St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26TH SEPTEMBER 2018
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

PUBLIC BOARD AGENDA				Paper	Presenter
09:30	1.	Patient Story			Chair
09:45	2.	Employee of the Month			
		2.1	August		
		2.2	September		
09:55	3.	Apologies for Absence			
	4.	Declaration of Interests			
	5.	Minutes of the Previous Meeting held on 25th July 2018		Attached	
		5.1	Correct Record & Matters Arising		
		5.2	Action Log	Attached	
Performance Reports					
10:05	6.	Integrated Performance Report		NHST(18) 76	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Nik Khashu
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.25	7.	Committee Report – Executive		NHST(18) 77	Ann Marr
10:35	8.	Committee Report – Quality		NHST(18) 78	Val Davies
10:45	9.	Committee Report – Finance & Performance		NHST(18) 79	Denis Mahony
10.55	10.	Committee Report – Audit		NHST(18) 80	Su Rai
		10.1	Audit Letter Sign-Off		

BREAK				
Other Board Reports				
11.20	11.	Strategic & Regulatory Report *incl Board Development Programme*	NHST(18) 81	Nicola Bunce
11.30	12.	Complaints, Claims and Incidents Report	NHST(18) 82	Sue Redfern
11.40	13.	Freedom To Speak Up Self-Assessment and Action Plan	NHST(18) 83	Anne-Marie Stretch
12.10	14.	CQUINS Healthy Food Progress Report	NHST(18) 84	Nik Khashu
12.20	15.	Medical Revalidation Annual Declaration	NHST(18) 85	Kevin Hardy *(Terry Hankin in attendance)*
12.25	16.	Infection Prevention Control Annual Report 2017/18	NHST(18) 86	Sue Redfern
12:35	17.	Effectiveness of Meeting		Chair
	18.	Any Other Business (i) Learning From Deaths Update (Kevin Hardy)		
	19.	Date of Next Meeting – Wednesday 31st October 2018		

NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 25th July 2018 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mr D Mahony	(DM)	Non-Executive Director
	Ms S Rai	(SR)	Non-Executive Director
	Mrs V Davies	VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
	Ms N Bunce	(NB)	Director of Corporate Services
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Mr G Appleton	(GA)	Chair, St Helens CCG *(Co-opted Member)*
	Ms C Howarth	(CH)	Patient Experience Manager *(for Patient Story)*
	Cllr C Loftus	(CL)	Halton Council *(Observer)*
	Mr K Lomas	(KL)	Reporter, St Helens Star *(Observer)*
	Mrs K Hughes	(KH)	Head of Media, PR & Comms *(Observer)*
	Mrs S Conroy	(SC)	Radiology Clinical Operational Manager *(Observer)*
Apologies:	Prof D Graham	(DG)	Non-Executive Director
	Prof K Hardy	(KH)	Medical Director
	Mr P Williams	(PW)	Director of Estates & Facilities Management

1. Patient Story

1.1. Clare Howarth, Patient Experience Manager, accompanied Mr & Mrs L and family, who provided Board members with a poignant account of L's patient story as a result of sepsis from first admission on 5th February 2017 and her experiences in the Intensive Treatment Unit, the Plastics Unit and the Seddon Rehabilitation Unit until she was discharged on 14th September 2017.

1.2. L was very grateful for all the care she had received and the support to help her regain her health and independence. She and her family had thought hard about their experience and wanted to make some positive suggestions that could help other patients in similar circumstances. She suggested that a discounted price could be negotiated for television access for long-stay patients

as it had become very expensive for her and the family over the months that she was an inpatient. SRe believed there was a scheme already in existence and would investigate why this had not been offered to Laura and her family. ACTION – SRe to update the Board.

1.3. L felt that the diary she and her family had been given to complete was a wonderful idea, as it had helped her make sense of what had happened to her, however they had not been aware that the diary would become part of the patient record. Patients/relatives should be informed of this from the start as it might change the nature of what was recorded in the diary. SRe confirmed this would be fed back. ACTION – SRe to update the Board.

1.4. RF thanked L and her family for their courage in reliving and sharing their story, which had been very moving and inspirational. On behalf of the Board he wished L well for her continued recovery and thanked her for the positive suggestions, which the Trust would take on board.

2. Employee of the Month

2.1. The Employee of the Month Award for July 2018 was awarded to Ann-Marie Graham, Staff Nurse, Plastic Surgery Day Unit, St Helens Hospital.

3. Apologies for Absence

Apologies were noted as above.

4. Declaration of Interests

4.1. RF declared that he continued in the role of interim Chair of Southport & Ormskirk Hospitals NHS Trust.

5. Minutes of the previous meeting held on 27th June 2018

5.1. Correct Record

5.1.1. The minutes were accepted as a correct record of the meeting.

5.2. Action List

5.2.1. Action 5 - Minute 12.4 (30.05.18): *First Stage Complaints* – SRe to obtain data to show how the Trust compared with other Trusts in the region, to include in the next scheduled report on 26th September.

5.2.2. Action 6 - Minute 5.2.10 (27.06.18): *IPR – Operational Indicators* – AM/RC to resolve the discrepancies of national reporting of Type1/ All Types (mapped) A&E access target performance figures for the Trust. This was not yet fully resolved, although the issues had been raised with the national team. The update would be given at the September meeting.

5.2.3. Action 7 - Minute 6.4 (27.06.18): *Preventing A&E re-attendances* – TH to monitor the A&E attendance rate for patients from the Marshalls Cross Primary Care practice to evaluate if the new service model was impacting on re-attendance rates compared to other practices locally. Ongoing – with the update planned for September.

5.2.4. Action 8 - Minute 8.4 (27.06.18): Finance & Performance Committee Assurance Report: following a report from the Clinical Director of the Emergency Department, NB had asked for all risks in relation to ED performance to be added to the Risk Register. NK/NB had confirmed that all the identified risks had been reported and were on the Trust risk register – ACTION CLOSED.

6. Integrated Performance Report (IPR) – NHST(18)64

The key performance indicators (KPIs) were reported to the board, following in-depth scrutiny of the whole IPR at the Quality and Finance and Performance Committees.

6.1. Quality Indicators

6.1.1. SRe advised that the CQC core services inspections had been undertaken the previous week, with the Maternity, A&E, Surgery and Community (including Intermediate Care) services being inspected. It was not known if there would be further core service inspection before the Well Led inspection which was scheduled to start on 21st August.

6.1.2. The initial feedback from the CQC inspection team had been encouraging, but the final report and any impact on the Trust ratings would not be published for several months.

6.1.3. SRe presented performance reported for June against the key quality indicators.

6.1.4. There were no never events in June or year to date (target = 0).

6.1.5. There were no MRSA bacteraemia cases in June or year to date (target = 0).

6.1.6. There were 5 C.Difficile (CDI) positive cases reported in June 2018. YTD there have been 9 cases (YTD tolerance = 16). The annual tolerance for CDI for 2018/19 is 40.

6.1.7. There were no grade 3 or 4 avoidable pressure ulcers reported in May and none year to date.

6.1.8. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May was 97.4%, year to date performance 96.5%.

6.1.9. During the month of May 2018 there was 1 inpatient fall resulting in severe harm.

6.1.10. Venous thromboembolism (VTE) performance for May was 95.3%. Year to date performance is 95.2% against a target of 95%.

6.1.11. The latest reported Hospital Standardised Mortality Ratio (HSMR) for 2017/8 was 99.1 (February 2018).

6.2. Operational Indicators

6.2.1. RC presented the update on operational performance.

6.2.2. Performance against the 62-day cancer standard was above the target of 85.0% (May 2018) at 89.9%.

6.2.3. In relation to a query regarding the 62-day target from DM, AM confirmed it was difficult because the pathway spanned other providers which this Trust could not control. Everything was done to ensure that our parts of the pathways were completed as quickly as possible and the transfer of the patient was expedited. AM was now the senior responsible officer for cancer services across Cheshire and Merseyside STP and in the role was able to monitor and push for improvements across the whole of the pathway. In addition, the Cancer Alliance Board and NHSI had also been tasked to review the issues to reduce delays.

6.2.4. The 31-day target was achieved with 99.6% performance in May against a target of 96%. The two week referral target had also been achieved.

6.2.5. A&E performance was 78.7% (type 1) which was a 6.9% improvement on the May position of 71.8%. Activity was high again in June with 9,674 attendances (average of 322 per day). The all type mapped STHK footprint performance for June 2018 was 89.3%.

6.2.6. Medical staffing to manage the increased activity continued to be a major issue impacting performance in the month. The long term strategy to achieve greater sustainability through the development of the Advanced Clinical Practitioner role was progressing, but in the short term there continued to be a reliance on locum doctors.

6.2.7. Ambulance notification to handover had been fully compliant at 10:39 minutes on average against a target of 15:00 minutes (which was the best in Cheshire & Merseyside and Greater Manchester).

6.2.8. In line with the national expectation to reduce the number of Super Stranded patients (patients with a length of stay greater than 21 days) by 25%, work had continued to maintain low numbers of 'good to go' patients as well as ensuring effective MDT management of clinically unwell patients. In response to a query, RC confirmed this target related to any patient with a length of stay over 21 days, not just those that were medically optimised.

RC also took the opportunity to detail for the Board the additional actions being taken to validate the patient tracking lists, until the Medway systems were fully embedded in to routine practice. This meant that the Trust was not reporting the June RTT position until there was assurance of complete accuracy. This had been agreed with commissioners and NHSI.

6.2.9. **Financial Indicators**

6.2.10. NK presented the update on financial performance.

6.2.11. The Trust had reported an overall income and expenditure deficit of £3.6m at month 3, in line with agreed plans. Included within the financial position was an assumption of receiving the full allocation of Provider Sustainability Fund (PSF) worth £1.9m. Whilst the Trust had not achieved 90% A&E performance in Q1 there had been significant improvements, with the margin being less than 1% and the Trust remained in dialogue with its regulators. If the A&E allocation of PSF was not secured the financial position would deteriorate by c£0.6m, and the Board would review its financial risks once this decision was known.

6.2.12. Within the YTD position the Trust had had a £1.1m benefit non-recurrently from elements relating to the previous year.

6.2.13. The Trust continued to deliver above the plan for the CIP target with £1.8m delivered YTD against a plan of £1.6m. The Finance and Performance Committee continued to review the CIP in detail each month and monitor the risks to delivery.

6.2.14. The Trust cash balances continued to be above planned levels as a result of receiving the national PFI support in April.

6.2.15. The financial performance for the month delivers a Use of Resources level of 3.

6.3. Workforce Indicators

6.3.1. AMS presented the update on the workforce indicators.

6.3.2. Absence in June was 4.4% and YTD was 4.2%. This was below the Q1 target of 4.25%. The increased level of absence in June is high for this time of the year.

6.3.3. Mandatory training compliance was 96.3%. Appraisal compliance was 80.8% which was below the target by 4.2%, with a recovery action plan in place.

7. Committee Report – Executive – NHST(18)65

7.1. AM presented the report to the Board, which summarised Executive Committee meetings held during June 2018, and highlighted some of the points for the Board's attention.

7.1.1. Lilac Centre Capacity

The Executive Committee had reviewed options to increase capacity in the Lilac Centre in response to increasing demand for outpatient chemotherapy and been able to agree plans to create 6 additional treatment spaces, with the move of the cancer information team to another location.

7.1.2. Mid Mersey Hyper Acute Stroke Unit (HASU)

The Trust proposals to accommodate phase 2 of the stroke services development had been agreed. Phase 2 involved providing the acute care for all patients suspected of having a stroke in the mid Mersey region. To be able to achieve phase 2, additional dedicated stroke beds were needed to cope with the increased workload. Identifying and ring fencing this capacity at Whiston Hospital was a significant challenge, when the Trust was responding to continued high non-elective demand and very high bed occupancy, however. Phase 2 of the HASU development was being planned to take place during quarter 3 of the current financial year.

7.1.3. Operating Department Practitioner (ODP) Apprenticeship

A proposal to utilise the apprenticeship levy to develop an ODP training course with local Higher Education Institutions to provide a career development path for Operating Department Assistants had been approved. The Executive Committee had agreed to support an initial cohort of 4 places on the course with backfill costs, and then evaluate its effectiveness.

7.1.4. Overseas Healthcare Worker Visas

The Government had announced that the visa cap for overseas healthcare workers was to be lifted. This was designed to make overseas recruitment easier and quicker, although the process to obtain UK registration with the appropriate professional bodies was still complex. VD asked what impact lifting of the visa cap would have on overseas recruitment to the Trust. AMS explained that although it was early days, it was anticipated that the process of overseas nurse recruitment would become quicker; the impact on medical staff recruitment was still being assessed.

8. Committee Report – Quality – NHST(18)66

8.1. As the Quality Committee scheduled for 17th July 2018 had been cancelled due to the start of the unannounced CQC core service inspections, on behalf of David Graham SRe presented issues from the meeting papers that needed to be reported to the Board this month, with all other issues being deferred until the next meeting.

8.2. 63 first stage complaints had been received in Q1; this represented an increase compared to the previous quarter. The Trust had responded to 94.4% of stage 1 complaints within the agreed timescales.

8.3. There had been no never events in Quarter 1 2018-19. However, a Never Event was reported on 10th July 2018. This related to a retained product in theatre. Duty of candour communications were immediately completed when the incident became known and a full investigation was in progress. Immediate actions were also implemented to ensure this does not occur in the future. The patient had returned to theatre the following day for the product to be removed and there had been no long term health implications.

8.4. Medicines Storage and Security Audit: Pharmacy staff and matrons performed a Trust-wide audit during June. The overall compliance score (excluding ED) was 89%. This was a substantial improvement over the previously reported audit in January where 61% compliance was reported. There is good evidence of engagement within clinical areas through completion of daily checklists and temperature monitoring. There were still instances of medicines not being locked away in some areas and there had been repeat audits to ensure this was now happening. The Emergency Department had received targeted support during 2018 with two-weekly audits and was now regularly scoring over 95% compliance.

9. Committee Report – Finance and Performance – NHST(18)67

9.1. JK presented the Chair's report to the Board, which summarised key issues arising from the Finance and Performance Committee meeting held on 19th July 2018.

9.2. The Clinical Director for A&E had presented the performance for June and the actions that were being put in place to improve performance. The Committee had challenged the robustness and ambition of the action plans and asked for more detailed outcome measures and key performance indicators of success to be presented to the next meeting in September.

9.3. In relation to operational performance, the Committee discussed the C-section rates and the changes to national guidance for maternity services that may have resulted in an increase in elective C-sections. The Executive Committee had received a detailed report from the Clinical Director explaining the changes and the other factors which impacted on the C-section rates. However, it was noted that the Trust was reporting a higher rate than its peers and this would continue to be monitored.

9.4. The Committee noted that due to the implementation of the new PAS system (Medway), additional validation checks on the RTT numbers were being undertaken and the performance for June had not been reported.

9.5. The Committee had received an update on the actions being taken to reduce agency and premium payments spend. The Trust had seen a significant increase in the Bank fill rate following the success of the internal bank recruitment campaign, which had reduced spend on external agency nurses. There remained significant spend on locum medical staff. The controls used by the Executive to ensure Director approval before agency shifts could be approved, were monitored each month and ensured that the use of agency staff was minimised wherever possible, if safe alternatives could be put in place.

9.6. RF thanked the Non-Executive Directors for undertaking the detailed scrutiny and challenge in the Committees which allowed for robust assurance to come to the Board.

10. Committee Report – Charitable Funds – NHST(18)68

10.1. DM presented the report.

10.2. The Committee had considered proposals from an external charity lottery provider; however there were further questions to be answered before the committee could make a recommendation. A further paper would be considered at the next meeting.

10.3. A presentation was made by the Burns & Plastics Therapies to seek access to a charitable fund grant for provision of specialist burns care garments. The proposal was to pump prime an 18-month post to evaluate the impact of the specialist garments for patient recovery. The committee had approved this application.

10.4. A proposal to site a charity office in the foyer of Whiston Hospital was being investigated.

10.5. The committee continued to consult with designated fund-holders to see if funds could be merged into a single hospital fund, which would give greater flexibility in how the funds could be spent in supporting patients and staff. This would only happen after suitable notification and in accordance with Charity Commission guidelines.

10.6. During a Quality Ward Round (QWR) of Ward 1A, staff had outlined to JK proposals for increasing space on the ward by removing one of the assisted bathrooms. JK asked if charitable funds could be used for such a proposal. It was agreed that JK should forward NK the details for him to review the proposal and check the rules of the Charitable Funds to see if they could be used for this purpose and ask the staff to prepare an application for the next Charitable Funds Committee, if required.

The Board discussed the benefits of QWRs, and Board members agreed they were a great opportunity for Directors to speak directly to employees

and hear about the challenges being faced. However it was suggested that a further improvement to the system would be for the Board to understand if the issues raised at the QWRs had been resolved. VD suggested a "You Said, We Did" quarterly report to Quality Committee stating how many QWRs had taken place, the challenges and resolutions. ACTION - SRe to develop a report for the Quality Committee.

11. Statutory and Regulatory Report – NHST(18)69

11.1. NB presented the report which provided the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.

11.2. The Rt. Hon Matt Hancock MP became Secretary of State for Health and Social Care on 6th July following a cabinet reshuffle, taking over from Rt. Hon Jeremy Hunt MP who had become the Foreign Secretary.

11.3. NHS England and NHS Improvement had published a combined Quarter 1 performance report for the NHS, comparing performance to the same period in 2017/18; this showed the increasing demand for NHS services.

11.4. Learning from Deaths Working with Families Guidance had been issued by the National Quality Board (NQB), to improve how the NHS engages with families and learns when things go wrong. The Trust would review its Learning from Deaths policy in light of this new guidance, to ensure that it was incorporated.

11.5. VD queried how the Board would be able to gain assurance that the key principles were being implemented by the Trust as the guidance didn't suggest any key performance indicators that would need to be reported. Dr Francis Andrews felt that some of the principles were auditable, but suggested that the Executive Committee be asked to consider appropriate key performance indicators whilst the Trust policy was being updated. ACTION - KH to review Learning from deaths policy and consider the appropriate controls to provide Board assurance.

11.6. RF commented that he was pleased to see the guidance also recognised the impact of these issues on staff, and the importance of supporting staff.

11.7. Beyond barriers: How older people move between health and social care in England - The Care Quality Commission (CQC) had published this report following the review of 20 local health and care systems, which had been requested jointly by the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government in the Autumn of 2017. The reviews focused on care for people aged over 65 and had been in response to increasing delayed transfers of care. Two of the health systems reviewed had been Halton and Liverpool. The key findings of the report supported the moves to more integrated working between health and social care.

11.8. Board members noted the report.

12. HR Indicators Report – NHST(18)70

12.1. AMS presented highlights from HR/workforce strategy and quarterly workforce indicators report covering data from April to June 2018.

12.2. A summary of the Trust's HR use of resources performance against national and North West benchmark data from the Model Hospital demonstrated that the Trust performed well in the majority of categories during the reporting period.

12.3. In terms of recruitment and retention, challenges specific to the Trust continued to reflect the national picture, however, on a positive note, 257 more registered nurses had joined the bank following an advertising campaign and a transfer "itchy feet" policy had been introduced, which facilitated transfers of staff to different wards in the Trust, which it was hoped would help improve retention.

12.4. In response to a query from AM, AMS confirmed the Trust's turnover of staff was higher in some areas than other local NHS organisations; therefore exit interviews were being conducted to understand why staff decided to leave the Trust.

12.5. A key element of the Trust's retention strategy included ensuring that staff had access to excellent health and well-being services. Sickness absence benchmarking data for the period June 2017 to May 2018 showed the Trust needed to improve in a number of areas. SR asked if the capacity of the Health Work and Wellbeing Service had increased to provide the necessary support for staff. AMS responded that the Trust's service compared favourably compared to other Trusts and the support could be tailored to individual needs.

12.6. The quarterly Staff, Friends and Family Test in May had produced a positive result, with 77% of respondents recommending the Trust as a place to work, placing St Helens and Knowsley Teaching Hospitals NHS Trust the best acute Trust in Cheshire and Merseyside and second nationally for acute trusts.

12.7. VD asked as a quality measure, whether the length of time to bring employee relations' cases to a conclusion was reported. AMS confirmed that this was monitored via the Employee Relations tracker, which AMS could share with VD. AMS to also review inclusion of this information as an additional KPI in future quarterly reports. ACTION: AMS to include employee relations' cases time to resolve KPIs in future HR indicators reports.

12.8. VD also asked for clarity on whether staff were given time for reflective practice and clinical supervision. SRe confirmed that every ward rota had an allocation of time for training and education, which would include reflective practice.

12.9. Board members received the report.

13. Corporate Risk Register – NHST(18)72

13.1. NB informed the Board of the risks that had been escalated to the Corporate Risk Register (CRR) from the Care Groups and Departments via the Trust's risk management systems.

13.2. The total number of risks on the risk register was 743.

13.3. 44% (328) 328 of the Trust's risks were rated as Moderate or High.

13.4. There were currently 13 high/extreme risks that had been escalated to the Corporate Risk Register.

13.5. VD asked whether the increased outpatient 'Did Not Attend' (DNA) rate was still an extreme risk. RC explained there was an issue post-transition to Medway, however the issue was being resolved and DNA rates were rapidly reducing. The risk was being reviewed frequently and would hopefully be reduced very soon.

13.6. RF noted the risk of another cyber-attack was still rated extremely high and asked CW for an update. CW confirmed there had been considerable investment in protection software and work was ongoing with Care Cert. All alerts were responded to and triangulated with other NHS organisations, however due to the changing nature of the potential threats the risk did remain high.

13.7. RF also asked CW for an update on the Outpatient service risks following the implementation of the new Medway PAS. CW confirmed that for most areas of the hospital the transition to the new Medway system had gone very smoothly and was now operating as business as usual, however for the outpatients' service this transition had proved to be more complex and these issues were giving rise to some service disruption. The Operational and Informatics teams were working to resolve these issues as soon as possible, which included some changes to the system to make it easier for staff to use. This was being monitored by the Executive Committee on a weekly basis. RF asked CW to pass on his thanks to all the team.

13.8. SR asked why the Apprenticeship Levy was still rated as a risk. AMS explained the Government had set the Levy at c£1m and stipulated that apprentices had to spend 20% of the time training away from the job which meant the Trust had to pay the apprentice's salary and also backfill the position while they were training offsite. There was therefore a financial risk; and in order to draw down the £1m levy the Trust had to spend more than £1m. One of the other challenges was the limited range of health related programmes currently on offer, e.g. apprenticeships were not available for careers such as Operating Department Practitioners (ODPs). Both of these issues had been fed back nationally.

13.9. NB confirmed to members that this risk was reviewed each month by the Risk Management Council and the score was likely to be reduced following

the first 12 months of operating with the apprenticeship levy.

