toolkit (DSPT) report for 2023/24 which provided assurance that MWL operated within the parameters defined in the DSPT and had completed the annual submission to demonstrate this compliance. MG reminded the meeting that all organisations that had access to and processed patient or personal data or systems had to use the DSPT toolkit to provide assurance that they practiced good data security, and that personal information was handled correctly and in line with data protection legislation. 12.1.2. MG highlighted the following: 12.1.3. MWL had submitted the DSPT assessment at the end of June 2024 for the 2023/24 submission and provided evidence against every assertion in the submission and this included the non-mandatory items. The Trust had achieved a 'standards met' rating. 12.1.3.1. Mersey Internal Audit Agency (MIAA) had audited a number of the DSPT submission assertions and given the submission a 'Substantial Assurance' rating. MG noted that the MIAA audit had included ten national data gathering standards , and the Trust had achieved 'substantial assurance' for each of these standards.
12.2.	**Information Governance Annual Report**
	12.2.1. MG presented the Information Governance Annual Report which provided assurance that the Trust has an effective Information Governance Framework. The report detailed the initiatives and progress made in information governance for the period July 2023 to March 2024 and MG noted the focus had been on data management, the establishment of key roles and the Freedom of Information (FOI) process for MWL. 12.2.2. MG highlighted the following: 12.2.2.1. During 2023/24 MWL had reported 895 data breaches and each one had been thoroughly investigated. One serious breach had been escalated to the Information Commissioners Office (ICO) and the response was currently outstanding. Data breach investigations were reviewed by the IG Steering Group to ensure that all agreed procedures and processes were being adhered to.

	12.2.2.2. Key roles in respect of information asset owners and information administrator roles had been established for MWL, post transaction. A new information asset register was being created for MWL and work was ongoing to ensure that information asset owners and administrators had sufficient training and a clear understanding of the importance of their role in keeping data safe. 12.2.2.3. A comprehensive systems register was also being established for MWL. 12.2.2.4. The high volume of FOI requests received during 2023/24 made this a challenging area and, the response rate was not where it needed to be. Work continued to refine the MWL process for handling FOI requests. Executive leads were now involved in the process to sign off all responses, and this had resulted in improving response times. 12.2.3. GB asked whether the self-reporting of data breaches and benchmarking encouraged the reporting of near misses. MG advised that it was hard to provide benchmarking for this as organisations had different interpretations or approaches to near misses. **RESOLVED:** The Board **noted** the Data Security and Protection Toolkit (DSPT) and Information Governance Annual Report
13.	**TB24/057 Learning from Deaths Quarterly Report**
	13.1. GB explained that PW had unexpectedly had to leave the meeting. AMS, on behalf of PW, presented the Learning from Deaths Quarterly Report which provided an overview of the mortality reviews which had taken place to provide assurance that deaths occurring in hospital undergo a robust review to identify lessons which could be learnt. AMS advised that as PW had to leave the meeting, any questions about the report would be noted, and PW would provide a written response. 13.2. AMS highlighted the following: <u>Whiston and St Helens Hospitals</u> 13.2.1. There were 1,064 deaths reported in Q2 and Q3 of 2023/24 and 201 had been selected for a Structured Judgement Review (SJR), with 40 SJRs still to be completed. From the completed SJRs, three were graded as Amber (subject to further detailed review and discussion at the Mortality Surveillance Group). There had been no SJRs graded as red. <u>Southport and Ormskirk Hospitals</u> 13.2.2. All inpatient deaths in Q4 had been reviewed by the Medical Examiner's Office. Learning had been identified in 42 cases and 13 cases underwent a SJR and in one case the care had been graded as poor (amber). Of the cases that had been reviewed by the Medical Examiner but were waiting for a SJR, four had been provisionally rated as "amber" and two as "red" and these would be subject to further detailed review and discussion at the Mortality Operational Group.

	13.3. CS asked about the proportion of cases that underwent a SJR and how these cases were selected. GB commented that PW had previously explained the process to her which had been helpful, and suggested CS arrange for PW to do the same for her. NB noted that the process had been outlined in Appendix 1 of the report and advised that there were some cases that were automatically reviewed, and others followed a different process. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report
14.	**TB24/058 Learning from Deaths Annual Report 2023/24**
	14.1. GB advised that in PW's absence the report would be deferred to the next Board meeting. **RESOLVED:** The Board resolved to defer the Learning from Deaths Annual Report 2023/24
15.	**TB24/059 Maternity and Neonatal Services Assurance Report Quarter 1**
	15.1. LB presented the Maternity and Neonatal Services Assurance Report for Q1 which provided information about the quality and performance of the maternity and neonatal services across the Trust. It was noted that a more in-depth report had been presented at the Quality Committee. LB extended her thanks to the Divisional Director of Midwifery for compiling the report. 15.2. LB advised that there had been a query by NHS Resolution (NHSR) about the training data that had been included in the Maternity Incentive Scheme (MIS) Year 5 submission for the Ormskirk Maternity Unit, compared to that provided to the CQC during their inspection of the Ormskirk Unit in December 2023. The Trust had submitted additional evidence to clarify the situation and NHSR had now confirmed they had closed the query. 15.3. A comprehensive update of the Year 6 MIS submission requirements had been presented at Quality Committee and it was noted that this would be a single MWL submission for the first time. LB outlined the processes that were being put in place to achieve and maintain the training compliance above the required level for MIS. 15.4. LB drew the Board's attention to the following: 15.4.1. Perinatal Mortality (MIS Safety Action 1) - there had been two reportable deaths recorded in Q1 (one early neonatal death and one stillbirth). Both cases were undergoing review, and the families were involved in the process. 15.4.2. No never events were reported in Q1.

	15.4.3. There had been no new cases reported in Q1 that met the criteria for a Maternity and Neonatal Safety Investigation (MNSI). A summary of cases previously reported to MNSI was included in the report and LB noted that this could be a lengthy process, with full involvement of families. 15.4.4. A summary of the Saving Babies Lives bundle had also been included in the paper, which included prevention of stillbirth, reduction of smoking in pregnancy, risk assessment and surveillance of fetal growth restriction and management of pre-existing diabetes. LB noted that these were often difficult areas to evidence, but the Trust was on track to deliver the agreed actions as agreed with the Local Maternity and Neonatal System (LMNS). 15.4.5. The final reports following the CQC inspections of the maternity units on 07 and 08 December 2024 had been published and the action plans in place to deliver the recommended improvements were on track. 15.4.6. Monthly Maternity Safety Champions meetings and walkabouts had taken place and LB noted that RT (NED maternity champion) and herself tended not to do the walkabout together but would do it with other members of the team. Additionally, LB advised that she also undertook walkabouts on an ad hoc basis in between the scheduled times. 15.4.7. The Maternity Safety Champions reviewed the Perinatal Quality Surveillance Model (PQSM) tool at the monthly meetings, and this would include training compliance information going forward. 15.4.8. Work was ongoing with the Maternity and Neonatal Maternity Voices Partnership (MNVP) and the MNVP leads for Whiston and Southport Maternity Units provided feedback into the Safety Champions meetings. 15.4.9. A 15 steps Maternity and Neonatal event, which was a review of maternity and neonatal services from a service user perspective, had taken place at Ormskirk site on 09 February 2024 led by the MNVP lead and positive feedback had been received. A similar event had also taken place at Whiston site on 16 May 2024 and preliminary feedback received had also been positive. 15.4.10. The midwife to birth ratio for Q1 at Ormskirk site was recorded as 1:24 and 1:27 at the Whiston site. 15.5. LB reported that the neonatal unit diverts had been reviewed and reported to the Executive Committee. There were no concerns about the rationale for each divert but it had been noted that the Trust, mainly the Maternity Unit at Whiston Hospital, was an outlier for the number of neonatal diverts. The review had been benchmarked to other maternity units in C&M, and it was demonstrated that the maternity unit at Whiston had a higher acuity, and the commissioned cot capacity was not sufficient to meet the growing demand. Additionally, LB advised that previously the Ormskirk pathway was to divert high risk births to Liverpool Women's NHS Foundation Trust (LWH) but since the transaction these were now being transferred internally to Whiston, which was creating more demand. LB reported that a review of the allocation of cots across MWL was underway in advance of the wider review being undertaken by Specialist Commissioning of neonatal cots.

	15.6. An Ockenden review visit was due shortly and members of the LMNS would be visiting both maternity units. 15.7. A new North West Region Maternity Performance Oversight Panel (MPOP) report had been developed and the MWL data would be added to this ahead of the LMNS visit. LB noted that this was a big piece of work for the maternity team, in addition to the existing reporting requirements. 15.8. AMS reflected on the discussion around the 90% training compliance that had to be achieved by the end of November 2024 for the MIS Year 6 target and noted that the rolling average at the end of June 2024 included in the paper indicated there was still some way to go to achieve the target. LB agreed that there needed to be a focus on achieving compliance as soon as possible. GB commented that it would be important to maintain compliance once it had been achieved. LB noted that all the MIS safety standards were based on evidence and outcomes of cases that had been reviewed nationally. 15.9. GB congratulated the team on the feedback from the 15 Steps report for the Ormskirk Maternity Unit and commented that she had met with the Chair of the Ormskirk MNVP who had been very engaged. 15.10. RT commented that from the information provided it seemed that the neonatal service was not sufficiently funded to meet the growing demand. LB agreed that it felt like the funding should reflect demand and this was why there was a piece of work underway with the specialist commissioners around the reconfiguration of neonatal cots across the region, however, the Executive team had felt that this could not wait and were completing their own review of the internal distribution of resources. **RESOLVED:** The Board **noted** the Maternity and Neonatal Services Assurance Report Quarter 1
Concluding Business	
16.	**Effectiveness of Meeting**
	(AM rejoined the meeting) 16.1. GB asked PG for his reflections as this was his last Board meeting. PG commented that the meeting had been well chaired, and he had been assured by the contents of the reports presented. Additionally, PG commented that every Board meeting highlighted how hard everyone at the Trust was working to achieve the best care for our patients under a great deal of pressure.
17.	**Any Other Business**
	17.1. GB advised that as it was PG's last Board meeting, she wanted to formally record the Board's thanks for all he had done during his six year tenure at the Trust (and its predecessor) and wish him all the best for the future.

	The being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.15 The next Board meeting would be held on **Wednesday 25 September 2024 at 10.00**

Meeting Attendance 2024/25												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)	✓	✓	✓	A								
Ann Marr	✓	✓	✓	✓								
Anne-Marie Stretch	A	✓	✓	✓								
Geoffrey Appleton	✓	✓	✓									
Lynne Barnes	✓	✓	✓	✓								
Gill Brown	✓	✓	✓	✓								
Nicola Bunce	✓	✓	✓	✓								
Ian Clayton	✓	✓	A	✓								
Steve Connor	✓	✓	✓	✓								
Rob Cooper	✓	✓	✓	✓								
Malcolm Gandy	✓	✓	✓	✓								
Paul Growney	✓	✓	✓	✓								
Lisa Knight	✓	✓	✓	✓								
Gareth Lawrence	✓	✓	✓	✓								
Lesley Neary	✓	A	A	✓								
Sue Redfern	A	A	A	A								
Hazel Scott	✓	✓	✓	A								
Carole Spencer		✓	✓	✓								
Malise Szpakowska			✓	✓								
Rani Thind	✓	✓	✓	✓								
Peter Williams	✓	✓	✓	✓								
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball	A	A	✓	✓								
Richard Weeks	✓	✓	✓	✓								
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 20 September 2024

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
12	31/01/2024	**MWL TB24/010 Learning from Deaths Quarterly Report** 12.1 STHK sites	The Board requested a summary of the themes, learning and actions plans from the Quarterly Learning from Deaths Report be brought together in to an annual report each year. PW agreed to do this for July and NB to update the Board workplan to include this. Update (April 2024) Board workplan updated	PW	Jul-24		**Completed**
7	31/07/2024	**TB24/051 Executive Committee Assurance Report** (Quality Ward Rounds)	LB to circulate further information and guidance about the new MWL Quality Ward Round process September Update LB circulated the information and guidance about the new MWL Quality Ward Round proccess to Board members.	LB	Sep-24		**Completed**
8	31/07/2024	**TB24/052 Integrated Performance Report** 8.2 Operational Indicators	LN to share the F&P presentation about the C&M UEC programme governance and success metrics with all Board members. September Update LN circulated the presentation to Board members.	LN	Sep-24		**Completed**

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
8	29/05/2024	**TB24/039 Committee Assurance Reports** 8.1 Executive Committee	RT reflected on the item about the introduction of the long day shifts for nursing on the legacy STHK sites asked whether this was the same for maternity services. LB commented that she was not aware of any different issues in maternity services who had also implemented the 12-hour shifts and had personally only received positive feedback. It was noted that questions about the long day shifts were part of the quality walkabouts. RT agreed that the feedback she had received had also been positive but asked if this allowed for sufficient staffing at times of high demand. AM agreed that the Executive Committee would review this.	LB	Jul-24	**31/07/2024** - This was reviewed at a Whiston Safety Champion walkabout on 16 July 2024. Staff were much happier with new shift pattern. Staffing numbers on 2E raised by staff. Sue Orchard (SO) completing skill mix review across maternity and will be reported in the Q2 maternity report. The units use bank and overtime to flex staffing during activity peaks.	**Closed**
8	29/05/2024	**TB24/039 Committee Assurance Reports** 8.1 Quality Committee	The number of closures of the Whiston neonatal unit seemed to be a cause for concern, although it had been noted that additional staff had been allocated to support the transitional care plan and this might make a difference. AM agreed that the issue needed to be examined further and suggested the executive undertake a deep dive to examine the causes and any recurrent themes. The Executive Team to undertake a deep dive in to the Q4 neonatal unit closures at Whiston Hospital	LB	Jul-24	**31/07/2024** - Q4 NNU diverts presented to Executive Committee alongside the Neonatal ODN capacity and demand for C&M. HD/IC cots well utilised compared to peer. All diverts appropriate to maintain safety of the department. Internal capacity and demand to be completed to ensure adequate staffing numbers. Further report to be presented at Executive Committee.	**Closed**
9	29/05/2024	**TB24/040 Aggregated Incidents, Complaints and Claims Report**	A review of the PALs service to be undertaken and feedback to be presented at Executive Committee.	LB	Jul-24	**31/07/2024** - PALs review completed and presented to Executive Committee. Backlog noted at the time of report but now fully resolved. Update presented at Quality Committee in July 2024.	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 September 2024
Agenda Item	**TB24/062**			
Report Title	**Integrated 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 2024/25 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 Board is asked to note performance 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	Dec-23	84.1	100	93.0	Best 30%
FFT - Inpatients % Recommended	Aug-24	94.7%	90.0%	94.8%	Worst 50%
Nurse Fill Rates	Jul-24	93.1%	90.0%	95.8%	
C.difficile	Aug-24	9		33	
E.coli	Aug-24	14		72	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.22	0.00	0.15	
Falls ≥ moderate harm per 1000 bed days	Jul-24	0.21	0.00	0.21	
Stillbirths (intrapartum)	Aug-24	0	0	0	
Neonatal Deaths	Aug-24	1	0	5	
Never Events	Aug-24	0	0	1	
Complaints Responded In 60 Days	Aug-24	51.6%	80.0%	68.1%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-24	74.6%	77.0%	72.4%	Worst 30%
Cancer 62 Days	Jul-24	80.8%	85.0%	79.3%	Best 20%
% Ambulance Handovers within 30 minutes	Aug-24	55.4%	95.0%	51.7%	
A&E Standard (Mapped)	Aug-24	81.1%	78.0%	77.0%	Best 30%
Average NEL LoS (excl Well Babies)	Aug-24	4.3	4.0	4.2	Best 30%
% of Patients With No Criteria to Reside	Aug-24	22.0%	10.0%	21.7%	
Discharges Before Noon	Aug-24	17.0%	20.0%	18.0%	
G&A Bed Occupancy	Aug-24	96.9%	92.0%	97.4%	Worst 30%
Patients Whose Operation Was Cancelled	Aug-24	1.0%	0.8%	0.9%	
RTT % less than 18 weeks	Aug-24	58.5%	92.0%	58.5%	Best 40%
RTT 65+	Aug-24	455	0	455	Worst 50%
% of E-discharge Summaries Sent Within 24 Hours	Aug-24	84.0%	90.0%	82.8%	
OP Letters to GP Within 7 Days	Jul-24	70.3%	90.0%	71.4%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-24	74.2%	85.0%	74.2%	
Mandatory Training	Aug-24	89.2%	85.0%	89.2%	
Sickness: All Staff Sickness Rate	Aug-24	5.7%	5.0%	5.7%	
Staffing: Turnover rate	Aug-24	1.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Aug-24		16,500	10,900	
Cash Balances - Days to Cover Operating Expenses	Aug-24	2.0	10		
Reported Surplus/Deficit (000's)	Aug-24		-18,030	-19,930	

Board Summary - Quality

Quality

Friends and Family Test – achieved the overall target despite lower recommendation rates within Maternity areas. An action plan which covers all four maternity touch points is in place, with the intention of increasing response rates and improving the overall care experience. When results are compared to the most recently available NHSE data, MWL remains above the national average for the % patients who rate the service very good or good for all touchpoints within maternity.

Clostridium difficile infection – A CDI Improvement Plan remains on track, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training. Hydrogen peroxide vapour will be used for terminal cleaning following cases of CDI across the three main sites and the feasibility of a preventative bay-by-bay deep clean programme continues to be scoped and trialled within this improvement plan.

E coli -The E coli Improvement Plan continues, and the Trust is also collaborating on an ICB-led North Mersey IPC/AMR action plan, with a focus on reducing E coli BSIs and hydration.

Pressure Ulcers - The TVN team continue to identify areas of concern, deliver ward education, and provide ongoing quality improvement to ensure the sustained reduction in the number of avoidable harms that occurs from pressure ulcers.

Patient Falls – The Falls Team have put together a specific action plan to reduce the risk of falls in higher incidence areas, with focussed support offered to the A&E department. There are regular audits of falls compliance and bespoke ED falls teaching sessions have been arranged. Falls team ward visits and reviews and Senior nurse walk-abouts are ongoing across MWL. Trail project on decaffeinated beverages is currently ongoing on 2 wards.

Never Events – No Never Events were reported in August (YTD 1).

Neonatal death – this was a lady who had not booked for any care in pregnancy who attended in labour, estimated to be around term. Following birth, the baby was transferred to the NNU. On admission a heart murmur was identified and on further investigation the baby had significant cardiac abnormalities. The baby was transferred to Alder Hey and was not suitable for active treatment, orientated to palliative care and subsequently sadly died.

HSMR - Latest data available gives HSMR up to and including Dec-23. A delay in coding at Southport and Ormskirk sites has lead to a delay in further Trust wide data for HSMR being available. An action plan in in place to resolve this. YTD the Trust HSMR remains low at 93.0, with both sites below 100 (STHK site 91.0 and S&O 98.0). The YTD S&O HSMR has increased from 22-23. The factors driving the rise in HSMR have been reviewed and this appears to be driven by a fall in palliative care coding and a drop in patients recorded as having septicaemia. Action has been taken to ensure that patients are coded as accurately as possible to ensure an accurate HSMR. The Trust continues to monitor and investigate any alerting diagnosis groups. Crude mortality remains unchanged. Review of individual SMR diagnosis groups have raised no concerns.
The SHMI remains within expected levels at 1.06 for the period until March 2024.

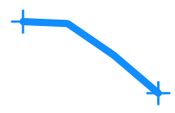
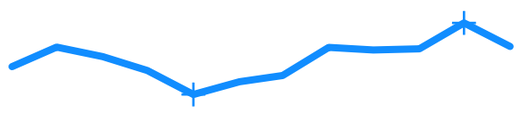
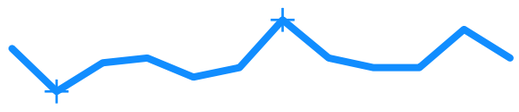
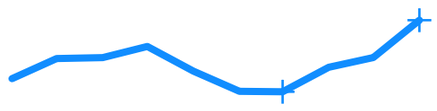
Complaints - % of stage 1 complaints resolved in 60 working days – Performance has been impacted by signing-off the backlog of complaints. There is targeted work ongoing to target specific breaches which is producing positive results thanks to the collaborative working of the corporate and divisional teams and temporary change in process. It is anticipated there will be a much-improved position in the next reporting cycle.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Dec-23	84.1	100	93.0	Best 30%	
FFT - Inpatients % Recommended	Aug-24	94.7%	90.0%	94.8%	Worst 50%	
Nurse Fill Rates	Jul-24	93.1%	90.0%	95.8%		
C.difficile	Aug-24	9		33		
E.coli	Aug-24	14		72		
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.22	0.00	0.15		
Falls ≥ moderate harm per 1000 bed days	Jul-24	0.21	0.00	0.21		
Stillbirths (intrapartum)	Aug-24	0	0	0		
Neonatal Deaths	Aug-24	1	0	5		
Never Events	Aug-24	0	0	1		
Complaints Responded In 60 Days	Aug-24	51.6%	80.0%	68.1%		

Board Summary - Operations

Operations

A&E - 4-Hour performance increased in August, achieving 76.4% (all types), national performance 76.3% and providers across Cheshire & Merseyside averaging 74.3%. The Trusts mapped 4-Hour performance achieved 81.1%. The Trust continue to utilise all escalation capacity across both sites.

Patient Flow - Bed occupancy across MWL averaged 104.3% in August equating to 88 patients - a decrease from 105.8% in July. There was a peak of 125 patients (55 at S&O, 70 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 5% lower than last August, driven by an 11% decrease in 0 day, with a 1% increase in 1+ LOS activity. Average length of stay for emergency admissions is high, at 10.3 at S&O and 7.5 at StHK, with an overall average of 8.9 days, the impact of non CTR patients being 22% at Organisation level, 1.6% higher than July - (25% StHK and 16% S&O).

18 Weeks - The Trust had 2,751 52-week waiters at the end of August (372 S&O and 2,379 StHK) and 6 78 week waiters. The 52-week position is an increase of 82 from July. 18 Week performance in August for MWL was 58.5%, S&O 65.6% and StHK 55.9%. National performance (latest month July) was 58.8% and C&M regional performance was 57.1%.

Cancer - Cancer performance for MWL in July increased to 74.6% for the 28 day standard (target 77%), with Southport achieving 69.6% and St Helens performance being 77.8%. Latest published data shows national performance of 76.2% and C&M regional performance of 74.1%. Performance for 62-day increased to 80.8% (target 85%), with Southport achieving 63.1% and St Helens 88%. C&M performance was 75.9% and National 67.7%. Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2024/25.

Diagnostics - Diagnostic performance continued to exceed the target in August, achieving 96% for MWL, S&O 93.7% and StHK 97.1%. MWL performance is ahead of national performance (latest month July) of 77.6% and C&M regional performance of 91%.