13.10. Dr Francis Andrews asked if there were any stipulations that employees undertaking funded training should agree to work for the Trust for a period of time on completion of the course. AMS confirmed employees were asked to sign an agreement to stay for 2 years; however this was not legally enforceable.

13.11. **ACTION:** AMS to prepare a briefing for RF on the concerns about the apprenticeship levy to discuss at the next NHSI Chairs meeting.

14. Board Assurance Framework Review – NHST(18)73

14.1. NB presented the proposed changes to the BAF since April to ensure that the Board had sufficient controls in place to assure the delivery of its strategic objectives.

14.2. Board members agreed the proposed changes.

15. Draft Trust Strategy 2018 to 2021 – NHST(18)74

15.1. NB presented the new Trust Strategy for approval.

15.2. The draft strategy had been considered at the closed Board meeting in June and a number of changes proposed. NB had redrafted the document to take account of these suggestions.

15.3. VD suggested that the Trust should have a formal integration strategy to support the Trust strategy. GA and RF both supported this and suggested it should be included as a direction of travel. It was agreed that the strategy would be amended to reflect this addition.

15.4. The strategy was approved, subject to the inclusion of an integration strategy as one of the key supporting strategies.

15.5. ACTION: The Executive to develop an Integration Strategy.

16. Learning from Deaths Quarterly Update – NHST(18)75

16.1. FA provided Board members with an overview of the quarterly learning from deaths report.

16.2. In response to SR's query asking if the Trust was in line with other organisations, FA confirmed the Trust's outcome of 0.7% for Red-rated reviews where the 'balance of probability was that death may have resulted from problems in care delivery/service provision' was in line with national figures; most recent data indicated around 1% was a reasonable estimate.

16.3. FA explained two key learning priorities were identified quarterly and disseminated throughout the organisation; a good system was in place and the learning was now coming through.

16.4. RF observed that despite the best training, procedures and 5 star patient care, all human beings can make mistakes and when staff were dealing with severely ill people it was amazing the outcome was less than 1%.

16.5. FA countered that despite this the Trust did not rest on its laurels and were mindful there were grieving relatives. It was important to remember the Trust had many safety mechanisms in place, so that problems could be identified before they became fatalities.

16.6. It was noted that the learning from deaths quarterly report had not been updated with the two new key learning points for the latest quarter or the audit of dissemination of the learning points from the previous quarter, therefore an updated report would be presented at the next Board meeting in September.

17. Any Other Business

17.1. RF reminded members that Dr Andrews would be leaving the Trust to take up a new role at Bolton Hospital Foundation NHS Trust. He thanked Dr Andrews for being an excellent colleague and ambassador for patient safety. He would be missed from a clinical point of view and also for his great ability to remain objective in the face of any difficulty.

17.2. Dr Andrews thanked RF for his comments and his colleagues for their help and support during his time at the Trust.

18. Effectiveness of Meeting

18.1. RF asked those in attendance for feedback.

18.2. GA had found the patient story exceptionally inspirational and moving and a tribute to how Trust staff came together to care for their patient.

18.3. RF thanked everyone for their feedback.

19. Date of Next Meeting

19.1. The next meeting is scheduled for Wednesday 26th September 2018 in the Boardroom, Level 5, Whiston Hospital, commencing at 09:30 hrs.

Chairman: .....

Date: 25.07.18 26.09.18 .....

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 26TH SEPTEMBER 2018

No	Minute	Trust Public Board Action Log	Lead	Date Due
1.	30.05.18 (12.4)	First Stage Complaints: SRe to obtain data to show how the Trust compared with others in the region, for next scheduled report.	SRe	26.09.18
2.	27.06.18 (5.2.10)	IPR – Operational Indicators: AM/RC to meet outside of the Trust Board meeting to discuss the reporting of Type 1/All Types performance figures. To be brought back in September.	AM/RC	26.09.18
3.	27.06.18 (6.4)	Re preventing A&E attendances, TH agreed to monitor the attendance rate from the Marshalls Cross Practice to evaluate the impact of the new service model. Verbal update planned for September.	TH	26.09.18
~~4.~~	~~27.06.18 (8.4)~~	~~Finance & Performance Committee Assurance Report: following a report from the CD of ED, NB asked for all risks in relation to ED performance to be added to the Corporate Risk Register~~. **ACTION CLOSED**	~~JK/NK~~	~~25.07.18~~
5.	25.07.18 (1.2)	SRe to report back to Board members on why Laura Lambert had not been offered a discounted price for television access as she had been a long-stay patient and pass on the feedback in relation to the privacy of diaries being incorporated into patient notes.	SRe	26.09.18
6.	25.07.18 (10.6)	SRe to develop a QWR "You Said, We Did" quarterly report to Board for members to understand whether issues raised at QWRs had been resolved.	SRe	31.10.18
7.	25.07.18 (11.5)	KH to review Learning from Deaths policy in light of the Working with Families Guidance and consider the appropriate controls to provide assurance.	KH	31.10.18
8.	25.07.18 (12.7)	AMS to include employee relations' cases time to resolve KPIs in future HR Indicators reports.	AMS	30.01.19
9.	25.07.18 (13.11)	AMS to prepare a briefing for RF on the concerns about the apprenticeship levy to discuss at the next NHSI Chairs meeting.	AMS	For Chairs' meeting
10.	25.07.18 (15.5)	The Executive to develop an integration strategy to support the Trust Strategy 2018 to 2021.	NB	31.10.18
11.	25.07.18 (16.6)	KH to bring updated Learning from Deaths quarterly report to September Board meeting.	KH	26.09.18

Paper No: NHST(18)76
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

During April the Trust implemented a new Patient Administration System which has impacted on the timeliness of some indicators.

Patient Safety, Patient Experience and Clinical Effectiveness

England's Chief Inspector of Hospitals (CQC) awarded the Trust an overall rating of **Outstanding** for the level of care it provides across ALL services. St Helens Hospital was rated as **Outstanding.** Whiston Hospital has been rated as **Good with Outstanding Features** placing it amongst the best hospitals in the NHS. **Outpatient and Diagnostic Imaging Services** at **BOTH** hospitals have been given the highest possible rating **Outstanding** – The first Outpatient and Diagnostic service in the country to ever be awarded this rating.

There has been 1 never events year to date (target = 0).

There have been no MRSA bacteraemia cases year to date (target = 0).

There was 1 C.Difficile (CDI) positive cases in August 2018. YTD there have been 11 cases . The annual tolerance for CDI for 18-19 is 40.

There have been no grade 3 or 4 avoidable pressure ulcers year to date.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for July 2018 was 95.1%. YTD performance is 96.5%.

During the month of July 2018 there was 1 fall resulting in severe harm , which occurred in outpatient department.

Performance for VTE assessment for July 2018 was 95.10%. YTD performance is 95.15% against a target of 95%.

YTD HSMR (April to March) for 2017-18 is 99.1

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 18/19 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 26th September 2018

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (July 2018) at 89.5%. The 31 day target was also achieved with 98% performance against a target of 96%. 2 week rule compliance has underperformed at 86.5% against a target of 93.0%. This underperformance is due to a combination of an increase in 2 week wait referral activity, patient rearrangements and issues related to the migration of the Trust patient administration system.

Accident and Emergency type 1 performance was 80.4%, an increase on Julys performance of 74.4%. The all type mapped STHK Trust footprint performance for August, was 90.5% an increase on July 18 (87.5%). Type 1 attendances for August 18 were 9,307, a reduction of 681 on July 18 (9,988). An executive led urgent and emergency care summit is planned for September 12th, bringing together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance.

Whiston ED ambulance notification to handover time was 11.12 mins on average for the month of August (target 15 mins). The Trust was the best performing adult emergency department, for ambulance notification to handover times in Cheshire , Merseyside and Greater Manchester.

In line with the national expectation to reduce the number of Super Stranded patients (patients with a length of stay of greater than 21 days) by 25%, the trust has achieved a 13% reduction against this target. Work has continued to maintain low numbers of 'good to go' patients as well as ensuring effective MDT management of clinically unwell patients.

Following migration of the Trust patient administration system in April, whilst being successful across the majority of the Trust, the issues within outpatients continue. The level of scrutiny and validation of the patient tracking list required post go live with Medway, has lead to a continued inability to accurately report RTT performance. The actions to address this situation are ongoing, with a view to return to reporting RTT within Q3.

Financial Performance

At the end of August(M5) the Trust is reporting an overall YTD I&E deficit of £2.4m which is behind plan by £0.6m. The deterioration relates to NHSI instructing the trust to remove £0.6m from the Provider Sustainability Fund due to non-delivery of the 90% A&E target in Q1, despite significant improvements in that quarter. Rules mean that the Trust is not able to claim this back if performance going forward is above the 90% target and impacts on outturn.

Within the YTD position the Trust has utilised £1.5m non-recurrent resources, this is offsetting some of the cost pressures and impacts from Medway as well as under performance in Clinical Income.

The Trust continues to deliver above the plan of the CIP target with £4.1m delivered YTD against a plan of £3.7m. Whilst there are plans and ideas for delivery of the full £19m CIPs, a significant proportion are deemed currently as high risk. The risk on the schemes identified outside of the organisation have increased in month as a result of NHSi communicating that they will not uplift the PFI support the Trust receives.

The Trust cash balances at the end of M5 were £6.2m which was £0.7m behind plan. The Trust is yet to receive overperformance payments from its main commissioners relating to Q1, with payments now expected during September. The Trust is currently in discussions with NHSi and Health Education England (HEE) around NHS organisations delaying payments for Lead Employer trainees.
As a result of the challenges within the external element of the CIP the forecast outturn position will be challenging. This will be reviewed during the coming months.

The financial performance in the month delivers a Use of Resources level of 3.

Human Resources

All staff absence in August remained static at 4.7% and YTD is 4.4% against last years outturn of 4.7%. Qualified Nursing & Midwifery sickness (excluding HCAs) was 5.9% (5.4% YTD) and is below the Q2 target of 4.35% by 1.55%.

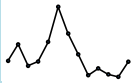
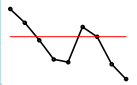
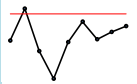
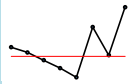
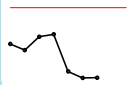
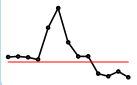
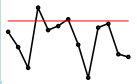
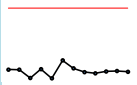
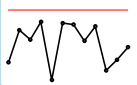
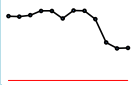
Mandatory Training compliance is 96.7% (target = 85%). Appraisal compliance is 84.3% (target = 85%).

The following key applies to the Integrated Performance Report:

▲ = 2018-19 Contract Indicator
▲£ = 2018-19 Contract Indicator with financial penalty
● = 2018-19 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

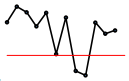
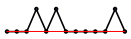
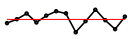
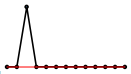
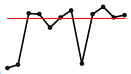
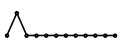
Aug-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Aug-18	2.2%	2.0%	No Target	2.4%		SHMI improvement has been sustained. SHMI lags behind HSMR nationally. HSMR is dramatically improved and currently substantially better than English average. Crude mortality has also fallen.	Patient Safety and Clinical Effectiveness	Continue measures to improve clinical effectiveness and reduce unwarranted variation.	KH
Mortality: SHMI (Information Centre)	Q	▲	Dec-17	1.02		1.00						
Mortality: HSMR (HED)	Q	▲	Apr-18	81.9	81.9	100.0	99.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Apr-18	96.1	96.1	100.0	95.8					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Mar-18	111.9		100.0	101.2		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Readmissions have risen nationally in the last 2 years. It was suggested that ambulatory readmissions might have been a result of inappropriate coding of elective returns - audit has shown that this is not the case	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust is conducting an internal analysis of emergency readmissions and taking part in a district audit with CCG partners.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Feb-18	87.2		100.0	90.6		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Feb-18	109.1		100.0	99.2					
% Medical Outliers	F&P	T	Aug-18	0.0%	0.4%	1.0%	2.3%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in reconfiguration of some surgical beds to medical thus significantly reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Aug-18	35.4%	40.0%	52.5%	48.7%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Jul-18	69.1%	69.0%	90.0%	69.5%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. We're seeking CCG approval at CQPG before implementation.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Jul-18	89.1%	88.5%	95.0%	89.5%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jul-18	97.0%	97.5%	95.0%	99.1%					

Aug-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

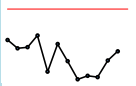
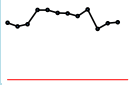
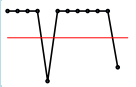
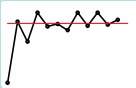
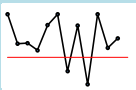
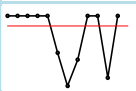
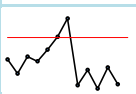
	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Jul-18	88.9%	86.7%	83.0%	90.3%		Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Following previous months deterioration, plans for improvement have resulted in achievement against the target	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	Aug-18	0	1	0	2		A patient incident reported from Whiston theatres met Never event criteria in July 2018.	Quality and patient safety	Immediate actions implemented and formal RCA underway. The National safety standards for invasive procedures will provide further mitigation against future never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Aug-18	99.1%	98.9%	98.9%	98.9%		Achieving standard YTD	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Aug-18	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Aug-18	0	0	0	2		Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Aug-18	1	11	40	19					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Aug-18	3	16	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jul-18	0	0	No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Jul-18	1	3	No Contract target	22		1 severe harm fall reported in July 2018 (Outpatient)	Quality and patient safety	RCA is currently being undertaken. Falls action plan progressing and monitored through Strategic Falls Group. New initiatives and awareness session programmes planned.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Jul-18	95.10%	95.15%	95.0%	93.67%		VTE performance monitored since implementation of Medway. The ePrescribing solution will be implemented imminently.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending an electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jun-18	2	6	No Target	31					
To achieve and maintain CQC registration	Q		Aug-18	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Jul-18	95.1%	96.5%	No Target	93.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety		SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jul-18	0	0	No Target	1					

Aug-18

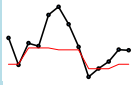
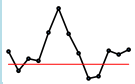
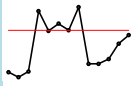
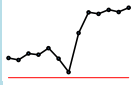
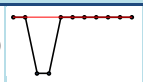
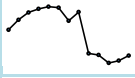
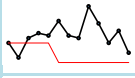
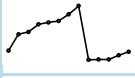
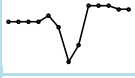
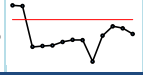
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jul-18	86.5%	90.5%	93.0%	95.0%		31 and 62 day targets achieved YTD. Underperformance against the 2ww target in July due to a combination of an increase in 2 week wait referral activity, patient rearrangements and issues related to the migration of the Trust patient administration system.	Quality and patient experience	1. All DMs tasked to produce action plans by specialty 2. Consultant radiologist recruitment efforts intensified 3. Focus group being established to address skin 2WW capacity challenges. 4. Shared working between B&P and Dermatology to address capacity shortage	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jul-18	98.0%	98.6%	96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jul-18	89.5%	90.9%	85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-18	93.7%	93.7%	92.0%	94.0%		The level of scrutiny and validation of PTL reports required post go live with Medway, has lead to an inability to accurately report RTT performance within the required timescales to report the monthly position. On going backlog clearance plans continue with good effect but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	Surgical Beds have now been converted to Medical bed capacity. Bed availability to manage the Surgical demand could result in backlog increasing. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Mar-18	100.0%		99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Aug-18	0.6%	0.8%	0.8%	0.6%		Achievement of cancelled ops target for August. One patient breached the 28 day re-list target in July due to the procedure being deemed to be more complex than anticipated.	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Jul-18	98.2%	99.3%	100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Aug-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Aug-18	80.4%	75.5%	95.0%	78.2%		Accident and Emergency type 1 performance was 80.4%, an increase on Julys performance of 74.4%. The all type mapped STHK Trust footprint performance for August, was 90.5% an increase on July 18 (87.5%). Type 1 attendances for August 18 were 9,307, a reduction of 681 on July 18 (9,988). An executive led urgent and emergency care summit is planned for September 12th, bringing together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance. Whiston ED ambulance notification to handover time was 11.12 mins on average for the month of August (target 15 mins). The Trust was the best performing adult emergency department, for ambulance notification to handover times in Cheshire , Merseyside and Greater Manchester. In line with the national expectation to reduce the number of Super Stranded patients (patients with a length of stay of greater than 21 days) by 25%, the trust has achieved a 13% reduction against this target. Work has continued to maintain low numbers of 'good to go' patients as well as ensuring effective MDT management of clinically unwell patients.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Aug-18	90.5%	88.0%	95.0%						
A&E: 12 hour trolley waits	F&P	▲	Aug-18	0	0	0	0					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Aug-18	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Aug-18	23	116	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. There has been a decrease in the number of new complaints received in the last month.	Patient experience	The Complaints Team continue to improve the timeliness of responses, with 100% of first stage complaints responded to within agreed timescales for the last three months.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Aug-18	26	92	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Aug-18	100.0%	96.7%	No Target	67.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)		T	Jul-18	22	15	40	20		In July 2018 the average number of DTOCS (patients delayed over 72 hours) was 22.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Friends and Family Test: % recommended - A&E	Q	▲	Jul-18	86.2%	84.8%	90.0%	87.5%		The YTD recommendation rates remain below target for A&E, maternity (postnatal community) and outpatients, but are above target for in-patients, antenatal, birth and postnatal ward maternity services. Outpatients have seen an overall dip in recommendation rates from March 2018.	Patient experience & reputation	Feedback from the FFT responses is fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback to improve morale. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement, which are then displayed as 'you said, we did' posters. Work will take place in outpatients to address any specific concerns fed back in the comments for this area.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jul-18	95.4%	95.5%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jul-18	95.9%	98.2%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jul-18	98.7%	98.4%	98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jul-18	97.3%	96.0%	95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jul-18	100.0%	96.6%	98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jul-18	93.7%	93.9%	95.0%	94.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Aug-18	4.7%	4.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		In August overall absence remained static at 4.7% which is still high when reviewed against the Q2 target of 4.35%. Qualified & HCA sickness increased in month by 0.2% to 5.9%. YTD performance has decreased again to 5.4% against the target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The Absence Support team continue to support the HR Advisors with welfare visits and stages to ensure timely action is taken and staff and managers are supported during this very busy period. These figures include the summer holidays which is historically a challenging period. HRBP's are undertaking deep dives and action plans within their care groups.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Aug-18	5.9%	5.4%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	Aug-18	84.3%	84.3%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 11.7%. Appraisal compliance is below the target by 0.7%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers to ensure on-going maintenance of compliance for Mandatory Training & to improve the rate of compliance for Appraisals with non-compliance being reviewed by the Trusts Executive Committee on a monthly basis and also at department level finance & performance meetings.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Aug-18	96.7%	96.7%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q1	93.4%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	Findings from the Q1 survey have been shared with Survey Champions in Medical Care Group following the publication of the results in July. The Q2 survey in Surgical Care is currently underway.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q1	81.3%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Aug-18	0.7%		No Target			Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. The Trust is undertaking a project with NHSE regarding retention of Nurses and this is part of our wider retention strategy and action plan for 2018/19 for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P UOR	T	Aug-18	3.0	3.0	3.0	3.0		At the end of August (M5) the Trust is reporting an overall YTD I&E deficit of £2.4m which is behind plan by £0.6m The Trust is currently forecasting delivery of the plan. During Q2 the Trust will review the forecast to identify the respective risk and mitigations in delivering the Control Total. Better payment compliance is currently not being achieved on invoice numbers but is being achieved on value.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Aug-18	4,099	4,099	19,000	12,325					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Aug-18	(2,383)	(2,383)	10,993	5,001					
Cash balances - Number of days to cover operating expenses	F&P	T	Aug-18	6	6	2	12					
Capital spend £ YTD (000's)	F&P	T	Aug-18	1,492	1,492	9,516	9,180					
Financial forecast outturn & performance against plan	F&P	T	Aug-18	10,416	10,416	10,993	5,001					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Aug-18	92.5%	92.5%	95.0%	91.4%					

APPENDIX A

			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	2018-19 YTD	2017-18 Target	FOT	2017-18	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	95.7%	99.1%	85.0%		97.0%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	0.0	0.0	0.0	0.5	0.5			3.5		
Lower GI	% Within 62 days	▲ £	92.3%	84.6%	69.2%	88.9%	82.4%	78.6%	80.0%	91.7%	75.0%	100.0%	76.5%	100.0%	100.0%	92.5%	85.0%		84.0%		
	Total > 62 days		0.5	1.0	2.0	0.5	1.5	1.5	2.0	0.5	1.5	0.0	2.0	0.0	0.0	2.0			12.5		
Upper GI	% Within 62 days	▲ £	33.3%	88.9%	80.0%	100.0%	86.7%	100.0%	100.0%	63.6%	100.0%	80.0%	80.0%	80.0%	66.7%	78.6%	85.0%		87.2%		
	Total > 62 days		1.0	0.5	0.5	0.0	1.0	0.0	0.0	2.0	0.0	1.0	1.0	0.5	0.5	3.0			5.0		
Urological	% Within 62 days	▲ £	83.3%	81.3%	87.5%	77.4%	90.2%	96.6%	60.9%	96.8%	86.2%	93.8%	90.0%	77.4%	81.5%	85.4%	85.0%		82.5%		
	Total > 62 days		3.0	4.5	1.5	3.5	2.0	0.5	9.0	0.5	2.0	1.0	2.0	3.5	5.0	11.5			37.0		
Head & Neck	% Within 62 days	▲ £	75.0%	42.9%	20.0%	100.0%	83.3%	80.0%	33.3%	66.7%	100.0%	50.0%	66.7%	33.3%	57.1%	50.0%	85.0%		64.6%		
	Total > 62 days		0.5	2.0	2.0	0.0	0.5	0.5	1.0	0.5	0.0	0.5	0.5	2.0	1.5	4.5			8.5		
Sarcoma	% Within 62 days	▲ £		0.0%	100.0%			50.0%	33.3%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	93.3%	85.0%		66.7%		
	Total > 62 days			0.5	0.0			0.5	1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.5			2.5		
Gynaecological	% Within 62 days	▲ £	68.8%	55.6%	83.3%	100.0%	94.1%	55.6%	90.9%	66.7%	77.8%	87.5%	72.7%	50.0%	100.0%	80.0%	85.0%		78.2%		
	Total > 62 days		2.5	2.0	0.5	0.0	0.5	2.0	0.5	0.5	1.0	0.5	1.5	0.5	0.0	2.5			12.0		
Lung	% Within 62 days	▲ £	100.0%	72.7%	71.4%	87.5%	66.7%	100.0%	80.0%	100.0%	100.0%	87.0%	95.8%	88.9%	100.0%	92.9%	85.0%		84.7%		
	Total > 62 days		0.0	1.5	1.0	0.5	3.0	0.0	1.5	0.0	0.0	1.5	0.5	0.5	0.0	2.5			11.5		RC
Haematological	% Within 62 days	▲ £	71.4%	100.0%	50.0%	100.0%	85.7%	76.9%	100.0%	88.9%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	85.0%		80.6%		
	Total > 62 days		1.0	0.0	3.0	0.0	0.5	1.5	0.0	0.5	1.0	0.0	0.0	0.0	0.0	0.0			9.5		
Skin	% Within 62 days	▲ £	93.9%	93.0%	88.9%	95.2%	98.2%	97.7%	100.0%	95.5%	92.5%	100.0%	91.4%	97.7%	93.8%	95.2%	85.0%		95.2%		
	Total > 62 days		1.5	1.5	2.0	1.0	0.5	0.5	0.0	1.0	2.0	0.0	2.5	0.5	1.5	4.5			13.0		
Unknown	% Within 62 days	▲ £	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		75.0%	100.0%	100.0%		100.0%	100.0%	85.0%		78.4%		
	Total > 62 days		1.0	0.0	0.0	1.0	0.0	0.0	0.0		1.0	0.0	0.0		0.0	0.0			4.0		
All Tumour Sites	% Within 62 days	▲ £	87.1%	84.5%	80.6%	89.5%	90.3%	90.6%	85.2%	89.1%	89.6%	94.2%	89.9%	90.3%	89.5%	90.9%	85.0%		87.4%		
	Total > 62 days		11.0	13.5	12.5	6.5	9.5	7.0	15.0	8.0	8.5	4.5	10.0	8.0	9.0	31.5			119.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%		100.0%		100.0%	100.0%					100.0%	100.0%	100.0%	85.0%		100.0%		
	Total > 31 days			0.0		0.0		0.0	0.0					0.0	0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £					100.0%						100.0%			100.0%	85.0%		100.0%		
	Total > 31 days						0.0						0.0			0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)77

Title of paper: Executive Committee Chair's Report – September 2018

Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.

Summary:

The paper provides a summary of the issues considered by the Executive Committee at the meetings held during July and August 2018.

There were a total of 5 Executive Committee meetings held during this period, due to the UoR assessment day and follow up, the Executive Committee time out and the CQC Well Led Inspection.

The Executive Committee agreed:

- The preferred option for Microbiology equipment procurement
- Plans to finalise the digitisation of all medical records and the demolition of the current records library
- Adoption of the National Core Skills Framework for core mandatory training
- Enhanced staffing for the Dermatology Service to deliver planned service developments and increase the long term sustainability of the service
- Options to increase community step down bed capacity, and the development of a business case for Board consideration

The Executive Committee also received the regular assurance reports covering Marshalls Cross Primary Care Centre, the Integrated Performance Report, agency and locum usage, safer staffing and vacancies, appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register. There was also a weekly progress report on the action taken to resolve the Medway PAS implementation issues.

Trust objectives met or risks addressed: All 2018/19 Trust objectives.

Financial implications: None arising directly from this report.

Stakeholders: Patients, Patients Representatives, Staff, Commissioners, Regulators

Recommendation(s): That the report be noted

Presenting officer: Ann Marr, Chief Executive

Date of meeting: 26th September 2018

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
July and August 2018

1. Introduction

There were 5 Executive Committee meetings in July and August 2018.

2. 19th July 2018

2.1 Redundancy Business Case

The business case for redundancy of 1 member of staff following the completion of the organisational change process for the A&E Department management structure was formally agreed and would be presented to the Remuneration Committee on 25th July.

2.2 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly review of the BAF. Proposed changes to update the BAF were agreed for presentation to the Trust Board at the July meeting.

2.3 Risk Management Council and Corporate Risk Register Report

The Director of Corporate Services presented the monthly Chair's report from the Risk Management Council (RMC) held on 10th July and the update on the Corporate Risk Register (CRR). It was noted that one of the Trust's highest risks concerning staffing on DMOP and frailty had been reduced as a result of a positive targeted recruitment campaign.

2.4 Mandatory Training and Appraisal Monthly Report

The Deputy CEO/ Director of Human Resources presented the monthly position in relation to mandatory training and appraisals against the Trust targets. Mandatory training compliance was above target, but further focus was required to ensure that the staff appraisal position continued to improve.

2.5 Medway PAS Update

The Director of Operations and Performance presented the weekly progress report, detailing the actions being taken to improve the outpatient booking processes and validate the RTT waiting list. The changes being implemented to address issues being experienced by Clinical Directors and the reducing DNA rates were noted. There were improvements to coding speed as a result of the new system which was positive. A further extension to the flex and freeze dates for contract payment had been agreed with commissioners for the month to ensure additional validation checks could be completed.

2.6 Executive Committee Time Out 26th July

The Executive Committee agreed the priority agenda items for the Executive Time Out planned for 26th July, these were preparation for the planned CQC Well Led

inspection, planning the Urgent Care summit and reviewing plans for winter bed capacity.

2.7 Medical Leadership

The planned changes to the senior medical leadership structure supporting the Medical Director were discussed, alongside methods of improving two way communications with the Care Group Medical Directors and the new Assistant Medical Directors when the new structure was in place.

3. 2nd August 2018

3.1. Microbiology Equipment Procurement

The Director of Operations and Performance presented the recommendations from the microbiology equipment option appraisal exercise to enter into a new contract for Managed Equipment Services (MES). The preferred option allowed greater efficiency and cost improvement and enabled the department to consolidate existing contracts with a single supplier. There was also flexibility to cope with any future growth either as a Trust or as a pathology network hub. The Executive Committee approved the preferred option.

3.2 Gender Pay Gap Information

The Deputy CEO/Director of Human Resources presented additional information to the Executive Committee following the new requirement that NHS organisations publish gender pay gap information each year. The presentation focused on applicants, appointees and the salaries of new starters in senior roles between April 2017 and March 2018. The information provided assurance that the review of hiring decisions did not identify any preference for male appointments over female or evidence of any underlying bias in the starting salaries offered to successful candidates.

3.3 Agency Usage/Premium Payments Report

The Deputy CEO/Director of Human Resources presented the report from the Premium Payment Scrutiny Council which detailed the number of agency shifts and cost of using agency staff. The total spend on agency staff in month 3 was £907k, with the largest spend being on medical and qualified nursing staff. The number of engagements that exceeded the NHS Improvement (NHSI) agency capped rates was continuing to decrease. The Committee noted that more needed to be done for the Trust to remain within the agency cap target set by NHS Improvement. It was decided that in future a single report should cover all temporary staffing, so the relationship between internal bank usage and agency requests could be monitored. The additional controls for approval of agency requests and sign off of any that breached the new lower agency cap, were agreed.

3.4 E-Rostering Quarter 1 Key Performance Indicators

The Deputy CEO/Director of Human Resources presented the report which demonstrated that there was now a higher level of compliance with the system and

performance against the 5 core key performance measures was improving. Work would continue to maximise the benefits of the eRostering system.

3.5 Marshalls Cross Primary Care Practice - Update

The Director of Transformation presented the monthly performance report. The number of patients registered with the practice had remained stable, the utilisation of available appointments was high and DNA rate remained relatively low (4.3%). Path links requests and medicines management requests were being managed within 48 hours in line with the target. Staffing and permanent recruitment remained the greatest risks, but there are mitigation plans in place.

3.6 Medway PAS – Weekly Report

The Director of Informatics presented the report detailing the introduction of Sustenuto system management software to help manage the requests to the Patient Booking Service (PBS). Activity comparisons with July 2017 showed that activity levels e.g. number of appointments, number of outpatient procedures were recovering to pre Medway levels. Work to validate the patient tracking list was continuing, and detailed work was being undertaken with a number of specialities to resolve specific issues and provide further training.

4. 9th August 2018

4.1 National Pay Awards

The Deputy CEO/Director of Human Resources gave an update on the Agenda for Change (AfC) pay award that had been announced in July and the pay award for Medical and Dental staff that had just been announced. For AfC staff incremental progression would be linked to satisfactory appraisal which would support the Trust objective for all staff to have an annual appraisal. It was noted that the pay increases would be a cost pressure for the Trust going forward unless this was recognised in the national funding settlement.

4.2 Medical Records Library

The Director of Informatics presented proposals to complete the digitisation of all medical records by November as the current Medical Records library building at St Helens hospital was no longer fit for purpose. These proposals were approved. The Director of Estates and Facilities confirmed that the current building would be demolished and the site would then be available for redevelopment as part of the Trusts strategic long term estates development plans.

4.3 Medway PAS – Weekly Report

The Director of Informatics presented the latest weekly update on the actions being taken to achieve a business as usual position in relation to outpatients and referrals. The redesign work continued and staff were receiving intensive support. The informatics, operational and information teams continued to work closely together to implement the solutions, and it was planned that normal activity reporting would resume from quarter 3.

4.4 Cancer Hub

The Chief Executive provided feedback on the process to select the Eastern Cancer Hub that had been agreed by commissioners. The Trust was to present its proposals to the panel on 22nd August. It remained unclear if the cancer hub would include linear accelerators and if it would have to be located on an acute site. The Trust had options to locate a cancer hub on either the Whiston or St Helens sites.

4.5 2018/19 CQUINS

The Director of Nursing, Midwifery and Governance gave an update on the 2018/19 CQUIN targets and proposed success measures that continued to be negotiated with the commissioners. The delay in agreeing the CQUINs and how they would be measured so late in the financial year was a cause for concern and potential financial risk.

5. 16th August 2018

5.1 Mandatory Training and Appraisals Report

The Deputy CEO/ Director of Human Resources presented the performance against Trust targets for July, the rate for appraisals continued to be below target. Proposals to improve the timeliness and accuracy of the data entered into and reported from ESR were discussed, to ensure that the whole Trust based actions on a single information source.

5.2 Re-alignment of Mandatory Training Refresher Periods

The Deputy CEO/Director of Human Resources presented proposals to align the Trust's mandatory training refresher periods to the National Core Skills Framework that had been developed by the National Skills Academy and Health Education England and recently adopted by the Cheshire and Merseyside Workforce work stream. The refresher periods for some of the core skills were 36 months, and training undertaken in other NHS organisation was transferrable. The Executive Committee approved this proposal and asked for clarity on the arrangements for subjects where mandatory training was required but were not covered by the Core Skills Framework and where annual refresher training was expected. It was also agreed that there needed to be a formal process for approving any new subjects to be added to the mandatory training framework.

5.3 Medway PAS Weekly Update

The Director of Informatics and Director of Finance presented the report. The number of Patient Booking Service (PBS) queries and the number of patients attending out patients without an appointment had continued to fall. In depth work was being undertaken with Gynaecology and Endoscopy to understand how the patient pathways could be managed with the new referral based PAS. About 300 staff were in the process of receiving additional training on how the system operated. Comparison data showed how the referral rates had changed compared

to the same period in 2017/18, to give a more realistic understanding of underlying activity changes. The patient tracking list continued to be validated.

5.4 Integrated Performance Report (IPR) - July

The Director of Finance presented the IPR for month 4. There had been 1 never event and 3 cases of c-Diff reported in July. Concerns remained about the A&E four hour access target performance and cancer two week waiting times in some specialities. The Executive Committee agreed a number of actions to address these areas of concern.

5.5 CQC Well Led Inspection Interview Timetable

The Director of Corporate Services presented the schedule of interviews requested by the CQC lead inspector for the upcoming Well Led Inspection. It was likely that more interview requests would be received during the 3 day inspection.

6. 30th August 2018

6.1 Dermatology Service – Options Appraisal

The Director of Operations and Performance introduced the presentation which presented the service development plans for dermatology. Plans included a single triage service working with St Helens CCG and the existing GPSI's, the development of the nursing workforce and permanent recruitment to the Consultant positions currently filled by locums. The importance of maintaining a local service as the regional skin cancer service was acknowledged, especially as other Trusts were withdrawing from providing this service. The current 18 week backlog and plans to increase capacity to address this were also debated. The Executive Committee approved the creation of a new nurse consultant post and continued efforts to recruit substantive consultant staff.

6.2 Step Down Winter Beds

The Director of Operations introduced the paper which provided an update on the options to create additional step down bed capacity. There were a number of options still being explored, but only one that could realistically deliver additional beds during winter 2018/19. The Executive Committee agreed that both the short term and medium term options needed to be developed further and a business case taken to the Board in September to approve the capital and revenue expenditure.

6.3 Contract Quality and Performance Group (CQPG) - 29th July 2018

The Director of Nursing provided feedback from the CQPG meeting, in particular the concerns about the new CQUIN monitoring process.

6.4 Safer Staffing and Vacancy Dashboard

The Director of Nursing presented the report which detailed the safer staffing figures and vacancy dashboard for July. The overall fill rate had been 94.48% with no ward falling below 90% for care staff.

6.5 Medway PAS Weekly Update

The Director of Informatics presented the weekly report. The System C intensive support team had undertaken a 2 day visit and a number of improvements had been identified. A joint action plan was being developed. Proposals to fast track the validation of the remaining Patient Tracking List (PTL) were discussed and it was agreed that this must be a priority to be able to resume routine RTT reporting. The hard work and dedication of staff across the organisation to resolve the issues, was formally acknowledged.

Options to implement NEWS2 were in development and would be presented in the near future.

6.6 Stroke Services – Phase 2

The Director of Finance reported on a meeting with Warrington and Halton Hospitals and Warrington CCG where the next phase of the stroke service development had been discussed. The Trust was ready to move forward to receive all the stroke patients from Warrington as soon as the other parties had agreed.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)78

Title of paper: Committee Report – Quality Committee Chair's Report

Purpose: To summarise the meeting papers from the 18 September 2018 and escalate issues of concern.

Summary:

QC(18)109 Complaints Update: 23 first stage complaints were received and opened in August; this represents a decrease. The Committee noted that the previous 3 months has shown an upward trend possibly due to Medway issues. The Medway data will be removed to check this is the case. The Trust responded to 100% of stage 1 complaints within the agreed timescales.

QC(18)110 IPR: the main issues to be noted from the IPR are as follows:

- 1 never events year to date
- No MRSA bacteraemia year to date
- 1 C.Diff case reported; 11 YTD
- 1 inpatient fall resulting in severe harm in the Outpatient department
- VTE assessment 95.10% with a YTD performance of 95.15% (target 95%)
- HMSR 99.1%
- 2WW compliance underperformed at 86.5% against target of 93% due to an increase in referral activity, patient re-arrangement and issues related to Medway
- A&E Type 1 performance 90.5% which is an improvement on July
- Ambulance turnover improved 11.12 minutes (target 15 minutes)
- Trust £0.6K behind plan due to losing provider sustainability fund for non-delivery of the A&E target in Q1.

QC(18)111 Safer Staffing: Overall Trust % staffing fill rates for RN were 95.44% and 111.7% for HCAs. Staffing fill rates remain challenging and a Staffing Summit was proposed to address the issues.

QC(18)112 NG Tube Action Plan Update: All actions now complete; there have been no further NG Tube incidents in ICU.

QC(18)113 CQC Update: 250 document requests received since inspections in July and August. An action plan has been developed to address areas highlighted for improvement. CQC draft report due imminently.

QC(18)114 Infection Control Report: During 2017/18 the IPC performance improved in comparison to the previous year and the following were reported:

- 19 cases of Clostridium difficile infection (CDI) against an objective of no more than 41 (of which 6 were classified as unavoidable)
- 2 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) 1 true bacteraemia (i.e. clinical infections) and 1 contaminant
- 22 cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia
- 65 Hospital Acquired E coli bacteraemia

2018-19 data to date:

- There have been no cases of MRSAb
- Clostridium difficile infection (CDI) objective for 2018-19 is of no more than 40. In quarter there has been 12 cases compared to 15 in the same reporting period last year (20% reduction); 2 cases are for appeal as no lapses of care were identified in the RCA

- 12 cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia, which is 2 more than the same reporting period last year
- 22 Hospital Acquired E coli bacteraemia compared to 27 cases in the same reporting period last year (20% reduction)
- Zero cases of CPE bacteraemia.

QC(18)115 HPTP & Medicines Optimisation Strategy Update Report: New format report received and noted. Our application has been approved for a manufacturing licence for the Aseptic service. The key objective is to increase availability of ready-made IV products on wards and to collaborate with STP partners.

QC(18)116 Medicines Storage and Security Audit Report: Report provides evidence of 89% compliance.

QC(18)117 Inpatient Survey Update: An action plan has been developed to respond to areas where the Trust scored lower than other trusts and for areas that showed a deterioration in performance. The Executive Committee to do a deep dive to consider appropriateness of actions, prioritisation and timescales.

QC(18)118 Just Culture Guide: Guide published by NHSI in March 2018, report highlighted key actions to embed it within the Trust.

Feedback from Councils/Committees:
QC(18)119 Patient Safety Council: Summary page was noted and the following highlighted:
- Level 1, 2 and 3 children and adults safeguarding training all above required target in June 2018. Prevent/WRAP training currently provided to nominated staff, is being revised due to revision of TNA and will align to level 2 safeguarding training, requiring additional training to a number of additional staff by March 2019. A training plan has been developed which must be complete by March 2019, however there is a target of 2000 modules to be achieved which may prove challenging to deliver.

QC(18)120 Patient Experience Council: Summary page noted, no issues to escalate.

QC(18)121 Clinical Effectiveness Council: Summary page was reviewed and noted. The following were identified for escalation:
- There were 9 nil responses from NICE Report.
- There is no current forum whereby clinical standards can be discussed, need a strategy for these cases. Clinical engagement forum to be considered.
- Pain management policy and plans: Maternity dashboard:- % of women seen by 12 weeks and 6 days of pregnancy 88.7%, a slight increase from May (88.5%). YTD 87.3% (Target 90.0%) The issues resulting from the implementation of Medway PAS at the end of April are on-going. Increasing concerns regarding issue, with a lack of resolution.

QC(18)122 CQPG: No update provided.

QC(18)123 Workforce Council: Summary page noted, no issues to escalate.

Policies/Documents for Approval: There were no items presented for approval.

Policies/Documents for Approval by Councils: None received.

Items to be brought to the attention of the Board:
- 1 Never Event in July in Theatres
- PREVENT Training issue
- Aseptic Service manufacturing licence approved

Corporate objectives met or risks addressed: Five star patient care and operational performance.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: Chair of Committee
Date of meeting: 26 September 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)79

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 20th September 2018

Summary:

Agenda Items

For Information

- CIP Council

The briefings were accepted.

For Assurance

- A&E Update
  - The Committee reviewed the presentation from the ADO for Urgent Care on the current performance.
  - It was noted that work had been undertaken to correlate performance with available physical and staff resources and that this would continue to be refined to support increases in performance.
  - The action plan following the Urgent care summit was reviewed and discussed. The Committee took limited assurance from the proposals put forward, with more refinement of the plan required. This action was transferred to the Executive Committee to conclude.
- Integrated Performance Report Month 5
  - Discussion took place around operational performance. There had been no grade 3 or 4 avoidable pressure ulcers YTD and no MRSA bacteraemia cases YTD.
  - The committee noted that there have been 11 C-Difficile cases YTD, with a tolerance of 40 for the year.
  - It was noted that due to the implementation of our new PAS system, data quality on our RTT numbers being recorded needs to be completed. Progress was being to achieve reporting of this standard by Q3.
- Finance Report Month 5 2018/19
  - The month 5 financial position was presented to the committee showing a £2.4m deficit position with includes all allowable PSF funding for Q2. The Committee noted that there was a risk on the PSF as a result of the A&E performance and further discussion are taking place with the regulator.
  - The following elements were reviewed and discussed:
    - Cash of £6.2m, with cash balances challenging as a result of delays in payments from NHS organisations.
    - Capital spend of £1.5m with plans in place for full allocation.
    - The financial position was supported by £1.5m non-recurrent support which will be affecting the underlying position.
    - UoR of 3 which was in line with plans.
    - CIP is above plan by £0.4m with green schemes now representing 2.5% of total income, which is higher than the national planning assumptions.
- CIP Programme update
  - The committee noted the improvement in green rated schemes with £9.6m now

delivered. This is an increase from M4 by £1.6m. The committee also noted that there was a significant increase in performance compared to 2017/18 with 60% more CIP delivered compared to the same period last year.
    - The Committee discussed the risks associated within the STP schemes. It was noted that these now represent a risk to the forecast outturn as a result of the PFI indexation and delays in the other STP schemes outside the span of control of the Trust.
- CIP Programme update – SCG
    - The Care Group presented their position with the improvements in their planned delivery.
    - The Committee reviewed the proposals that the Care Group had identified to mitigate their respective CIP target and were assured that progress is being made.

Risks noted

- Inclusion of PSF within financial position for A&E performance for Q2
- CIP profile and step up in delivery from Q3 onwards
- Delay of STP saving schemes providing risk to forecast outturn (£4.5m)
- Cash risk as a result in delays to payments from other NHS organisations (Lead Employer)
- Non-recurrent measures utilised within financial position
- A&E performance
- RTT reporting

Issues to be raised at Board

- Continued challenge to achieve A&E performance.
- Risks to the forecast outturn given the slow process of the STP to deliver system wide savings.

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members

Recommendation(s): Members are asked to note the contents of the report

Presenting officer: Denis Mahony, Non-Executive Director

Date of meeting: 26th September, 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)80

Title of paper: Committee Report – Audit

Purpose: To feedback to members key issues arising from the Audit Committee.

Summary: The Audit Committee met on 1st August 2018.

The following matters were discussed and reviewed:

External Audit :

- Annual audit letter (GT) – Agreed by the Committee

Internal Audit:

- Progress/update report on Internal Audit including follow-up on previous audit reviews (MIAA)

Anti-Fraud Services:

- Anti-Fraud progress report (MIAA)

Trust Governance and Assurance:

- The Director of Nursing update (DoN).

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the period 1st April 2018 to 30th June 2018 (ADoF).
- Aged debt analysis as at end of June 2018 (ADoF).
- Tender and quotation waivers report (ADoF).

Any Other Business:

- Routine review of the Corporate Governance Manual (ADoF) - some minor changes were made, principally:
  - To correct references to organisations where organisations have changed (For example, references to the Department of Health have now been changed to the Department of Health and Social Care; also references to NHS Protect have now been amended to the NHS Counter Fraud Authority);
  - To make permanent the temporary change, for operational reasons, to the authorisation limits assigned to the X-Ray and Pathology managers agreed in August 2017;
  - To correct some issues regarding references to the Remuneration Committee as advised by the Director of Corporate Services (eg. aligning the Trust's SOs and SFIs with the current terms of reference for that Committee).