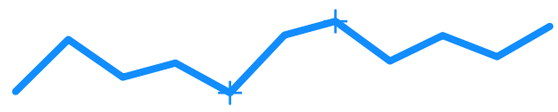
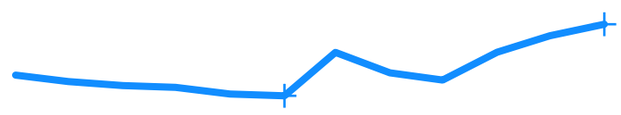
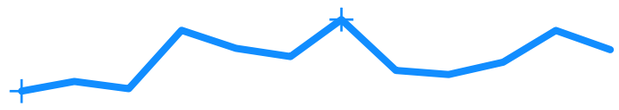
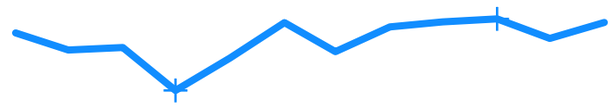
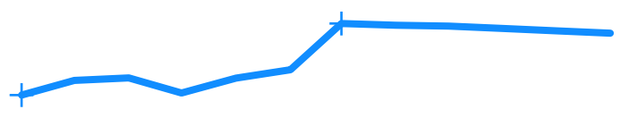
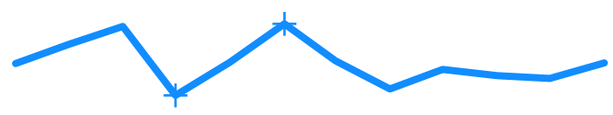
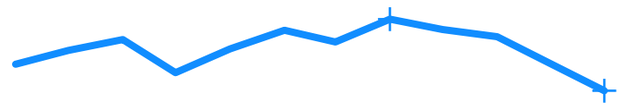
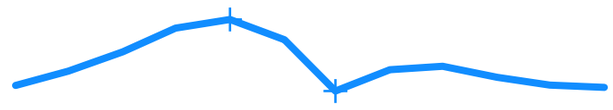
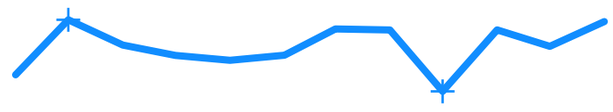
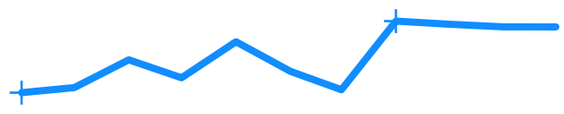
Letters - The Trust had a significant improvement in performance in letters sent to GP's within 7 days. The interim solution will continue to be rolled out. Urgent letters are being produced within 48 hours of appointment.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Jul-24	74.6%	77.0%	72.4%	Worst 30%	
Cancer 62 Days	Jul-24	80.8%	85.0%	79.3%	Best 20%	
% Ambulance Handovers within 30 minutes	Aug-24	55.4%	95.0%	51.7%		
A&E Standard (Mapped)	Aug-24	81.1%	78.0%	77.0%	Best 30%	
Average NEL LoS (excl Well Babies)	Aug-24	4.3	4.0	4.2	Best 30%	
% of Patients With No Criteria to Reside	Aug-24	22.0%	10.0%	21.7%		
Discharges Before Noon	Aug-24	17.0%	20.0%	18.0%		
G&A Bed Occupancy	Aug-24	96.9%	92.0%	97.4%	Worst 30%	
Patients Whose Operation Was Cancelled	Aug-24	1.0%	0.8%	0.9%		
RTT % less than 18 weeks	Aug-24	58.5%	92.0%	58.5%	Best 40%	
RTT 65+	Aug-24	455	0	455	Worst 50%	
% of E-discharge Summaries Sent Within 24 Hours	Aug-24	84.0%	90.0%	82.8%		
OP Letters to GP Within 7 Days	Jul-24	70.3%	90.0%	71.4%		

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 89.2% against a target of 85%.

Appraisals - The Trust is currently in its annual appraisal window achieving 74.2% against a target of 85%. There has been an in month increase in compliance across both legacy sites with the lower compliance on legacy STHK sites achieving 72.5% and legacy S&O sites achieving 77.5%.

Sickness - In-month sickness remains above target, at 5.7% against the 5% target.

This is a 0.3% in month decrease. The top reason for absence is Anxiety, Stress and Depression. This is consistent with the top reason for absence across the NHS. The Trust continues to focus on supporting all employees who are absent due to Anxiety/Stress/Depression by ensuring that all supportive actions have been undertaken. Further targeted work has also been undertaken as part of our overall absence management approach:

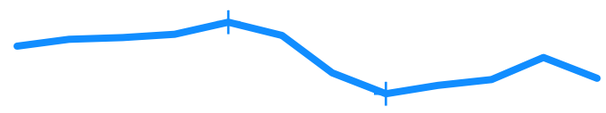
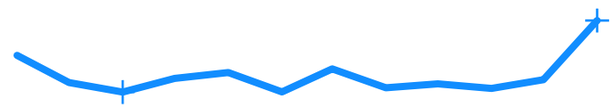
- Ensuring that welcome-back conversations (renamed from return to work), welfare meetings and trigger meetings are being undertaken
- Carrying out internal audits of areas to ensure the processes are being followed and providing support and training to line managers
- Delivering Attendance Management training sessions to new and existing managers.
- Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
- Facilitating early engagement of all employees who are absent due to musculoskeletal problems.
- Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
- Facilitating early engagement of all employees who are absent due to musculoskeletal problems.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Aug-24	74.2%	85.0%	74.2%		
Mandatory Training	Aug-24	89.2%	85.0%	89.2%		
Sickness: All Staff Sickness Rate	Aug-24	5.7%	5.0%	5.7%		
Staffing: Turnover rate	Aug-24	1.9%	1.1%	1.0%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 24/25 gives a deficit of £26.7m, which assumes:

- Payment of £12m funds in line with transaction business case
- Delivery of £36.2m recurrent CIP
- Delivery of £11.8m non-recurrent CIP
- Delivery of the 24/25 activity plan, in order to achieve planned levels of income including ERF/API variable funding
- Contract agreements in line with planned values

Surplus/Deficit – At Month 5, the Trust is reporting a year to date deficit of £19.9m which is a £1.9m negative vriance from plan due to the impact from industrial action in June and july. This position includes underperformance YTD against the activity plan which is currently mitigated by non recurrent underspends elsewhere in the position.

CIP - The Trust's CIP target for financial year 2024/25 is £48.0m, of which £36.2m is to be delivered recurrently and £11.8m non-recurrently. As at Month 5, the Trust has successfully transacted CIP of £31.7m in year of which £29.1m is recurrent, with a further £1.4m of recurrent CIP at finalisation stage.

Cash - At the end of M5, the cash balance was £3.9m, the Trust will require cash support throughout the year and will need to provide significant assurance to recieve this. The application for M5 has been submitted in line with plan. Trust will continue to monitor Lead Employer cash balances to ensure no detrimental impact to the Trust.

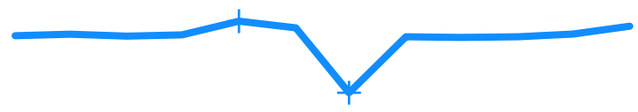
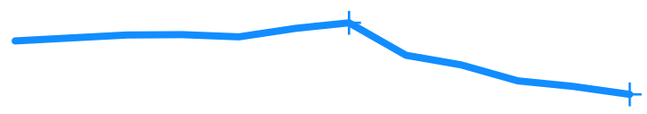
Capital - Capital expenditure for the year to date (including PFI lifecycle) totals £10.9m. This is below plan due to timing of projects and will be fully utilised by the end of the year. The capital plan will require external PDC cash support, this is forecast to be required after M7.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Aug-24		16,500	10,900		
Cash Balances - Days to Cover Operating Expenses	Aug-24	2.0	10			
Reported Surplus/Deficit (000's)	Aug-24		-18,0...	-19,9...		

Board Summary

Legacy S&O

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Dec-23	81.4	100	98.0	
FFT - Inpatients % Recommended	Aug-24	94.8%	90.0%	94.2%	
Nurse Fill Rates	Jul-24	90.8%	90.0%	93.3%	
C.difficile	Aug-24	4		13	
E.coli	Aug-24	6		26	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.16	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Jul-24	0.23	0.00	0.24	
Stillbirths (intrapartum)	Aug-24	0	0	0	
Neonatal Deaths	Aug-24	0	0	1	
Never Events	Aug-24	0	0	0	
Complaints Responded In 60 Days	Aug-24	45.5%	80.0%	70.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-24	69.6%	77.0%	68.4%	
Cancer 62 Days	Jul-24	63.1%	85.0%	65.4%	
% Ambulance Handovers within 30 minutes	Aug-24	61.5%	95.0%	63.0%	
A&E Standard (Mapped)	Aug-24				
Average NEL LoS (excl Well Babies)	Aug-24	5.7	4.0	5.4	
% of Patients With No Criteria to Reside	Aug-24	16.2%	10.0%	16.5%	
Discharges Before Noon	Aug-24	18.8%	20.0%	19.0%	
G&A Bed Occupancy	Aug-24	97.0%	92.0%	97.3%	
Patients Whose Operation Was Cancelled	Aug-24	0.7%	0.8%	0.9%	
RTT % less than 18 weeks	Aug-24	65.6%	92.0%	65.6%	
RTT 65+	Aug-24	25	0	25	
% of E-discharge Summaries Sent Within 24 Hours	Aug-24	82.1%	90.0%	79.5%	
OP Letters to GP Within 7 Days	Jul-24	74.8%	90.0%	75.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-24	77.5%	85.0%	77.5%	
Mandatory Training	Aug-24	90.4%	85.0%	90.4%	
Sickness: All Staff Sickness Rate	Aug-24	6.0%	5.0%	5.9%	
Staffing: Turnover rate	Aug-24	1.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Aug-24				
Reported Surplus/Deficit (000's)	Aug-24				

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy STHK

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Dec-23	84.9	100	91.0	
FFT - Inpatients % Recommended	Aug-24	94.7%	94.0%	95.1%	
Nurse Fill Rates	Jul-24	95.4%	90.0%	98.4%	
C.difficile	Aug-24	5		20	
E.coli	Aug-24	8		46	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.25	0.00	0.17	
Falls ≥ moderate harm per 1000 bed days	Jul-24	0.20	0.00	0.20	
Stillbirths (intrapartum)	Aug-24	0	0	0	
Neonatal Deaths	Aug-24	1	0	4	
Never Events	Aug-24	0	0	1	
Complaints Responded In 60 Days	Aug-24	55.0%	80.0%	66.9%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-24	77.8%	77.0%	75.0%	
Cancer 62 Days	Jul-24	88.0%	85.0%	85.3%	
% Ambulance Handovers within 30 minutes	Aug-24	52.2%	95.0%	45.8%	
A&E Standard (Mapped)	Aug-24				
Average NEL LoS (excl Well Babies)	Aug-24	3.8	4.0	3.8	
% of Patients With No Criteria to Reside	Aug-24	25.2%	10.0%	24.6%	
Discharges Before Noon	Aug-24	15.2%	20.0%	17.1%	
G&A Bed Occupancy	Aug-24	96.8%	92.0%	97.4%	
Patients Whose Operation Was Cancelled	Aug-24	1.1%	0.8%	0.8%	
RTT % less than 18 weeks	Aug-24	55.9%	92.0%	55.9%	
RTT 65+	Aug-24	430	0	430	
% of E-discharge Summaries Sent Within 24 Hours	Aug-24	84.4%	90.0%	83.7%	
OP Letters to GP Within 7 Days	Jul-24	67.8%	90.0%	69.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-24	72.5%	85.0%	72.5%	
Mandatory Training	Aug-24	88.7%	85.0%	88.7%	
Sickness: All Staff Sickness Rate	Aug-24	5.5%	5.0%	5.6%	
Staffing: Turnover rate	Aug-24	1.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Aug-24				
Cash Balances - Days to Cover Operating Expenses	Aug-24				
Reported Surplus/Deficit (000's)	Aug-24				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 September 2024
Agenda Item	**TB24/063 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the five Executive Committee meetings held in July and August 2024		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were nine Executive Committee meetings held during July and August 2024. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. At each meeting the weekly vacancy control panel decisions were also reported.		
04 July 2024		
July Trust Board Agenda and Employee of the Month	• The Director of Corporate Services presented the draft Trust Board agendas, including the agenda for the extraordinary meeting to be held during July to approve the Electronic Patient Record preferred bidder. The agendas were were reviewed and agreed. • The Employee of the Month (EOTM) nominations received in June were reviewed and a winner selected.	Approval
Payroll Contract Opportunity	• The Acting Director of HR outlined the opportunity to expand the payroll services by taking on the contract for another Cheshire and Merseyside Trust. • Subject to the agreement of appropriate terms to cover the onboarding costs and commercial risks, the proposal was agreed.	Approval
Review of Neontal Unit Closures	• The Acting Director of Nursing, Midwifery and Governance presented the review of neonatal unit closures during 2023/24. The data showed that each closure had been appropriate and was in line with the agreed regional protocol. • The review highlighted the increased activity and acuity, particularly at the Whiston unit, where the maternity service were taking more high risk births from Ormskirk Hospital.	Assurance

	• It was noted that the neonatal network were already undertaking a review of the distribution of neonatal cots across the region. It had been acknowledged that MWL was an outlier for demand, occupancy and therefore closures. • Committee also noted the difference in admission rates across the two MWL units and agreed that this should be investigated further.	
Patient Advice and Liaison (PALs) Review	• The Acting Director of Nursing, Midwifery and Governance presented the report which set out the actions being taken to improve PALs response times, particularly at Whiston Hospital, where the service had faced a number of challenges in recent months. • Best practice was being shared and mutual aid provided across the two legacy Patient Advise and Liaison Service (PALs) teams. • The Committee discussed the relationship between PALs and formal complaints and with the 'Ask Ann' email system. • Committee were assured by the review and planned actions and would continue to monitor progress until the backlog had been eliminated and the system stablised.	Assurance
Better Payment Practice Code (BPPC)	• The Director of Finance and Information reported that Trust performance against the Better Payment Practice Code (BPPC) standard had dipped post transaction, but this had been expected as the financial systems were aligned. • Performance had then improved until a dip in May 2024 when performance was 74% by volume against the 95% target. • This dip had been investigated and three issues had been identified, two of which had been resolved and the third required a change of practice which had been implemented and was being tested by internal audit (MIAA). • The Committee noted the report and that performance had returned to over 90% with the rectification of the first two issues.	Assurance
Cost pressures	• The Director of Finance and Information briefed the Committee on the Month 2 position, and the actions needed to improve the run rate back to plan.	Assurance

	• There were a number of issues outside the Trust's control, such as inflation and continued industrial action by doctors in training. • However other issues such as activity rates and agency spend could be influenced internally. A number of actions were agreed to review the current plans in these areas. • The Integrated Care Board (ICB) wide position was significantly behind plan at Month 2 which had prompted NHS England to add Cheshire and Merseyside to the ICBs which would receive Investigation and Intervention (I&I) support from external advisors.	
11 July 2024		
Maternity and Neonatal Services Patient Experience Action Plan	• The Director of Nursing, Midwifery and Governance introduced the paper which summarised the Friends and Family (FFT) response and recommendation rates and bechmarked these with other local units. Over the four maternity FFT touchpoints MWL scored above the national average for recommendation rates. • The paper then detailed the actions the service was taking to enhance patient experience. It was noted that the national maternity survey results did not triangulate with either the FFT or local patient surveys and other feedback. • The focus remained on understanding patient feedback in real time, so staff could adjust care and respond during the inpatient stay. • It was agreed that the focus of the actions was positive and the themed approach was appropriate. • The report was noted and updates would continue to be provided via the quarterly maternity and neonatal performance reports.	Assurance
Premium Payment Scrutiny Council Assurance Reports	• The Director of Finance and Information presented the Council Assurance Reports and proposed that the actions agreed with each division would also be discussed at the monthly Divisional Finance and Performance meetings, from which a summary would be reported to the Executive Committee.	Assurance

Freedom of Information (FOI) Requests Performance Report	• The Director of Informatics presented the FOI performance report. • There were 190 open FOI requests in June, which often contained multiple information requests and could be complex to answer. • There were 42 completed FOI responses awaiting director approval. • The Trust was not achieving the 20 working day response target and further actions were being taken to address this.	Assurance
Electronic Patient Record (EPR) Procurement Update	• The Director of Informatics reported the recommendation for a preferred supplier following the EPR procurement process. • It was agreed that a meeting should be arranged to allow the Executive Committee to be briefed in detail on the procurement process before the recommendation was taken to the Extraordinary Board meeting scheduled for 26 July.	Assurance
Temorary Workforce Hamonisation update	• The Acting Director of HR provided an update on the implementation plan to harmonise nursing temporary workforce pay rates from 01 August. • The main impact of the change would be for band 5 staff. • Roster planning was identifying potential areas of concern where fill rates were lower than expected at this point in the planning cycle, and mitigating actions had been identified that would be employed if required. • Committee agreed that the implementation should continue and confirmed that staff should be paid the same hourly rate across MWL. The fill rates and impact of mitigations would be reviewed on a weekly basis and escalated back to the Committee if required.	Assurance
Review of car park charges	• The Director of Corporate Services presented the paper, which detailed the costs of providing car parking facilities for patients, visitors and staff, which had increased significantly and exceeded income. • Staff parking charges had been harmonised across MWL in 2022/23 when staff car parking charges were re-instated nationally after the Covid-19 pandemic. • Patient and visitor car parking charges at the legacy Trust sites were very different and had	Approval

	not been reviewed at the STHK sites since 2019/20. • Benchmarking information showed that the MWL car parking charges were lower than neighbouring trusts. • Options for increasing patient and visitor, and staff charges were agreed for recommendation to the CEO.	
Risk Management Council (RMC) Assurance Report - July	• The Director of Corporate Services presented the Council Assurance Report • There were 1,068 risks on the MWL risk register with 39 escalated to the Corporate Risk Register (CRR). • The Divisional Leadership teams were reviewing risks to remove duplicates, align services and ensure consistency of risk scoring across their risk registers, and would work with the lead directors for each CRR risk.	Assurance
18 July 2024		
Sickness Absence Deep Dive	• The Acting Director of HR introduced the deep dive which had reviewed how sickness is presented by staff group, grade/band, length of service, ethnicicty and disability. • This was an exploratory exercise to identify areas for further investigation and targeted interventions to help reduce sickness absence rates and improve workforce health and well being. • Committee agreed that sickness absence should also be mapped to deprivation to see if there was a link with health inequalities. • Any corrolation to staff survey results would also be explored as part of the next stage of investigation. • The Committee supported a more targeted and nuanced approach to reducing sickness absence, to enhance the Trust absence management policy.	Assurance
Data Security and Protection Toolkit (DSPT)	• The Director of Informatics reported that the first DSPT assessment had been undertaken for MWL and all ten standards had been achieved. • The DSPT had been audited by MIAA who had given a rating of substantial assurance. • The DSPT results would be reported to the Trust Board in July.	Assurance

Policy/Procedural Document Report	• The Acting Director of Nursing, Midwifery and Governance introduced the quarterly report. • There was now a single MWL database of all 865 policies from the two legacy trusts. 89 policies had been fully harmonised, and a further 11 are site/service specific. • 20% of the policies were overdue for review or due to expire in the next three months. • Of the 20 priority clinical safety policies identified as a transaction risk, 17 had been harmonised and the others were progressing through the approval process. • Status reports were to be circulated to each Director for the policies sitting in their portfolios and also to each governance council to which they were aligned for approval.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the quarterly review of the BAF. • Changes were agreed to recommend to the Board.	Assurance
Mandatory Training and Appraisal Compliance	• The Acting Director of HR presented the report. • At Month 3 of the appraisal window 74.4% of appraisals for Agenda for Change staff had been completed. The window closes at the end of September and the trajectory was similar to previous years (noting this was the first year the appraisal window had been used for legacy S&O staff). • Mandatory and compulsory training compliance was 85.5%, with all Divisions reporting an improved position, although it was noted there remained some subjects and services that remained below the target of 85%.	Assurance
Information Governance (IG) and Freedom of Information (FOI) Annual Report	• The Director of Informatics presented the 2023/24 IG and FOI Annual Report to demonstrate how the Trust fulfilled its statutory obligations. • The reports were due to be presented for approval at the July Trust Board meeting.	Assurance
Investigation and Intervention (I&I) Update	• The Director of Finance and Information provided an update on the I&I process being undertaken by PricewaterhouseCoopers International Limited (PWC).	Assurance

	• The Trust had completed a self-assessment against the seven I&I criteria for financial "grip and control". • Committee reviewed the self-assessment and noted that in some areas the Trust had alternative mechanisms for achieving the same results and other areas were known post transaction issues that were being addressed.	
Integrated Performance Report (IPR)	• The Director of Finance and Information presented the June IPR and Committee discussed the red indicators and the commentary required before the reports were circulated to the Committees.	Assurance
25 July 2024		
Managed Equipment Service (MES) Contracts	• The Director of Finance and Information introduced the report and explained that both legacy Trusts had MES contracts in place for diagnostic equipment. • The legacy STHK MES contract was part of the Public Finance Initiative (PFI) arrangement and could continue to be, if this was the preferred option. • A number of options could be considered for the future replacement and maintenance of diagnostic equipment and there were benefits and disbenefits of moving to a single MES contract for MWL. • It was noted that the current contracts had different terms and financial envelopes. • The Finance Department were exploring whether external approval was required for these decisions, because they were a continuation of existing spend. • The Committee agreed that a full option appraisal and project timetable should be developed to be reviewed in September.	Approval
Theatre Activity Recovery Plan	• The Chief Operating Officer introduced the report which detailed plans to recover theatre activity levels against the annual plan when the two new theatres opened at Whiston Hospital in August. This included recruitment of the remaining additional staff needed and options to increase utilisation of theatres at both the Southport and Ormskirk sites, but there were limitations to the specialities that could use these sites due to bed capacity.	Approval

	• The additional planned work to upgrade two other theatres with clean air canopies was also being reviewed, with a proposal to replace one air canopy during 2024/25 and delay the second until 2025/26. This proposal was agreed.	
Reference Costs	• The Director of Finance and Information reported that reference costs for 2023/24 had now been published. The information had been submitted by each legacy Trust as the transaction did not take place until after the deadline. The reference cost for legacy STHK was 90 and for legacy S&O was 102 (against the national average of 100). • For 2024/25 the guidance for the cost collection exercise had changed and trusts were required to adjust for the impact of IFRS16 of PFI schemes. • There was a concern that this accounting treatment change would artificially skew the MWL costs and the Trust was in dialogue with the national cost collection team to seek assurance that the impact would be adjusted to maintain an even playing field between all trusts. There was a risk that if the IFRS16 impact was not added to the submission the Trust would be excluded from the national exercise.	Assurance
Consultant Rota – Southport Emergency Department (ED) Business Case	• The Chief Operating Officer presented the business case for additional consultant posts for the ED at Southport Hospital. • The ED consultant rota did not currently meet Royal College standards and current gaps were filled by locums, therefore it was more economic to fill the posts on a substantive basis. • The Clinical Director was confident of being able to recruit adult ED consultants following the recent changes in the department. • Committee approved the business case and set a stretch target for improving ED four hour waiting time performance to demonstrate the benefit of having substantive staff. • It was noted that although an improvement with these positions filled, the ED rota would still not fully meet Royal College guidance.	Approval

MWL Operational Management On-Call Proposal	• The Chief Operating Officer presented the report which detailed proposals for creating a single MWL operational on-call structure. • The legacy on call arrangements had been maintained while managers became familiair with the different sites/services but now the divisional management teams were in place it was time to move to a MWL system. • The proposal was for three levels of management on call; Strategic (Director/Deputy Director), tactical (operational managers) which would be Trust wide and operational (site managers) which would be site based. • Committee discussed the historic on call arrangements and payments and the need to harmonise these across MWL. • It was agreed that the process of consulting with staff impacted by the proposed changes could start. It was acknowledged there would be a requirement for training and new operating guidance for staff.	Approval
Incident Reporting System – Implementation Costs	• The Director of Informatics presented the revised business case for a single MWL Incident Reporting System (used for incidents, risks, complaints and claims) to replace the two legacy DATIX systems. • The costs of the single system could be met by the existing budgets. • Implementation costs had been revised, following feedback from the Executive Committee. • The proposed system was compliant with the national Patient Safety Incident Response Framework (PSIRF) reporting requirements. • The revised business case was approved.	Approval
Primary Care Industrial Action	• The Medical Director briefed the Committee on the outcome of the British Medical Association (BMA) ballot of GPs to take “collective action” in pursuit of their claim for additional funding. There was a menu of actions a practice could take and it would be for each practice to decide which they would adopt. Therefore the local impact on acute and community services was difficult to predict, but was likely to cause disruption.	Assurance
1 August 2024		