Key:

GT= Grant Thornton (external auditor)

MIAA = Mersey Internal Audit Agency (internal audit and anti-fraud services)

DoF = Director of Finance DoN = Director of Nursing, Midwifery & Governance ADoF = Assistant Director of Finance (Financial Services) NB. There was no meeting required of the Auditor Panel required on this occasion.
Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): For the Board to note and, in respect of the Corporate Governance Manual, to approve amendments.
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 26th September 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)81
Title of paper: Strategic and Regulatory Update Report – September 2018
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: The report provides a briefing on the key policy and regulatory developments including; 1. Proposed Board Development Programme for 2018/19 2. NHS England Chairman 3. NHS Improvement Action s in response to the Independent Review of Liverpool Community Health 4. Development of the NHS 10 year plan
Trust objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, C&M H&SCP, Commissioners, Regulators
Recommendation(s): The Board is asked to approve the Board development programme and note the other items.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 26th September 2018

Strategic and Regulatory Update Report – September 2018

1. Proposed Board Development Programme for 2018/19

In line with good governance practice as outlined in the NHS Improvement Well Led Framework the Board agrees a Board development programme each year. The 2017/18 programme was completed in July 2018, and the draft programme for 2018/19 is attached (appendix 1).

The purpose of the Board development programme is the collective development and education of Directors, rather than the Personal Development Plans (PDP) or mandatory training of individual members. The programme is designed to ensure that the Board has time outside of the routine Board meetings to gain knowledge, develop strategy and support effective unitary working.

The Board development programme is based on two time out sessions each year and effective utilisation of the Strategy Board meetings. The programme is always flexible to respond to changing needs e.g. the preparation for the Use of Resources (UoR) assessment, CQC inspection and responding to the national planning timetable deadlines.

2. NHS England Chairman

Lord Prior of Brampton will take over as Chairman of NHS England from October 2018, when Sir Malcolm Grants term of office ends. Lord Prior is a former health minister and currently Chair of University College Hospital London. His appointment was approved by the Health Select Committee on 10th September 2018.

3. Review of the Fit and Proper Persons Test Regulations

As part of the response to the Independent review of Liverpool Community Health led by Dr Bill Kirkup, the Department of Health and Social Care has engaged Tom Kark QC to conduct a review of the effectiveness and operation of the fit and proper person test as it is applied within the NHS. The review will consider the scope, operation and purpose of the fit and proper person test as a means of specifically preventing the re-deployment or re-employment of senior NHS managers where their conduct has fallen short of the values of the NHS.

NHSI and NHS England are also working together to develop a more integrated approach to regional oversight that will address the need to ensure relevant information is passed on to successor organisations locally.

4. Development of the NHS 10 year plan

Over the summer detail has emerged of how the 10 year plan for the NHS is being developed, in response to the Prime Ministers announcement in March 2018 of a “sustainable long term plan” for the NHS backed by “a multiyear funding settlement”.

The Prime Minister set a number of priorities for the 10 year plan:

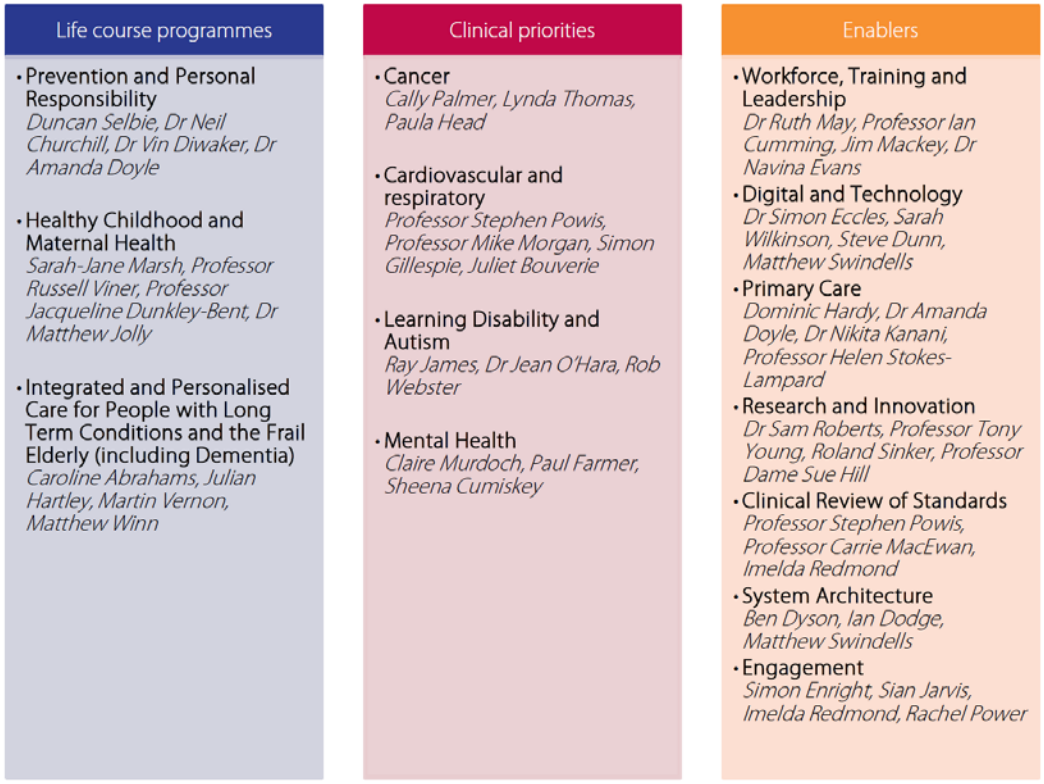
- getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care
- transforming cancer care so that patient outcomes move towards the very best in Europe
- better access to mental health services, to help achieve the government’s commitment to parity of esteem between mental and physical health
- better integration of health and social care, so that care does not suffer when patients are moved between systems
- focusing on the prevention of ill-health, so people live longer, healthier lives”

The government also set the NHS five financial tests to show how the service will put the service onto a more sustainable footing:

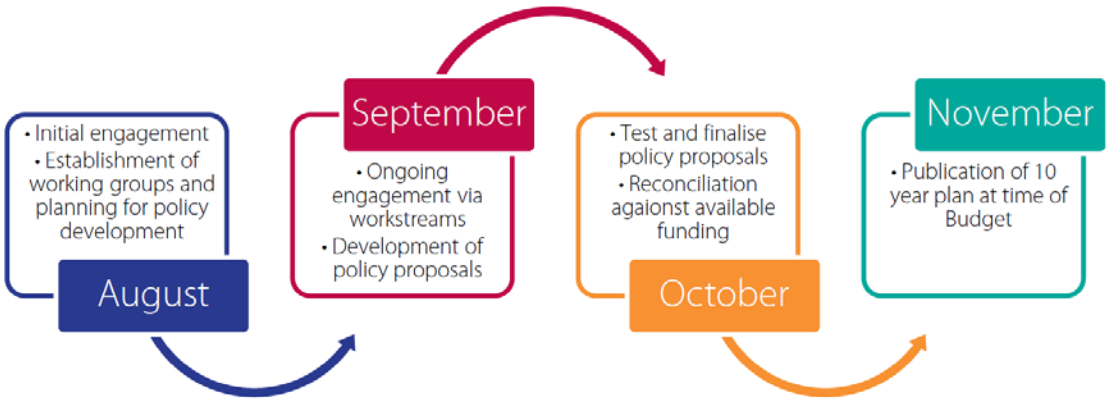
- Improving productivity and efficiency
- Eliminating provider deficits
- Reducing unwarranted variation so people get the consistently high standards of care wherever they live
- Managing demand effectively
- Making better use of capital investment

A number of working groups have been established to consult with the service and develop elements of the 10 year plan (see below).

NHS 10 Year Plan Working Groups



The timetable for the development and publication of the plan has also been set out, so that it coincides with the autumn budget.



The timing of the Board time out in December is designed to enable the Board to review the published plan and consider the implications for the Trust and local health system.

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

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BOARD DEVELOPMENT PROGRAMME 2018/19

Purpose	Provider/Lead	Date
Initial feedback from the CQC Well led inspection and NHSI UoR Reports (if received)	Sue Redfern/ Nicola Bunce/ Nik Khashu	26th September 2018 Board Meeting
Corporate Law annual update	Hill Dickenson LLP	31st October 2018 Strategy Board
Review of CQC/UoR report from 2018 inspection and action planning	Sue Redfern/Nicola Bunce/Nik Khashu	
Mid-year review against Trust objectives	Nicola Bunce	28th November 2018 Board Meeting
Mid-year review against operational and financial plans	Nik Khashu/Rob Cooper	
Developing an integration strategy – Patient experience/quality, financial and governance	Nicola Bunce	12th & 13th December 2018 Board time out
Review of NHS 10 year plan and exploring the implications for the Trust and its partners (with Care Group Senior leadership teams)	Ann Marr	
Introducing the new Integrated Performance Framework/explaining the UoR metrics	Nik Khashu	
2019/20 Planning assumptions and timetable	Nik Khashu	30th January 2019 Board Meeting
Equality and Diversity Training	Andy Woods (TBC)	
IT update and demonstration Medway PAS – benefits realisation update St Helens Shared Care Record	Christine Walters	27th February 2019 Strategy Board

Approval of 2019/20 draft operational plan, opening budgets and Trust objectives	Nik Khashu/Nicola Bunce	27th March 2019 Board Meeting
Approval of the final Operational Plan	Nicola Bunce	24th April 2019 Strategy Board
Review of "winter" 2018/19 and lessons learnt	Rob Cooper	
Non-executive Directors – Mandatory Training	NEDs	April 2018
Estates Strategy Annual Progress Report	Nicola Bunce	May 2019 Dates TBC Board time out
St Helens Cares – what next for placed based care	Ann Marr	
Review of 2018/19 performance against the Trust objectives	Nicola Bunce	29th May 2019 Board Meeting
Annual Board Effectiveness Review Feedback and development recommendations	Nicola Bunce	
Approval of the Annual Report and Accounts and Quality Account	Ann Marr	
Clinical and Quality Strategy Annual Progress Report	Kevin Hardy	26th June 2019 Strategy Board
Technology Strategy Annual progress Report	Christine Walters	
HR Strategy Annual Progress Report	Anne-Marie Stretch	31st July 2019 Board Meeting

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)82

Title of paper: Aggregated incidents, complaints & claims report for Quarter 1 2018-19

Purpose:

The purpose of this paper is to present an overview of incidents, complaints, PALS and claims activity and performance during Quarter 1 (Q1) 2018-19 to identify if there are any key themes or trends that need further investigation and to provide the Board with assurance that there are systems and processes in place to report and manage these issues.

Summary for 01 April 2018 to 30 June 2018 (Quarter 1):

The number of incidents reported has remained steady between Q1 2018-19 and Q4 2017-18, but has increased by nearly 10% from the same period last year. There was a slight increase in incidents related to moderate harms and above.

Incidents Q1

- 3608 incidents (all incidents – clinical and non-clinical) occurred in Q1
  - Decrease of 79 (2.1%) from Q4
  - Increase of 319 (9.7%) from Q1 2017-18
- 3011 patient incidents occurred in Q1
  - Decrease of 37 (1.2%) from Q4
  - Increase of 273 (10.0%) from Q1 2017-18
- The rate of patient incidents per 1,000 bed days in Q1 was 48.6
  - Increase of 2.1% from the Q4 (47.6 per 1000 bed days)
  - Increase of 7.8% from Q1 in 2017-18 (45.1 per 1000 bed days)
- 58 moderate and above patient harms in Q1
  - Increase of 9 (18.4%) from Q4
  - Decrease of 10 (14.7%) from Q1 2017-18
- The rate of incidents affecting patients and resulting in moderate harm or above per 1,000 bed days was 0.94, in comparison to 0.76 per 1000 bed days in Q4
- 7 incidents were reported on StEIS

Complaints and PALS

The number of first stage formal complaints and PALS contacts increased compared to the same quarter last year and the previous quarter

Complaints Q1

- 63 1st stage complaints were received and opened in Q1.
- An increase of 23.5% compared to the previous quarter and an increase of 19% compared to same quarter last year.
- The Trust closed 11 less1st stage complaints than it received in Q1.

PALS Q1

- 8% increase compared to the previous quarter and 64% increase compared to the equivalent quarter in 2017-18.

Claims

The number of claims received fluctuates each quarter; however, there was a marked increase in Q1 which will be monitored going forward.

Clinical Negligence Claimants (Q1)

- 40 new clinical negligence claims were received in Q1, an increase of 10 from the 30 received in Q4 (33.3%).

Corporate objectives met or risks addressed: Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.

Financial implications: There are no direct financial implications arising from this report

Stakeholders: Patients, carers, commissioners, regulators and Trust staff.

Recommendation(s): Members are asked to review the report and consider if there are any issues that need to be referred to the Quality Committee for further investigation.

Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance

Date of meeting: 26th September 2018

1. Introduction

The Trust uses the same Datix system to record reported incidents, complaints, PALS contacts and claims. This allows the Trust to link any related occurrences.

This report highlights if there are any trends and the learning derived from these. The information includes all reported incidents, complaints, PALS and litigation (claims and inquests). The data included in this report covers Q1 April to June 2018-19.

1.1 Governance of complaints, incidents and claims

The Quality Committee receives a monthly report on complaints management, with a more detailed report submitted monthly to the Patient Experience Council. The Patient Safety Council receives a monthly report on incidents and a quarterly report relating to claims. Each of the Councils provides a chair's report, with escalation of any areas of concern, to the Quality Committee. The Claims Governance Group meets monthly and reviews any potential new claims, high value claims and lessons learned as a result of claims. A chair's report is submitted monthly to the Risk Management Council, which reports to the Executive Committee.

1.2 Reasons and Themes

The table below compares the reasons for incidents, complaints, PALS contacts and claims reported during Q1, to identify if there are any common themes.

Table 1: Q1 top five themes from incidents, complaints, PALS and claims

Incidents	Q1	Complaints	Q1	PALS	Q1	New Clinical Negligence Claim	Q1
Accident that may result in a personal injury	910	Clinical treatment	27	Communications	144	For all specialities failure to diagnose or delay in diagnosis	12
Implementation of Care or ongoing Monitoring	553	Values and staff behaviour	7	Admission & Discharges (excl. delayed discharged re: care packages)	86	Fail/delay treatment	9
Clinical Assessment (Investigations, Images and lab test)	385	Communications	4	Patient Care Nursing Care	77	Failure to recognise complications of treatment	2
Access, Appointment, Admissions, transfer	344	Admission & Discharges (excl. delayed discharged re: care packages)	5	Clinical treatment	77	Failure to warn (informed Consent)	1
Medication	308	Patient Care Nursing Care	5	Appointments	104	Delay in performing an operation	0

Note: The charts above should be used as guidance only as there are often more than one category, for example there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding the care received. The categories used for reporting are indicated by external bodies, for example the clinical negligence ones are set by NHS Resolution and the complaints codes are used to report the KO41 via NHS Digital as required by the Department of Health.

Rank	Theme
1st	Clinical care
2nd	Access/admission/discharge issues
3rd	Communication and records
4th	Attitude/behaviour/competence

The top category in each of the areas has been consistent for the last five quarters.

From this analysis it can be seen that the most common theme across all areas is clinical care, followed by access/admission/discharge issues. This analysis will be repeated each quarter to see if the profile changes over time.

2. Incidents

There were 3608 incidents reported by staff during this period in Q1, with 7 incidents reported to StEIS and 58 categorised as moderate, severe harm or death.

Charts 1 and 2 below show the Trust's incident reporting activity from Q1 2016-17 to Q1 2018-19. This shows an increase in incident reporting but a stable trend in levels of significant harm resulting from the incidents. This indicates an improving culture of reporting.

Chart 1: total incidents reported

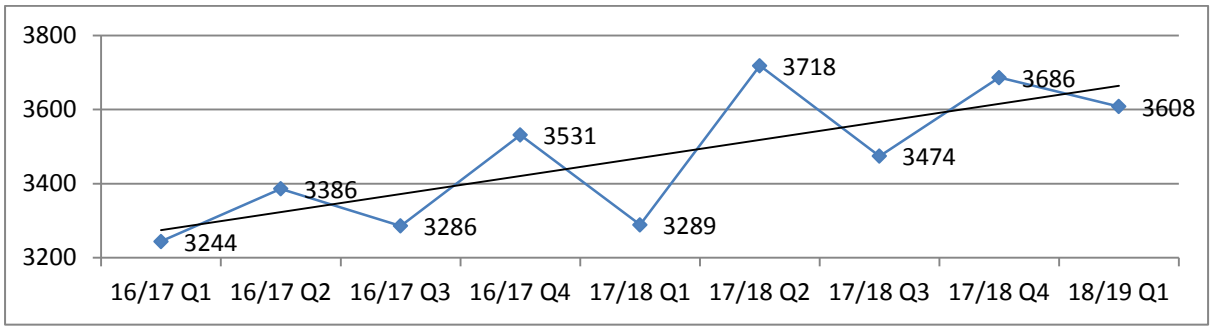
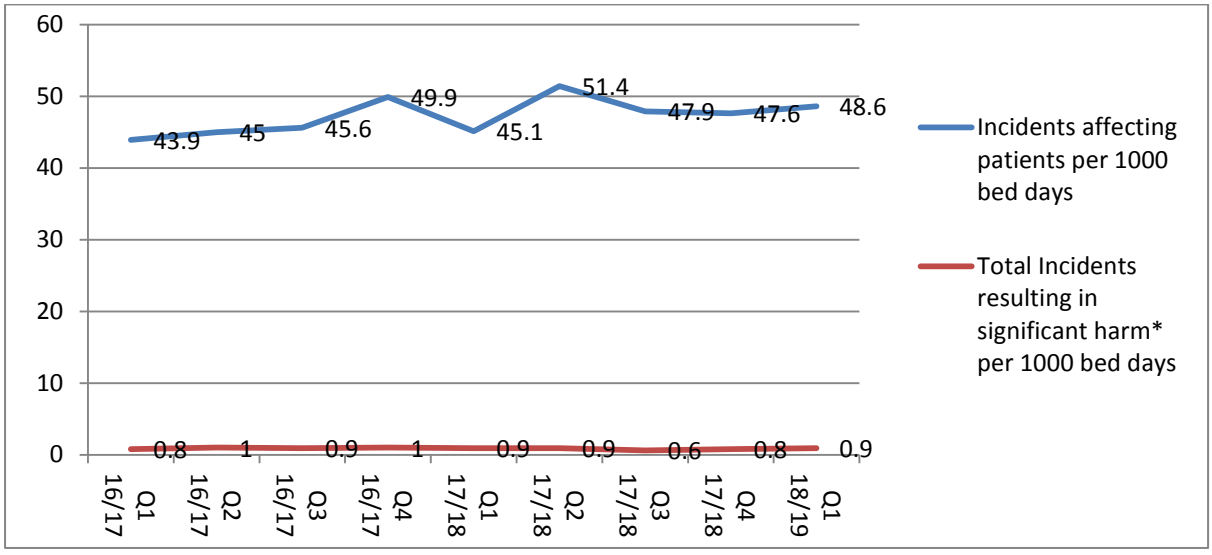


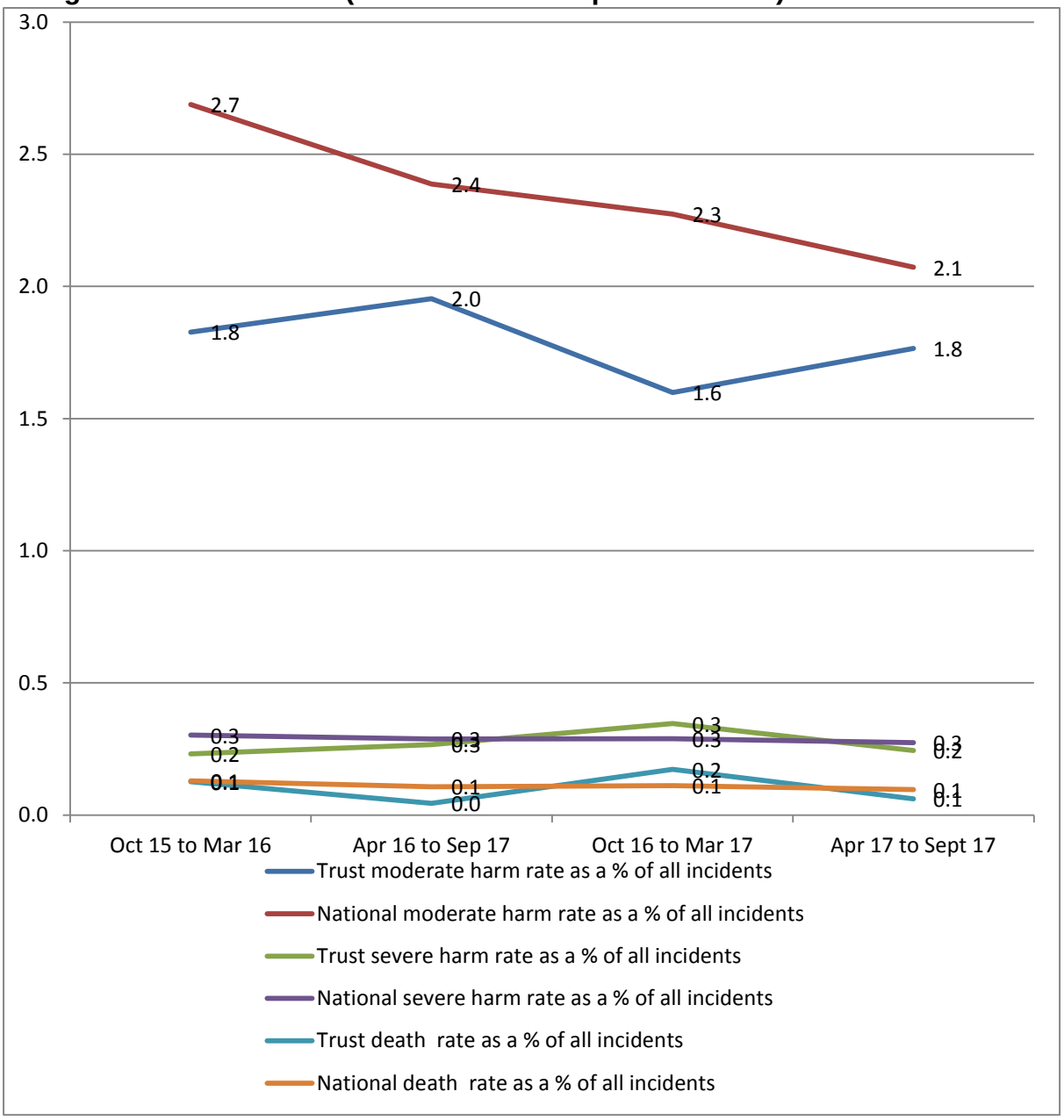
Chart 2: Incidents affecting patients per 1000 bed days



*significant harm = incident resulting in moderate/severe harm or death

Chart 3 shows the most recent data provided by NHS England comparing patient safety incidents reported to the National Reporting and Learning System (NRLS) by the Trust to the national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe or death vary in comparison due to the relatively small numbers.