Nurse Safer Staffing – June 2024	• The Acting Director of Nursing, Midwifery and Governance presented the report which showed the overall Registered Nurse/Midwife fill rate in June was 96.3% and the Health Care Assistant (HCA) fill rate was 112.2% (which included supplementary care at the legacy STHK sites) • The teams continued to work towards harmonised reporting of safer staffing across MWL. • The report summarised bank and agency usage, the vacancy rate and recruitment pipelines for both substantive staff, the bank and sickness absence levels in the nursing workforce • Committee noted the increase in nursing and HCA sickness and the challenges of harmonising systems and pay rates across MWL.	Assurance
NHS England – Workforce, Training and Education Visit Action Plan	• The Medical Director presented the proposed actions to address the concerns raised by junior doctors to NHSE and the General Medical Council (GMC) about the lack of senior consultant review (post take ward round (PTWR)) of patients in ED, when a decision had been made to admit. • The pressures on the system caused by increased bed occupancy and numbers of delayed discharges were acknowledged. • Interim proposals to increase consultant capacity for PTWR were approved to mitigate the risk. • The Medical and Urgent Care Division were asked to bring forward a business case for a substantive solution to address this issue.	Approved
Staff, Associate Specialist and Speciality (SAS) doctors Automomous Practice Acediation Scheme Update	• The Medical Director briefed the Committee on the work being undertaken to agree an MWL accreditation scheme for SAS doctors to address differences inherited from the two legacy organisations. • Discussions had taken place with the Joint Local Negotiating Committee (JLNC) • The importance of the SAS doctor workforce and the need to create a career development path was recognised, but there is no national guidance on how this should be acheived.	Assurance

	• The implications of introducing an accreditation scheme and impact on rates of pay were reviewed. • Actions were agreed to undertake a full option and economic appraisal to present a proposed way forward to the Committee.	
8 August 2024		
ITU Consultant Staffing Business Case	• The Managing Director introduced the business case which sought approval to transition to a consultant of the week rota at the Whiston Hospital ITU. • The case proposed the recruitment of two additional substantive consultants and a reduction in the reliance on locum cover overnight and at weekends. • This would result in a small financial saving • The Clinical Director was confident of recruitment as there had been interest from trainees who were ready to qualify. • The move had been discussed and agreed by the current ITU consultant team. • The business case was approved as it would improve care and reduce costs. • It was also agreed that as soon as possible proposals should be brought forward to implement a consultant of the week rota for the Southport Hospital ITU.	Approval
Escalation beds	• The Managing Director introduced the report which reviewed the cost effectiveness of adding a fifth Bed to a four bed bay in the wards at Whiston hospital to increase beds in response to operational pressures. • The Committee noted that due to step costs in volume this was not necessarily the most cost effective option. However, it was recognised that the escalation beds continued to be required to minimise the need for corridor care in ED. Therefore an extension of the current temporary fundings was agreed, to allow time for other options to be explored.	Assurance
Huyton Walk In Centre (WIC)	• The Chief Operating Officer clarified the position with regards to the Huyton WIC activity as part of the MWL footprint for ED performance. • The Huyton WIC was commissioned from MWL but currently subcontracted to	Assurance

	MerseyCare to deliver and the activity was mapped to MWL, Alder Hey and Liverpool University Hospitals NHS Foundation Trust (LUHFT). • There was a need for the contract to be more effectively performance managed against the agreed costs and KPIs. • It was agreed that there would be a further review in January 2025	
Cheshire and Mersyside (C&M) Payroll Pricing Model	• The Acting Director of HR presented the proposals that the Trust had been asked to develop for a C&M payroll pricing model. • The scale of costs were based on the level of automation the participant trusts could achieve, with lower prices offered to those who could achieve the highest level of process automation, which made managing the payroll more efficient. • The model was based on the current client base but would alter if the remaining C&M trusts moved to the MWL payroll service. • The Committee approved the proposals to be presented to the ICB.	Approval
National CQC Inpatient Survey	• The Acting Director of Nursing, Midwifery and Governance introduced the presentation of the first MWL inpatient survey results, reflecting the views of patients surveyed in November 2023. • The national results would be published in August and would provide additional benchmarking information. • In several areas the results were disappointing and a cause for concern. In particular the results seemed to be negative where patients had waited a long time in ED before being admitted and this was reflected in the patient comments. • Committee reviewed and agreed the proposed action plan and that all the patient comments would be circulated to Executive Committee members to review and identify any additional actions.	Assurance
Staff Support	• Following the major incident in Southport and recent communications from NHSE, the Committee reviewed the current policies and communications with staff in relation to zero tolerance of abuse or violence to staff.	Assurance

	• A CEO message would be circulated to increase awareness of how to report incidents and access support.	
C&M Diagnostic Collaborative Bank (Endoscopy)	• The Acting Director of HR reported that the Trust had delivered the pilot diagnostic collaborative staff bank on behalf of the C&M Pathology Network • The report set out the evaluation of the success of the pilot and proposals for transitioning to business as usual. • It was agreed that, if all trusts committed to using the diagnostic collaborative bank and it was supported by the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) CEOs, then MWL would continue to host the service.	Approval
15 August 2024		
Provider Workforce Return (PWR) - May & June	• The Acting Director of HR presented the latest PWR submissions for May and June. • The PWR reported the difference between the submitted workforce plan and actual worked WTEs (including bank and agency staffing) • In both May and June, MWL was reporting a total workforce slightly below plan. • The differences were driven by higher than planned vacancies and maternity leave • Bank usage was increasing as agency use reduced, but demand remained higher than planned due to continuing requirements for supplementary care for patients awaiting packages of care to be discharged. • In June the ICB was 0.6% over plan as a system	Assurance
Urology Clinical Nurse Specialist (CNS) Business Case	• The Chief Operating Officer presented the report which sought to secure substantive funds for the Urology CNS when the current C&M Cancer Alliance funding ended. • The CNS had made a significant improvement for urology patients and was able to manage a caseload which generated income. • The post would continue to make a financial contribution if it was funded internally. • Committee approved the business case • Committee requested a review of all CNS posts funded by the Cancer Alliance across	Approval

	MWL, to plan for when funding grants were due to end.	
Theatre Utilisation Improvement Plan	• The Chief Operating Officer introduced the presentation. • The Surgical Division had undertaken a review of theatres productivity and data validation across MWL to align reporting practices. • The work had corrected some reporting anomalies and improved the MWL benchmarking position with other C&M acute trusts. • With an accurate and consistent baseline the team were now moving on to investigate opportunities to improve theatre productivity. • The utilisation rates at St Helens hospital were discussed and these were attributed to the high volume, low complexity plastics activity as a result of the Trust being the regional skin cancer centre. The clean and reset time was the same between short cases and longer cases, and therefore led to a higher proportion of downtime per session. • Plans were being implemented to address Did not Attends (DNAs) for surgical procedures which were particularly high in urology. A post list DNA call back trail had been initiated to find out the reasons for DNAs. • The Division also wanted to adopt the Palantir Theates Management System across MWL to help standardise policies and list planning. • Plans to move activity that did not need to be undertaken in theatres, but could happen in a procedure room were also in development. • An update on the impact of each planned action on theatres activity against the 2024/25 plan would be provided after four weeks.	Assurance
Virtual Wards	• The Director of Strategy outlined the changes to the funding and delivery model of virtual wards that had been agreed by the Mental Health, Learning Disabilities and Community Services Provider Collaborative. • Virtual ward utilisation across C&M had been variable in 2023/24 and there was now a move to a more standardised generic model, and a standard payment per virtual bed,	Assurance

	alongside a 40% reduction in available funding • An options appraisal was being undertaken to determine the best way forward for MWL	
22 August 2024		
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the RMC assurance report. • There were 1,092 reported risks with 39 escalated to the Corporate Risk Register (CRR) with new risks escalated and others removed from the CRR. • 49 risks had been closed during July • The implementation of a single incident and risk reporting system across MWL will support the Divisions to have effective oversight of duplicate risks and any misaligned scoring • Of 106 live CIP schemes, 74 had completed the quality impact assessment process at the end of July • The Emergency Preparedness, Resilience and Response (EPRR) Operational Group report detailed the progress being made to achieve the annual EPRR core standards declaration • The RMC approved the Swithcboard Incident Response Operating Procedure	Assurance
Legal Services Business Case	• The Acting Director of Nursing, Midwifery and Governance introduced the business case to supplement the staffing in the the legal services team to meet demand and reduce reliance on external legal advice. • Committee supported consolidation of the temporary resource already committed, but requested additional evidence of the potential for cost reduction/avoidance in relation to the remainder of the request.	Approval
MWL 5 Star Ward Acreditation Scheme Pilot Update	• The Acting Director of Nursing, Midwifery and Governance provided an update on the ward acreditation scheme pilot that had started in June 2024 • 17 accreditation assessments had been completed during the pilot, with the team conducting two assessments a week. • four wards had been awarded 4 stars, ten wards three stars and three had been classed as aspiring.	Assurance

	• All wards had an action and improvement plan following the ward accreditation with the aspiring wards being scheduled for a further review in eight to 12 weeks. • There had been positive feedback from the wards about the process and these wards would go on to the share their successes and improvement actions at the Quality Ward Rounds with Directors that were due to start in September. • The committee thanked the Quality Matrons for implementing the new accreditation scheme and agreed that this set a consistent high standard for ward care across MWL.	
Future MWL Temporary Worforce Model	• The Acting Director of HR presented the report which detailed the options for delivering the Trust's temporary nurse staffing requirements. • The two legacy organisations had historically taken different approaches and these were compared, and the benefits and costs assessed. • The Committee agreed that roster alignment across the Trust should be progressed, as this would be needed whatever the eventual solution, while planning for a single temporary workforce model continued.	Assurance
Corporate Services Benchmarking 2023/24	• The Trust results of the annual corporate benchmarking exercise were presented. • This was the first submission for MWL and each Director had been involved in verifying the information for their areas of responsibility, which would provide a baseline of costs for the year of the transaction. • Variations from the previous legacy STHK and S&O results were clarified, including changes of national definitions. • The national results would be published in early 2025 and the Trust position would be reviewed again at that point.	Assurance
National Cost Collection	• Changes to the accounting treatment of PFI costs because of IFRS16 rules, had meant the Trust had raised concerns about consistency and benchmarking with non-PFI organisations.	Assurance

	• The Trust had agreed to exclude the PFI revaluation figures until a national solution had been found. • Unfortunately the national cost collection team had now taken the decision to exclude all MWL data from the national exercise. • This meant MWL 2023/24 data would not be uploaded to Model Hospital.	
System Financial Recovery	• The PWC targeted financial support draft report had now been received for factual accuracy checking, following the submission of all information requests and meetings with the Chair, CEO and DoF. • The Trust had been categorised as “amber” in respect of being able to deliver the 2024/25 financial plan, with some risks and further mitigating actions identified. • The Trust had responded detailing risks, such as unfunded pay awards, unfunded inflation costs and receiving the financial support agreed in the Transaction agreement with NHSE and Commissioners. • Other acute trusts in C&M and the ICB continued to experience significant financial pressures and Committee discussed the further action that might be taken by NHSE.	Assurance
Electronic Patient Record Procurement Update	• The Director of Informatics reported that the unsuccessful supplier had challenged the procurement outcome and asked for an extension of the stand still period. • NHSE and the ICB were being briefed as this could impact some of the agreed project milestones.	Assurance
29 August 2024		
Trust Board Agenda and Employee of the Month (EOTM)	• The Director of Corporate Services presented the draft September Trust Board agenda for review, and the EOTM nominations received during the previous month. • Committee selected an EOTM for September	Assurance
Mandatory Training and Appraisal Compliance Reports	• Committee reviewed the appraisal and mandatory training compliance figures for July. • All Divisions and staff groups except medical and dental were now achieving above the 85% target. • Compulsory skills training compliance had increased to 86.3%	Assurance

	• Appraisal compliance for July was 72.1% with two months of the annual appraisal window remaining.	
Nurse safer staffing exception report	• The Acting Director of Nursing, Midwifery and Governance presented the report for July. • The overall MWL fill rate was 111%, with 8.2 care hours per patient Day (CHPPD). • Committee reviewed some of the differences across sites and asked for investigations to understand why these were requested. • The use of bank and agency staff, particularly to support supplementary care needs, remained high. • Sickness absence for both Registered Nurses/Midwives and Health Care Assistants (HCAs) remained above the Trust average. • The band 5 and HCA recruitment pipelines remained strong with two recruitment events planned in September and October.	Assurance
Team to Team Proposals	• The Chief Operating Officer presented proposals for team to team meetings between the Executive Committee and the Divisions as part of the Trust's performance management framework • The framework and the standard agenda for the team to team meetings were agreed and would be arranged to start in September	Approval
Horatio's Garden Proposals	• The Director of Strategy provided an update on the work with the Horatio's Garden charity which was working to provide outside spaces for every Spinal Injury Unit in the UK. • The space constraints and strategic challenges at the Southport hospital site meant that a non standard approach was required and alternative proposals had been developed which would now be presented to the the Horatio's Garden charity	Assurance
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during July and August 2024 were:</u> • Recruitment of three WTE substantive ED consultants to achieve a compliant rota for the Southport Hospital ED and reduce locum spend. • MWL Incident Reporting System to meet national standards and integrate reporting across the Trust – year 1 implementation costs		

- Increased consultant sessions to create capacity for post take ward rounds in ED at Whiston hospital
- Recruitment of two WTE substantive ICU consultants so the Whiston ICU could achieve the Consultant of the week best practice model and reduce locum spend.
- Urolology Clinical Nurse Specialist – make the post substantive following the end of pump priming funding from the C&M Cancer Alliance

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 September 2024
Agenda Item	**TB24/063 (8.2)**		
Committee being reported	Extraordinary Audit Committee		
Date of Meeting	30 July 2024		
Committee Chair	Ian Clayton, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
MWL External Audit draft Audit Findings report (ISA 260) and draft Annual Auditors Report	Grant Thornton (GT) provided an overview of the external audit findings and shared the draft Audit Findings report (ISA 260) and draft Annual Auditors Report. The ISA 260 contains five recommendations along with associated management responses. The Annual Auditors report contains six recommendations along with associated management responses. The reports noted that no material errors or areas of significant weakness had been found to date and that the area of significant weakness identified in the 2022/23 accounts has been resolved and removed as a recommendation. There is one unadjusted non material misstatement of in the accounts relating to the treatment of an asset under construction. Given this is non material the Trust has not adjusted this in the accounts. The Audit team are working through a number of outstanding items and aim to share a final opinion in August in line with the audit plan.	Assurance
MWL Accounts adoption	Committee reviewed and approved the annual accounts for MWL 2023/24.	Approval
MWL Annual Report and Annual Governance Statement	Committee reviewed and approved the draft annual governance statement for MWL 2023/24.	Approval
Trust Standards of Business Conduct Policy	Committee reviewed and approved the Trust Standards of Business Conduct Policy.	Approval

Alerts:

- Nil

Decisions and Recommendation(s):

MWL Accounts adoption and MWL Annual Report and Annual Governance Statement
The final 2023/24 accounts, annual report and annual governance statement were approved by the Committee subject to satisfactory conclusion to the external audit. Approval of the final accounts will be concluded outside of the meeting following the release of final external audit reports.

Trust Standards of Business Conduct Policy
Policy was approved by committee

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 September 2024
Agenda Item	**TB24/063 (8.3)**		
Committee being reported	Quality Committee		
Date of Meeting	17 September 2024		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	• Minutes of the meeting held on 23 July 2024: Following a few minor clarifications and additions to the action tracker the minutes were approved as a correct and accurate record of the proceedings.	Approved
Matters arising/Action Log	• Noted actions aligned to agenda items on the meeting with remaining actions due at future meeting and within the meeting pack. • Action 63 Nutrition metrics - review against CQC regulations and Quality Contract confirmed appropriate metrics are in place. Ongoing monitoring in place with updated / revised action plan to be presented to next committee meeting. Additional narrative requested in Corporate Performance Report (CPR) to provide further assurance. • Action 64 Assurance - no themes or correlation to deaths at weekends. Ongoing monitoring through learning from deaths team. • Action 65 - no themes following review of Orthopaedic claims. • Action 48, 54, 64, 65 completed.	Assurance
Quality Committee Corporate Performance Report	• **No Never Events in August** • **Validated Pressure Ulcers:** eight of grade 2 plus with lapses in care. Themes and shared learning ongoing. • **Patient Falls (with moderate harm or above):** Eight moderate or severe harm. Falls team focus on areas requiring focused support. • **Safe Staffing:** 93.1% fill rate against 90% target.	Assurance

	• **VTE** below target. Assurance provided within improvement work including electronic system reviews.
	
	• **Patient Safety Incident Investigations (PSII):** zero
	
	• **Infection Prevention and Control:**
	  • Zero Healthcare associated Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteraemia. YTD one
	  • Nine Clostridioides difficile (C Diff). YTD 33 against MWL target of 113.
	  • Nine Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA). YTD 37
	  • 14 Escherichia coli (E Coli). YTD 72. Alignment with Trust improvement plans for Nutrition and hydration and catheter devices.
	  • Two Klebsiella
	  • Zero Pseudomonas
	  • Zero Vancomycin-resistant enterococci (VRE)
	
	• **Complaints:**
	Increase in formal complaints associated partly to focus on Patient Advise and Liaison Service (PALS) backlog. Noted reduction in formal complaints received in August. Overdue complaints reduced. No themes associated in reported reduction in Southport site performance – redirection of resources from Southport site to assist with improvement work at Whiston.
	
	• **Friends and Family Test (FFT):** Low response rate in four maternity areas – deep dive completed. Work continues with response rate improvements.
	
	• **Mortality:** Data up to December 2023. Action plan to reduce delays in coding by October 2024.
	
	• **Hospital Standardised Mortality Ratio (HSMR):** 84.1%. YTD low at 93.
	
	• **Summary Hospital-level Mortality Indicator (SHMI):** 1.06. YTD 1.05
	
	• **One Neonatal death:** No adverse findings.	

	• **Admission to ICU (Maternity):** Further information requested for Quality Committee assurance. • **Percentage of women smokers (Maternity):** Improved position due to changes in the system and redirection of resources. • **Increased Forceps delivery:** Ormskirk site – 9.5% monitoring ongoing. • **Improvement in E-Discharge:** Continuing work with clinical teams with improvement in clinic correspondence. • **Sepsis screening:** NICE guidance changes noted and transferred learning with ongoing work with AQUA to assure against metrics. • **Safeguarding:** Improvements in level 3 training requires improvement with e-learning in place to support improving compliance. • **Practice Educators:** The Chair noted her recent visit to Southport Hospital and congratulated for improvements against Infection Prevention and Control (IPC), and mandatory training performance at Orthopaedics Ward (Southport). • **Stroke performance:** Sharing of best practice and cross working across the Southport and Whiston sites noted to support improved performance and outcomes across MWL Stroke units, with focus on Southport unit, particularly for Therapies. Business cases currently being produced to support improvements. National issues with workforce noted and discussed.	
Councils Terms of Reference (ToR) for review	• Terms of Reference for Clinical Effectiveness, Clinical Engagement and Patient Safety Councils presented, and amendments requested. To be re-presented for approval at Quality Committee in October.	Assurance

Patient Safety Report (including. Council Chair's report).	• **Patient Safety Incident Response Framework (PSIRF) 12 Month Review** presented.
	  • 486 Learning reviews/Expanded learning since October 2023, 15 PSIIs.
	  • 35 PSII training places secured.
		Assurance

	• Revision of MWL PSIRF policy and Patient Safety Incident Response Plan (PSIRP) with embedding of divisional governance process. • Mixed feedback noted from families. • Supportive conversations with staff to enrich skills noting benefits of feedback from investigators to support learning opportunities. Learning from the maternity Perinatal Mortality Review Tool (PMRT) process to be shared with staff undertaking PSIRF processes. Thirlwall Inquiry learning also noted. • **Patient Safety Report:** - June-July 2024 • Zero PSII commissioned. • 15 incidents identified requiring Patient Safety Incident Review (PSIR). • Ten Learning Reviews /ELRs requested. • 2024/25 - one reportable PSII Maternity Services • Total incidents for MWL end of July – 5,745 • Pressure Ulcers highest reported incidents - Good reporting culture and focused work with key focus on documentation with ongoing education and awareness to improve compliance. • World Patient Safety Day recognised across MWL. • MWL Falls total 484 - slight increase which aligns to historical pattern. No site variances. Review of incidents acknowledges focus on falls risk assessment in AED. • Perinatal Quality Surveillance Model - June/July total two neonatal deaths elsewhere. Learning will be shared via PMRT process. • Trust compliant with Learning from Patient Safety Events (LFPSE) since October 2023. • InPhase reporting system live January 2025. • Patient Safety Council Report received. • Further assurance provided against PSI07 and PSI08 (Delay in Cancer Diagnosis). Prospective audit reporting process. Confirmed annual audit supporting identification of incidents and the Trust's proactive steps to assure any changes made are robust and working. Assurance provided on mandated follow up-dates in Trust systems - Pilot in place. • Action requested for further information to be reported to the Committee regarding alerts in	

	place for histology reports, where there is a significant finding.	
Patient Experience Report (including. Council Chair's Report)	• **National Inpatient Survey (NIP) 2023:** Disappointing results recognising eight areas where the Trust has performed worse or somewhat worse. Site specific breakdown of positive responses for 2023 and legacy site scores for 2022 shared for comparison. Local reduction in performance themed with particular focus on kindness and compassion (new section), pain management, respect and dignity and communication. Assurance against Executive level oversight of the improvement plan with further assurance provided through supportive deep dive into the effectiveness of the actions proposed. Timeframes noted against actions prior to next inpatient survey which will include our inpatients in November 2024. Assurance provided with the inclusion of AED within the Trust improvement plans recognising the impact of every point in the patient journey. Noted "unbeleafable" campaign. Assured on peer support taken from Liverpool University Hospitals NHS Foundation Trust (LUHFT). Noted comments and reflections on the subjectiveness of acts of kindness and compassion and actions to be taken forward including back to basics such as re-launch of "Hello my name is" and smiling. Assurance on walkabouts including AED. • **Tendable audits July and August:** Harmonisation of audit programme for MWL. Audit tool to be standardised across all sites with inclusion of new nursing care indicator for pain reflective of NIP. 42 inpatient areas audited during July and August. Areas for recognised improvement noted with key initiatives commenced including review of patient information for discharge, training on the impact of noise at night, continued practice of Johns campaign.	Assurance

	• **FFT:** Southport and Ormskirk sites – positive satisfaction rates met in all areas with the exception of birth and post-natal ward-improvement plans in place. Whiston and St Helens and Knowsley Sites - all areas met positive recommended target rates with the exception of maternity areas. Divisional improvement plans in place. • **Communication themes Q4 and Q1:** Deep dive requested by the Quality Committee completed. From review of data collection across all sites the most frequent themes within concerns raised regarding communication are communication with patients, communication with relatives, co-ordination of medical treatment/delay in giving information and/or results. Assurance in alignment of deep dive findings with NIP action plan. • Patient Experience Council report received.	
Quality Committee Improvement Action Plan	• Improvement Plan is progressing, but more improvement required. • Ongoing reporting to next Audit Committee. • Two Items on the Committee calendar not on the agenda to be presented at next Committee meeting. • Confirmed Clinical Effectiveness Council (CEC) reporting bi-monthly.	Assurance
Any Other Business	None	

Alerts:

- National Inpatient Survey (NIP) 2023: Improvement plan in place.

Decisions and Recommendation(s):

The Board is recommended to note the report, alerts and the assurances sought by the Committee.

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 September 2024
Agenda Item	**TB24/063 (8.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	16 September 2024		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
SPC 0924/03 – Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on the 22 July 2024 and approved them as a correct and accurate record of proceedings.	Decision
SPC 0924/04 Action Log and Matters Arising	The Committee reviewed the outstanding and approved the completed actions.	Assurance
SPC 0924/05 – Workforce Dashboard	The CPR dashboard was presented focusing on the key indicators for the Strategic People Committee (SPC). The following points were noted: • Mandatory training exceeded target at 89.2% for May, against the target of 85%. • The Trust is currently in its annual appraisal window achieving 74.2% against a target of 85%. There has been an in month increase in compliance across both legacy sites with the lower compliance on legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) sites achieving 72.5% and legacy Southport and Ormskirk Hospital NHS Trust (S&O) sites achieving 77.5%. • In-month sickness remains above target, at 5.68% against the 5% target. The Committee will receive a deep dive into sickness absence. • Health Care Assistants (HCA) sickness decreased to 9.5% • Time to hire is exceeding the 40-day target, achieving 56.4 days in month. Three candidates drive this delay as individuals often waiting for bank accounts, IDs, or visas. • Vacancy rates are positively below target at 6.9% (target 8%). Healthy pipeline around HCAs 13%	Assurance

	and Allied health professionals 10.3% • Health, Work and Well Being (HWWB) Did not Attends (DNA) rates 14.4%. There is an improvement, but further work needs to be done. A discussion took place at People Performance Council (PPC) in terms of what can be done differently. The business manager mandate received staff feedback on missing appointments and DNA. The new occupational health system, supported by investment, will provide a choose and book system, which is not currently available. • The Registered General Nurses (RGN) Vacancy rate at 5.1% is overall positive. • Turnover in month is above target at 1.9% however remains positively below target over a rolling 12-month period is positively below target (12.5%).	
SPC 0924/06 –Southport Incident	A presentation was delivered to the Strategic People Committee with a detailed overview of how MWL supported our workforce during the Southport major incident and the following key points were noted: **1. <u>Southport Major Incident - Context</u>** The Southport Major Incident took place on Monday 29 July 2024, involving knife attacks which led to multiple casualties and three deaths (11 people in total). Southport and Ormskirk Hospitals and teams responded to the major incident, in addition to other trusts within the Cheshire and Merseyside (C&M) region. Riots started within the Southport community on the night of Tuesday 30 July 2024 as a result of the major incident and violence and aggression continued within local and wider communities, in the days and weeks that followed. Staff safety was a concern for our Black, Asian and Minority Ethnic (BAME) staff and wider communities leading on from the riots, due to targeted attacks on certain ethnicities. **2. <u>Health and Wellbeing Engagement and Support</u>** The Trust deployed trained Health and Well Being (HWB) staff on-site from 30 July 2024 at Southport and Ormskirk Hospitals with ongoing periodic remote and in-person engagement support for targeted areas and teams. Dedicated landing pages were created on the Trust's intranet with specific post incident resources and support for staff. The HWB	Assurance

	team created specific resources and guidance for out of hours support and weekend, including on call teams, wider weekend workers and the wellbeing champion network. This included support and resource packs to around 150+ wellbeing champions and included the methodology guidance around how to support, post a traumatic incident. **3. <u>Human Resources Support</u>** The HR team switched their weekly management meeting to welfare check-in /offer of support to colleagues and HWWB resources were discussed and shared. Contact was made with colleagues who went home or felt they could not attend to offer support via HWWB. Supportive welfare conversations continue with those identifying as needing support. Trust-wide management briefings were held to affirm the Trust's zero tolerance approach, this involved key stakeholder engagement and contributions. HR presence is ongoing with the most recent visit in the week commencing 26 August 2024 to offer general support / HR guidance. HR drop-in sessions as part of the wider divisional workforce plan are currently being scheduled. **4. <u>Lead Employer Support</u>** The Lead Employer (LE) service received a few enquiries from trainees due to join placements in August particularly in General Practice who were worried about their safety following the riots across the UK. An initial communication was sent to all Doctors in Training on the 06 August 2024to advise them of the Lead Employer support available to them. The LE Helpdesk contact details were reshared with all trainees along with advice to speak to the local host organisation for immediate support on safety issues particularly when travelling to and from work using public transport and support for our newly appointed overseas Doctors. There was a reiteration of the MWL zero tolerance approach – this involved key stakeholder engagement with NHSE and the British Medical Association (BMA). Hosts were advised to offer buddy systems, flexible work patterns to leave early or travel to and from work in groups. A further communication was sent to Doctors in Training reiterating earlier support of HWWB and	

	the Employee Assistant Programme which included a dedicated Safety guidance document. **5. <u>Communications and Engagement</u>** • BAME community engagement, and session led by Equality, Diversity, and Inclusion (ED&I) and the Acting Human Resources Director (HRD) • MWL remembrance sessions • Post incident debriefs and lessons learnt. • Supporting our Partners, collaboration within C&M major incident meetings. • Dedicated workforce communications addressing incident support and conduct around social media and violence and aggression towards our people communities. **6. <u>Staff Safety</u>** **Southport Major Incident – Crime Prevention and Reduction** • The Trust worked closely with detectives from Merseyside Police and ensured that all information was provided without delay and visited staff who received victims as part of those investigations and provided reassurance to staff with safety concerns. • Bodycams have been installed in Southport Accident and Emergency Department (A&E), training has been completed and staff are actively using them. A Crime Prevention and Reduction Officer was based at Southport Hospital A&E one day per week to provide onsite guidance, support, and reassurance. • A trial for the MWL Management of Violence, Abuse and Unacceptable Behaviour Policy has been agreed between the Crime Prevention and Reduction Officer and Southport A&E. **On-Going Support** • The Trust and Merseyside Police are achieving consistent positive results for our staff through close partnership working on Operation Cavell. • The MWL Management of Violence, Abuse and Unacceptable Behaviour Policy has been drafted and is out for consultation. • There is active monitoring of Exclusion Notices.	

	• Introduction of the use of civil powers i.e. civil injunction orders with a view to reducing incidents of violence and abuse. • Hands on education, guidance, and support from Crime Prevention Officer through the management of live incidents. • Introduction of a Violence, Abuse and Security bulletin in response to staff feedback around not being aware of ongoing work.	
SPC 0924/07 Staff Story – Southport Incident	A BAME member of staff who lives with his family in Southport shared the experiences of himself, his family, friends and other BAME staff following the Southport incident. The following summarises the staff story: The staff member explained how as soon as the misinformation was posted on social media about the incident, he and his family felt vulnerable when they left their home to go about their normal daily activities. He described feeling intimidated taking his young children to the local park and visiting the town centre. He and other BAME residents felt they were being stared at and were advised by concerned people they met to go home and stay safe. This led to them moving to Manchester for a few days and avoiding visiting public places. The Committee heard how BAME staff who lived and worked in Southport felt unwelcome due to the negative vibes around and friends and family were bringing groceries so they could stay at home. The staff member set up a Whatsapp group for mutual support which staff have found very useful. Whilst usually based at Whiston the staff member's manager agreed that he should be based at Southport for a few weeks as he was concerned about his colleagues. Drop-in sessions to allow BAME staff to share their concerns and seek support were set up. Since the face-to-face drop-in sessions to the wards started, positive feedback has been received. The drop-in sessions will continue to be held every Friday in collaboration with the ED&I team. The Strategic People Committee noted that this was a subject that required further discussion to ensure that staff feel safe and supported.	Assurance

SPC 0924/08 Medical Workforce Leadership Programme Update	The Committee received an update on the development of the Medical Workforce Leadership Programme which included details on the purpose, content, timetable, and delivery plans. It was noted that the first cohort will be reserved specifically for Clinical Directors to support the current change process and the aim is to offer the programme across the medical workforce in due course: The programme aims to equip Clinical Directors with the necessary skills and knowledge to function effectively in their roles. The program is designed to address the needs of clinical directors, who operate in complex leadership roles. This includes eLearning, distance learning, virtual online sessions, and face-to-face learning. The programme will equip Clinical Directors with a mixture of leadership and transactional management theory and practice to support their role more effectively. It will cover time management, delegation, relevant MWL systems and processes, the impact of ED&I on their role, team development, job planning, understanding their own and their teams' learning and working styles, managing difficult conversations with colleagues, patients, and families, and having compassionate conversations. The programme will consist of nine workshops, each offered twice during the 12-month period. To complete the programme, Clinical Directors must complete all nine modules. Subject matter experts will be recruited for each subject area, including finance experts, effective job planning colleagues from the HR team, and virtual learning sessions from outside organisations. The programme is expected to launch on the 02 October 2024.	Assurance
SPC 0924/09 - Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Report from the People Performance Council.	Assurance
SPC 0924/10 Terms of Reference (ToR)	The Committee reviewed and approved the refreshed TORs. • Employee Relations Oversight Group • HR Commercial Services Council	Decision

SPC 0924/11 - Items for Escalation to Trust Board	The Strategic People Committee requested that the Southport Incident update and staff story should be escalated and noted by the Trust Board.	Assurance
SPC 0924/12 Any Other Business	A discussion took place about the Apprenticeship Levy and if there might be an opportunity for the Trust to provide an Apprenticeship programme for Clinical Coders. The new growth and skills levy was discussed as a future option. It was noted that an Apprenticeship standard for Clinical Coders is already available but that it would not be feasible for the Trust to deliver our own training due to regulation on assessment therefore the Trust needs to partner with external providers that offer and can independently assess the training.	Assurance
SPC 0924/13 – Effectiveness of Meeting	Feedback from the Committee indicated this meeting has been effectively chaired.	Assurance

Alerts:

None

Decisions and Recommendation(s):

The Committee approved the refreshed TORs for the following councils:

- Employee Relations Oversight Group
- HR Commercial Services Council

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 September 2024
Agenda Item	**TB24/063 (8.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	19 September 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
MWL FC24/145 – Director of Finance Update	• Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) will be excluded from the National Cost Collection due to the exclusion of the change in accounting treatment of PFI IFRS 16. • Following agreement over pay awards across all staffing types there is a significant amount of cash required for back pay in the coming months. This is a specific issue for the Trust due to the lead employer arrangements with a cash requirement of circa £120m. The Trust is liaising with NHSE and relevant trusts to mitigate risk of running out of cash.	Assurance
MWL FC24/146 – Financial Improvement	• The Committee received update on activities over the summer including system financial improvement process, NHSE led process and deficit funding allocation.	Assurance
MWL FC24/147 – Integrated Performance Report Month 5 2024/25	• Bed occupancy across MWL averaged 104.3% in August equating to 88 patients – a decrease from 105.8% in July. • Average length of stay for emergency admissions is high at 8.9, 10.3 at S&O and 7.5 at STHK, the impact of Non-Criteria to Reside (NCTR) patients has increased by 1.6% in August, being 22% at organisation level (25% STHK and 16% S&O). • 4-Hour performance increased in August achieving 76.4% (all types), national performance 76.3% and providers across Cheshire and Merseyside averaging 74.3%.	Assurance

	• Super Multi Agency Discharge Event (MADE) event held during August and learning being incorporated into the Urgent and Emergency Care (UEC) Recovery Plan. • Trust identified nationally as needing Tier 1 support on the Whiston site, currently awaiting further information. • 18 Week performance in August for MWL was 58.5%, S&O 65.6% and STHK 55.9%. National Performance (latest month July) was 58.8% and C&M regional performance was 57.1% • The Trust had 2,751 52-week waiters at the end of August (372 S&O and 2,379 STHK) and 6 78-week waiters. • Diagnostic performance in August for MWL achieved target at 96%, S&O 93.7% and StHK 97.1%. • Cancer performance for MWL in July increased to 74.6% for the 28-day standard and 80.8% for the 62-day standard.	
MWL FC24/148 – Finance Report Month 5 2024/25	• The Trust is reporting a deficit of £19.9m which is £1.9m worse than plan due to the impact of industrial action. • The Trust's combined 2024/24 Cost Improvement Programme (CIP) target is £48m of which £11.8m is non-recurrent. As at Month 5, the Trust has transacted CIP of £31.7m in year and £29.1m recurrently. • At Month 5, agency spend is £10.7m to date, 4.2% of total pay costs. Premium Payment Scrutiny Council review and address the drivers of agency costs with actions taken through executive committee. Further review meetings being set up to address ongoing pressures. • The Trust has a closing cash balance of £3.9m at Month 5. Cash approvals are now being reviewed monthly by NHSE. Ongoing discussions regarding mitigating cash risk regarding requirement for pay awards. • Better Payment Practice Code (BPPC) has not been achieved for non-NHS suppliers but has been impacted by a large volume of small value agency invoices. • The capital plan for the year is £48.4m (including PFI Lifecycle). Spend to date is	Assurance

	£10.9m in line with plan. The plan requires external PDC support (£17m) which has not yet been drawn down.	
MWL FC24/149 – Implied Productivity	• Overview of what implied efficiency/productivity means and looks like for MWL and how this compares to others. • For 2023/24 implied productivity is a reduction of 7.2% compared to a national reduction of 12.5%. Adjusting for services which have increased costs but not activity the MWL productivity is a slight reduction of 0.6%. This does not include any adjustment for industrial action which has been estimated nationally at 3%.	Assurance
MWL FC24/150 – Month 5 2024/25 CIP Programme Update	• Total targets for 24/25 is £48m in year and £36.2m recurrently. • There is currently a delivered/low risk value of £33.7m in year (70% of the £48m target) and £30.6m recurrently (84% of the £36.2m target). • Schemes identified to date are £60m with £56.8m recurrent. Based on historic performance a further £10m of schemes is required to be identified to continue with the progress made to date. • Focus on providing training to improve timeliness of Quality Impact Assessments (QIA) completion. •	Assurance
MWL FC24/151 – Cancer Targets Performance review	• Overview provided of the latest cancer position for MWL by tumour site and update of key actions being taken to improve performance. • Focus on capacity for first appointments by using learning from faster diagnosis programme and Community Diagnostic Centre (CDC) workstreams to maximise current capacity, working with specialties to join up pathways to reduce delays from diagnosis to treatment. • Work ongoing to improve quality of referrals in conjunction with primary care partners to ensure resource is ringfenced for the right cohort of patients.	Assurance
Assurance Reports from Subgroups:	• 13.1 MWL FC24/153 – Procurement Council • 13.2 MWL FC24/154 - CIP Council	Assurance

	• 13.3 MWL FC24/155 - Capital Planning Council • 13.4 MWL FC24/156 –Estates & Facilities Management Council	
Alerts		
None		
Decisions and Recommendation(s):		
None		

Title of Meeting	**Trust Board**			**Date**	25 September 2024
Agenda Item	**TB24/064**				
Report Title	Medical Revalidation Annual Declaration 2023/24				
Executive Lead	Peter Williams, Medical Director				
Presenting Officer	Peter Williams, Medical Director				
Action Required	X	**To Approve**		**To Note**	

Purpose

The purpose of this report is to provide assurance to the Trust Board that Mersey and West Lancashire Teaching Hospitals NHS Trust 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 2023 to 31 March 2024.

As of 31 March 2024, 857 doctors had Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) as their registered Designated Body. In 2023-2024 a total of 768 doctors completed medical appraisal in line with General Medical Council (GMC) guidance. Due to changes in reporting, 48 doctors completed an appraisal within the correct timescale, but this was not signed off before 31 March. These would have been previously reported as an agreed exception. Of the 41 doctors who did not complete appraisals, 41 were approved Missed appraisals (e.g. due to sickness) and zero were unapproved.

During this time, a total of 277 revalidation recommendations were made to the GMC with 259 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 2023/2024 no doctors were referred to the GMC for further action and zero were referred to the Practitioner Performance Advice Service for support. No doctors were excluded from practice in this period.

In January 2024, Dr Kathryn Clark became the Trust's Responsible Officer to cover the long-term absence of Dr Jacqui Bussin (previous Responsible Officer). During 2023/24 the Medical Revalidation Teams have worked closely and aligned processes to ensure a consistent approach to appraisal and revalidation across the Trust.

In 2024/25, the organisation will continue to work towards complying with Medical Professional Regulations. During the coming year, the Trust will agree and implement a revised Medical Appraisal and Revalidation Policy following the implementation of single appraisal IT system for MWL. This will ensure consistency of processes across the Trust and incorporate best practice from both legacy organisations.

Financial Implications

Not applicable	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to approve the 2023/24 Medical Revalidation Annual Declaration submission.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
	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

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West:

Mersey & West Lancashire Teaching Hospitals NHS Trust

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Mersey & West Lancashire Teaching Hospitals NHS Trust.** On 1st July 2023 St Helens & Knowsley NHS Trust and Southport & Ormskirk NHS Trust merged to become Mersey and West Lancashire Teaching Hospitals NHS Trust. This is the first annual report as one organisation following the transaction.
What type of services does your organisation provide?	Acute Hospital Care

	Name	Contact Information
Responsible Officer	Dr Kathryn Clark	Kate.Clark@sthk.nhs.uk 0151 430 1134
Medical Director	Dr Peter Williams	Peter.Williams3@sthk.nhs.uk 0151 430 1134
Medical Appraisal Lead	Dr Stephen Allsup	Stephen.Allsup@sthk.nhs.uk 0151 430 2419
Medical Appraisal Lead	Mr Kevin Thomas	Kevin.Thomas2@merseywestlancs.nhs.uk 01704 704781
Assistant HR Business Partner	Ann Higgin	Ann.Higgin@merseywestlancs.nhs.uk 01704 704 193
Assistant HR Business Partner	Michelle Langton	Michelle.Langton@sthk.nhs.uk 0151 430 1650
Medical Appraisal & Revalidation Officer	Cameron McCall	Cameron.McCall@sthk.nhs.uk 0151 676 5270

Please note:

Following the merger of the two organisations, any ‘actions from last year’ which were reported on the individual Trusts 2022/2023 Annual Board Report are no longer relevant or have been superseded by updated objectives, as we now work together as one organisation. Therefore, individual legacy actions have not been included.

Service Level Agreement

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

No

Organisation: N/A

Please describe arrangements for Responsible Officer to report to the Board:
This report will be presented to the Board on 25th September 2024.

Date of last RO report to the Board:
27th September 2023.

Action for next year:

No action required

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board of Mersey and West Lancashire Teaching Hospitals NHS Trust can confirm that:

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

Comments:	Yes.
Action for next year:	

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Comments:	
Action for next year:	

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Comments:	The GMC Connect list of doctors is reviewed daily. A monthly cross check of this list with all doctors on the electronic appraisal system and with ESR full staff reports occurs. Any anomalies are actioned accordingly.
Action for next year:	To continue with the communication from the Recruitment Team and to ensure the data is reviewed and kept up to date.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Comments:	The Medical Appraisal and Revalidation policy was extended until September 2024. The policy is currently under review. Other policies to support Medical Revalidation are regularly reviewed which include Maintaining High Professional Standards, Handling Medical Concerns, Disciplinary Policy, Remediation Policy, and Grievance Policy.
Action for next year:	To ensure the successful role out of the revised MWL Medical Appraisal and Revalidation policy for all non-training grade doctors. The policy will be communicated to doctors through various channels including the Trust intranet, emails and medical forums. It will also be included in all emails as part of the escalation process for any doctors who are non-compliant with the appraisal process.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Comments:	MWL are in the process of confirming arrangements to be part of an appraisal and revalidation peer review group with Warrington & Halton Teaching Hospitals and Liverpool University Hospitals FT. It is planned that one review will be undertaken per year, starting in October 2024, with MWL being reviewed in 2026 to enable time for new systems and processes to be embedded post-merger.
Action for next year:	Incorporate any best practice identified from the initial peer review.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Comments:	The Trust continues to provide support with appraisal and revalidation for all doctors including those on short term contracts and those working solely on the Trust's medical bank. All of these doctors undergo Trust induction and are provided with relevant information to enable safe working. For any doctor 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. There is currently some inconsistency between sites regarding how supporting information in relation to any complaints and incidents is provided to doctors to enable reflection. Work is currently being undertaken to address this.
Action for next year	To provide consistency across the whole of the organisation in how doctors are provided with governance information to support their appraisal and revalidation.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Comments:	All doctors completing an appraisal whilst working at our Trust are required to declare their whole practice and provide supporting information in their appraisal from any external organisations where they undertake other work. This includes clinical outcome reports where appropriate. Information is provided to the doctor pertaining to work undertaken within the Trust and they are asked to provide information for work undertaken for any other body such as a formal letter of no concerns.
Action for next year:	Improve governance processes to ensure all information relating to the doctor's fitness to practice such as complaints, incidents, and clinical outcome data is provided in a consistent manner.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments:	There is a process in place for any doctors not complying with the GMC/Trust requirements in relation to completion of annual appraisal which includes expected actions
Action for next year:	Continue review of processes to ensure consistency for all doctors across the trust.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Comments:	Yes
Action for next year:	To ensure the successful role out of the revised MWL Medical Appraisal and Revalidation policy for all non-training grade doctors, including updating on the trust intranet and referencing in relevant appraisal communications.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Comments:	As at 31.3.2024 the Trust has a total of 159 trained medical appraisers, both consultants and specialty doctors. This covers 857 doctors across the trust. The Trust endeavors to recruit new appraisers as required.
Action for next year:	To review the job planning and appraisee allocation process to ensure divisional involvement in confirming appraiser requirements and encouraging appraiser recruitment

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Comments:	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' which are run regularly throughout the year. The doctors are provided with feedback summaries detailing anonymised feedback/commentary from their appraisees. Appraisers have been provided with the facility to undertake online update training from MIAD training.
Action for next year:	To continue to provide appraisers with feedback.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments:	Appraisal compliance is monitored bi-weekly at the Medical Case Review Meeting and reported to the Strategic People Committee. The Annual Submission, Annual Board Report and Statement of Compliance form the basis of reporting to the Strategic People Committee before being presented to the Board and then submitted to NHSE. Appraisal completion rates are published monthly.
Action for next year:	The Trust will continue to monitor appraisal compliance and report this to the Medical Case Review Meeting and Strategic People Committee.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Comments:	All doctors are supported and encouraged to ensure they have met the revalidation requirements in a timely manner. Where this does not occur, information is recorded in the appraisal management system.
Action for next year:	To continue to support doctors to comply with the revalidation process and provide the Responsible Officer with the required information to recommend doctors for revalidation when they meet the requirements

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Comments:	Prior to a recommendation being made to the GMC, the Team will discuss the potential recommendation with the doctor. If any deferral is necessary, this will be discussed with the doctor in advance and an action plan put in place to help facilitate the doctor successfully revalidating in the future. This information will be recorded in the appraisal management system. A Recommendation Assurance Form signed by the RO is also competed and retained on the system. Once any recommendation has been made, the Team will email the doctor to confirm.
Action for next year:	To continue to provide support and assurance to doctors to help them achieve the requirements for a positive revalidation recommendation in the required timescales, avoiding any necessity for deferral where at all possible.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Comments:	There are systems in place for reporting and reviewing incidents, complaints, and clinical performance. Openness and reporting of incidents are encouraged. The trust has implemented the Patient Safety Incident Response Framework (PSIRF). The Medical Director chairs a Clinical Effectiveness Committee and divisions report through this committee as well as through the Quality and Safety Committee. 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.
Action for next year:	The Trust will embed a new process of patient safety incident reporting and investigation at Divisional and Trust Levels which will ensure incidents are identified, investigated and actions shared across the whole Trust.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Comments:	There are several policies and processes in place that include – • Whistleblowing • Speaking out Safely • PSIRF • Respect and Dignity at Work • Medical Appraisal and Revalidation Policy • Handling Medical Concerns Policy There is a bi-monthly case review meeting to review any concerns or performance issues involving the RO, Head of Medical Workforce, relevant HRBP's and members of the Appraisal and Revalidation Team. Actions are tracked via this forum. This feeds into a Strategic Workforce Review which is chaired by the Director of HR. Quarterly meetings are held between the RO and the GMC's Employer Liaison Advisor 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. For doctors in training a Trainees Requiring Extra Support (TRES) meeting is held monthly. This also includes oversight of international recruits and items would be escalated through medical education or the RO as needed.
Action for next year:	Continue to monitor the governance in place for monitoring conduct and performance.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Comments:	Yes – this includes information in relation to complaints, claims, incidents to enable reflection.
Action for next year:	To continue to provide doctors with the necessary information to include and reflect upon in appraisal and align processes across sites where necessary.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Comments:	The Strategic Case Review Meeting and Medical Case Review Meetings allows for discussion and reviews of any ongoing cases with senior colleagues across the Trust. Policies to support this would include – • Handling Medical Concerns Policy • Disciplinary Policy • Remediation Policy
Action for next year:	The Remediation Policy will be reviewed and updated in the next year.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Comments:	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. Numbers, types and outcomes of concerns are discussed at the Employer Relationship Oversight Group (EROG) which feeds into the Trust Board. The EROG whose members include a non-executive director monitor demographics and characteristics of all staff, including doctors involved in performance and practice processes. The Board also receives Workforce Racial Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and gender pay gap reports.
Action for next year:	Continue to review any trends identified.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Comments:	When a doctor joins the Trust, a RO Transfer of Information Form is requested. Any concerns received are escalated to the Responsible Officer. Any issues raised in relation to a doctor working at the Trust whether they are directly connected to our trust and working elsewhere or connected to another organisation but working at the Trust would result in RO-to-RO contact being made to transfer any relevant information. Information is transferred electronically via a generic email which is monitored every working day. Should a doctor leave the Trust where concerns had not been resolved and the doctor had not connected to a new designated body, then the GMC ELA would be informed to enable contact to be made with the relevant RO once a new connection had been made. Where appropriate a Health Professionals Alert Notice (HPAN) would be documented on the doctors GMC record.