Chart 3: Comparison of Trust's rates (as per NRLS data) of moderate harm and above against national rates (October 2015 – September 2017)



2.1. Thematic analysis of incidents reported to StEIS* in Q1 2018-19

*Only those incidents outlined in the Serious Incident Reporting Framework are reported on StEIS. These include any incident where the Trust causes severe harm or death, IG breaches, allegations of abuse and a number of other categories.

In Q1 the Trust reported 7 incidents to StEIS.

Table 2: incidents reported to StEIS in Q1 2018-19

Incident category	Number
Abuse/alleged abuse of adult patient by staff	2
Slips, Trips & Falls	1
Difficulty in delivery and resuscitation	1
Inadvertent IV administration of drug	1
Delayed intubation following delivery	1
Sub-optimal care of child with sepsis	1

Eight SI reports were due for submission to the CCG in Q1, of which 6 reports were submitted within agreed time frames. Two reports were submitted to the commissioners with a slight delay. There are no outstanding pending reports for submission from Q1.

2.2. Learning from StEIS reportable incident reports provided to the CCG in Q1 2018-19

A root cause analysis investigation is undertaken for each serious incident, with recommendations and an action plan produced to reduce the risk of a reoccurrence. Examples of lessons learned from reports submitted to the CCG in Q1:

2018/4010 Patient fall suffering a fractured left neck of femur
Lessons learned:

- Patient had a pre-existing reduction in his mobility and intermittent cognitive impairment
- Information from patient's relatives regarding his increasing confusion was not adequately considered when planning care
- Need for clearer completion of documentation
- At the time of the fall, the patient had a poor/disturbed sleep pattern due to frequency of micturition
- At time of the fall the lighting in the ward area would have been dimmed as it was early morning

2018/980 Patient fed via misplaced nasogastric tube (never event)
Lessons learned:

- Clear and robust methods of communicating clinical incidents and near misses within the medical and nursing team to ensure that all members of the team are aware of lessons learned
- Robust system in place to train and assess competency of clinicians in the interpretation of chest X-Rays to confirm correct placement of NG tubes to help reduce the likelihood of future incidents
- Consistent guidance on the same procedures to ensure no confusion for those carrying out the procedure
- The handover process should be standardised in order to ensure that all key tasks or information are passed over to the incoming team

2018/1262 Patient sustained a fractured neck of femur
Lessons learned:

- A full risk assessment was completed in accordance with Trust policy, however the risk assessment identified the patient as having a low falls risk which was inaccurate as the patient was admitted with a history of falls

2.3 Actions and learning from other incidents

Description: Incident regarding incorrect banding of haemorrhoids	
Recommendations	Action to achieve recommendation
Surgical Registrar counselled re incident by Consultant and reflected on the incident.	All surgeons to be informed of incident
Incident to be shared at Surgical Directorate Meeting and Endoscopy/Medical Care	All team members to be made aware of incident.
Incident to be shared at Surgical Care Group	Care Group awareness for lessons

Governance and Risk Meeting	learned
Description: Delayed diagnosis lung cancer	
Recommendations	Action to achieve recommendation
Review and Improve process of communication of cytology results – audit trail required to ensure that the result has been communicated received and acted on appropriately	Pathology Manager and Ward Manager to review process for communication of paper based cytology results to the ward. A written SOP to be produced that shows clear audit trial of the movement and communication of results between departments. SOP to be shared with all ward staff and roll out of the procedure to all wards.
Explore opportunities for electronic process that would provide an audit trial for management of results	Pathology manager to review opportunities to develop an electronic process for recording and communication of results in Medway Pathology Manager to reiterate process for booking samples in at the laboratory reception to reduce transcription errors Pathology Manager to ask staff to also telephone the referring Consultant's secretary to alert that an abnormal result needs action – audit trail to be in place to show that the call has taken place
Description: Misdiagnosis/incorrect reporting of kidney ultrasound	
Recommendations	Action to achieve recommendation
Remind referring clinicians of the importance of providing accurate and concise clinical information on radiology referrals.	Communication to Clinical Directors.
Highlight importance of adhering to the Perinatal Institute's GROW protocol regarding third trimester serial scans.	Discussion with obstetric consultants and midwifery teams.
Ensure that maternal BMI is recorded on all antenatal referrals for booking scans.	Discussion with antenatal clinic manager and community midwifery managers.
Audit of booking scans to ensure that: a) BMI is recorded and b) Third trimester serial scans are arranged	Audit a sample of booking scan referrals between September 2018 and December 2018. Identify whether BMI has been recorded. Identify whether third trimester serial scans have been arranged after 20 week fetal anatomy scan.

Lessons learned from incidents are shared via the bi-monthly safety bulletin included in Team Brief, via the Ward Manager and Matrons' meetings, Care Group governance meetings and specialist area meetings such as medicine safety group and falls strategy group.

3. Complaints

In Q1, 63 1st stage complaints were received and opened; an increase of 23.5% compared to the previous quarter. The Trust closed 52 1st stage complaints in Q1 compared to 46 in Q4 and responded to 94% within the agreed timescale above the 90% target. The total number of overdue complaints fell again at the end of Q1 2018-19, from 1 to none. The total number of open complaints increased to 51 at the end of Q1 2018-19 compared to 39 at the end of quarter 4 2017-18, reflecting the

increase in complaints received.

The chart below contains 1st stage complaints (written and verbal) received by quarter, since April 2016. This shows a continuing, reducing trend in the overall number of complaints received in the last eight quarters.

Chart 4: complaints received by each quarter from Q1 2018-19

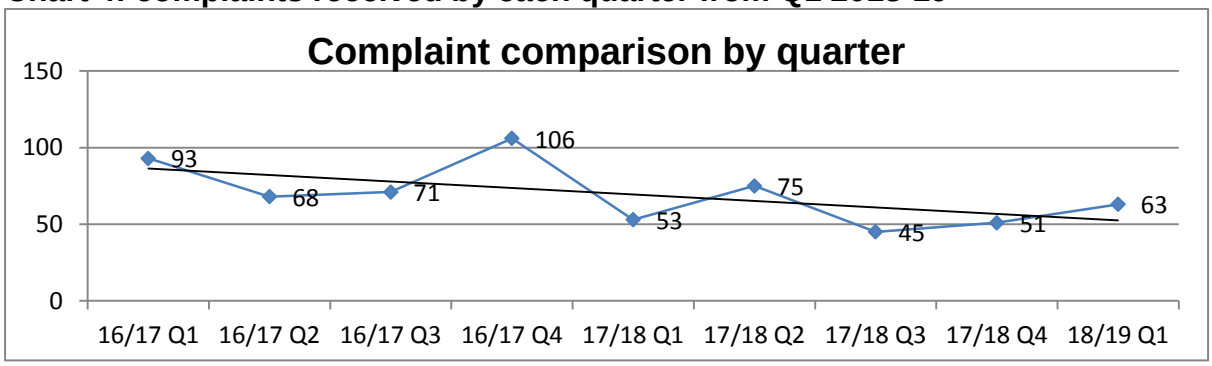
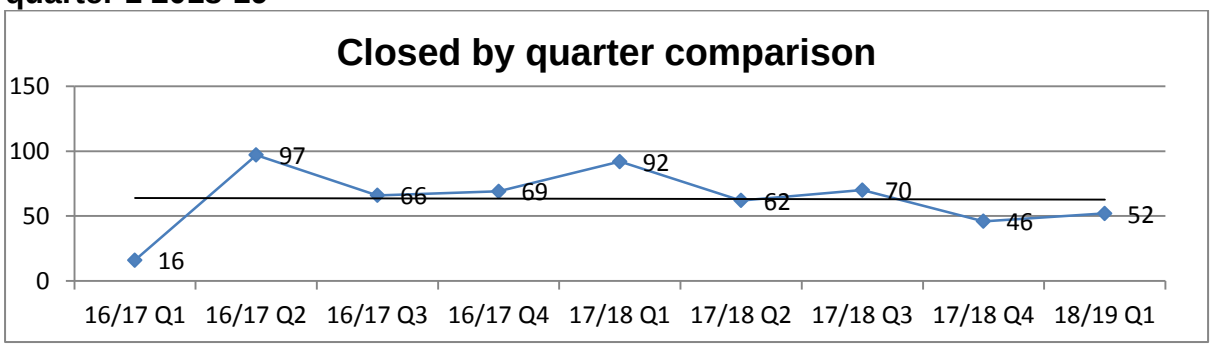


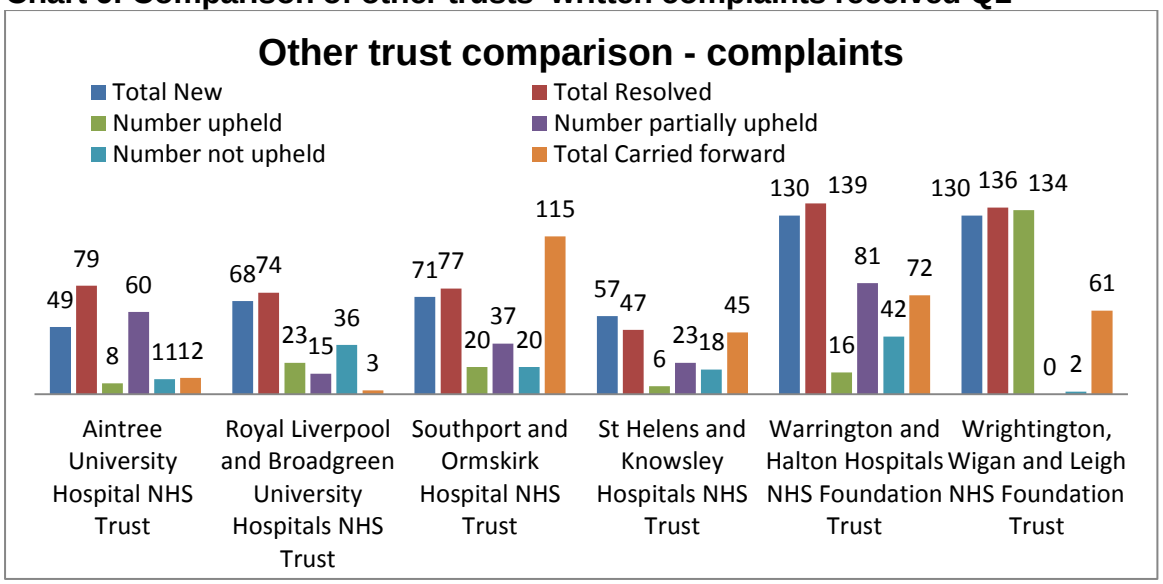
Chart 5: Comparison of number of written 1st stage complaints resolved in quarter 1 2018-19



3.1. Complaints – local and national comparison

NHS Digital collates details of trust written complaints (which are a sub set of all the complaints received and recorded) via a quarterly return (KO41a). The chart below shows a comparison with neighbouring trusts.

Chart 6: Comparison of other trusts' written complaints received Q1



The Q1 figures indicate that the Trust has received less written complaints compared to four of the five Trusts above. In addition, the Trust has the lowest level of complaints upheld.

3.2. Actions taken as a result of complaints

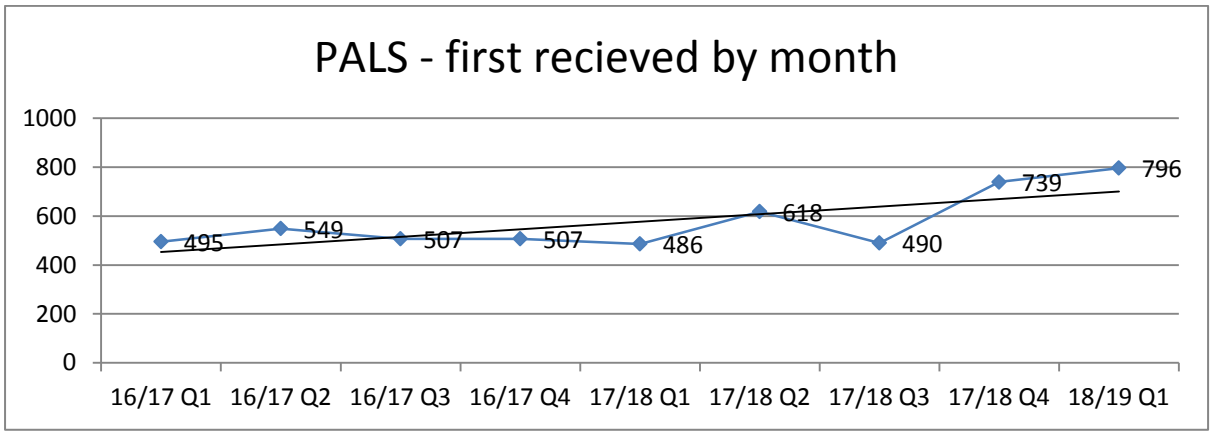
Each complaint response includes any learning that has been identified and the necessary actions for each area. A summary of lessons learned and actions taken from incidents and complaints across the Trust is shared at the Matron and Ward Manager meetings for onward cascade to each department/ward. In addition, complaints are a standing agenda item on the Care Group and ward governance meetings' agenda to ensure that lessons are shared and to embed any actions taken to improve the quality of patient care. The following are examples of actions in Q1:

- Staff reminded of importance of documentation in meeting
- Posters placed in the ED to inform patients of availability of wheelchairs
- Review of signage and cleaning schedule on a ward
- Staff reminded to adhere to ACE behavioural standards, Bristol Safety Checklist and green bag system
- Provision of upgraded equipment to support review and analysis of reports
- An Acute Assessment Nursing Proforma has been introduced to ensure patients waiting on the GPAU have appropriate care prior to review
- Training package to be undertaken regarding how deceased patients are to be dealt with prior to family viewing
- Steps taken to ensure breast feeding room in paediatric department is used only for feeding with signs displayed

4. PALS

There were 796 PALS contacts/enquiries during Quarter 1 2018-19. This represents an 8% increase compared to the previous quarter and a 64% increase compared to the equivalent quarter in 2017-18 when 486 were received.

Chart 7: PALS contact by quarter



The main themes for PALS contacts are shown in table 1 and remain generally consistent other than appointments which are now in the top 5. This will be monitored

going forward. There was a conversion rate of 3.7% of PALS enquiries becoming complaints (30 of 796 contacts) slightly similar to 3.16% conversion rate for the previous quarter.

5. Legal Services

5.1. Clinical negligence claims

In Q1, the Trust received 40 new claims, representing an increase compared to the 30 new claims in Q4. Twenty-three of the new claims were received by the Surgical Care Group (a 17.4% increase on the previous quarter) and sixteen by the Medical Care Group (a 43.7% increase on Q4). No claims were received that related to Clinical Support Services in Q1 in comparison to Q4 when two were received. Medicines Management received 1 claim in Q1 but none in Q4. As shown in the table below, the amount of new claims received in Q1 is the highest received by quarter in the last year and this will be monitored going forward.

Table 3: Quarterly clinical negligence claim by Care Group

	2017-18				2018-19	
	Q1	Q2	Q3	Q4	Q1	Total
Medical Care Group	9	9	9	9	16	52
Surgical Care Group	12	13	13	19	23	80
Clinical Support Services	1	0	2	2	0	5
Medicines Management	0	0	0	0	1	1
Total	22	22	24	30	40	138

There was an increase of 10.5% in active clinical negligence claims (361) in Q1 in comparison to 323 open clinical negligence claims in Q4. The numbers of clinical negligence claims (with and without damages) that were closed fell. There was a decrease in damages paid in Q1 compared to Q4. During this period, there was a 42% increase in new insurance claims compared to Q4.

5.2. Actions taken as a result of claims

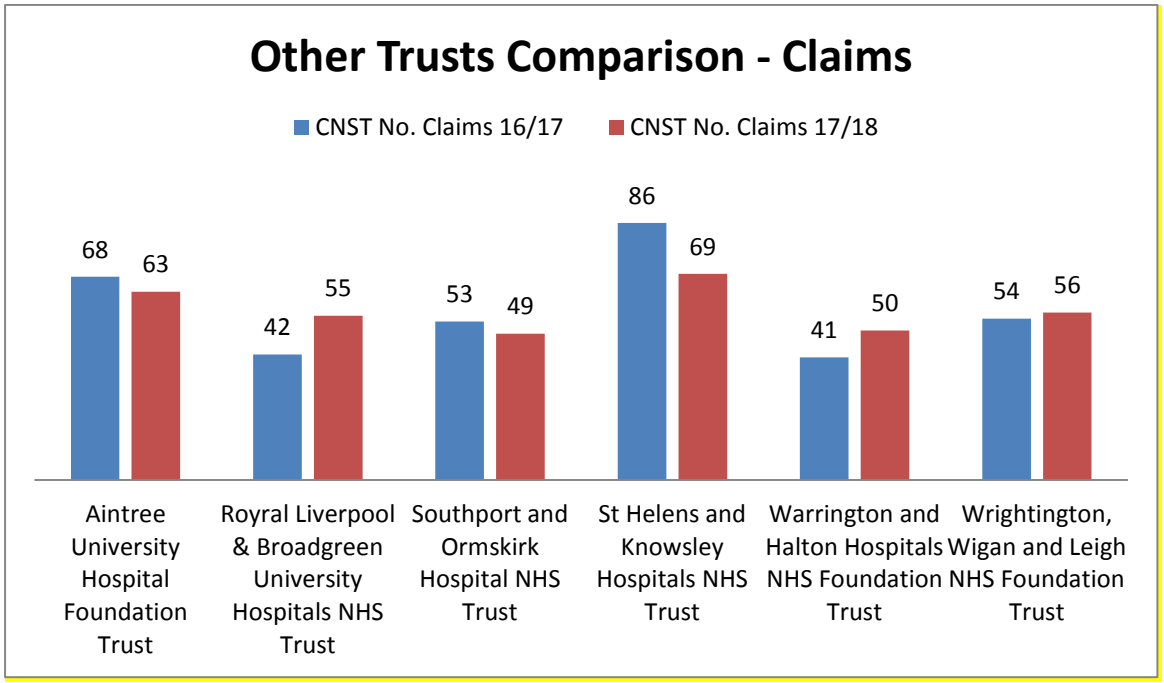
Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of claims in Q1:

- Skin tears to be included on consent form as a potential risk of surgery
- Posters displayed in examination rooms to alert staff to safe distance of lamp
- Ongoing local training given on use of lamps
- Emphasis on importance of timely response to post-operative observations
- Reflection on clinical diagnosis and management at departmental meeting

5.3. Benchmarking data for claims

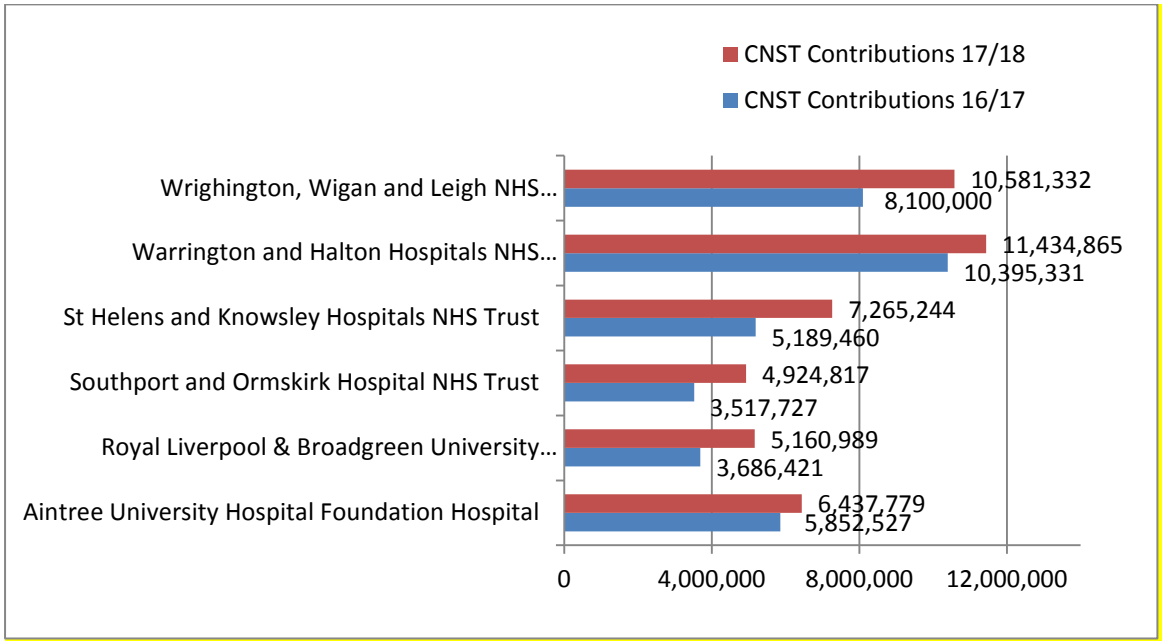
Quarterly benchmarking data is not available for NHS Trusts. However, NHS Resolution does produce annual figures for claims notified in previous financial years. The data for 2016-17 and 2017-18 are in the chart below.

Chart 8: Comparison of other Trusts - Number of Claims



The table shows that the number of claims received in the Trust has decreased by 19.7%. The Trust received the highest number of claims over the last two years in comparison to the other trusts within the region, but paid lower clinical negligence scheme (CNST) contributions than two trusts in 2017-18. This will continue to be monitored going forward.

Chart 9: Comparison of CNST contributions with other local trusts



The chart above shows that the trust had an increase of 28.57% in respect of the level of CNST contribution paid in 2017-18 compared to 2016-17. Overall, there was an increase in the CNST contributions paid by all the trusts above.

5.4. Inquests

The Trust, via the Legal Department, proactively manages non-routine inquests. These inquests are when members of Trust staff are called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned and require a corporate witness to inform the Coroner of these lessons and what action has been subsequently taken to prevent recurrence. The Media and Communications Department are kept informed if there is any potential for media interest and therefore a risk to the organisation's reputation.

Currently there are 21 open inquests that fall within the above criteria. One inquest was held in Q1 with no actions arising for the Trust.

6. Conclusion

Proactive monitoring is necessary to determine if the slight increase in incidents relating to moderate harms and above continues and if the actions put in place following incidents are effective in reducing this trend.

The lack of any overdue complaints and the achievement of 94% response rate within the timescales agreed with complainants demonstrates the improvement work within the department.

PALS increased in Q1 compared to Q4, with communications remaining the leading reason for enquiries to PALS.