Action for next year:	Continue to share information on doctors with other Trusts and GMC when transferring to and from the Trust

1D(vii) 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 (reference GMC governance handbook).

Comments:	This is monitored through the EROG and reported as described in Section 1D(v). Concerns are also discussed with the PPA.
Action for next year:	Continue to work closely with PPA and monitor the characteristics of any patients referred to the GMC through EROG.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Comments:	Through trust governance, national reviews, reports, and enquiries are integrated into trust policies and procedures and ultimately reported to the Quality and Safety Committee. Cultural oversight is reported through the Strategic People Committee. The trust has recently undertaken staff engagement to develop new cultural values for MWL. There is a standard agenda item within the Executive Committee to consider any strategic issues that would influence trust governance. From a medical staff perspective, a clinical leadership forum lead by the medical director is used as a platform for discussion of any items of relevance.
Action for next year:	Continue to integrate national guidance into Trust policies, procedures and culture

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Comments:	There is a bi-weekly medical case review meeting, in addition to the Professional Standards group (discussing all healthcare professionals) and EROG to ensure consistency and fairness.
Action for next year:	Continue sharing of information through Professional standards Meetings

1E – Employment Checks

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

Comments:	Yes – in line with the NHS Employment Standards
Action for next year:	Continue to ensure all pre-employment checks take place prior to commencement of post

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Comments:	The Trust has recently engaged with all staff groups to develop and launch new vision and values underpinned by our 5-star patient care objectives. This promotes continuous improvement, innovation and excellence and all supporting professional activities should be linked to a standard or trust objective. All staff undertake annual appraisals and have opportunities to work towards a personal development plan with objectives that support excellence in clinical care.
Action for next year:	Continue to promote culture of continuous improvement through education, training and creating a positive learning environment for all staff members

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Comments:	The revised trust values and vision promote inclusivity and kindness. All Executive Directors have agreed objectives to support equality diversity and inclusion. A variety of training and education programs are available to managers and staff to improve their knowledge and inclusivity. The Trust is involved in the pilot scheme for Compassionate Conversations which will be incorporated into the clinical director development program.
Action for next year:	Continue to embed the new Trust values Run the first Compassionate Conversations courses in the Trust

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Comments:	There are several policies and process in place that include – • Whistleblowing • Speaking out Safely • PSIRF • Respect and Dignity at Work Effectiveness of the policies are monitored through the groups previously mentioned reporting through Strategic People Committee. The Trust socialises the information on platforms such as a closed social media page, trust intranet page, weekly Trust Brief Live meetings, posters, daily global emails and weekly MWL newsletters. There are 6 Freedom To Speak Up Guardians across the Trust who are allow to staff to raise concerns in confidence. The FTSUG meet regularly to share themes around incidents which have been raised in order to reduce the likelihood of recurrence.
Action for next year:	Continue to promote the Freedom To Speak Up Guardians to staff and ensure that they feel able to raise concerns.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Comments:	Where concerns have been raised about a doctor, they are offered support through health and wellbeing as well as the opportunity of a support buddy to enable them to receive any required support. This also acts as a feedback mechanism. Where a doctor has been subject to an investigation, all relevant policies are provided. A named HR contact is also assigned to the doctor to provide support during the process. Doctors are asked to provide feedback in relation to their appraisal.
Action for next year:	Continue to seek feedback on professional standards process

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Comments:	Yes, there is a monthly TRES meeting and a bi-weekly Medical Case Review meeting. Information from both groups is reviewed within the EROG.
Action for next year:	Continue to International Medical Graduates with structured education sessions to support doctors working in their first post in the NHS

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Comments:	The Responsible Officer and Medical Appraisal and Revalidation Team members attend the Responsible Officer network meetings. The Medical Appraisal and Revalidation Team members also attend local bi-monthly network meetings.
Action for next year:	Continue to attend RO Network Meetings The trust will take part in a local peer review meeting with two other local trusts starting in October 2024.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	857

2B – Appraisal

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

Total number of appraisals completed	768*
Total number of appraisals approved missed	41
Total number of unapproved missed	0

*Due to changes in reporting 48 doctors completed an appraisal within 9-15 months of their last appraisal but it was not signed off before 31st March, these would have been previously reported as an agreed exception.

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	277
Total number of late recommendations	2
Total number of positive recommendations	259
Total number of deferrals made	18
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	45
Total number of trained case managers	6
Total number of new concerns registered	18

Total number of concerns processes completed	21
Longest duration of concerns process of those open on 31 March	227 calendar days

Median duration of concerns processes closed	201.5
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	33
Number of new employment checks completed before commencement of employment	33

2F – Organisational culture

Total number claims made to employment tribunals by doctors	2
Number of these claims upheld	N/A
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
On 1st July 2023 St Helens & Knowsley NHS Trust and Southport & Ormskirk NHS Trust merged to become Mersey and West Lancashire Teaching Hospitals NHS Trust. This is the first annual report as one organisation following the transaction. Actions for legacy organisations have been reviewed and were appropriately referenced within the body of the report.
Actions still outstanding
• Agree and implement a revised Medical Appraisal and Revalidation Policy following implementation of single appraisal system for MWL. • Ensure consistency of processes incorporating best practice from legacy organisations.
Current issues
• Consistency of approach to appraiser identification and allocation • Different systems and processes following transaction. These should be aligned within the next 6 months
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Continue to review resources whilst embedding new systems and processes. • Incorporate any best practice identified from the initial peer review. • To provide consistency across the whole of the organisation in how doctors are provided with governance information to support their appraisal and revalidation. • To ensure the successful role out of the revised MWL Medical Appraisal and Revalidation policy for all non-training grade doctors. • To review the job planning and appraisee allocation process to ensure divisional involvement in confirming appraiser requirements and encouraging appraiser recruitment.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Following the transaction of the two legacy organisations in July 2023, the newly formed Mersey and West Lancashire Teaching Hospitals NHS Trust, continues to develop a new organisational structure which includes a review of the HR and Medical Appraisal and Revalidation function.

As with any transaction which takes place, there have obviously been challenges in two organisations becoming one including integration and review of processes and procedures.

However, we have identified from both legacy organisations, improved ways of working which will help us achieve over the next 12 months one seamless medical appraisal and revalidation system to support all our doctors.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of the designated body	Mersey & West Lancashire Teaching Hospitals NHS Trust

Name:	Malise Szpakowska
Role:	Acting Director of HR
Signed:	
Date:	September 2024

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 September 2024
Agenda Item	**TB24/065**			
Report Title	Learning from Deaths Annual Report 2023/24			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To summarise the work of the Learning from Deaths Team at Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) over the last 12 months and the learning which has been made following the review of deaths which have occurred across the Trust

Executive Summary

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has well-established processes at both legacy trusts to review deaths occurring in hospital and identifying areas of learning where practice can be improved.

The teams involved in review and learning from deaths (LFD) are now working together to ensure that the processes of review are robust and consistent, and that learning is shared across the whole Trust. Where concerns have been identified these have received further peer review and escalated as appropriate via the Trust's Patient Safety processes.

The predominant themes were around care at the end of life and improving flow through the Emergency Department. Lessons were learned around the reversal of anticoagulation and administration of medication and the importance of communication (including use of translation services) for patients reaching the end of their life. Lessons learned are shared widely throughout the Trust and Divisions will create action plans and evidence their completion to address any concerns.

Financial Implications

None

Quality and/or Equality Impact

The Learning from Deaths process promotes continuous learning in order to foster a culture which leads to ongoing improvement of care, pathways and services.

Recommendations

The Board is asked to note the Learning from Deaths Annual Report 2023/24 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
	SO5 5 Star Patient Care - Systems

	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and identify where they could do more.

A CQC review in December 2016, *"Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England*" found some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. We are now helping trusts to meet the requirements of the new guidance.

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has embraced the Learning from Deaths (LFD) Process to encourage continuous improvement and enable lessons to be learned when patients die in hospital.

2. Approach to Mortality Review across the Trust

Both legacy Trusts at MWL have different process for reviewing and learning from deaths. Although there are differences in the approach, both provide robust, consistent and transparent review of deaths in hospital.

	Process	**Reporting to**
Legacy S&O	Merged ME and LFD process All deaths in hospital reviewed by Medical Examiner Team. Outcome recorded on Careflow system. Any concerns around lapses in care are logged on DATIX, cases with learning are referred directly to clinical directors. SJR requests are made for those without concerns but meet NQB definitions. Mortality Outcomes Group reviews learning from ME reviews, SJRs as well as SMR analysis	Clinical Effectiveness Council
Legacy STHK	Separate ME and LFD process Deaths in hospital within scope (Appendix 1) referred for SJR and review at Mortality Surveillance Group. Any concerns around lapses in care logged on DATIX.	Clinical Effectiveness Council

The process to merge the two review groups (Mortality Outcomes Group and Mortality Surveillance Group) has begun in order to have a single Trust-wide group for review of in-hospital deaths. Both groups work closely with Specialist Palliative Care Teams to identify actions which can be taken to improve End of Life Care.

3. Annual Review of Deaths across MWL

In 2023/24 at legacy STHK there were 2174 deaths, of which 328 were identified for Structured Judgement Review. Of these, 237 have been completed, the outcomes of which are detailed below.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4*	Total
RED	0	0	0	0	0
AMBER	1	2	1	0	4**
GREEN	46	42	35	1	124
GREEN - WITH LEARNING	17	17	16	0	50
GREEN WITH LEARNING - POSITIVE FEEDBACK	20	25	14	0	59
Total	84	86	66	1	237

**Q4 has not yet been reported in full*
*** all 4 cases have been managed via the patient safety incident framework process*

In 2023/24 at legacy S&O there were 937 deaths of which 48 of which have been identified for SJR with 42 completed. the outcomes of which are detailed below.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Very Poor Overall	0	0	0	0	0
Poor Overall	0	0	1	1	2*
Adequate Overall	2	0	5	5	12
Good Overall	7	3	3	3	16
Excellent Overall	6	0	3	4	13
Total	15	3	12	13	43

** both cases have been managed via the patient safety incident framework process*

4. Themes identified in Mortality Reviews in 2023/24

<u>End of Life Care</u>

Usual medication at the end of life

When patients are reaching the end of their life (and may not be able to take oral medication) it is still important to ensure that essential medication is given, if this will help to alleviate symptoms or prevent distress

- Methadone should not be stopped in patients who are already prescribed this drug but can be given via syringe driver if required
- Parkinson's Disease medication can be converted to a patch for patients at the end of life to prevent worsening of symptoms.
- A patient's usual Anti-epileptic medication should not be stopped at the end of life and can be given via syringe driver if required.
- Fentanyl patches must not be removed and should continue to be replaced as patients are dying

Anticipating death and advanced care planning.

Awareness and acknowledgement that patients are reaching the end of their life can ensure that advanced care planning can take place, allowing patients to die in their preferred place of care. Unfortunately in some circumstances, advanced care plans are not followed as intended, resulting in avoidable hospital admission. Close working between Primary, Secondary and Community Care providers ensures that the wishes of patients and their loved ones are followed wherever possible at the end of life.

For patients where death can be anticipated, investigations or interventions with minimal benefit to the patient should be carefully considered, with the involvement of patients and their loved ones in these discussions. Cases have highlighted where supportive treatments for those who were dying were delayed while the patient awaited other interventions. In some of those cases, families have also not felt listened to when their loved one has been ill or deteriorating.

<u>Emergency Department flow</u>

Long waits for admission to a ward for patients seen in the Emergency Department have been noted across the Trust due to increased inpatient length of stay. This leads to ED crowding and delays for patients awaiting a bed. The Royal College of Emergency Medicine estimates that harm can be caused to patients once the delay to admission exceeds 8h. The Trust is working closely with system partners to reduce hospital length of stay which is the main driver of ED overcrowding, with additional resource allocated to maintain safety and quality of care for patients as they wait in the ED.

Mortality reviews frequently identify long waits for patients in ED with an associated impact on the quality of care. Thus far no deaths have been directly attributed to delays in the ED however clinical teams should continue to ensure that patients waiting an inpatient bed receive the same level of care of those in inpatient areas.

5. Lessons Learned from Mortality Reviews in 2023/24

GKI (Glucose/Potassium/Insulin regime)

- This should only to be used with patients who have a definite diagnosis of diabetes. If used in patients that are non-diabetic, this may lead to a detrimental outcome.
  Action – Communication to all clinicians and discussion at junior doctor training.

Palliative Care and End of Life Care

- Blood glucose monitoring may still be required in patients who are diabetic to prevent the distress of a hypoglycaemic episode during the final stages of life
- Prior to using sedating drugs, other causes of agitation should be considered (eg. Constipation, urinary retention, nicotine or alcohol withdrawal)
  Action – Communication to all clinicians in trainee education and clinical governance meetings

Preventing harm from falls

- Following a death in a patient who had suffered a fall in the hospital, a change to the process and guidance for the emergency reversal of anticoagulants in patients with Head Injury has been made
  Action – Update of policy on reversal of anticoagulation and ensure treatments are easily accessible across all sites

Dealing with health inequalities in patients whose first language is not English

- Following a death in ED for a patient whose first language is not English it was identified that some staff members were not clear how to access translation services in emergency situations (A relative helped to translate for the patient in this case)
  Action - A Task and Finish group has been established to review the availability and suitability of translation services both for emergency and elective situations across the Trust. Communication to all staff in Medicine and Emergency Care Division on how to access translation services.

Learning from coroner's cases

Cases which are referred by the Medical Examiner's Team to the Coroner also undergo Trust review and implementation of actions to prevent similar incidents. Inquests into the cases concluded in 2023/34 .

Case 1

Death following an elective procedure

Failure to recognise an unexpected post-operative course and ongoing deterioration until emergency laparotomy was performed, with ensuing delay in transfer to critical care which may have contributed to a patient's death.

Lessons Learned:

- The frequency of consultant review of gynaecology inpatients or for the post operative review by the operating surgeon should be clearly identified
- Clinical deterioration can be reflected in:
    - Worsening laboratory tests
    - NEWS score
    - Worsening pain scores
    - A prolonged length of stay
    - General concern, from patients or relatives.
- Ward staff need to feel empowered to escalate patients who they have concerns about in the absence of NEWS triggers and scores
- Wards which do not routinely manage critically unwell patients should be targeted for training in recognition and treatment of the deteriorating patient

Actions Taken:

- Consultant (hot) of the week has oversight of all in-patients
    - Consistent senior doctors ward round with clear escalation plans and discussion with operating team as necessary
- Deteriorating patient policy and proforma education for nursing and medical teams in gynaecology wards

Case 2

A patient suffered complications following a ruptured uterus. A caesarean section was originally planned electively but had been postponed due to emergency cases taking priority on a single list. The patient re-presented as an emergency and was taken to theatre urgently out of hours. Despite resuscitation from major haemorrhage and eventual transfer to ICU, the lady died from a hypoxic brain injury in the subsequent days.

Actions Taken:

- A clinically led process for planning elective caesarean sections with identification of clinical urgency.
- Separation of the elective and emergency processes so that emergency work does not impact on the ability to do planned elective cases.
- Dedicated elective maternity theatre lists

The Lancashire coroner agreed that death could have been avoided if surgery had proceeded electively but commended the trust for the changes that had been put in place, commenting that 'these will save lives'.

Case 3

A patient was admitted with chest pain at home and a INR >8 on admission. They suffered an unwitnessed fall in hospital sustaining a subdural haematoma. There was suboptimal coagulation reversal and falls risk assessment before and after fall. Following a second fall, CT showed a worsening subdural haematoma which was not suitable for intervention.

Coroner found that the cause of the fall was collapse due to medical causes but that death could have been avoided if reversal of anticoagulation had been completed following the first fall.

Actions Taken:

- Work with nursing teams to ensure falls risk assessments are completed accurately and reviewed following any change in the patient's condition
- Review of the guidance on emergency reversal of anticoagulation to ensure clarity of guidance and availability of reversal agents across Trust

Appendix 1

Total Deaths in Scope – Legacy STHK Mortality Surveillance Group

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

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

Appendix 2

Forums and channels were learning is shared within the Trust

Forum/Communication Channel	Chair	Support
Trust Board	Richard Fraser	Juanita Wallace
Clinical Effectiveness Council	Peter Williams	Helen Burton
Patient Safety Council	Rajesh Karimbath	Kim Jeffrey
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Elspeth Worthington	Jane Bennett
Medical Division Safety and Governance Meeting	David Snow/Gemma Causer	Joy Woosey
Surgical Division Safety and Governance Meeting	John McCabe/Helen Hurst	Gina Friar
Women and Children's Division Safety and Governance Meeting	Kevin Thomas/Sue Orchard	Julie Rigby
Community and Clinical Support Division Safety and Governance Meeting	Vinod Gowda/Tracy Greenwood	Sam Barr
ED and AMU Teaching	Ragit Varia/Sarah Langston/Michael Aisbitt	Ann Thompson
Foundation Year Teaching	Sue Priestley (W&StH)/Ann Holden (S&O)	

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 September 2024
Agenda Item	**TB24/066 (11.1)**			
Report Title	**Emergency Preparedness, Resilience and Response (EPRR) MWL Annual Report 2023/24**			
Executive Lead	Lesley Neary, Chief Operating Officer obo Sue Redfern, Accountable Emergency Officer, EPRR			
Presenting Officer	Lesley Neary, Chief Operating Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

To approve MWL Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2023/24.

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.

The EPRR annual report has been presented at EPRR Working Group Meeting, Risk Management Council and the Executive Committee before being presented to the Board.

The report sets out an update against each of the legal obligations alongside an update on exercises, training and communication during 2023/24. **Appendix 1** sets out the incidents in 2023/24 or where services were required to enact business continuity plans.

The report also presents the Trusts compliance level for 2023/24 for the Core Standards for EPRR. In 2023/24 the Trust was compliant with 27 out of 62 Core Standards (44%), an overall EPRR assurance rating of 'non-compliant' for 2023/2024. The statement of compliance set out in A**ppendix 2** and A**ppendix 3** contains a breakdown of compliance levels against each of the core standards domains.

The report then sets out the governance and oversight for EPRR in the Trust and partnership working.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Emergency Preparedness, Resilience and Response (EPRR) MWL Annual Report 2023/24.

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

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) MWL ANNUAL REPORT 2023/2024.

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 2023 to 31 March 2024.

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 suite of plans to deal with major incidents and business continuity issues. These conform to the CCA (2004) and current NHS-wide guidance. All plans have been developed in consultation with stakeholders to ensure cohesion with the 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 Head of Emergency Preparedness and supported by a designated Consultant within the Whiston and Southport Emergency Departments. 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 Risk Management Council (RMC).

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 Director of Nursing, Midwifery & Governance and Head of Emergency Preparedness at the Local Health Resilience Partnership (LHRP) Strategic and Tactical meetings and relevant subgroups.

The Trust has hosted a multi-agency exercise and has participated in meetings with multi agency partners, including NHS England Cheshire and Merseyside Integrated Care Board (ICB), provider Trusts, commissioners and other partners including the Police, Mersey Fire and Rescue Service (MFRS) and North West Ambulance Service (NWAS).

b) Risk Assessment

Under the CCA (2004), the Trust, as a Category 1 responder, is required to assess risks associated with emergencies. This includes evaluating potential impacts on patients, staff, and facilities.

EPRR risk assessments are conducted based on the National Risk Register (NRR) and Community Risk Registers (CRR). These assessments help identify and mitigate risks to the Trust's operations. Currently, the top national risks include pandemics, loss of critical infrastructure, and climate change effects such as flooding, heatwaves, and space weather. The Local Resilience Forum (LRF) CRR reflects similar priorities.

Any identified concerns or risks are reviewed at EPRR meetings and may be added to the Trust Risk Register if necessary. These risks are then discussed at RMC to ensure appropriate oversight and action.

EPRR considerations are integrated into the Trust's Board Assurance Framework (BAF) to provide oversight and ensure that preparedness measures align with the organisation's overall risk management strategy.

c) Emergency Planning

The Major Incident Plan and the Business Continuity Management Plan are essential documents that require formal approval from the Board.

To ensure their continued effectiveness and relevance, these emergency plans undergo a comprehensive review at least annually and are shared with multi-agency partners. Following development or updates, the plans are rigorously tested through exercises to assess their practicality and effectiveness.

Lessons learned from these exercises, as well as from real-life incidents, are carefully documented during debrief sessions. These lessons are subsequently monitored by the EPRR Group and RMC until all action items are addressed and the situation returns to a new business as usual (BAU) state.

Capturing and acting on these lessons is crucial for continuous improvement in our emergency planning arrangements, ensuring that our strategies adapt effectively to emerging challenges and opportunities.

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 statutory duty to share information with partner organisations. This obligation is a fundamental aspect of civil protection work, facilitating cooperation and coordination across various entities.

The Trust actively engages in this information-sharing mandate through the use of Resilience Direct, an online private network managed by the Cabinet Office. This platform enables civil

protection practitioners to collaborate effectively across geographical and organisational boundaries during the preparation, response, and recovery phases of an event or emergency.

Resilience Direct supports organizations in meeting their responsibilities under the CCA (2004) by ensuring that information is shared seamlessly, and actions are coordinated. This collaborative approach is essential for effective emergency management and response.

f) Business Continuity Management

The Trust's Business Continuity Management Policy is reviewed and updated at least every three years. This policy outlines the framework for responding to disruptions in accordance with legal obligations and EPRR guidance. It is the responsibility of each ward and department to develop and maintain their own continuity plans, which must be updated annually and immediately following an incident or service change. Support for these plans is available from the EPRR Team as needed.

Throughout the year, the Trust has faced various disruptions, including industrial actions, power outages, and IT downtime. To mitigate the impact of these incidents, the Trust continually seeks improvements. Debriefs are conducted to gather valuable insights and develop action plans aimed at enhancing performance and addressing issues identified. These incidents and subsequent actions are discussed and recorded during EPRR Group meetings.

The Trust has activated its Business Continuity Plans (BCPs) on multiple occasions in response to both planned and unplanned outages. Planned downtimes were managed in coordination with the EPRR Group or Senior Operational meetings, while unplanned outages across hospital sites necessitated the activation of BCPs by affected wards and departments (Appendix 1).

3. ASSURANCE

In line with the EPRR 2023-2024 Assurance Process requirements, compliance is assessed based on the percentage of Core Standards fully met against established rating thresholds. The Trust was compliant with 27 out of 62 Core Standards, 44%, an overall EPRR assurance rating of ‘non-compliant’ for 2023/2024. The main reasons for non-compliance were related to:

1. **Transaction:** The transaction was completed in July 2023 which significantly expanded the Trust’s operations, now serving a population of over 600,000 and employing approximately 10,000 staff. This merger introduced the necessity to harmonise emergency plans across the newly unified Trust.
2. **New Evidence Submission Process:** The introduction of a new process for submitting evidence, scrutinised by NHS England through a legal perspective, highlighted areas needing improvement.
3. **Lessons from Major Incidents:** Insights from recent critical incidents, such as the Manchester Arena bombing, underscored the need for enhanced preparedness.
4. **Training and Exercising:** Increased focus on the training and exercising of staff across all healthcare services was required.