The numbers of clinical negligence claims received in Q1 rose to 40 in comparison to 30 in Q4 and further work is required to understand the reasons behind this increase.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)83
Title of paper: Freedom to Speak Up Self-Assessment and Action Plan
Purpose: The purpose of this paper is to outline the Trust's position following completion of the self-review of our Freedom to Speak Up (FTSU) processes as required by NHS Improvement (NHSI)
Executive Summary In May 2018, NHSI and the National Guardian's Office (NGO) issued guidance requiring all NHS Trusts to complete a self-review their FTSU arrangements. The guidance and review tool was aligned with the good practice set out in the well-led framework and CQC well-led domain. The aim of the self-review is for Trust Boards to consider the leadership and governance arrangements in relation to FTSU and reflect on any areas for development. The self-review tool can then be used to measure progress against the development action plan going forwards. The draft self-review has been completed by the Deputy CEO/Director of Human Resources who is the Executive Lead for FTSU on behalf of the Board. The draft self-review and proposed action plan is presented to the Board for review and approval before submission to NHSI.
Corporate objectives met or risks addressed: Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.
Financial implications: There are no direct financial implications arising from this report
Stakeholders: Patients, carers, commissioners, regulators and Trust staff.
Recommendation(s): The Board is asked to approve the Freedom to Speak Up self-review and action plan.
Presenting officer: Nicola Bunce, Director of Corporate Services on behalf of Anne-Marie Stretch, Deputy CEO/Director of Human Resources
Date of meeting: 26th September 2018

1. Introduction

NHS Improvement (NHSI) and the National Guardian's Office (NGO) published a guidance document in May 2018 setting out expectations of boards in relation to Freedom to Speak Up (FTSU) and to help Trust Boards create a culture that is responsive to feedback and focused on learning and continual improvement. The self-review tool and associated guidance document provides a framework for the standards expected and enables Trust Boards to carry out in-depth reviews of its existing leadership and governance arrangements in relation to FTSU.

The Care Quality Commission (CQC) will also have assessed the Trust's speaking up culture and support arrangements, during the well-led inspection that was undertaken in August 2018.

The draft self-review and action plan (Appendix 1) is required to be approved by the Board before its submission to NHSI.

The self-review tool is very comprehensive, and sets out a number of questions in each of the following areas exploring themes to assess whether:

- Leaders are knowledgeable about FTSU
- Leaders have a structured approach to FTSU
- Leaders actively shape the speaking up culture
- Leaders are clear about their role and responsibilities
- Leaders are confident that wider concerns are identified and managed
- Leaders receive assurance in a variety of forms
- Leaders engage with all relevant stakeholders
- Leaders are focused on learning and continual improvement

In addition there is a section of individual responsibilities including:

- Chief Executive and Chair
- Executive lead for FTSU
- Non-executive lead for FTSU
- Human resource and organisational development directors
- Medical Director and Director of Nursing

The self-review has been completed by the Deputy CEO/Director of Human Resources who is the Executive Lead for FTSU on behalf of the Board, supported by the FTSU Guardian.

N.B. when the review refers to senior leaders, NHSI have defined this term as Executive and Non-Executive Directors.

2.0 Summary of outcomes from the self–review

The self-review was completed against all 69 questions on the template required by NHSI. Each question has been evaluated to assess if the Trust meets all the requirements. There were 3 indicators which were evaluated as met but with on-going actions needed and 1 indicator was assessed to be partially met. All other indicators were assessed as being met.

Indicators where on-going actions are required are:

Indicator 21 - Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or Minority Ethnic (BAME) workers and agency workers;

Indicator 24 - Lessons learnt are shared widely both within relevant service areas and across the trust;

Indicator 59 - Holding the Chief Executive, Executive FTSU lead and the Board to account for implementing the speaking up strategy. (Non-executive lead for FTSU)

The indicator which has been evaluated as partially met is:

Indicator 7 - The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian Office.

3.0 Action Plan

3.1 A bespoke Trust FTSU vision and strategy is currently in development, the strategy in its draft form will be subject to appropriate consultation with stakeholders.

3.2 Actions to further development the Trust approach to FTSU will be delivered by March 2019 by the FTSU Guardian:

- A programme of engagement with staff to include hard to reach and vulnerable staff groups. The Trust is currently in the process of developing a BAME in-reach programme/ establishment of network group based on recently conducted survey for BAME groups.
- Examples of learning and action taken from FTSU concerns to be communicated to staff.
- Ongoing promotion and awareness raising activity to include examples of positive outcomes from the FTSU process
- Learning from case reviews from the National Guardian Office will be included in reports to the Quality Committee.
- FTSU Guardian report to the Quality Committee to include evidence relating to staff confidence in speaking up and fair treatment.
- Development of a Trust FTSU strategy and non-executive lead for FTSU to scrutinise implementation of the strategy.

The self-review confirmed that a great deal of work has been completed across all the areas of FTSU agenda and that this initial baseline assessment was very positive. There were no areas where the Trust could not provide evidence of assurance or a plan of action.

4.0 Current position

4.1 Trust commitment

Following the recommendations of the Francis Report in February 2015 the Trust had FTSU Guardian since January 2016. The Trust has always aimed to provide a variety of ways for staff to raise concerns and has appointed 5 FTSU Guardians. This would be considered an exceptional commitment, in comparison with peer organisations.

Additionally, the Trust has also subscribed to an anonymous concern raising electronic system – SpeakInConfidence™. The system enables individual staff members to raise concerns without disclosing their identity, with a facility to maintain communication with the staff member through discreet messaging directly to the registered email, which can be either a personal or work email.

The Trust has a well-developed Raising Concerns policy, providing guidance and signposting to the different avenues for staff to raise concerns. There are also two confidential telephone hotlines relating to patient and staff concerns.

4.2 Involvement with National Guardians Office and regional network

The Trust has been proactively involved with activities hosted by the National Guardians Office, with attendance at foundation day training by one of the Guardians in 2018. The Trust has also participated in the FTSU national conference.

The Trust Guardians are active members of the North West FTSU regional group and will be collaborating in regional developments, including the development of a shared information platform.

4.3 Submissions to national database 2017/18

The Trust submits "speaking up" data to the National Guardians Office (NGO) each quarter. Cumulative information of Trust's submission for the year 2017/18 is as follows.

Table 1: Summary of concerns submitted to NGO in 2017-18

2017/18	**Anonymous (from speak in confidence)**	**FTSUG referral**		**Quarter total**
		Theme	**Professional Group**	
Q1	Estates	Safety concern	Medical	4
	Skill development (medical)			
	HR issue			
Q2	Listing form issue	Safety concern	Nurse	2
Q3	Nil	Safety concern	AHP	1
Q4	Skill development (nursing)	Safety concern	Medical	4
	Estates	Departmental process	AHP	
Total for 2017/18	**6**	**5**		**11**

The Trust submits data from all the "speaking up" method of raising concerns e.g. anonymous concerns raised through Speakinconfidence; referrals received by FTSU Guardians and via the telephone hotlines. All issues raised have been resolved and closed in agreement with the individual who raised the concern.

5.0 Recommendation

The Board is requested to review and approve the self-review of FTSU and to action plan to ensure further improvements.

The Quality Committee on behalf of the Trust Board will provide on-going assurance of implementation of the Trust's Raising Concerns policy and Freedom to Speak Up commitment.

The FTSU Strategy will be presented to the Board following consultation with staff.

ENDS

Appendix 1 – Freedom to Speak Up self-review tool for NHS trusts and foundation trusts (in draft)

National Guardian
Freedom to Speak Up

NHS Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question.

This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about Freedom to Speak UP (FTSU)			
1, Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Met	Ongoing engagement from Executive and Non-Executive Directors in Freedom to Speak Up role.	Non-executive and Executive directors are nominated FTSU Freedom to speak up report reviewed by Quality Committee at least biannually. Chief Executive (FTSU) and Deputy Chief Executive (Executive lead for FTSU) review of FTSU concerns and actions. Key policies – Raising Concerns, Respect & Dignity at Work - encourage and enable staff to be open and honest in raising any concerns.
2, Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Met	Ongoing engagement from Executive and Non-Executive Directors in Freedom to Speak Up role.	Trust values of being 'Open and Honest' and 'Listening and Learning' are commitments of the organisation with speaking up agenda. Continued organisational commitment to uphold ACE behavioural standards. Trust commitment with providing Executive lead

			for Freedom To Speak Up to review lessons learnt, periodically.
3, They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Met		Trust strategy 2018-2021, emphasises the commitment to attract and develop, caring, highly skilled staff. This is supported by a programme of work. The Trust's vision and values are widely known by staff and are continually embedded in everyday working practices throughout the Trust, as well as actively promoted by the senior leaders when interacting with staff. This includes learning from when things go wrong and making changes as a result of this, through plan, do, see and act cycles of improvement. Trust have a multitude of training opportunities for managers, which includes skill development in handling concerns.
4, Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Met		Trust Objectives: 'developing organisational culture and supporting workforce', encourages staff to speak up. Just culture elements built into Workforce ED&I action plan Quality ward rounds encourage staff to showcase

			achievements in individual areas, with executive and non-executive attendance and recognition. This also provides opportunities for staff to raise concerns to senior leaders directly. Regular meeting by senior leaders with FTSU guardians.
Leaders have a structured approach to FTSU			
5, There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Met		Clear and consistent Trust vision, encompassing speaking up and embedded throughout the Trust. Speaking up integrated into the New Trust strategy has recently been approved by the Board (July 2018) Clinical and Quality Strategy refreshed and approved by the Board in June 2018, links speaking up and being open process in ensuing patient and staff safety.
6, There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Met	Revision of the Trust raising concerns policy at intervals to update on required changes.	Policy for raising concerns and speaking out safely revised to include updated guidance on speaking up in accordance to National Guardian Office recommendation.

7, The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian Office.	Partially	FTSU Strategy in development in line with National Guardian Office recommendations. The Board to receive FTSU strategy	Speaking up integrated into the New Trust strategy has recently been approved by the Board (July 2018). Integrated strategy developed with consultation with FTSU guardians and National Guardians Office. Speaking up and being open is core to Trust values
8, Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Met	Ongoing review of strategy and compliance/ feedback	Freedom to speak up guardian report provided to National Guardian's office quarterly and report provided to Quality Committee Regular meetings between FTSU guardians and HR leads.
Leaders actively shape the speaking up culture			
9, All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Met	Ongoing commitment from senior leaders	Senior leaders have regular meetings with FTSU guardian to develop new ideas and initiatives. Recent development includes: Continuation of Quality Ward Rounds with executive/ board member participation. Development for screen savers for Speak in confidence system Development of secure database to capture

			concerns raised Development of attractive visual aids Market style stall to promote speaking up at nurses day. Regular Freedom to Speak up reports to Quality Committee.
10, They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Met		FTSU concerns raised with implications to patient safety are reviewed immediately and if required, immediate mitigation actions put in place as appropriate. OD Plans in a number of services which engage staff views and ideas to develop and improve the service they work in and the organisation. Service leads provide regular updates at Workforce Council on the progress of their OD plans Development of Team Talks - developing opportunities for a mixed group of staff, from a range of roles, from both clinical and non-clinical teams to come together to engage and interact directly with members of the Executive Team
11, Senior leaders are visible, approachable and use a variety of	Met	Continued visibility and availability of	Bi-monthly Team Talks hosted by CEO and Chair available for all staff to allow open conversation to

methods to seek and act on feedback from workers.		senior leaders to receive feedback from staff members	raise issues and make suggestions, with actions identified and responses fed back to attendees. Staff Engagement Strategy developed and in place Quality ward rounds encourage staff to showcase achievements in individual areas, with senior leaders' attendance and recognition, providing visibility. Multiple approaches for senior leaders to obtain feedback from workers – Freedom to speak up, Ask Ann, telephone hotlines, face to face forums, team meetings.
12, Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Met	Continued visibility and availability of senior leaders to listen to concerns from staff members	Assured access and support for FTSU guardians from senior leaders. Regular meetings between FTSU guardian and senior leaders
13, Senior leaders model speaking up by acknowledging mistakes and making improvements.	Met		Senior leaders acknowledge any concerns raised, with recognition of any mistakes or scope for improvement and enacts with priority.
14, The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Met	Ongoing awareness opportunities of raising concerns	Extremely positive Staff Survey 2017 results with support for being open and honest organisation.

		and Freedom to speak up agenda.	Team brief information on speaking up. Computer Screen savers and dedicated intranet web page for Freedom to speak up.
Leaders are clear about their role and responsibilities			
15, The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Met	Continued support from named executive and non-executive director responsible for speaking up.	Trust Chairman and a Non-Executive Director are nominated Trust guardians, providing support and organisational challenge to concerns raised to FTSU guardians. Chief Executive is a nominated Trust Guardian, providing leadership and operational support to FTSU issues.
16, They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Met	Regular meetings schedules between FTSU and senior leaders	Regulars meetings between senior leaders, chief executive, chair and FTSU Guardian/s are in place to provide support and advice in FTSU issues.
17, Other senior leaders support the FTSU Guardian as required.	Met		All senior leaders, provides operational and managerial support to FTSU Guardian/s as required in facilitating investigations and developing improvements.
Leaders are confident that wider concerns are identified and managed			

18, Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Met		FTSU Guardians have access to HR resources and advice to proactively identify any trends. FTSU guardian has regular meeting with Director of HR, to highlight any areas of concerns. One of the Trust FTSU guardian is invited to attend Trust workforce council, reviewing workforce related emergent issues and HR performance issues.
19, The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Met	Continuing support from senior leaders to FTSU	FTSU guardian has access senior leaders to escalate any concerns rapidly, preserving confidence of individuals as appropriate. At least biannual report provided to trust Quality Committee on FTSU issues.
Leaders receive assurance in a variety of forms			
20, Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Met	Continued availability of information	Policies for raising concerns and for raising staff grievances published on intranet for easy access of all staff members. Respect and Dignity at Work Policy enables staff to raise concerns relating to colleague or manager behaviour that negatively impacts upon them FTSU feedback and compliments from staff who

			have raised concerns, as positive experience. Regular team brief information on Freedom to speak up and raising concerns. Trust also provides anonymous concern raising platform Speak in confidence system. Information provided at Trust induction regarding raising concerns options and methods
21, Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	ongoing	Development of BME network, dependent on the results of BME staff survey.	A FTSU guardian is from BAME background facilitating openness and accessibility. Support and availability of anonymous concern raising system. Availability of multiple FTSU guardians for staff to access, from various ethnic and professional backgrounds. FTSU attendance to team meetings, familiarising individuals to the BAME staff members.
22, Speak up issues that raise immediate patient safety concerns are quickly escalated	Met	Speaking up issues with patient safety concerns are escalated to senior leaders immediately.	FTSU guardian has access senior leaders to escalate any concerns rapidly to appropriately address safety concerns.

		Same as question 19	
23, Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Met	Action to be taken as appropriate	All concerns raised relating to staff feeling/ being victimised is prioritised and immediately reviewed. Adequate support to staff members is ensured and appropriate actions taken. Confidentiality maintained in agreement with the concern raiser.
24, Lessons learnt are shared widely both within relevant service areas and across the trust	Ongoing	Continued provision and sharing of speaking up reports	Appropriate lessons learnt are shared within service areas. Key learning, subject to fulfilling preserving anonymity, confidentiality included in the Freedom to speak up reports provided to Quality Committee
25, The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Met	Regular review of handling issues by FTSU Executive lead	Handling of FTSU issues are reviewed at periodic intervals, with a report submitted to the Trust Quality Committee Development of new database to manage concerns as workflow to provide auditable data
26, FTSU policies and procedures are reviewed and improved using feedback from workers	Met	Ongoing and yearly review of policies and procedures scheduled	Feedback invited and obtained staff member raising concerns. Positive feedback on the approach and support

			noted anecdotally.
27, The board receives a report, at least every six months, from the FTSU Guardian.	Met	Work plan for Quality committee to receive reports to inform the board	Report submitted to the Trust Quality Committee for board review
Leaders engage with all relevant stakeholders			
28, A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Met		Speaking up is integrated in the Trust values, which were re reviewed through a range of mechanisms to ensure staff engagement including the use of Little 'Big' Conversations (World Café) sessions Range of engagement methods used to ensure understanding of vision & values
29, Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Met	Continued declaration of issues on public facing open web portals	Key themes of issues raised are recorded and uploaded on National Guardians portal for public access.
30, Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Met	Ongoing availability of non- executive lead for FTSU to facilitate any FTSU concerns at the	Emergent issues relating to FTSU would be made available for the board meetings through Quality Committee feedback. Chairman and Non-Executive Director are nominated FTSU, who can raise FTSU matters at the board meetings as

		board meetings	appropriate.
31, The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Met	High level information on speaking up to be included in future annual reports	Trust Quality Accounts 2017/18 highlights information on actions the trust is taking to support a positive speaking up culture and Freedom to Speak up Guardians
32, Reviews and audits are shared externally to support improvement elsewhere.	Met		Issues raised to FTSU are recorded and uploaded on National Guardians portal for public access
33, Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Met	Continued support for guardians to work with regional guardians and National Guardians Office	FTSU Guardians are involved with, and contributory to the regional FTSU Guardians network and positively supports regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture.
34, Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Met	Continued support for guardians to work with external stakeholders	FTSU Guardians are supported to develop partnership relationships with regulators, inspectors and other local FTSU Guardians. FTSU guardians regularly share ideas and contribute to local/ regional improvement plans
35, Senior leaders request external improvement support when required.	Met		Senior leaders would request external reviews or support in improvement support as and when required.

Leaders are focused on learning and continual improvement			
36, Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Met	Senior leaders continue to reflect on speaking up concerns and facilitate improvements as required.	Senior leaders support Speaking up process, which is integrated in the Trust values. Staff members are supported and appreciated for raising concerns, improving quality of care and improving staff experience. Senior leaders to recommend improvements to speaking up process from feedback, experience and best practice awareness.
37, Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Met	Continued support for guardians to work with external organisations	Senior leaders and the FTSU Guardian proactively networks with other trusts to identify best practice and improve processes. FTSUG guardians also participates regional FTSU meetings and National Guardians Office events to share and adopt best practice.
38, Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Met	Ongoing process as required	FTSU Guardian and senior leaders reviews guidance and published reports from the national guardians office to identify improvements
39, Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Met	Senior leaders continue to reflect on speaking up concerns and	Senior leaders are committed to learn and continually improve, and would reflect on the feedback received.

		facilitate improvements as required.	The Trust's vision and values are widely known by all staff including senior leaders and are continually embedded in everyday working practices throughout the Trust, as well as actively promoted by the Board when interacting with staff. This includes learning from when things go wrong and making changes as a result of this, through plan, do, see and act cycles of improvement.
40, The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Met	Annual FTSU review work plan with guardians to be continued	Executive lead responsible for FTSU has regular meetings with FTSU guardians to undertake review of concerns and monitor progress made with respect to improvements plans. Barriers and opportunities are identified and regularly reviewed. CEO and Chair, reviews and evaluates Freedom to speak up process as regular intervals
41, The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Met	Annual FTSU review work plan by executive lead with guardians to be continued	Raising concerns policy integrates FTSU process, and is regularly reviewed. The current policy has been reviewed against National Guardians Office recommendations and updated accordingly. Any feedback received from staff members is enacted and related policies are amended as required.

42, A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Met	Annual FTSU review work plan by executive lead with guardians to be continued	Investigations are conducted in independent, fair and objective way. FTSU will receive details of the investigation findings and actions. Staff member raising concerns are thanked and kept up-to-date with the progress of investigation and recommendations. Newly developed IT system to provide information in assurances received by FTSU, information provided to concern raisers.
43, Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Met	FTSU and Seniors leaders to continue to compliment and promote feedback to staff and positive outcomes as result	Staff feedback positive and complimentary to speaking up process. Comments noted on national quarterly returns and Trust FTSU reports

		of speaking up	
Individual responsibilities			
Chief executive and chair			
44, The chief executive is responsible for appointing the FTSU Guardian.	Met	FTSU Guardians to be available for staff	FTSU appointed across various staff groups. CEO ensures FTSU guardians are represented across various staff groups.
45, The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Met	Continued and ongoing review of FTSU arrangements	FTSU arrangements are reviewed periodically to ensure that they meet the needs of the staff members.
46, The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Met	Future annual reports to include information about FTSU Same as question 31	2017/18 Annual Quality accounts highlights Trust commitment to speaking and freedom to speak up guardians
47, The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Met	FTSU guardians supported with engagement with regional and national guardians	Chief Executive and Chairman ensure that FTSU guardians are supported to attend local/regional and national FTSU events, and are engaged with networks.

		office Same as question 33	
48, Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Met	Continued availability and support for FTSU Guardians as required.	Chief Executive and Chairman offers prioritised support, advice and availability for FTSU guardians as and when required.
Executive lead for FTSU			
49, Ensuring they are aware of latest guidance from National Guardian's Office.	Met	Continued review of NGO publications	Executive lead meets with FTSU guardians regularly to be updated with latest guidance from National Office and Trust actions if required.
50, Overseeing the creation of the FTSU vision and strategy.	Met	Draft strategy developed for board review	Executive lead provides leadership and support to the Board in developing FTSU strategy.
51, Ensuring the FTSU Guardian role have been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National guardian.	Met	FTSU guardian appointment through a fair recruitment process	Recruitment to FTSU guardian role undertaken through a fair and open recruitment process.

52, Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Met	Regular evaluation of FTSU guardians workload and resources	FTSU guardians are allocated time to undertake and fulfil the responsibility. CEO/ Chair and Executive lead regularly reviews FTSU referrals to monitor workload of FTSU guardians and if any additional support world be required.
53, Ensuring that a sample of speaking up cases have been quality assured.	Met	Review of cases during meeting with FTSU to continue	Cases discussed with CEO with actions and suggested recommendations. Appropriate challenge and scrutiny to the investigations and actions.
54, Conducting an annual review of the strategy, policy and process.	Met	Annual FTSU review work plan by executive lead with guardians to be continued Same as question 41	Executive lead, Guardian and CEO meeting to review strategy, policy and process. Options appraisals conducted, innovations reviewed and supported to be implemented. Ongoing work plan to review strategy and processes.
55, Operationalising the learning derived from speaking up issues.	Met	Continue to reflect on speaking up concerns and facilitate improvements as required Same as question 39	Review of cases and learning undertaken at periodic intervals

56, Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Met	Continued scrutiny of allegation of detriment as a result of speaking up	All concerns raised to FTSU guardians are promptly dealt with. Matters of staff feeling detriment are escalated to CEO
57, Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Met	Continued provision of reports.	Freedom to speak up report provided to Quality Committee for review and scrutiny.
Non-executive lead for FTSU			
58, Ensuring they are aware of latest guidance from National Guardian's Office.	Met	Continued accessibility to newsletters from NGO	Non-Executive lead receives regular updates from the National Guardians Office
59, Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Ongoing	Strategy in development	Non- executive lead reviews the concerns raised themes and trends.
60, Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Met	Continued availability of non-executive FTSU role to challenge board	Non- executive lead able to challenge the board on organisational culture to create a more responsive environment to receiving feedback from staff
61, Role-modelling high standards of conduct around FTSU.	Met	Continued professional standards maintained	Non- executive lead as a Freedom to Speak Up Guardians upholds the principles and process of FTSU Non-executive appointed meeting Fit and proper

			regulation requirement
62, Acting as an alternative source of advice and support for the FTSU Guardian.	Met	Ensure availability for FTSU guardians	Non- executive lead is available for FTSU guardians for support, advice and coaching.
63, Overseeing speaking up concerns regarding board members.	Met	Ensure availability to oversee concerns regarding board members	Non – executive lead is available as nominated FTSU guardian to oversee concerns regarding any board members.
Human resource and organisational development directors			
64, Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Met	Continued support for FTSU guardians by FTSU executive lead / HR Director	FTSU have support from Director of HR and HR team to triangulate information. A FTSU also attends Trust Workforce Council enabling intelligence gathering and any issues identified with speaking up culture
65, Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Met	Regular and ongoing review of HR process based on feedback	Trust raising concerns process and policy supported by HR team. Lessons learnt from individual experiences taken into account to improve processes and systems.
66, Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Met	Continued awareness development	Trust policy and required contact details are available on intranet. Information about speaking up and raising

			concerns offered through multiple methods.
Medical director and director of nursing			
67, Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Met	Accessibility to medical director and nursing director for FTSU guardians to continue	FTSU guardians have adequate access and support / advice on patient safety or safeguarding issues.
98, Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Met	FTSU guardians to be able to escalate patient safety concerns	All potential patient safety issues highlighted by speaking up have immediate actions and mitigations developed.
69, Ensuring learning is operationalised within the teams and departments that they oversee.	Met	Ongoing support to operationalise learning from concerns raised.	Key issues, improvements required and learning identified are actioned by relevant teams.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)84

Title of paper: Update on CQUIN 1b - Healthy Food for NHS staff, Visitors & Patients

Purpose: The purpose of this paper is to inform the Trust Board on progress to date relating to substantive changes made by the Trust and its external suppliers on healthier food products for NHS staff, visitors and patients (i.e. CQUIN 1b 2017/18 Standards).