5. **Multiagency Collaboration:** Emphasis on demonstrating effective multiagency collaboration with LHRP, LRF, ICB, and other EPRR peers.

Despite achieving the highest core standard result in the region, the 'non-compliant' rating prompted the Trust to implement mitigating actions to address identified concerns. These actions were incorporated into the EPRR Workplan for 2023/2024.

4. TRAINING

The EPRR Team has organised a range of training and awareness sessions for staff, including those responsible for on-call duties at Strategic and Tactical levels. The training programs offered include:

- **Strategic Commander Training**
- **Tactical Commander Training**
- **Legal Awareness for EPRR Training**

To further support senior managers on call, additional training courses are being sourced and will be implemented over the next 12 months.

Compliance with training requirements for senior managers is monitored and reported through the EPRR Group and RMC, in alignment with the Minimum Occupational Standards (MOS) and the EPRR Training Needs Analysis.

In addition to senior manager training, a staff awareness booklet on EPRR and incident response has been developed and distributed across the Trust. Signed declaration forms from staff members are collected by the EPRR Team, and compliance with this awareness training is monitored and reported through the governance groups mentioned above.

5. EXERCISES

In accordance with NHS England's EPRR Core Standards, Acute Trusts are required to engage in planned exercises with external partner organisations.

During this reporting period, the Trust conducted a Trust-wide Suspect Packages and Explosion Tabletop Exercise, named Exercise Guy Fawkes, on 13th September 2023.

This exercise aimed to evaluate the effectiveness of the Improvised Explosive Device (IED) Policy, the Access and Lockdown Plan and the Evacuation Plan across Southport and Ormskirk Hospitals.

The exercise was attended by key external partners, including Cheshire & Merseyside ICB, Cheshire Police, NWAS and MFRS. Feedback from the exercise was positive, and all lessons identified were documented during the debrief session.

6. COMMUNICATIONS

Effective communication is crucial in managing adverse incidents. To ensure preparedness, the Trust conducts regular communication exercises designed to test and enhance our incident response capabilities.

Twice yearly, the Trust holds a communications exercise, named "Dr Majax," at Whiston and St Helens Hospitals. Additionally, a full communications cascade exercise is conducted twice yearly at Southport and Ormskirk Hospitals. These exercises simulate a major incident communications cascade and are intended to assess and validate the Trust's ability to alert staff and initiate incident response processes effectively.

Lessons learned from the exercise cascades are captured in response plans.

7. GOVERNANCE AND OVERSIGHT

The EPRR Workplan is overseen by the EPRR Group, which is responsible for managing progress and actions. The EPRR Group reports on its activities and the status of the workplan to RMC, where ongoing actions and progress are reviewed and managed.

As a Category 1 responder, the Trust is required to report on progress and provide assurance regarding emergency planning directly to the Trust Board. This ensures that the Board is informed of the Trust's preparedness and compliance with emergency planning requirements.

8. PARTNERSHIP WORKING

The Trust actively collaborates with a variety of partner agencies through both formal and ad hoc arrangements. This collaboration is facilitated through formal standing meetings and committees.

Notably, the Trust is a member of the LHRP, among other formal committees. These partnerships are integral to ensuring effective coordination and resilience in our emergency preparedness and response efforts.

9. RECOMMENDATIONS

In accordance with our legal obligations as a Category 1 responder, it is crucial to maintain robust Business Continuity Management and Emergency Preparedness arrangements. The Trust Board is therefore requested to approve this Annual Report on EPRR.

The arrangements detailed in this report align with our legal responsibilities under the CCA (2004) and NHS England EPRR guidance, ensuring that the Trust meets its statutory obligations and maintains effective emergency preparedness.

Appendix 1: EPRR - Planned Work/Unplanned Incidents 2023 – 2024

INCIDENTS	
26/04/2023	Gas leak at the Sexual Health Community Clinic, St Hughes, Bootle
07 - 08/05/23	IT and Communications Outage
24 - 25/05/23	IT Outage
28/06/2023	Outpatient Incident - Contractor using F61 Heavy Duty Contact Adhesive
15/12/2023	Power Loss on ODGH Site
05/01/2024	Power Outage at ODGH
02/02/2024	Chemical Incident at local refuse centre - patients brought to ED and CBRN equipment used.
25/03/2024	MRI Scanner at Whiston down
FULL TO CAPACITY (OPEL 4)	
26/07/2023	Full to Capacity - OPEL 4 (Whiston)
02/11/2024	Full to Capacity - OPEL 4 (Whiston and Southport)
13/11/2023	Full to Capacity - OPEL 4 (Whiston and Southport)
01 - 06/12/23	Full to Capacity - OPEL 4 (Southport)
22/01/2024	Full to Capacity - OPEL 4 (Whiston and Southport)
INDUSTRIAL ACTION	
11 - 14/04/23	Junior Doctors' Industrial Action
14 - 17/06/23	Junior Doctors' Industrial action
13 - 18/07/23	Junior Doctors' Industrial Action
20 - 21/07/23	Consultants' Industrial Action
25 - 27/07/23	Radiographers' Industrial Action
11 - 15/08/23	Junior Doctors' Industrial Action
24 - 26/08/23	Consultants' Industrial Action
19 - 21/09/23	Consultants' Industrial Action
20 - 23/09/2023	Junior Doctors' Industrial Action
02 - 05/10/23	Junior Doctors' Industrial Action
02 - 05/10/23	Consultants' Industrial Action
03 - 04/10/23	Radiographers' Industrial Action
20-23/12/23	Junior Doctors' Industrial Action
03 - 09/01/24	Junior Doctors' Industrial Action
24 - 29/02/24	Junior Doctors' Industrial Action
14 - 17/03/24	Biomedical Scientists' Industrial Action
20 - 24/03/24	Biomedical Scientists' Industrial Action
27 - 31/03/24	Biomedical Scientists' Industrial Action
PLANNED UPGRADES / MAINTENANCE WORK (WARDS / DEPARTMENTS REVERT TO BC)	
04/04/2023	Network Remediation - Spinal affecting Physio and GUM
06/04/2023	Network Remediation - ODGH affecting X-Ray

18/04/2023	Stack 1 X-Ray, Ormskirk - no WiFI/phones (full BCP required)
19/04/2023	Ormskirk / Southport Unused Routes Removal - Internet / Teams / Outlook impacted (no BCP required)
20/04/2023	19:00-23:00 - IT Work - Switchboard, HSDU, Canteen, Mortuary, Cash Office, Porters Lodge impacted (no impact on EPMA Project)
22 - 23/04/23	Relocation of Switchboard to Porters' Lodge at Southport
22/04/2023	06:00-18:00 - IT Radiology CRIS System Downtime
24/04/2023	11:00 - 14:00 Network Remediation Work - affecting Hospedia Food Ordering on both sites
26/04/2023	00:00-06:00 - Network Remediation Work - affecting Spinal Level 2 at SDGH - Spinal and GUM
26/04/2023	19:00-22:00 Network Migration (Southport) - Internet/Teams/Outlook impacted (no BCP required)
27/04/2023	10:30:00-16:30 CT Downtime SDGH
27/04/2023	18:00-00:00 - Network Remediation Work - affecting ODGH PBX - Mortuary, Stores, Theatres and Maternity
11/05/2023	Second Switchboard Upgrade
11/05/2023	Network Remediation - Spinal Level 2 affecting Physio and GUM
16/05/2023	11:00-14:00PACS2 Work
13/06/2023	21:00-00:00 - Network Remediation at ODGH affecting Ascoms / RF Pagers (2222 off)
21/06/2023	21:00-21:30 - 2nd Ormskirk Migration
21/06/2023	22:00-00:00 - Ascom Migration at SDGH
28/06/2023	From 18:00 - ODGH Ormskirk Telephone System Maintenance
28/06/2023	20:00-21:00 - ODGH Network Remediation affecting X-Ray
29/06/2023	12:00-12:15 - Zebra Printing Maintenance
01/07/2023	08:00-13:00 - Relocation of Switchboard back to existing
09/07/2023	08:00-14:30 - Planned CT Downtime
12/07/2023	13:00-13:30 - Network Remediation - Mindray Cisco Migration (affecting ICU / CCU)
22/07/2023	06:00-09:00 - Radiology CRIS System Downtime
24/07/2023	08:00-09:00 - Upgrade OPCS Encoder
26 - 27/07/2023	22:00-04:00 - Hot and Cold Water Shut Down (water storage tank replacement)
30/09/2023	06:00-19:00 - CRIS Downtime
02/10/2023	20:00 - Final Connection to Car Park Lighting (power off to CMO for 3 hours)
06/10/2023	Network Remediation - Core Outage
23/10/2023	13:00-16:00 - Careflow Connect Work
08/12/2023	10:00-10:30 - Brainomix Server Upgrade
14-15/12/23	19:00-06:00 - Emergency Electrical Work at ODGH
16-22/12/23	Theatre Maintenance at ODGH (Theatre 1 and 2)
10/01/2024	11.00 - Server Reboot affecting Ascom Voice at SDGH
17/01/2024	21:00-02:00 - Hot Water Services Work at ODGH
30/01/2024	07:30 - Generator Test at SDGH and ODGH
06/02/2024	23:00-04:00 - EMIS Upgrade
13/02/2024	06:00-07:00 CRIS Downtime

17/02/2024	07:00-17:00 CT Planned Downtime
21/02/2024	12:00-14:00 CT Scanner Downtime at SDGH
29/02/2024	08:30-09:00 - Maternity System Upgrade
10/02/2024	08:00-20:00 - ESL Cab Migration
13 - 14/03/2024	19:00-07:00 - Water Shutdown to repair pipe in CMO (affects 14 A/B and Theatre 5)
14 - 15/03/2024	21:00-05:30 - Water Shutdown to repair faulty valve (affects 14 A/B)
25/03/2024	21:00-23:00 - Water Shutdown to allow new hot / cold feeds to CMO (affects 14B only)

Appendix 2: EPRR Statement of Compliance

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 Non-compliant (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 X	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

22/11/2023
Date signed

27/09/2023 Date of Board/governing body meeting	27/09/2023 Date presented at Public Board	Date published in organisations Annual Report

Appendix 3: Core Standards Self-Assessment

Version Control
2.1 28/07/23

Please choose your organisation type	Acute Providers

Generate Action Plan

Percentage Compliance	44%
Overall Assessment	Non-Compliant

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	0	9	2	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	1	6	0	0
Warning and informing	4	1	3	0	0
Cooperation	4	0	4	0	3
Business continuity	10	6	3	1	1
Hazmat/CBRN	12	6	6	0	7
Total	**62**	**27**	**32**	**3**	**11**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	6	4	0	0
Total	**10**	**6**	**4**	**0**	**0**

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.

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non Compliant' standards

Title of Meeting	**Trust Board**		**Date**	25 September 2024
Agenda Item	**TB24/066 (11.2)**			
Report Title	Statement of Compliance with National Core Standards for Emergency Planning Response & Resilience (EPRR) for 2024/25			
Executive Lead	Lesley Neary, Chief Operating Officer obo Sue Redfern, Accountable Emergency Officer			
Presenting Officer	Lesley Neary, Chief Operating Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

The Trust's annual statement of compliance with EPRR national core standards are required to be approved by the Trust Board prior to submission to the Integrated Care Board (ICB) on 27 September 2024.

This paper seeks approval from the Trust Board for submission.

Executive Summary

NHS England has a statutory requirement to formally assure both itself and the NHS in England of Emergency Preparedness, Resilience and Response (EPRR readiness).

This is provided through the EPRR Core Standards self-assessment annual assurance process.

There is a requirement that this Statement of Compliance is agreed by the organisation's board/governing body.

Following a Trust self-assessment, and in line with the definitions of compliance, the organisation currently declares that out of 62 areas applicable to acute trusts, the Trust is complaint with 50 areas, giving the Trust a total compliance level of 81%.

The Trust is therefore able to declare that it is **partially complaint** against the EPRR Core Standards.

Out of the 62 applicable standards, the Trust is fully compliant with 50 standards and partially compliant with 12 standards.

There are no standards that the Trust are non-compliant against.

The summary of the Trust position against each standard and actions to address areas of partial compliance are included in **Appendix 1**.

Financial Implications

No new financial implications as a direct result of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Statement of Compliance stating partial compliance and approve the submission noting immediate actions that will be taken to address the remaining areas of partial compliance in 2024/25.	
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

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Current Year RAG	Previous Year RAG	Reason for non-compliance	Actions to address compliance
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	**Fully compliant**	**Fully compliant**		
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	**Fully compliant**	**Fully compliant**		
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	**Fully compliant**	**Fully compliant**		
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	**Fully compliant**	**Fully compliant**		
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	**Partially compliant**	**Fully compliant**	Gap with EPRR Resource	* Business Case developed to be presented at executive committee recommending an increase in the EPRR resource - September 2024.
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	**Fully compliant**	**Fully compliant**		
Domain 2 - Duty to risk assess								

7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	**Fully compliant**	**Fully compliant**		
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	**Fully compliant**	**Fully compliant**		
Domain 3 - Duty to maintain Plans								
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	**Fully compliant**	**Partially Compliant**		
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Fully compliant**	**Partially Compliant**		
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	**Fully compliant**	**Partially Compliant**		
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	**Partially compliant**	**Partially Compliant**	Infectious Disease and New Emerging Pandemic Plan is due for review	* To be reviewed with the Infection Prevention and Control Guidelines - December 2024 * Exercise plan to be arranged once reviewed - October 2024 (external), March 2025.
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Partially compliant**	**Partially Compliant**	Infectious Disease and New Emerging Pandemic Plan is due for review	* To be reviewed with the Infection Prevention and Control Guidelines - December 2024 * Exercise plan to be arranged once reviewed - October 2024 (external), March 2025.

14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	**Partially Compliant**	**Non compliant**	New Plan to be developed in line with recently released national guidance	* Access to countermeasures to be included within the Chemical, Biological, Radiological and Nuclear (CBRN) Plan - March 2025 * Develop a separate Mass Countermeasures Plan in line with local risk assessments and new national guidance. This is to support arrangements for administration, reception and mass distribution of antidote/prophylaxsis and mass vaccination - March 2025.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	**Fully compliant**	**Partially Compliant**		
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Partially Compliant**	**Partially Compliant**	Alignment of 2 x legacy plans and update to reflect national guidelines.	* Awaiting release of new national guidelines. * Awaiting outcomes from the LHRP Evacuation and Shelter Group
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Fully compliant**	**Partially Compliant**		
18	Duty to maintain plans	Protected individuals	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.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Partially compliant**	**Non compliant**	Alignment of 2 x legacy plans and update to reflect national guidelines	* Awaiting release of new national guidelines. Will link with official visitors policy.
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Fully compliant**	**Partially Compliant**		
				Domain 4 - Command and control				

20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	**Fully compliant**	**Fully compliant**		
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	**Fully compliant**	**Fully compliant**		
Domain 5 - Training and exercising								
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	**Fully compliant**	**Fully compliant**		
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	**Fully compliant**	**Fully compliant**		
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	**Fully compliant**	**Fully compliant**		
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	**Partially compliant**	**Partially Compliant**	Needs to be part of mandatory training.	* Business Case for executive approval due September 2024 to create an internal eLearning package for staff awareness and to mandate training in line with other mandatory courses on the Core Skills Training Framework.
Domain 6 - Response								

26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	**Fully compliant**	**Partially Compliant**		
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	**Fully compliant**	**Fully compliant**		
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	**Fully compliant**	**Partially Compliant**		
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	**Fully compliant**	**Partially Compliant**		
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	**Fully compliant**	**Partially Compliant**		
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	**Fully compliant**	**Partially Compliant**		
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	**Fully compliant**	**Partially Compliant**		
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	**Fully compliant**	**Partially Compliant**		

34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	**Fully compliant**	**Partially Compliant**		
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	**Fully compliant**	**Partially Compliant**		
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	**Fully compliant**	**Fully compliant**		
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	**Fully compliant**	**Partially Compliant**		
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	**Fully compliant**	**Partially Compliant**		
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	**Fully compliant**	**Partially Compliant**		
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	**Fully compliant**	**Partially Compliant**		
Domain 9 - Business Continuity								

44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	**Fully compliant**	**Fully compliant**		
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	**Partially compliant**	**Partially Compliant**	In process of developing Business Continuity Management System for implementation within the Trust as per NHS guidelines.	* To develop and implement a BCMS within the Trust in line with the NHS BCMS Toolkit - March 2025
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	**Partially compliant**	**Partially Compliant**	Only local Business Impact Analysis undertaken at departmental level within local BCP's. Not done at divisional/organisational level.	* Plan BIA within each division to identify critical services and maximum tolerable period of disruption/recovery time objectives - June 2025
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	**Fully compliant**	**Partially Compliant**		

48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	**Fully compliant**	**Fully compliant**		
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	**Fully compliant**	**Fully compliant**		
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	**Fully compliant**	**Fully compliant**		
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	**Fully compliant**	**Non compliant**		
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	**Fully compliant**	**Fully compliant**		
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	**Fully compliant**	**Fully compliant**		
Domain 10 - CBRN								
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	**Fully compliant**	**Fully compliant**		

56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	**Fully compliant**	**Partially Compliant**		
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	**Fully compliant**	**Partially Compliant**		
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a	**Partially compliant**	**Partially Compliant**	Plan to be reviewed in line with national guidance and internal risk assessment	* To review the CBRN plan in line with internal CBRN Risk Assessment and with requirements to demarcate/control ingress and egress - March 2025
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	**Fully compliant**	**Fully compliant**		

60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	**Fully compliant**	**Fully compliant**		
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	**Fully compliant**	**Fully compliant**		
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	**Fully compliant**	**Partially Compliant**		
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	**Partially compliant**	**Fully compliant**	Increased training in line with traiing needs analysis	* CBRN risk assessment added to the risk register - September 2024 * Plan in place at Southport and Ormskirk to increase training provision - including PRPS Suit training - from October 2024 onwards.

64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	**Partially compliant**	**Fully compliant**	Increased training in line with traiing needs analysis	* CBRN risk assessment added to the risk register - September 2024 * Plan in place at Southport and Ormskirk to increase training provision - including PRPS Suit training - from October 2024 onwards.
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	**Fully compliant**	**Partially Compliant**		
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	**Fully compliant**	**Partially Compliant**		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Emergency Preparedness Resilience and Response (EPRR)

Core Standards Self-Assessment 2024-2025

Lesley Neary

Chief Operating Officer

25th September 2024

Introduction

The EPRR Core Standards self-assessment 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 (CBRN) and Hazardous Material (HAZMAT).

Each year, alongside the annual assurance process, a ‘deep dive’ is conducted to gain valuable additional insight into a specific area. This year the ‘deep dive’ is:

- Cyber Security

Number of Applicable Standards

Acute Providers: 62

Specialist Providers: 59

NHS Ambulance Service Providers: 58

Community Service Providers: 58

Patient Transport Services: 42

NHS 111 Service: 43

Mental Health providers: 58

NHS England Region: 47

NHS England National: 45

Integrated Care Boards: 47

Commissioning Support Unit: 39

NHS England Compliance Process

2024/25 EPRR annual assurance process

This year's process largely remains unchanged from 2023/24. The process must promote inclusive, open and transparent dialogue; be supportive and encouraging; and enable the sharing of good practice and continual improvement. The following familiar actions are required as part of this year's assurance process:

All NHS funded organisations should undertake a self-assessment against the organisation-relevant NHS core standards for EPRR. The compliance level for each standard is defined as:

- Fully compliant: 100% compliant with the core standards
- Substantially compliant: 89 - 99% compliant with the core standards
- Partially compliant: 77 - 88% compliant with the core standards
- Non-compliant: < 76% compliant with the core standards

The outcome should then be presented and discussed at a public board meeting prior to submission and published in the annual report within the organisation's own regulatory reporting requirements.

Submission due date 27th September 2024.

Statement of Compliance

Following the Trust's self-assessment and in line with the compliance definitions, the organisation can currently declare compliance and provide hard evidence for 50 out of the 62 areas applicable to acute trusts, resulting in **81% compliance.**

Based on these results, the Trust is reporting to be **partially compliant** with the EPRR Core Standards for the 2024/2025 period.

- Out of the 62 applicable standards, the Trust is fully compliant with 50 standards and partially compliant with 12 standards.
- There are no standards that the Trust are non-compliant against.
- A detailed update on 2024/25 vs 2023/24 for each of the standards is provided in **appendix 1.**

For the areas that the Trust have declared partial compliance, there is an action plan that has been developed to address compliance levels within 12 months. A high level update on actions being taken is provided in **appendix 1.**

Comparative EPRR Compliance Levels

Year	Trust	Compliance Score	Compliance Rating
2022/23	STHK	77%	Partial Compliance
	S&O	97%	Substantial Compliance
2023/24	MWL	44%	Non-Compliant
2024/25	MWL	81%	Partial Compliance

- **New Evidence Submission Process:** The introduction of a new process for submitting evidence, scrutinised by NHS England through a legal perspective, highlighted areas needing improvement.
- **Lessons from Major Incidents:** Insights from recent critical incidents, such as the Manchester Arena bombing, underscored the need for enhanced preparedness.
- **Training and Exercising:** Increased focus on the training and exercising of staff across all healthcare services was required.
- **Multiagency Collaboration:** Emphasis on demonstrating effective multiagency collaboration with Local Health Resilience Partnership (LHRP), ICB, and other EPRR peers.
- **Transaction:** The transaction was completed in July 2023 which significantly expanded the Trust's operations, now serving a population of over 600,000 and employing approximately 10,000 staff. This merger introduced the necessity to harmonise emergency plans across the newly unified Trust.

Summary

Domain	Total Standards Applicable	Fully Compliant	Current Year %	Previous Year %
Governance	6	5	83%	100%
Duty to Risk Assess	2	2	100%	100%
Duty to Maintain Plans	11	6	55%	0%
Command and Control	2	2	100%	100%
Training and Exercising	4	3	75%	75%
Response	7	7	100%	14%
Warning and Informing	4	4	100%	25%
Cooperation	4	4	100%	0%
Business Continuity	10	8	80%	60%
HazMat/CBRNe	12	9	75%	50%
Overall Compliance	**62**	**50**	**81%**	**44%**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 September 2024
Agenda Item	**TB24/067**			
Report Title	Statutory Pay Gap Report			
Executive Lead	Malise Szpakowska, Acting Director of Human Resources			
Presenting Officer	Malise Szpakowska, Acting Director of Human Resources			
Action Required		**To Approve**	X	**To Note**

Purpose

To update the Board on the Gender Pay Gap as per regulations, and the disability, ethnicity and sexuality pay gaps as per the NHS High Impact Actions.

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 2024. Furthermore, in accordance with the NHS EDI High Impact Actions, the report also includes the Disability, Ethnicity, and Sexuality Pay Gaps.

The key headlines are:

Gender Pay Gap

- Mean Gender Pay Gap is **30.02%**
- Median Gender Pay Gap is **9.56%**
- Mean Gender Bonus Pay Gap is **9.17%**
- Median Gender Bonus Pay Gap is **0.00%**

Disability Pay Gap

- Mean Disability Pay Gap is **13.54%**
- Median Disability Pay Gap is **5.51%**
- Mean Disability Bonus Pay Gap is **-3.72%**
- Median Disability Bonus Pay Gap is **-7.91%**

Ethnicity Pay Gap

- Mean Ethnicity Pay Gap is **-39.15%**
- Median Ethnicity Pay Gap is **-21.12%**
- Mean Ethnicity Bonus Pay Gap is **3.37%**
- Median Ethnicity Bonus Pay Gap is **0.00%**

Sexuality Pay Gap

- Mean Sexuality Pay Gap is **4.59%**
- Median Sexuality Pay Gap is **4.19%**
- Mean Sexuality Bonus Pay Gap is **38.78%**
- Median Sexuality Bonus Pay Gap is 48.23%

Key causes of the pay gaps vary and include the number and distribution of employees by each equality category within the pay structure (vertical segregation), and different career groups (horizontal segregation); bonus pay gap practices; and individual employee choices relating to salary sacrifice practices.

An Action Plan will be developed in consultation with the Strategic People Committee, Valuing Our People Council (VOPC) and People Performance Council during the course if the reports governance processes.	
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 Board is asked to approve the Statutory Pay Gap report.	
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

Statutory Pay Gap Report

2024

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 (MWL) is pleased to report its annual Gender Pay Gap for March 2024, specifically the:

1. mean pay gap,
2. median pay gap,
3. proportion of each comparison group in 4 equal population quartiles,
4. mean bonus pay gap,
5. median bonus pay gap,
6. proportion of each comparison group receiving a bonus payment.

In June 2023 the NHS published the NHS EDI Improvement Plan which sets out 6 high impact targeted actions. High Impact Action 3 focuses on the NHS taking steps to address pay gap disparities. As part of this action NHS Organisations are now required to calculate and publish pay gaps for all protected characteristics.

MWL, in its commitment to the EDI Improvement Plan, has included the Disability Pay Gap, Ethnicity Pay Gap, and Sexuality Pay Gaps in accordance with the publication requirement set out in the NHS EDI Improvement Plan, High Impact Action 3[1].

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 2024; and the mean and median bonus pay gaps correspond to any bonus pay paid in the period of the 1st April 2023 to 31st March 2024 and where the recipients were still employed in March 2024.

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).

The Trust provides acute and community healthcare services at Ormskirk and District General Hospital, Southport and Formby District General Hospital, St Helens Hospital, and Whiston Hospital; 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.

[1] NHS EDI High Impact Action 3

The Trust 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. Lead Employer data is not included within this report.

1.2. What is the Statutory Pay Gap

The statutory pay gap is the difference between the hourly rate of pay between two population groups, expressed as a percentage. For the purposes of this report the following comparisons are included:

1. Male v Female[2],
2. No Known Disability v Known Disability,
3. White v Black & Minority Ethnic (BME),
4. Heterosexual v Lesbian, Gay, Bisexual & Other sexuality (LGBO).

Where the pay gap is a **positive black** number, the pay gap is in favour of the baseline population group (men, no known disability, white, heterosexual); and where the pay gap is a **negative red** number, the pay gap is in favour of the comparator group (women, known disability, BME, and LGBO).

For the purpose of the pay gap calculation, an employee means all posts/assignments that were paid in March 2024 and who received 100% of their expected hourly rate of pay (without deductions because they are on leave). These are known as the Full Pay Relevant Employees.

The Hourly rate of pay means the total amount of pay received by a post/assignment in March 2024, 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 Bonus Pay Gap is calculated from the total amount of Bonus Payments received in the 12-month period up to the snapshot date with the mean and median bonus pay gap calculated from the total value.

A pay gap of 5% or higher requires the Trust to take action to address the gap. A pay gap of 3-5% should be monitored, and if it persists action should be taken to reduce it. A pay gap of <3% is statistically insignificant and no action is required.

1.3. Bonus Payments

For the purpose of this report, Bonus Pay is a reference to the Local and National Clinical Excellence Awards (CEA) / Clinical Impact Awards (CIA). The CEA/CIA are

[2] For the purposes of *The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017*, the term gender is synonymous with the protected characteristic of ‘Sex’ and as such a Gender Pay Gap is a comparison between Men/Male and Women/Female.

a bonus scheme that is limited to eligible consultants only, to recognise clinical excellence in delivering services, leadership, education, and research.

1.4. Data source for Gender Pay Gap

The data for the Gender Pay Gap is provided by an inbuilt report in the Electronic Staff Record (ESR). Once data categories are selected for inclusion, the report automatically provides the data used for all of the gender pay gap data categories.

1.5. Data source for additional Pay Gaps

The aforementioned ESR report only reports data based on employee sex. To enable the pay gap for other characteristics to be completed, the Trust ESR Team merges additional data categories with the ESR report.

The Ethnicity and Sexuality population have high levels of “unknown” and “decline” data records. In order to complete the calculation these are removed from the population. This is sufficient to complete the mean, median, bonus mean, bonus median and quartile population calculations.

However, the Bonus Pay Population (Pay Relevant Employees) cannot be calculated from the report because it does not include the detailed population list from which the correct population can be identified.

Therefore, when calculating the bonus pay population, the relevant Full Pay Relevant Population is used instead. This is indicated by an asterix (*).

2. Summary

The high-level figures for each pay gap are outlined in Table 1.

Table 1: High Level Summary Pay Gap Figures

	Male v Female	White v BME	No Disability v Known Disability	Heterosexual v LGBO
Total Workforce				
Mean	30.02	-39.15	13.54	4.59
Median	9.56	-21.12	5.51	4.19
Bonus Mean	9.17	3.37	-3.72	38.78
Bonus Median	0.00	0.00	-7.91	48.23
Agenda for Change Only				
Mean	0.37	-1.56	3.72	2.62
Median	-5.41	-14.79	5.33	2.67
Bonus Mean	n/a	n/a	n/a	n/a
Bonus Median	n/a	n/a	n/a	n/a
Medical & Dental Only				
Mean	11.33	14.25	23.67	13.59
Median	21.15	25.07	40.41	35.02
Bonus Mean	9.17	3.37	-3.72	38.78
Bonus Median	0.00	0.00	-7.91	48.23

3. Gender Pay Gap

3.1. Population Summary

On the snapshot date of the 31st March 2024, the following number of employees were included in the data analysis:

Table 2: Trust Population by Sex

	# Total	# Female	# Male	% Female	% Male
Total	10,973	8762	2211	79.9%	20.1%
AfC	10,072	8378	1694	83.2%	16.8%
M&D	901	384	517	42.6%	57.4%

3.2. Mean Gender Pay Gap

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 3: Mean Gender Pay Gap

	Trust	AfC	M&D
Female	£18.84	£17.34	£51.52
Male	£26.92	£17.41	£58.10
Difference	£8.08	£0.07	£6.58
% Pay Gap	**30.02%**	**0.37%**	**11.33%**

3.3. Median Gender Pay Gap

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 4: Median Gender Pay Gap

	Trust	AfC	M&D
Female	£16.15	£15.73	£39.51
Male	£17.86	£14.92	£50.11
Difference	£1.71	£0.81	£10.60
% Pay Gap	**9.56%**	**- 5.41%**	**21.15%**

3.4. Proportion of males and females in each pay quartile

To calculate the population quartiles, and allow comparisons with other organisations, the total population is divided into 4 equal sizes, ranked from the smallest to largest by hourly rate of pay. Quartile 1 represents the lower and 4 the higher. The total number of men and women are counted in each quartile to produce the quartile populations.

Table 5: Quartile Populations (Sex)

	# Female	# Male	% Female	% Male
Quartile 1	2257	487	82.3%	17.7%
Quartile 2	2254	489	82.2%	17.8%
Quartile 3	2278	465	83.0%	17.0%
Quartile 4	1973	770	71.9%	28.0%

3.5. Mean and Median Bonus Gender Pay Gaps

For the purpose of this report, Bonus Pay is a reference to the Local and National Clinical Excellence Awards (CEA) / Clinical Impact Awards (CIA). The CEA/CIA are

a bonus scheme that is limited to eligible consultants only, to recognise clinical excellence in delivering services, leadership, education, and research.

The Local CEA/CIA was historically issued by the Trust through a competitive application process, however since COVID, the grant has been equally distributed to all eligible consultants without a competitive process.

The National CEA / CIA are awarded via a national competitive process and awarded via a regional/national assessment process. However, the payment of these awards is via the Trust payroll and are therefore included in the pay calculations.

The population used to calculate the Bonus Pay Gap is based on the total workforce, whether or not they are classed as Full Pay Relevant in the March snapshot date. This is to ensure that any person who received a bonus payment from the 1st April to the following 31st March, and where they are still employed on the 31st March, are included within the data. This group is known as the Pay Relevant Population.

Therefore, the total workforce population (Pay Relevant Employees) was 12,357 posts, of which 373 received a bonus payment. The mean and median bonus gender pay gaps were as follows:

Table 6: Mean Bonus Gender Pay Gap

Sex	Mean	Median
Female	£9815.50	£10,921.80
Male	£10,806.30	£10,921.80
Difference	£990.80	£0.00
% Pay Gap	**9.17%**	**0.00%**

3.6. Proportion of males and females receiving a bonus payment

Table 7 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were male and female.

Table 7: Number of Bonus Pay recipients.

Sex	MWL
% Female receive Bonus Pay	1.5%
% Male receive Bonus Pay	8.9%
% Bonus Pay recipients Female	40.2%
% Bonus Pay Recipients Male	59.8%

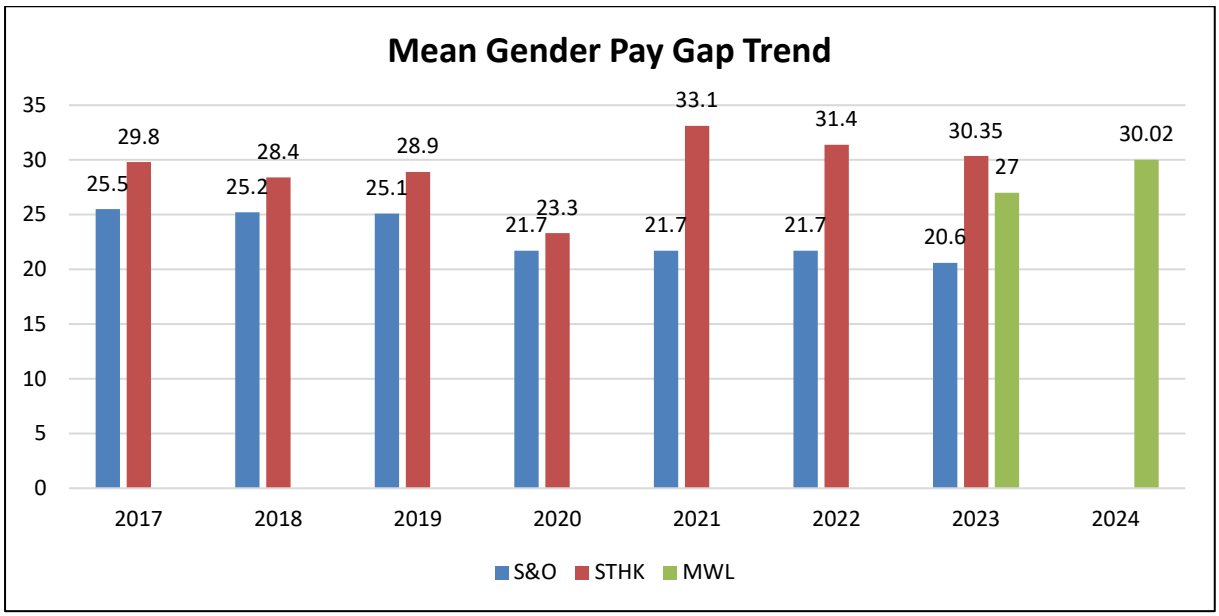
3.7. Gender Pay Gap Trend

In July 2023 Mersey & West Lancashire Teaching Hospitals Trust (MWL) was formed following the merger of Southport & Ormskirk District Hospitals Trust (S&O) and St Helens & Knowsley Teaching Hospitals Trust (STHK).

For trending purposes, below we report both S&O and STHK mean and median gender pay gap data from 2017 to 2023, and MWL for 2024.

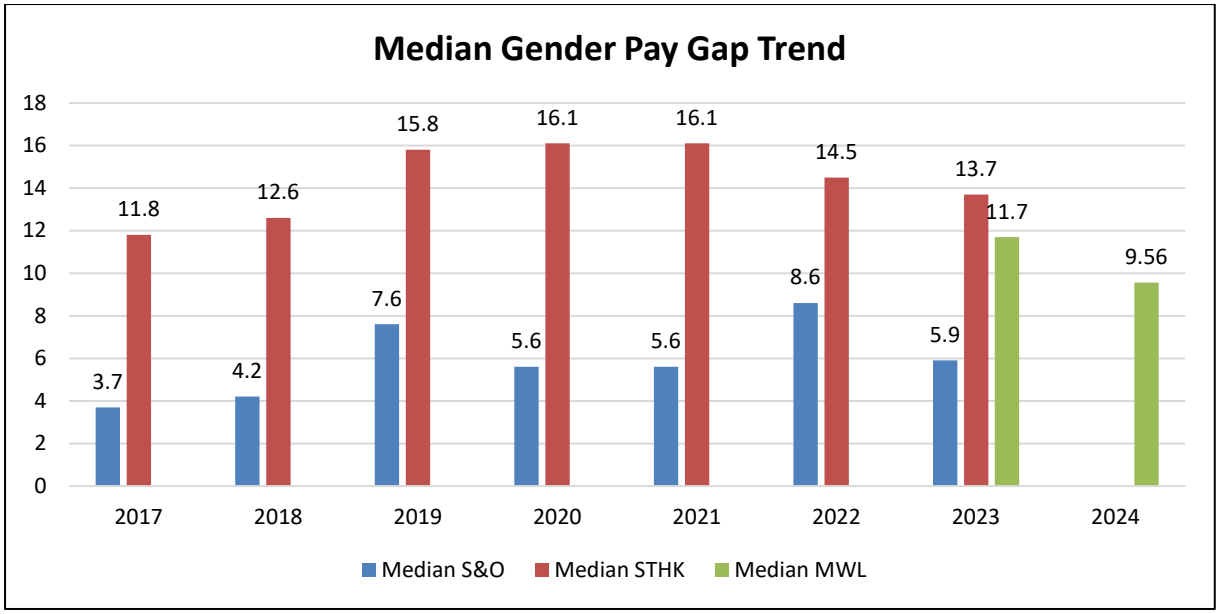
A theoretical MWL calculation was completed for 2023 merging the 2 data sets together to provide an indicative calculation, however, the different data sources will mean that the data is not 100% comparable with the 2024 MWL calculation.

3.7.1. Mean Trend 2017 to 2024



Overall, the S&O Mean Gender Pay Gap saw a year on year decrease from 2017 to 2023. STHK also experienced a decrease from 2017 to 2020, however, during the COVID period the mean increased, subsequently declining year on year. The high MWL figure for 2024 reflects the new workforce (10K+) and the impact of merging these staff groups into a single cohort. However, the data does show a slight decrease from 2023's STHK figure.

3.7.2. Median Trend 2017 to 2024



Overall the Median Pay Gap has fluctuated year on year for both S&O and STHK, now showing a general decreasing Trend since 2021. The 2024 MWL figure, although higher that S&O 2023 is lower than STHK 2023, a reflection of the larger data cohort (10k+ in 2024 v 6K+ in 2023), altering the mid pay point within the data.

4. Disability Pay Gap

4.1. Introduction

The Disability Pay Gap is a comparison between the No Known Disability population v the Known Disability population. Where an employee is recorded as Unknown, Blank or Decline, these have been counted as No Known Disability.

The following calculations are based only on data held within the Electronic Staff Record, which is known to hold underreported figures.

4.2. Population Summary

On the snapshot date of the 31st March 2024, the following number of employees were included in the data analysis:

Table 8: Trust Population by Disability

	# Total	# Dis	# No Dis	% Dis	% No Dis
Total	10,973	593	10,380	5.4%	94.6%
AfC	10,069	568	9501	5.6%	94.4%
M&D	901	25	876	2.8%	97.2%

4.3. Mean Disability Pay Gap

The mean disability pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole No Known Disability population, and the average hourly income of the whole Known Disability population expressed as a percentage.

Table 9: Mean Disability Pay Gap

	Trust	AfC	M&D
Disability	£17.83	£16.74	£42.48
No Disability	£20.62	£17.39	£55.66
Difference	£2.79	£0.65	£13.18
% Pay Gap	**13.54%**	**3.72%**	**23.67%**

4.4. Median Disability Pay Gap

The median disability pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole No Known Disability population, (from smallest to largest), and the middle value hourly income of the whole Known Disability population expressed as a percentage.

Table 10: Median Disability Pay Gap

	Trust	AfC	M&D
Disability	£15.60	£14.83	£27.60
No Disability	£16.50	£15.67	£46.32
Difference	£0.90	£0.84	£18.72
% Pay Gap	**5.51%**	**5.33%**	**40.41%**

4.5. Proportion of No Known Disability and Known Disability staff in each pay quartile

To allow the trust to compare the distribution of No Known Disability and Known Disability staff 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 No Known Disability and Known Disability staff are counted in each to produce the quartile populations.

Table 11: Quartile Populations (Disability)

	# Dis	# No Dis	% Dis	% No Dis
Quartile 1	188	2556	6.9%	93.1%

Quartile 2	137	2606	5.0%	95.0%
Quartile 3	153	2590	5.6%	94.4%
Quartile 4	115	2628	4.2%	95.8%

4.6. Bonus Disability Pay Gap

4.6.1. Mean and Median Bonus Disability Pay Gaps

The mean and median bonus gender pay gaps were as follows:

Table 12: Mean Bonus Disability Pay Gap

	Mean	Median
Disability	£10,791.0	£11,786.3
No Disability	£10,403.7	£10,921.8
Difference	£387.3	£864.5
% Pay Gap	**-3.72**	**-7.91**

4.6.2. Proportion of No Known Disability and Known Disability staff who received a bonus payment

Table 13 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were Known Disabled and No Known Disability.

Table 13: Number of Bonus Pay recipients.

	MWL
% Dis receive Bonus Pay	0.7%*
% No Dis receive Bonus Pay	3.6%*
% Bonus Pay recipients Dis	1.1%
% Bonus Pay Recipients No Dis	98.9%

5. Ethnicity Pay Gap

5.1. Introduction

The Ethnicity Pay Gap is a comparison between the White population v the combined ethnic minority population.

White includes White British, White Irish, Gypsy/Traveller, and Other White Background.

The ethnic minority population includes Bangladeshi, Chinese, Indian, Pakistani, White & Asian, Other Asian background; African, Caribbean, White & Black African,

White & Black Caribbean, Other Black background; Arab, Other Mixed background, and Other Ethnicity.

393 pay records have no known Ethnicity, accounting for 3.6% of the population. For the purposes of the following calculations these records have been omitted.

5.2. Population Summary

On the snapshot date of the 31st March 2024, the following number of employees were included in the data analysis:

Table 14: Trust Population by Ethnicity

	# Total	# EthMin	# White	% EthMin	% White
Total	10,580	1676	8904	15.8%	84.3%
AfC	9736	1224	8512	12.6%	87.4%
M&D	841	452	389	53.7%	56.3%

5.3. Mean Ethnicity Pay Gap

The mean ethnicity pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole White population, and the average hourly income of the whole Ethnic Minority population expressed as a percentage.

Table 15: Mean Ethnicity Pay Gap

	Trust	AfC	M&D
EthMin	£26.70	£17.60	£51.35
White	£19.19	£17.33	£59.88
Difference	£7.51	£0.27	£8.53
% Pay Gap	**-39.15%**	**-1.56%**	**14.25%**

5.4. Median Ethnicity Pay Gap

The median ethnicity pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole White population (from smallest to largest), and the middle value hourly income of the whole Ethnic Minority population expressed as a percentage.

Table 16: Median Ethnicity Pay Gap

	Trust	AfC	M&D
EthMin	£18.98	£17.42	£41.18
White	£15.67	£15.17	£54.96

	Trust	AfC	M&D
Difference	£3.31	£2.25	£13.78
% Pay Gap	**-21.12%**	**-14.79%**	**25.07%**

5.5. Proportion of White and Ethic Minority staff in each pay quartile

To allow the trust to compare the distribution of White and Ethnic Minority staff 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 White and Ethnic Minority staff are counted in each to produce the quartile populations.

Table 17: Quartile Populations (Ethnicity)

	# EthMin	# White	% EthMin	% White
Quartile 1	164	2481	6.2%	93.8%
Quartile 2	356	2289	13.5%	86.5%
Quartile 3	595	2050	22.5%	87.5%
Quartile 4	561	2084	21.2%	88.8%

5.6. Bonus Ethnicity Pay Gap

5.6.1. Mean and Median Bonus Ethnicity Pay Gap

The mean and median bonus ethnicity pay gaps were as follows:

Table 18: Mean Bonus Ethnicity Pay Gap

Ethnicity	Mean	Median
EthMin	£10,705.8	£10,921.8
White	£10,345.2	£10,921.8
Difference	£360.7	£0.00
% Pay Gap	**3.37%**	**0.00%**

5.6.2. Proportion of White and Ethnic Minority staff who received a bonus payment

Table 19 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were White and Ethnic Minority.

Table 19: Number of Ethnicity Bonus Pay recipients.

Ethnicity	MWL
% EthMin receive Bonus Pay	9.4%*
% White receive Bonus Pay	2.2%*

Ethnicity	MWL
% Bonus Pay recipients EthMin	44.2%
% Bonus Pay Recipients White	55.8%

6. Sexuality Pay Gap

6.1. Introduction

The Sexuality Pay Gap is a comparison between the known Heterosexual population v the combined Lesbian, Gay, Bisexual and Other sexuality population (LGBO).

1391 pay records have no known sexual orientation, accounting for 12.7% of the population. For the purposes of the following calculations these records have been omitted.

6.2. Population Summary

On the snapshot date of the 31st March 2024, the following number of employees were included in the data analysis:

Table 20: Trust Population by Sexuality

	# Total	# LGBO	# Hetero	% LGBO	% Hetero
Total	9582	342	9240	3.6%	96.4%
AfC	8796	312	8484	3.5%	96.5%
M&D	783	29	754	3.7%	96.3%

6.3. Mean Sexuality Pay Gap

The mean sexuality pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole Heterosexual population, and the average hourly income of the whole LGBO population expressed as a percentage.

Table 21: Mean Sexuality Pay Gap

	Trust	AfC	M&D
LGBO	£19.34	£16.88	£46.10
Heterosexual	£20.27	£17.34	£53.35
Difference	£0.93	£0.46	£7.25
% Pay Gap	**4.59%**	**2.62%**	**13.59%**

6.4. Median Sexuality Pay Gap

The median sexuality pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole Heterosexual population (from smallest to largest), and the middle value hourly income of the whole LGBO population expressed as a percentage.

Table 22: Median Sexuality Pay Gap

	Trust	AfC	M&D
LGBO	£15.74	£15.24	£28.23
Hetero	£16.43	£15.37	£43.45
Difference	£0.69	£0.13	£15.22
% Pay Gap	**4.19%**	**2.67%**	**35.02%**

6.5. Proportion of Heterosexual and LGBO staff in each pay quartile

To allow the trust to compare the distribution of Heterosexual and LGBO staff 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 Heterosexual and LGBO staff are counted in each to produce the quartile populations.

Table 23: Quartile Populations (Sexuality)

	# LGBO	# Hetero	% LGBO	% Hetero
Quartile 1	88	2308	3.7%	96.3%
Quartile 2	94	2302	3.9%	96.1%
Quartile 3	89	2306	3.7%	96.3%
Quartile 4	71	2324	3.0%	97.0%

6.6. Bonus Sexuality Pay Gap

6.6.1. Mean and Median Bonus Sexuality Pay Gaps

The mean and median bonus gender pay gaps were as follows:

Table 24: Mean Bonus Sexuality Pay Gap

	Mean	Median
LGBO	£6431.8	£5653.7
Heterosexual	£10506.2	£10921.8
Difference	£4074.4	£5268.1
% Pay Gap	**38.78%**	**48.23%**

6.6.2. Proportion of Heterosexual and LGBO staff who received a bonus payment

Table 25 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were Heterosexual and LGBO.

Table 25: Number of Sexuality Bonus Pay recipients.