CQUIN Overview:

During 2017/18 STHK and its external food and beverage suppliers were required to deliver national commissioning for quality and innovation (CQUIN) standards associated with healthy food for NHS staff, visitors and patients. These quality standards were split into 2 categories as described in 1.3 & 1.4 of the report attached.

STHK and its external food and beverage suppliers worked closely with the CQUIN regulator (NHS England) and devised a robust plan and actions guide to support delivery of all apart from one of the quality standards for 2017/18 (i.e. Nationally the plan and actions guide adopted by the Trust would not meet the quality standard relating to packaging and procurement of sandwiches meal deals).

Tables 2, 3 and 4 of the report attached, contains NHS England and external supplier letters that demonstrate compliance and non-compliance of the CQUIN 1b standards that the nationally agreed plan and actions guide achieves.

STHK and its external supplier looked at local options to deliver the non-compliant standard and innovatively introduced an 'Over the counter self-service sandwich range' within its restaurants, which ensured the national packaging and procurement issue was mitigated against during 2017/18.

The Trust has successfully delivered all of CQUIN 1b quality standards during 2017/18.

CQUINS attract financial payment from Commissioners and STHK is expected to provide the following evidence in order to receive financial payment worth £203,042. Evidence to be supplied after Q4 2017/18 entails the following which is currently still under discussion with Commissioners:

1. A signed document between the Trust and its external food supplier committing to keeping the changes including a robust action plan for compliance (see Tables 1 and 5 of the attached report);

2. Evidence improvements to a public facing board meeting. As the Trust only reports by exception, Table 6 represents some examples of CQUIN reports presented at committee and group meetings where CQUINs are discussed. The Trust will also provide the Commissioner with this report once tabled at Trust Board.

Corporate objectives met or risks addressed: Financial performance:

- At risk if CQUIN standards are not delivered.
- At risk that in order for the Trust to deliver proposed STP control totals for 2017-19, the Trust needs to plan for full delivery of CQUINs.

Financial implications: Financial risk worth overall £203,042 if all CQUIN standards not

delivered, noting part payment mechanism for partial achievement.
Stakeholders: Patients, carers, commissioners, regulators and Trust staff.
Recommendation(s): Members are asked to review the report and consider if there are any issues that need to be referred to the Quality Committee for further investigation.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 26th September 2019

1. Introduction

1.1 During 2017/18 the Trust and its external food and beverage suppliers have been allocated national commissioning for quality and innovation (CQUIN) standards associated to CQUIN 1b: healthy food for NHS staff, visitors & patients.

1.2 These standards fall into two sub categories:

1.3 Firstly continue to substantively maintain the following food and beverage changes introduced during 2016/17:

1. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)[1].
2. Aim to ban advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS);
3. The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts;
4. Ensure that healthy options are available at any point including for those staff working night shifts.

1.4 Secondly introduce three new changes to food and drink provisions throughout the Trust premises:

1. 70% of drink lines stocked must be sugar free by the end of the year (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).
2. 60% of confectionery and sweets stocked by the end of the year do not exceed 250 kcal (dependent upon weight value – TBC with Commissioner).
3. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g2.

1.5 The Trust is expected to provide Commissioners with the following evidence in order to receive financial payment worth £203,042. Evidence to be supplied after Q4 2017/18.

1. A signed document between the Trust and its external food supplier committing to keeping the changes including a robust action plan for compliance. (see Tables 1 and 5 of this report).
2. Evidence improvements to a public facing board meeting. As the Trust only reports by exception Table 6 represents some examples of CQUIN reports presented at committee and group meetings where CQUINs are discussed. The Trust will also provide the Commissioner with this report once tabled at Trust Board.

2. CQUIN Delivery

2.1 The Trust has delivered all of the CQUIN 1b quality standards by the end of Q4 2017/18 via:

- ✓ Maintaining in 2017/18 the food and beverage changes introduced during 2016/17 (see Table 5)
- ✓ Introducing the three new 2017/18 required changes to food and drink provision throughout Trust premises in 2017/18 (see Table 5)

3. Evidence Supplied To Commissioners In Support Of Financial Payment:

3.1 After Q4 reporting 2017/18 the Trust has supplied the Commissioner with documents in support of this CQUIN delivery. The following tables reflect what the Trust has supplied to Commissioners to date as minimum evidence:

Table 1: Signed compliance agreement between STHK & external suppliers, agreeing CQUIN 1b standards and monitoring requirements for 17/18 (sent to Commissioners 15th June 2018).

Table 2: External suppliers' plans & actions guide along with Trust Deputy Director e-mail confirming overall 100% compliance (sent to Commissioners 8th May 2018).

Table 3: NHS England letter confirming external suppliers' plans & action guide CQUIN compliance (sent to Commissioners 8th May 2018).

Table 4: Compass National Letter (sent to Commissioners 17th July 2018).

Table 5 Updated CQUIN Monitoring Report 2017/18, updated to include actions taken to support compliance (sent to Commissioners 22nd August 2018) and monthly example of C&M High Action Plan Compliance Report (sent to Commissioners 26th July 2018). Also attached is e-mail from Trust DoN to Commissioner with examples of audit (sent to Commissioners 22nd August 2018)

Table 6 Examples of exception CQUIN reports submitted to STHK committees or boards (sent to Commissioners 21st June 2018) and example of monthly internal CQUIN meeting where by exceptions will be reviewed (sent to Commissioners 26th July 2018). Also further detailed examples of F&P CQUIN papers (sent to Commissioners 22nd August 2018).

3.2 Note other evidence has been supplied to Commissioners.

TABLE 1: Signed Compliance Agreement between STHK & External Suppliers Agreeing CQUIN 1b Standards & Monitoring Requirements for 2017/18.

St Helens and Knowsley Teaching Hospitals NHS Trust

HEALTHY FOOD
CQUIN 1b
St Helens & Knowsley Teaching Hospitals

Compliance agreement in partnership with Medirest

April 2017

Healthy Food – CQUIN 1b

Introduction

Medirest are the Trusts supplier of Catering Services for patients, staff and visitors. This contract forms part of the Trusts PFI (private finance initiative) contract with New Hospitals for the provision of its hospital buildings and Estates and Facilities services.

Compliance Agreement 2017 / 2018

The Trust and Medirest have discussed in detail the CQUIN requirements of the Healthy Food 1b standard.

It is recognised that Compass Group (Medirest parent company) are working nationally with NHS England regarding compliance with this CQUIN target. St Helens and Knowsley Teaching Hospitals NHS Trust in partnership with Medirest locally have agreed the 17/18 standards and monitoring requirements as follows:-

St Helens and Knowsley Teaching Hospitals NHS Trust

CQUIN OWNERS: Dyan Clegg, Jane Mathers, Frank Carroll, Andy Cannon

CQUIN 1	Improving staff health and wellbeing
Indicator 16	Healthy food for NHS staff, visitors and patients
Services Covered	Patient feeding, Spice of Life Restaurant, Costa, vending facilities and WH Smiths at both hospitals
Requirements	Maintain the changes implemented in the 2016 / 2017 CQUIN and strive to implement changes as required in both 17/18 and 18/19

Description	Action required / taken	Monitoring Method	Owner Compliance
a) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) The following are common definitions and examples of price promotions: 1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal); 2. Multi- buy discounting: for example buy one get one free; 3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS) 4. Price pack or bonus pack deal (for example 50% for free); and 5. Meal deals (in 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals) only water and suitable alternatives		• Catering Audits • Nutritional Steering Group • PFI Service Provider Contract meeting	Medirest

Dyan Clegg February 2017
Head of PFI and Facilities Management

b) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS); The following are common definitions and examples of advertisements: 1. Checkout counter dividers 2. Floor graphics 3. End of aisle signage 4. Posters and banners		• Catering Audits • Nutritional Steering Group • PFI Service Provider Contract meeting	Medirest
c) The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts; The following are common definitions and examples of checkouts; 1. Points of purchase including checkouts and self-checkouts 2. Areas immediately behind the checkout		• Catering Audits • Nutritional Steering Group • PFI Service Provider Contract meeting	Medirest
d) Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue		• Catering Audits • Nutritional Steering Group • PFI Service Provider Contract meeting	Trust

Dyan Clegg February 2017
Head of PFI and Facilities Management

Contract & Facilities Management

Description	Action required / taken	Monitoring Method	Owner Compliance
In year one (2017/18) a) 70% of drinks lines stocked must be sugar free (less than 5grams of sugar per 100ml.) In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).		• Catering Audits • PFI Contract meeting	Medirest
b) 60% of confectionery and sweets do not exceed 250kcal		• Catering Audits • PFI Contract Meeting	Medirest
c) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680kj) or less per serving and do not exceed 5.0g saturated fat per 100g2		• Catering Audits • PFI Contract Meeting	Medirest
In year two (2018/19) a) 80% of drinks lines stocked must be sugar free (less than 5 grams per 100ml.)		• Catering Audits • PFI Contract Meeting	Medirest
b) 80% of confectionery and sweets do not exceed 250kcal		• Catering Audits • PFI Contract Meeting	Medirest
c) At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680kj) or less per serving and do not exceed 5.0g saturated fat per 100g		• Catering Audits • PFI Contract Meeting	Medirest

Dyan Clegg February 2017
Head of PFI and Facilities Management

Monitoring

The specification for catering services includes specific parameters that cover nutrition and healthy eating. The Trust carries out a robust performance monitoring regime to ensure Medirest complies with the specified standards. Non-compliance is reported at the monthly contract meeting and financial penalties levied accordingly.

Compliance of the CQUIN targets will be incorporated into the monthly contract performance monitoring regime and any non-compliance or actions required will be reported through the Service Performance Review Group.

Signed on behalf of St Helens & Knowsley Teaching Hospitals

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Signed on behalf of Medirest

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TABLE 2: External Suppliers Plans & Action Guide 2017/18 agreed by NHS England Along With Deputy Director E-mail Confirming Overall 100% Compliance.

COMPASS GROUP

CQUIN 2017/18

Plan and Actions Guide

medirest

HEALTHCARE RETAIL

HEALTH & WELLBEING

Introduction to Compass Group

Compass Group UK & Ireland is the country's leading provider of food and support services, employing over 60,000 people across 15,000 client sites. The Healthcare arm of our business incorporates Medirest and Healthcare Retail. Medirest works with many NHS Trusts, delivering market-leading services including catering, cleaning, logistics and support services, driving efficiency, quality and value. Healthcare Retail operates almost 200 retail outlets within the NHS, including well-known high street brands Costa, Subway and M&S Simply Food, which deliver an annual net contribution of over £17.5million to the NHS.

What is CQUIN?

CQUIN stands for Commissioning for QUality and INnovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.
CQUIN targets have historically been focussed on clinical issues. However, in March 2016 the first non-clinical target focussing on NHS Staff Health & Wellbeing incorporating a section on healthy eating was released by NHS England. Indicator 1b: Healthy food for NHS staff, visitors and patients is a specific set of targets which affect every food and drink outlet on NHS premises. This created a responsibility for retailers and foodservice providers who operate within the NHS to focus on making healthier food and drink more widely available.

Why is it important?

The aim of this indicator is to influence behaviours and drive a culture of healthier food and drink choices. It has previously been estimated that around 700,000 NHS staff are obese. One of the main causes of obesity and its related diseases is poor diet, particularly the overconsumption of foods high in fat, salt and sugar (HFSS).

Definition of HFSS foods

HFSS foods are defined as:
• Any product where there is a high content of fat, salt, saturates or sugar, as indicated by a red box on front of pack nutritional labelling, or
• Where front of pack nutritional labelling is not present, any product that exceeds the relevant nutritional guidelines (based on a per portion or per 100g basis).

More specific information on the gram per 100g/per portion classifications can be found on page 14 of the "front of pack nutrition label for pre-packed products" document, which can be downloaded from the gov.uk website.

Definition of Sugary Drinks

Pre-packaged beverages with more than 5g of added sugar per 100ml are classed at SSBs. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g/100ml) and milk based drinks (with sugar content of over 10g per 100ml).

Compass Group Health & Wellbeing Achievements

At Compass Group UK & Ireland our Healthcare sector is the UK's leading provider of food and support services within the NHS. Through our work in this field we have recognised for some time the increasing importance being placed on health and wellbeing, not only for the NHS workforce but also the wider public.

With our unique position in the market we decided we should start to make some positive changes and created our Health & Wellbeing strategy in 2014. Prior to this in March 2011 we were the only foodservice provider on the Public Health Responsibility Deal plenary group.

Below are some of the more recent positive changes that we have made as a business, from CQUIN 1b and beyond:

- Complete removal of sugar added drinks with over 5gms sugar per 100ml from our meal deal, this removed 228,658g of sugar in 12 months
- Introduced more healthier snacking options to our meal deal, dried fruit, baked crisps and fruit
- Moved to semi-skimmed milk as standard in Costa outlets across Compass Healthcare removing 14.25 million kcals per week, which is a staggering 746 million kcals full year from our standard hot beverage range
- Introduced a 100% sugar compliant, stocked cold beverage range in our Costa outlets
- Moved to 1% milk in our recipes
- Introduced 'Today's Healthier Choice' concept to every restaurant, our balanced hot meal, not high in fat, sat fat, sugar or salt and includes at least one of your 5 a day!
- Moved to Eatwell cheese in our own brand recipes
- 100% GBS compliant vending with 28% healthier products
- We introduced fruit stands and healthy till points across our units, meaning only fruit and water is to be displayed and upsold at the till, this saw the purchase of both fruit and water rocket by up to 60%
- Adhere to the GBS best practice target of only sugar added drinks 330ml and under to be stocked in our staff & visitor restaurants
- Adhere to the GBS best practice target for single serve confectionery being 250kcals or less
- Worked with our sandwich supplier to remove 200M calories across the Chop Chop portfolio
- Reduced calories in 37 sandwich products, 33% of our total Chop Chop range
- 132M calories removed from the top 5 sandwich products, 60 calories removed from BLT to make this top selling line compliant!
- The introduction of our healthier sandwich range cut over 11 million kcals and 150kg of sat fat from this range alone
- We already outperform the market on low and zerocalorie drink sales. While certain brands are working towards a target of 50% of their sales to be zero or low-calorie by 2018, we are leading the field with the current volume of zero and low-sugar drinks sold in our retail out lets and restaurants at over 70%.

Plan & Actions

Our plan towards CQUIN for 2017/18 will first and foremost be to uphold and maintain the changes implemented last year to continue our full compliance to the 2016/17 targets;

A. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)

Notes for clarification:

1. No new price promotions or advertising campaigns on HFSS food and drink should have been implemented from 1 April 2017.
2. It is recognised that some items may be classified as HFSS but may offer a healthier alternative to other HFSS snacking. Where portion size requirements are adhered to, the following items will be considered CQUIN compliant:

a. 35g of plain dried fruit and plain dried fruit with vegetable products with no additions or 40g of processed fruit and nut products with no other added ingredients.

b. 40g plain nuts and seeds. These should not include salt, coatings, toppings or additions.

** A list of examples of compliant healthier snacks can be found in Appendix A **

- We have created a Healthcare-specific promotional calendar which runs on a monthly cycle and price promotes CQUIN compliant (healthier) products only. These are the only price promotions running in our outlets.
- We have a Meal Deal offer in place which includes any sandwich, with a CQUIN compliant snack and CQUIN compliant drink.
- We removed all added sugar drinks (with >5g of sugar per 100ml) from Meal Deals in November 2016. Over 12 months, this cut a staggering 228,658g of sugar and almost 1 million calories across our Compass Group Healthcare business.
- Our work around Sugar Sweetened Beverages (SSBs) resulted in a huge 70% reduction in the sales of SSBs in the overall Compass Group Healthcare business last year.

B. The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS)

- Compass Group own brand outlets only advertise healthier products.
- Definitions of advertising include posters, banners, table cards, fridge barkers and display units.

C. The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts

- All Compass Group own brand outlets have only fruit and water on sale at checkouts.

D. Ensuring that healthy options are available at any point including for those staff working night shifts

- All vending operated as part of a Compass Group Healthcare contract is 100% GBS compliant and 28% of the products on offer are healthier products.
- We offer a '24' solution to our clients which can be implemented for NHS staff to use and access via a swipe card system 24 hours a day. This is a self-serve service offer with a self-scan checkout. It contains hot and cold food options, a hot drinks machine, snacks and cold beverages, a microwave and can also have comfort able seating areas for staff use only.
- In our staff and visitor restaurants we have implemented a balanced hot meal option called 'Today's Healthier Choice', which is: under 500kcals, includes at least 1 of your 5 a day and is not high in fat, saturated fat, sugar or salt.
- We have introduced highly visible fruit stands in our own brand outlets which are placed either near tills or in a prominent position within the outlet. This has had a demonstrable impact on sales, with fruit sales increasing as much as 61% as a result.

Plan & Actions 2017/18

This year NHS England are introducing three new changes to food and drink provision, and we fully intend to comply to all of these targets across the Medirest business.

A. 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g/100ml) and milk based drinks (with sugar content of over 10grams per 100ml).

All cold beverage planograms across the Compass Healthcare sector are compliant, hitting at least 70% of stocked lines being compliant. This is true across our Restaurants, Delimarches, Mondos, Baguette Co. outlets and Amigo convenience stores. All unit mangers should refer to the consumer connections page to find their relevant plannogram, but you will see an example of our most popular Cold Beverage planograms below which demonstrate our compliance.

Delimarche - Coffee Shop 70%
90cm 2 shelf cold beverage planogram

Amigo - Convenience 71%
2m 4 shelf cold beverage planogram

Restaurant 82%
1.4m 2 shelf cold beverage planogram

B. 60% of confectionery and sweets do not exceed 250 kcal.

All confectionery planograms across the Compass Healthcare sector are compliant, hitting at least 60% of stocked lines being compliant. This is true across our Restaurants, Delimarches, Mondos, Baguette Co. outlets and Amigo convenience stores. All unit mangers should refer to the consumer connections page to find their relevant plannogram, but you will see an example of our most popular confectionery planograms below which demonstrate our compliance.

Delimarche - Coffee Shop 92%
Top 12 tier stand confectionery planogram

Amigo - Convenience 69%
2m 5 shelf confectionery planogram

Restaurant 100%
Top 12 stand confectionery planogram

C. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

All sandwich and chilled planograms across the Compass Healthcare sector are compliant, but we have over exceeded in this target by hitting at least 70% of stocked lines being compliant. This is true across our Restaurants, Delimarches, and Amigo convenience stores where this target is applicable.

Please note that our Baguette Co. and Mondos outlets are not applicable to this target as they are freshly made on site to customer bespoke order, and not pre-packaged items.

All unit mangers should refer to the consumer connections page to find their relevant plannogram, but you will see an example of our most popular confectionery planograms below which demonstrate our compliance.