	MWL
% LGBO receive Bonus Pay	2.6%*
% Hetero receive Bonus Pay	3.9%*
% Bonus Pay recipients LGBO	2.4%
% Bonus Pay Recipients Hetero	97.6%

7. Discussion

Our analysis shows that the key cause of the Trust Pay Gaps is the inclusion of the Agenda for Change, and Medical & Dental pay T&C within the single calculation. This is having a significant effect of inlfuencing the data, in particular for the gender and ethnicity pay gaps. When considering the AfC and M&D separately, for the latter, the pay gap reduces significantly, and in some instances, to statistically insignificant levels.

The Trust understand that the reporting requirements of the statutory regulations is based on the whole Trust approach, but in terms of our analysis and subsequent action planning, our aim is to understand where the most significant impacts are occurring, and take steps to address these.

Our key observations include:

- Although the Trusts workforce is 80% female, pay gaps continues to exist. This is predominantly impacted by the lower proportion of women in senior medical roles, as well as the smaller proportion of men in Bands 1-4. We recognise that it will take time for parity to be achieved in the medical senior leadership as women progress in their careers. We are determined to ensure that there are no discriminatory barriers to this progression.
- Although the pay gaps are generally in favour of ethnic minorities, we recognise that we still have work to do to make the Trust inclusive and supportive, and truly Anti-Racist. This activity is not specifically related to reducing the ethnicity pay gaps, but linked to the opportunities for ethnic minority staff to progress, and to address any negative day to day experiences because of their ethnicity.
- The disability and sexuality pay gaps are relatively low, but there is a high degree of uncertainly relating to the validity of the data. The official disability

disclosure rate of 5-6% is far lower than reporting figures within the staff survey, and over 1000 staff have not answered the sexual orientation monitoring question. We welcome the lower reported pay gaps for these groups but recognise that work is needed to ensure the data set is robust, and that this is not a statistical anomaly.

Below we summarise the key causes for each respective protected characteristic.

7.1. Gender Pay Gap

The main cause of the Trusts (MWL) Gender Pay Gap are:

- **Total Gender Pay Gap:** A far larger proportion of male employees are Medical & Dental (23.4%) compared to women (4.4%) which has higher starting salaries, pay scales and enhancements than Agenda for Change. The starting salary of a Foundation 1 doctor is the equivalent to Band 5 AfC, With 45% of the female workforce earning less than a F1, this causes a significant pay disparity for the total workforce.
- **AfC Gender Pay Gap**: The mean pay gap is statistically insignificant, whereas the Median pay gap is in favour of women. This reflects the fact that 83% of AfC employees are female and form the majority on all pay bands.
- **M&D Gender Pay Gap**: 58.7% of Doctors are male increasing to 61.7% for Consultants. A higher proportion of male medics are Consultants (52.3% v 46%) and a higher proportion of female medics are F1/F2 (26% v 17%). The causes of the male and female ratio of consultants will be impacted by a number of factors including training rates, progression lag times, career breaks, and recruitment/retention trends.
- **Bonus Pay:** CEA/CIA are limited to Medical Consultants who are more likely to be male, with a larger proportion of that group receiving the national pay awards, causing the mean pay pap. The median pay gap is 0% caused by the standardised LCEA payments.

7.2. Disability Pay Gap

The main cause of the Trusts (MWL) Disability Pay Gap are:

- **Total Disability Pay Gap:** A far higher proportion of AfC staff have disclosed a disability compared to Medical & Dental (5.6% v 2.8%). The number of disabled staff in M&D roles is very small, but those that are, are less likely to be in a Consultant role compared to No Known Disability (24% v 50%). This is causing the Mean and less degree Median pay gaps.
- **AfC Disability Pay Gap**: The Mean is comparatively low at 3.7% caused by the higher than average disclosure rates at Band 3,4, 6 and 7. The Median is slightly higher at 5.3% which is an effect of lower than expected distribution of disabled staff on Bands 5, 8A, 8D-Exec

- **M&D Disability Pay Gap**: The significantly low disclosure rates for M&D, and the fact that 40% of those are F1 id causing the significant pay gaps.
- **Bonus Pay:** The Mean and Median Disability Bonus Pay Gaps are both in favour of disabled employees. However, this is based on a population of ≤10 disabled consultants compared to 441 non-disabled consultants, where individual values are having a larger impact.

7.3. Ethnicity Pay Gap

The main cause of the Trusts (MWL) Ethnicity Pay Gap are:

- **Total Ethnicity Pay Gap:** A far larger proportion of ethnic minority employees are Medical & Dental (27%) compared to White (3.3%) which has higher starting salaries, pay scales and enhancements than Agenda for Change. The starting salary of a Foundation 1 doctor is the equivalent to Band 5 AfC. Within AfC roles, ethnic minority staff are not equally distributed within the bands, with 53.6% being on Band 5 compared to v 16.3% of White staff. However, 50% of White staff are on Band 1-4 compared to 27.5% of AfC ethnic minorities. Taken together, that ethnic minority staff a significantly more likely to be M&D, and be AfC Band 5, this is causing the significant pay gap in favour of the ethnic minority population.
- **AfC Ethnicity Pay Gap**: Although ethnic minority staff are not equally distributed through the AfC pay bands, they are more likely to be in the middle/upper bands reflecting that the majority are nursing and midwifery roles. 72.4% of ethnic minority AfC employees are on Band 5+ compared to 49.8% of White employees with 53.6% of ethnic minority employees bunched on Band 5. This is resulting in the mean statistically insignificant pay gap in favour of ethnic minority employees and the median statistically significant pay gap.
- **M&D Ethnicity Pay Gap**: Overall 53.7% of M&D roles are held by ethnic minority employees. Although this is the majority, the mean and median pay gaps are in favour of White employees. When looking at the distribution of White employees in the bands, they are more likely to be a Consultant (59.8%) compared to ethnic minority employees (42.3%). Overall, 55.2% of Consultants are White compared to 44.8% being from an ethnic minority.
- **Bonus Pay:** The Mean Ethnicity Bonus Pay Gap is 3.4%, which is caused by a slightly higher number of White employees receiving a higher bonus value than ethnic minority employees.

7.4. Sexuality Pay Gap

The main cause of the Trusts (MWL) Sexuality Pay Gap are:

- **Data Sample:** 1391 or 12.7% of pay records have no known sexual orientation, including 12.6% of AfC, 13.1% of M&D employees. The proportion

of LGBO known employees through the band pays fluctuates from 0% to 7.7%, and the omission of a large data set may impact on the accuracy of the overall calculation.

- **Total Sexuality Pay Gap:** The Pay Gap is low at 4.6% Mean and 4.2% Median in favour of Heterosexual staff. This is caused by a slightly higher proportion of Heterosexual staff on Bands 8C+, and LGBO on Band 1-2.
- **AfC Sexuality Pay Gap**: The pay gap is statistically insignificant at 2.6% and 2.7% for mean and median respectively.
- **M&D Sexuality Pay Gap**: With a relatively low LGBO population sample, small distribution changes within the pay bands will have a larger impact. Overall, a far larger proportion of LGBO staff are F1 (31%) compared to Heterosexual employees (10.7%), and far less likely to be Other Specialist (17.2% v 30.7%). 37.9% of Consultants are LGBO compared 47.8% of Heterosexual employees. This unequal distribution of LGBO employees within the pay bands is the cause of the mean, and specifically the median pay gaps.
- **Bonus Pay:** This is significantly impacted by the low number of recipients. Of the 9 LGBO recipients, none received a bonus value greater than £11k, whereas 3.7% of Heterosexual recipients did.

8. Cheshire & Mersey ICB Benchmarking 2023

For the March 2023 Gender Pay Gap, with the snapshot date preceding the creation of MWL, the Gender Pay Gap calculation was completed by each legacy Trust. The data was reported to the government portal as per regulations, and the benchmarking report has been sourced from this data set.

It is therefore not possible to provide a accurate MWL Gender Pay Gap data set for benchmarking purposes, and the following data is reported for Legacy STHK and Legacy S&O Trusts.

A comparison between the STHK and S&O with the Cheshire & Merseyside ICB area for the Gender Mean, Median, Bonus Mean and Bonus Median is reported below.

When using this data, the following caveats needs to be considered:

- The type of Trusts varies from Acute, Specialist and Community Trusts whose workforce profiles will differ based on the services they offer
- 11 of the Trusts have workforce profiles of between 1000-4999, and 6 Trusts have workforce profiles in the range of 5000 to 20,000 (as reported in the GPG Portal).
- Local Pay and Workforce Practices are not considered which may impact on the respective calculations and ranking. For example, the provision of salary sacrifice practices such as car loans and electric goods within each Trust is

unknown, as well as the specific methodologies used to create their GPG data reports.

The ultimate target is to have a pay gap of 0% for all indicators. The following ranking is therefore based on 1st place being closest to or actually 0% and all trusts ranked in order from lowest to highest , with 17th place having the highest pay gap.

Overall when compared to the Trusts within the ICB Legacy STHK ranked:

- 16 out of 17 for the highest Mean Pay Gap, and 14 out of 17 for the highest Median Pay Gap,
- 10 out of 17 for Bonus Mean Pay Gap and equal 1st for the Median Bonus Pay Gap.

Legacy S&O ranked:

- 7 out of 17 for the Mean Pay Gap and 6 out of 17 for the Median Pay Gap,
- 5 out of 17 for the Bonus Mean Pay Gap and equal 1st for the Median Bonus Pay Gap.

The lower the ranking the better the results when compared to other Trusts.

9. Action Planning

The Trust will develop an action plan as part of the report approval process, engaging with the Executive, Board, Valuing our People Council and the People Performance Council. Actions will be incorporated into the new EDI Operational Plan 2025-2028 and annual operating plans as appropriate. High Level recommendations are:

Activity	Responsible
Data Quality: We will work with departments with significantly lower disclosure rates to identify opportunities to communicate with staff and facilitate updating ESR.	HR
Disability Disclosure: We will work to increase the disability disclosure rate of Medics to 5% by: • working with the clinical senior leadership team to implement the reasonable adjustment processes. • To further embed disability disclosure and reasonable adjustments processes into Recruitment and Onboarding to capture staff early • We will work with Lead Employer to understand the potential causes of the drop in disclosure rates at the different training stages, and into employment at STHK in particular the use of the RA passport.	HR
Outreach: • We will work to ensure that men, ethnic minorities, and disabled people have the same opportunities to engage in Work Experience and Volunteering • We will work with the ICB and NHSNW to investigate how to encourage men to pursue careers in nursing. • We will expand out school relationships to engage young people early to support the long-term aspirations	Workforce Development, Volunteering, Work Experience, Recruitment
Career Development: We will work to support the career development of all through initiatives including: • Development of self-help and structured development on career planning and progression • Publication of workforce profiles, career routes, and guidance • Investigate the feasibility of targets interventions including the Springboard Women's Programme • Engage with Medics to understand barriers or issues relating to career progression	HR, L&OD, Clinical Ed Divisions
Family Leave: We will engage with staff to understand any concerns or consequences they experience following family leave breaks that has impacted on their career progression and identify solutions.	EDI Team
Bonus Pay: Ensure future bonus pay and reward systems are equitable following the termination of the clinical excellence award / impact programmes	HR

Ranking: We will work with Trusts in the ICB to understand their methodologies, identify commonalities, and understand their workforce and payment best practices to improve MWL standing within the region.	EDI Team
Staff Networks: We will develop a staff network framework that better supports network leaders, leader activity and recognition in order to improve employee voice and engagement.	EDI Team
HR Strategy: All HR Strategy Leads to identify and incorporate activity into their 2025-2028 strategies and actions plans that specifically supports the reduction in the pay gaps and underlying causes, with specific reference to the NHS High Impact Actions.	HR SLT

10. Conclusion

The analysis of the 2024 data indicates that there remains pay gap differences within the workforce, caused by a combination of factors including the number of staff from each equality group, where those individuals are located within the staff groups (horizontal segregation) and within the pay scale (vertical segregation).

In addition, the limited eligibility of the clinical excellence / impact awards and the varying values of those payments and pay practices, continues to cause varying bonus pay gaps.

Title of Meeting	**Trust Board**		**Date**	**25 September 2024**
Agenda Item	**TB24/068**			
Report Title	Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement (JWA) and Committee in Common (CIC) updates			
Executive Lead	Ann Marr, Chief Executive			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

To seek Board endorsement of the updates to the CMAST Joint Working Agreement (JWA) and Committee in Common (CIC) Terms of Reference (ToR) following a review requested by the CMAST Leadership Board and signed off by the CMAST Board (Trust CEOs and Chairs) on 06 September.

Executive Summary

CMAST brings trusts together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action.

CMAST members have now worked together for a period and its ways of working codified and set out including arrangements for shared decision making, when and as required, through a Joint Working Agreement and Committees in Common Terms of Reference (ToR) that were first agreed in summer 2022. As these arrangements have now been in place for two years and in accordance with the ToR they have been reviewed by the relevant Trust Company Secretaries or equivalent at each member Trust.

Few significant changes have been recommended to the documents following the review but the areas of both discussion and proposed changes are detailed below, as relevant to each of the two key documents:

1. Joint Working Agreement (JWA) - Appendix 1:

- 2.1 – updated vision to align with streamlined vision as per the CMAST Annual Plan 2024/5
- 2.3 – framed CMAST priorities as Clinical Improvement, Transformation and Sustainability and Value as per CMAST Annual Plan 2024/5 to better enable the achievement of the existing priorities (still referenced)
- Section 3.6.7 made specific reference to 104-week waiters which was a policy priority in 2022. This text has been updated to reflect the long waiters, rather than a specific annual target.
- Section 4.4 refers to a rotation of Meeting Lead (or CMAST Chair). This has been updated to state that the first review will take place by no later than 2025 and will take place periodically at the will of the membership.
- 8.10 referred to an expectation an information sharing agreement would be developed and/or required. To date the Leadership Board has not identified this requirement, preferring to rely on established Integrated Care Board (ICB) / Integrated Care System (ICS) practices and arrangements. The reference has been updated to state arrangements will be developed when and if the Leadership Board judges that they are required.

Suggestions noted but resulting in no proposed amendment to JWA:

- Reference to city or sub system workstreams – logic for determination is that the Provider

Collaborative has been designed, built and operated, to date, sitting above individual and subgroupings of actions and to complement not compete,

- Greater reference to the financial challenges the NHS is facing – logic for determination is that the Triple Aim of the NHS is referenced which includes a need for value for money and therefore efficiency.
- Reference the range and scope of professional groups that exist within CMAST – logic for determination is that a more generic reference to professional groups is already made.

2. Committee in Common - Terms of Reference (CiC ToR) – Appendix 2:

- Suggestions noted but resulting in no proposed amendment to ToR:
- Reference to shared posts and need for clarification of voting – logic for determination is that the detailed CMAST Committee in Common arrangements (not joint committee) support single vote committees to operate on behalf of each Trust, meeting in common, therefore no changes to voting is required as this is linked to the relevant Trusts.
- Section 6 sets reporting expectations. It has been questioned whether these remain valid. It is suggested that when, and if, CMAST CICs take on delegations that the level or reporting described remains applicable.

3. Consistent factual updates

- Updating references to Mersey and West Lancashire Teaching Hospitals NHS Trust (from Southport and Ormskirk and St Helens and Knowsley)
- Updated references to be active e.g. ICB delivery rather than time bound references to ICB establishment.

It is proposed that the revised documentation captures and appropriately reflects the necessary changes proposed by the Trust leads nominated by the CMAST Leadership Board and supports the continued effective operation, use and application of CMAST governance mechanisms.

Financial Implications
None as a direct result of this report.
Quality and/or Equality Impact
Not applicable.
Recommendations
The CMAST Leadership Board recommends the approval of the updated documentation following a scheduled periodic review (after two years of operation), to member Trust Boards.

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

X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Dated 20242

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

~~**(3) SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**~~

~~(4)~~(3) WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

~~(5)~~(4) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

~~(6)~~(5) THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

~~(7)~~(6) LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST

~~(8)~~(7) THE WALTON CENTRE NHS FOUNDATION TRUST

~~(9)~~(8) LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

~~(10)~~(9) ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

~~(11)~~(10) EAST CHESHIRE NHS TRUST

~~(12)~~(11) ~~ST HELENS AND KNOWSLEY~~MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST

~~(13)~~(12) MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

and

~~(14)~~(13) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, ~~Southport And Ormskirk Hospital NHS Trust~~, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT,

	Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire ~~St Helens And Knowsley~~ Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

~~2.1 CMAST has the immediate and short-term vision to ensure the coordination of an effective provider response to current system and NHS priorities including: ongoing pandemic response; NHS service restoration and elective recovery; support and mutual aid; sharing best practice, increasing standardisation and reducing variation. CMAST Trusts will work together to speak with one voice, enhancing our ability to lead on system wide programmes and workforce development, including harnessing clinical and professional leadership resources.~~

~~2.2 In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality. CMAST will work with the wider system and the ICB to ensure finances and organisational structures facilitate change and do not obstruct progress. The Trusts will work together, in places and with partners to ensure that those in greatest need have access to high quality services.~~

Key functions

~~2.3~~2.2 The key functions of CMAST are to:

~~2.3.1~~2.2.1 Deliver the CMAST vision;

~~2.3.2~~2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

~~2.3.3~~2.2.3 Align priorities across the member Trusts,

~~2.3.4~~2.2.4 Support ~~establishment of~~delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

~~2.3.5~~2.2.5 Direct operational resources across Trust members to improve service provision;

~~2.3.6~~2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

~~2.3.7~~2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

~~2.4~~2.3 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:~~:~~

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

~~2.4.1~~2.3.3 Reduce health inequalities;

~~2.4.2~~2.3.4 Improve access to services and health outcomes;

~~2.4.3~~2.3.5 Stabilise fragile services;

~~2.4.4~~2.3.6 Improve pathways;

~~2.4.5~~2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

~~2.4.6~~2.3.8 Achieve financial sustainability.

~~2.5~~2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

~~2.6~~2.5 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

~~2.6.1~~2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

~~2.6.2~~2.5.2 Cancer Alliance delivery and enablement – subject to ~~the~~ requests of the Alliance;

~~2.6.3~~2.5.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

~~2.6.4~~2.5.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

~~2.6.5~~2.5.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

~~2.6.6~~2.5.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

~~2.6.7~~2.5.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in ~~104~~ long ~~week~~ waiters ~~reduction delivery~~; and

~~2.6.8~~2.5.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

~~2.7~~2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the ~~current~~ lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2025.~~for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].~~

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Scale of involvement/impact	Approach to decision
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will seek to ensure that each CMAST programme has the opportunity for ~~should have~~ a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

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

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

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

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

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

8.4.2 Trusts' manner of operations, staff or procedures;

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

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

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

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

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

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to ~~will seek to~~ agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMAST across the Trusts as envisaged if and when required.~~under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement~~. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the

Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

~~**This Agreement is executed on the date stated above by**~~

~~……~~
~~For and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**~~

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of ~~**ST HELENS AND KNOWSLEY**~~**MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

~~Appendix 3 – TERMS OF REFERENCE FOR THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS FOUNDATION TRUST CIC~~

~~[Insert Terms of Reference for the Southport and Ormskirk Hospital NHS Foundation Trust CiC]~~

~~Appendix 4~~APPENDIX 3 – TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

~~Appendix 5~~APPENDIX 4 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

~~Appendix 6~~APPENDIX 5 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

~~Appendix 7~~APPENDIX 6 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

~~Appendix 8~~APPENDIX 7 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

~~Appendix 9~~APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

~~Appendix 10~~APPENDIX 9 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

~~Appendix 11~~APPENDIX 10 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

~~Appendix 12~~APPENDIX 11 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey and West Lancashire ~~St Helens and Knowsley~~ Teaching Hospitals NHS Foundation Trust CiC]

~~Appendix 13~~APPENDIX 12 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

~~Appendix 14~~APPENDIX 13 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

~~Appendix 15~~APPENDIX 14 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

~~Appendix 16~~APPENDIX 15 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

Appendix 2

V 14-refresh ~~3- 5~~ September 2024~~2~~

CMAST LEADERSHIP BOARD
TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the **[TRUST]** CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
[TRUST] CiC	the committee established by **[TRUST]** NHS Foundation Trust, pursuant to these Terms of

	Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
[TRUST] NHS Foundation Trust	**[TRUST]** NHS Foundation Trust of [Address];
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, ~~Southport And Ormskirk Hospital NHS Trust,~~ Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire ~~St Helens And Knowsley~~ Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The [Trust] NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the [TRUST] CiC

2.1 The aims and objectives of the [Trust] CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the [Trust] CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The **[TRUST]** NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the **[TRUST]** CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the **[TRUST]** CiC.

3.2 The **[TRUST]** CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The **[TRUST]** CiC is a committee of **[TRUST]** NHS Foundation Trust's board of directors and therefore can only make decisions binding **[TRUST]** NHS Foundation Trust. None of the Trusts other than **[TRUST]** NHS Foundation Trust can be bound by a decision taken by **[TRUST]** CiC.

3.4 The **[TRUST]** CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The **[TRUST]** CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in **[TRUST]** NHS Foundation Trust's Constitution.

4.2 **[TRUST]** CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the **[TRUST]** CiC in paragraph 4 of these Terms of Reference shall be retained by **[TRUST]** NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of **[TRUST]** NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the **[TRUST]** CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to **[TRUST]** NHS Foundation Trust's Board for inclusion on the private agenda of **[TRUST]** NHS Foundation Trust's next Board meeting in order that **[TRUST]** NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The **[TRUST]** CiC shall send the minutes of **[TRUST]** CiC meetings to **[TRUST]** NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

6.3 **[TRUST]** CiC shall provide such reports and communications briefings as requested by **[TRUST]** NHS Foundation Trust's Board for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

7 Membership

7.1 The [TRUST] CiC shall be constituted of directors of [TRUST] NHS Foundation Trust. Namely the [TRUST] NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each **[TRUST]** CiC Member shall nominate a deputy to attend **[TRUST]** CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for **[TRUST]** NHS Foundation Trust's Chief Executive shall be an Executive Director of **[TRUST]** NHS Foundation Trust.

7.4 In the absence of the **[TRUST]** CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend [TRUST] CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of [TRUST] CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a **[TRUST]** CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the **[TRUST]** CiC shall be nominated by the **[TRUST]** CiC.

7.6 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of [TRUST] CiC. The **[TRUST]** 's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where ~~where~~ the CiC feels it is appropriate – see CMAST JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of **[TRUST]** CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of **[TRUST]** CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons

in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of **[TRUST]** CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, [TRUST] CiC meetings shall take place monthly.

9.2 The [TRUST] CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the [TRUST] CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the [TRUST] CiC shall be confidential to the [TRUST] CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of [TRUST] Board.

10 Quorum and Voting

10.1 Members of the [TRUST] CiC have a responsibility for the operation of the [TRUST] CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the [TRUST] CiC shall have one vote. The [TRUST] CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the [TRUST] CiC shall comply with the provisions on conflicts of interest contained in [TRUST] NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of

doubt, reference to conflicts of interest in [TRUST] NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the [TRUST] CiC.

11.2 All Members of the [TRUST] CiC shall declare any new interest at the beginning of any [TRUST] CiC meeting and at any point during a [TRUST] CiC meeting if relevant.

12 Attendance at meetings

12.1 [TRUST] shall ensure that, except for urgent or unavoidable reasons, [TRUST] CiC Members (or their Nominated Deputy) shall attend [TRUST] CiC meetings (in person) and fully participate in all [TRUST] CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the [TRUST] CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the [TRUST] CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each [TRUST] CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant [TRUST] CiC meeting.

13.2 The agenda for the [TRUST] CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE [TRUST] CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [TRUST] NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the [TRUST] CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the [TRUST] CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [TRUST] CiC meeting with a view to [TRUST] CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [TRUST] NHS Foundation Trust's Board). Any proposals discussed at the [TRUST] CiC meeting outside of these parameters would come back before [TRUST] NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to [TRUST] CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the [TRUST] CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);

	Decisions delegated to [TRUST] CiC
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.

	Decisions delegated to [TRUST] CiC
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]