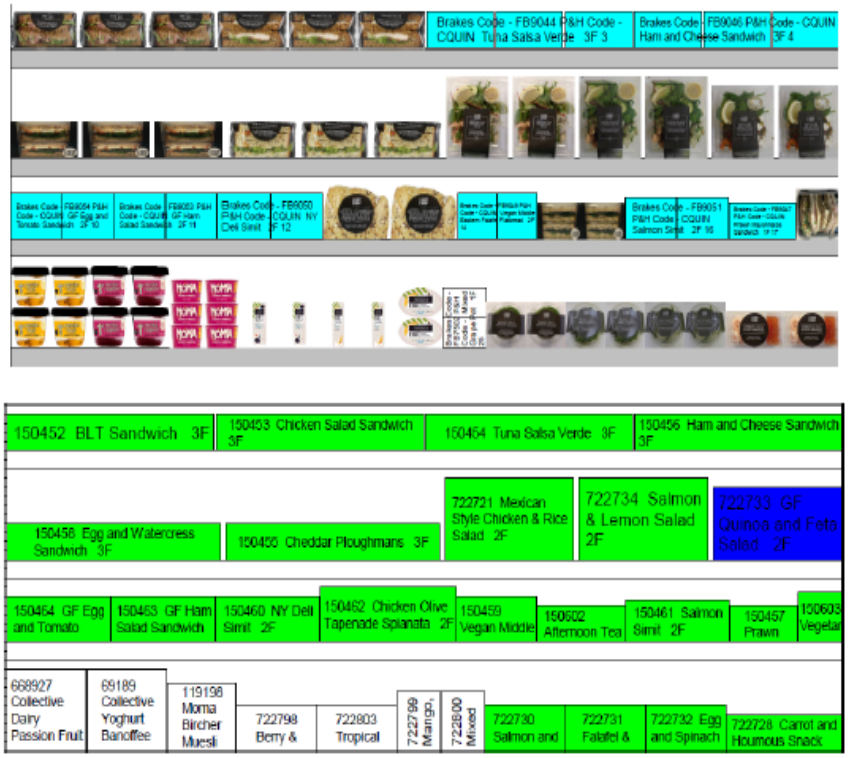
Restaurant/Convenience Meal Deal Planogram Example

Compliance

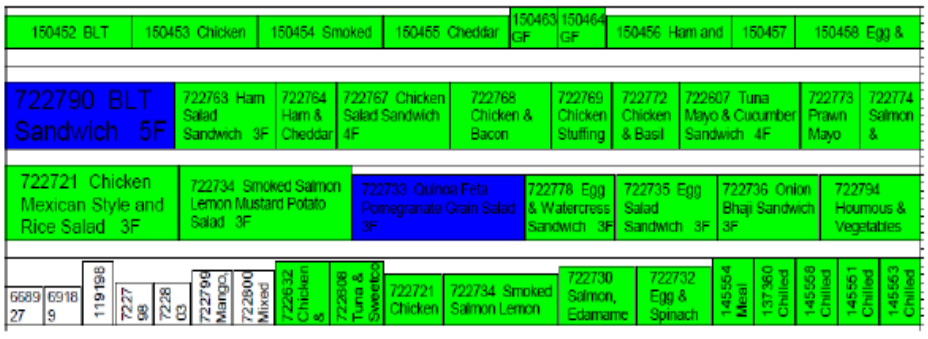
CQUIN

NON CQUIN

Coffee Shop Premium Sandwich Planogram Example



Coffee Shop Premium/Core Mix Sandwich Planogram Example



Full Planogram Listing of Compliance

Convenience Confectionery	Compliance
Top 5 Tier Stand(5 Shelf)	100%
Top 8 Stand(2 Shelf)	78%
10 Tier Stand(5 Shelf)	100%
Top 12 Stand(3 Shelf) with/without Hanging Bags	75%
1m Low Level(4 Shelf) with/without Hanging Bags	80%
2m 4 Shelf with/without Hanging Bags	71%
3m 4 Shelf with/without Hanging Bags	62%
4m 4 Shelf with/without Hanging Bags	66%
1m 5 Shelf with/without Hanging Bags	75%
2m 5 Shelf with/without Hanging Bags	69%
3m 5 Shelf with/without Hanging Bags	66%
4m 5 Shelf with/without Hanging Bags	66%
1m 6 Shelf with/without Hanging Bags	79%
2m 6 Shelf with/without Hanging Bags	72%
3m 6 Shelf with/without Hanging Bags	67%
4m 6 Shelf with/without Hanging Bags	66%
1m 7 Shelf with/without Hanging Bags	80%
2m 7 Shelf with/without Hanging Bags	75%
3m 7 Shelf with/without Hanging Bags	68%

Coffee Shop Confectionery	Compliance
Top 5 Tier Stand(5 Shelf)	100%
10 Tier Stand(5 Shelf)	90%
Top 8 Stand(2 Shelf)	100%
Top 12 Stand(3 Shelf)	92%
1m Low Level(4 Shelf)	90%

Restaurant Confectionery	Compliance
Top 5 Tier Stand(5 Shelf)	100%
10 Tier Stand(5 Shelf)	100%
Top 8 Stand(2 Shelf)	89%
Top 12 Stand(3 Shelf)	100%
Stand Top 12(3 Shelf)	92%
1m Low Level(4 Shelf)	85%

Restaurant Cold Beverages	Compliance
Single Door(5 Shelf)	80%
Double Door(5 Shelf)	88%
1.2m(4 Shelf)	82%
1.5m(4 Shelf)	85%
1.8m(4 Shelf)	78%

Convenience Cold Beverages	Compliance
Single Door(5 Shelf)	70%
Double Door(5 Shelf)	70%
Triple Door(5 Shelf)	70%
1.2m(4 Shelf)	71%
1.2m(5 Shelf)	71%
2m(4 Shelf)	71%
2m(5 Shelf)	70%
3m(4 Shelf)	72%
3m(5 Shelf)	70%
4m(4 Shelf)	70%
4m(5 Shelf)	72%
5m(4 Shelf)	72%
5m(5 Shelf)	71%
6m(4 Shelf)	76%
6m(5 Shelf)	76%

Coffee Shop Cold Beverages	Compliance
Single Door(5 Shelf)	75%
Double Door(5 Shelf)	70%
90cm(1 Shelf)	70%
90cm(2Shelf)	70%
90cm(3 Shelf)	72%
90cm(4 Shelf)	73%
120cm(2Shelf)	78%
120cm(3 Shelf)	75%
120cm(4 Shelf)	74%
150cm(1 Shelf)	75%
150cm(2Shelf)	73%
150cm(3 Shelf)	70%
150cm(4 Shelf)	70%
180cm(1 Shelf)	71%
180cm(2Shelf)	71%
180cm(3 Shelf)	70%
180cm(4 Shelf)	72%
210cm(1 Shelf)	73%
210cm(2Shelf)	72%
210cm(3 Shelf)	70%
210cm(4 Shelf)	70%

Franchise Partners

We have been working with our franchise partners to influence them to create their own CQUIN compliance plans for 2017/18. This has been a great success demonstrating the collaborative way in which we work with our partners.

Our partners listed below have committed to comply with CQUIN 1b 2017/18 by 31st March 2018 and, where required, have had their own dialogue directly with NHS England to confirm their own plans are robust, and clarify that their offers are acceptable to comply.

M&S Simply Food and M&S Café
Subway

Each franchise partner has released their own partner operational guide on CQUIN 1b 2017/18, which outlines their approach to CQUIN, any changes that need to take place in the units together with timescales for the changes to take place.

Costa will also be providing their own unit brief for CQUIN 2017/18, we are still awaiting this but it is due imminently.

NHS England Approvals

Based on the plans in this document that we have shared with NHS England they consider Compass to be compliant to five of the six target areas for CQUIN 2017/18. This achievement reflects our ongoing commitment to this agenda and the significant changes that we have made at Compass during 2017/18.

However due to packaging and procurement issues with our sandwich range, we have not been able to remove all HFSS sandwiches from our meal deal range which means that we will not be fully compliant to the indicator 'No price promotions on sugary drinks and foods high in fat, sugar or salt'. This indicator is worth 12.5% of total food and drink CQUIN value in the payment schedule guidance.

Please see below more specific detail around our work towards this CQUIN indicator,
A. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)

The following table details the common definitions and examples of price promotions, and the detail of Compass' compliance against each area of price promotions;

1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal)	**Compliant**
2. Multi-buy discounting: for example buy one get one free	**Compliant**
3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS)	**Compliant**
4. Price pack or bonus pack deal (for example 50% for free)	**Compliant**
5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals).	**All drinks compliant** **All snacks compliant** Only 70% of sandwiches in meal deal are compliant

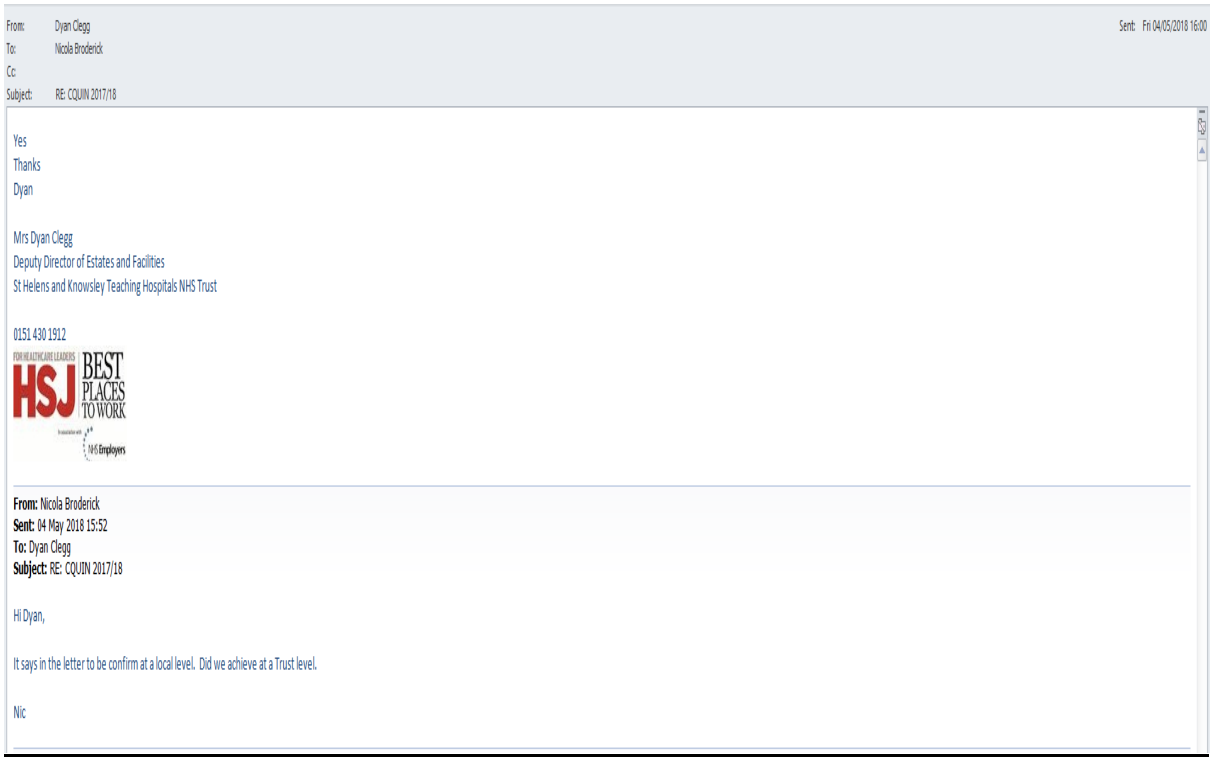
Note: STHK delivered 100% compliance during 2017/18 by introducing 'Over the counter self-service sandwich range' within the restaurants.

Appendix A - Compliant Healthier Snack Examples

Graze natural energy nuts
Whitworths Snack Pack Apricot
Whitworths Snack Pack Prunes
Whitworths Snack Pack Pear
Whitworths Snack Pack Mango
Whitworths Snack Pack Banana Coins
Whitworths Snack Pack Pineapple
Emily Fruit Crisps Apple
Emily Fruit Crisps Pineapple
Emily Fruit Crisps Banana
Snact Apple & Mango
Snact Apple & Raspberry
Yu! Fruit Mango Chews
Yu! Fruit Blueberry Chews
BEAR Sour Strawberry & Apple
BEAR Sour Mango & Apple
BEAR Strawberry
BEAR Raspberry
BEAR Claws Strawberry & Butternut
BEAR Claws Apple, Pear & Pumpkin
Urban Fruit Smashing Strawberry
Urban Fruit Magnificant Mango
Urban Fruit Perfectly Pineapple
Nakd Bars – all flavours

Key point of contact for enquiries

Lauren Davidge-Stringer
Marketing Manager
Compass UK & Ireland - Healthcare Sector
Mobile: 07766468694
Email: lauren.davidgestringer@compass-group.co.uk



From: Dyan Clegg
To: Nicola Broderick
Cc:
Subject: RE: CQUIN 2017/18
Sent: Fri 04/05/2018 16:00

Yes
Thanks
Dyan

Mrs Dyan Clegg
Deputy Director of Estates and Facilities
St Helens and Knowsley Teaching Hospitals NHS Trust

0151 430 1912

FOR HEALTHCARE LEADERS HSJ BEST PLACES TO WORK NHS Employers

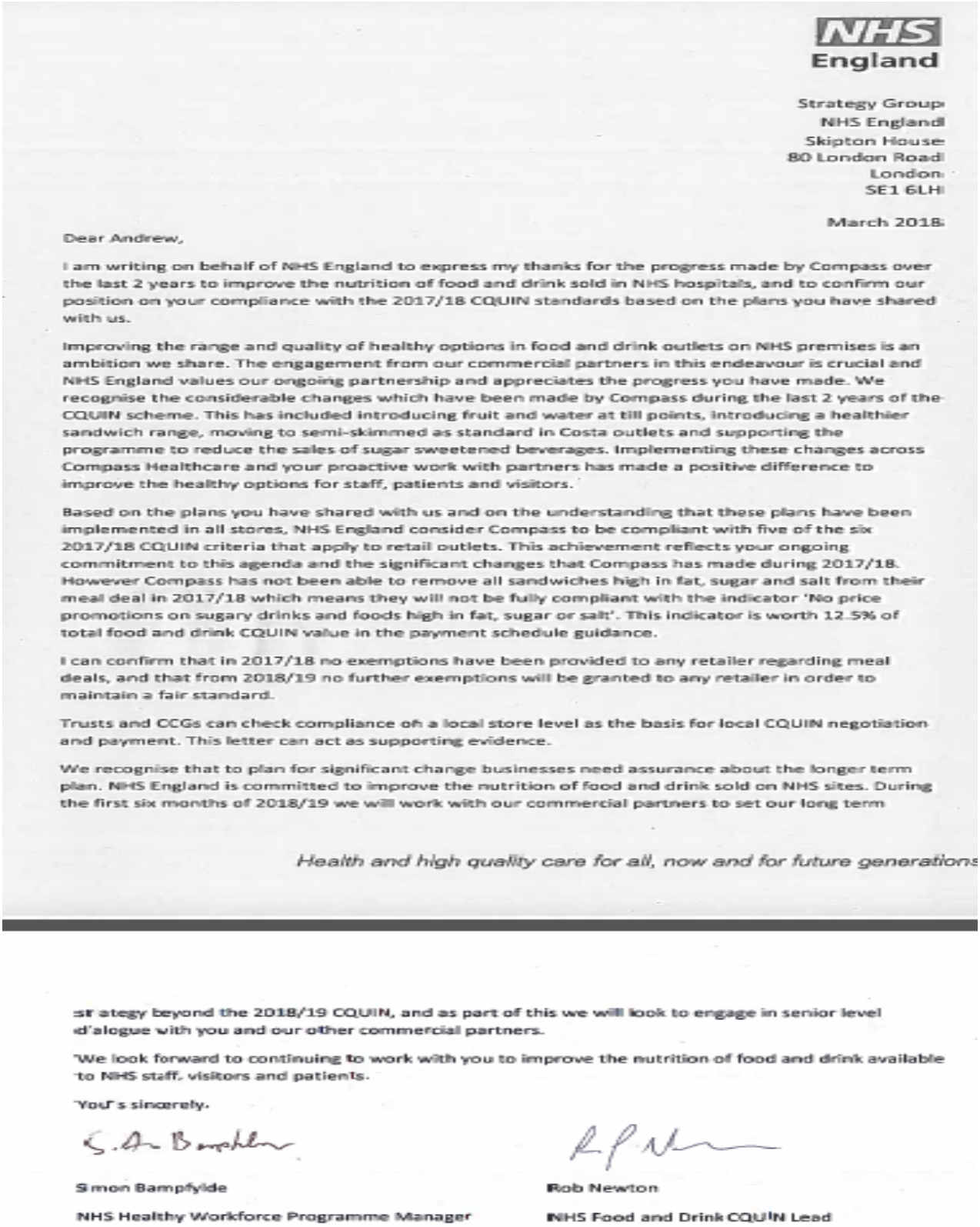
From: Nicola Broderick
Sent: 04 May 2018 15:52
To: Dyan Clegg
Subject: RE: CQUIN 2017/18

Hi Dyan,

It says in the letter to be confirm at a local level. Did we achieve at a Trust level.

Nic

TABLE 3: NHS England Letter Confirming External Suppliers Plans & Action Guide CQUIN Compliance



NHS England

Strategy Group
NHS England
Skipton House
80 London Road
London
SE1 6LH

March 2018

Dear Andrew,

I am writing on behalf of NHS England to express my thanks for the progress made by Compass over the last 2 years to improve the nutrition of food and drink sold in NHS hospitals, and to confirm our position on your compliance with the 2017/18 CQUIN standards based on the plans you have shared with us.

Improving the range and quality of healthy options in food and drink outlets on NHS premises is an ambition we share. The engagement from our commercial partners in this endeavour is crucial and NHS England values our ongoing partnership and appreciates the progress you have made. We recognise the considerable changes which have been made by Compass during the last 2 years of the CQUIN scheme. This has included introducing fruit and water at till points, introducing a healthier sandwich range, moving to semi-skimmed as standard in Costa outlets and supporting the programme to reduce the sales of sugar sweetened beverages. Implementing these changes across Compass Healthcare and your proactive work with partners has made a positive difference to improve the healthy options for staff, patients and visitors.

Based on the plans you have shared with us and on the understanding that these plans have been implemented in all stores, NHS England consider Compass to be compliant with five of the six 2017/18 CQUIN criteria that apply to retail outlets. This achievement reflects your ongoing commitment to this agenda and the significant changes that Compass has made during 2017/18. However Compass has not been able to remove all sandwiches high in fat, sugar and salt from their meal deal in 2017/18 which means they will not be fully compliant with the indicator 'No price promotions on sugary drinks and foods high in fat, sugar or salt'. This indicator is worth 12.5% of total food and drink CQUIN value in the payment schedule guidance.

I can confirm that in 2017/18 no exemptions have been provided to any retailer regarding meal deals, and that from 2018/19 no further exemptions will be granted to any retailer in order to maintain a fair standard.

Trusts and CCGs can check compliance on a local store level as the basis for local CQUIN negotiation and payment. This letter can act as supporting evidence.

We recognise that to plan for significant change businesses need assurance about the longer term plan. NHS England is committed to improve the nutrition of food and drink sold on NHS sites. During the first six months of 2018/19 we will work with our commercial partners to set our long term

Health and high quality care for all, now and for future generations

st ategy beyond the 2018/19 CQUIN, and as part of this we will look to engage in senior level d'alogue with you and our other commercial partners.

We look forward to continuing to work with you to improve the nutrition of food and drink available to NHS staff, visitors and patients.

Yours sincerely,

Simon Bampfylde
NHS Healthy Workforce Programme Manager

Rob Newton
NHS Food and Drink CQUIN Lead

Note: STHK delivered 100% compliance during 2017/18 by introducing 'Over the counter self-service sandwich range' within the restaurants.

TABLE 4: National External Supplier Letter.

COMPASS GROUP

Dear Trust

Compass Group UK & Ireland Healthcare sector (incorporating Medirest and Healthcare Retail) has made substantial headway in the field of Health & Wellbeing. We have implemented our 2020 Health & Wellbeing Strategy, a longer-term plan to continue driving improvement in the Health and Wellbeing of our customers across our business, as well as making a number of specific improvements to our Healthcare sector through the CQIUN and Government Buying Standards.

In March 2016, NHS England released the first ever CQUIN focussed on NHS Staff Health & wellbeing incorporating healthy food and drink provision. We engaged early with the Strategy team at NHS England to understand the implications of CQUIN 1b: Healthy food for NHS staff, visitors and patients.

Last year we worked with NHS England to create a compliance plan for CQUIN 2016/17 and achieved full compliance to all indicators. Despite the commercial position that this put our business in, we felt that the social responsibility message was more important and we understood our unique position in the market to influence consumers to make healthier choices.

This year we have created a CQUIN compliance plan to CQUIN 1b 2017/18, which has been supported by NHS England. This plan has been written into a guide that we are pleased to be able to share with you, giving you the confidence you need to demonstrate CQUIN compliance across Compass Group managed outlets within your hospital.

Based on the plans in the attached document that we have shared with NHS England, they consider Compass to be compliant to five of the six target areas for CQUIN 2017/18. This achievement reflects our ongoing commitment to this agenda and the significant changes that we have made at Compass during 2017/18.

However due to packaging and procurement issues with our sandwich range, we have not been able to remove all HFSS sandwiches from our meal deal range which means that we will not be fully compliant to the indicator 'No price promotions on sugary drinks and foods high in fat, sugar or salt'. This indicator is worth 12.5% of total food and drink CQUIN value in the payment schedule guidance and there is further detail on our position in the attached Plan & Actions document.

Please share this letter, along with the enclosed letter from The Healthy Workforce team at NHS England and our 'CQUIN 2017/18 Plan & Actions Guide' with your local commissioner to ensure that they have all the necessary information required when audits take place after 31st March 2018.

Yours faithfully

Steven Cenci
Managing Director - Healthcare
Compass Group UK & Ireland

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Registered in England, Registered Number 2272248, VAT number 466/4777/01
www.compass-group.co.uk

great people *great* service *great* results

Note: STHK delivered 100% compliance during 2017/18 by introducing 'Over the counter self-service sandwich range' within the restaurants.

Table 5: Updated CQUIN Monitoring Report 2017/18.

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Estates & Facilities Management
CQUIN Summary 17/18

CQUIN OWNERS: Dyan Clegg, Deputy Director of Estates and Facilities
Andrew Cannon, Regional Manager, NewHospitals
Frank Carroll, Contract Director, Medirest
Sylvia Sinclair, Deputy Contract Manager
Steve Wealleans, Facilities Manager

CQUIN 1b	Improving staff health and wellbeing - 17/18 Summary
Indicator 16	Healthy food for NHS staff, visitors and patients
Services Covered	Patient feeding, Spice of Life Restaurant, Costa, vending facilities and WH Smiths at both hospitals
Requirements	Maintain the changes implemented in the 2016 / 2017 CQUIN and implement changes as required in both 17/18 and 18/19

Description	Action completed	Monitoring Method	Action to be taken
a) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) The following are common definitions and examples of price promotions: 1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal); 2. Multi- buy discounting: for example buy one get one free; 3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS) 4. Price pack or bonus pack deal (for example 50% for free); and 5. Meal deals (in 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals) only water and suitable alternatives	Compliance achieved and validated via:- Monthly audits carried out by Trust monitoring team with Medirest staff in line with PFI Catering Performance Monitoring System. Daily / Adhoc audits carried out through the month by Monitoring Team and Medirest. Updates reported at the PFI contract meeting. Medirest monitored externally in line with the planogram plan and action guide.	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19. Continue to monitor local progress regarding packaging of sandwiches.

Dyan Clegg - Deputy Director of Estates and Facilities
Agreed:- February 2017
Updated:- April 2018

b) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS); The following are common definitions and examples of advertisements: 1. Checkout counter dividers 2. Floor graphics 3. End of aisle signage 4. Posters and banners	All PFI providers have agreed that all advertising will comply with CQUIN. This is monitored as detailed in a).	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19.
c) The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts; The following are common definitions and examples of checkouts; 1. Points of purchase including checkouts and self-checkouts 2. Areas immediately behind the checkout	All PFI providers have agreed that all checkouts will comply with CQUIN. This is monitored as detailed in a).	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19.
d) Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue	All PFI providers have agreed that all healthy options will be available including for staff that work night shift. This is monitored as detailed in a).	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	New vending contractor must be CQUIN compliant

Dyan Clegg - Deputy Director of Estates and Facilities
Agreed:- February 2017
Updated:- April 2018

Estates & Facilities Management
CQUIN Summary 17/18

Description	Action completed	Monitoring Method	Action to be taken
In year one (2017/18) a) 70% of drinks lines stocked must be sugar free (less than 5grams of sugar per 100ml.) In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).	Information provided on the quarterly basis from Medirest to Trust demonstrating volume of sales. Monitoring team audit planogram	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19.
b) 60% of confectionery and sweets do not exceed 250kcal	Monthly audits carried out by Trust monitoring team with Medirest staff in line with PFI Catering Performance Monitoring System. Daily / Adhoc audits carried out through the month by Monitoring Team and Medirest.	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19.
c) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680kj) or less per serving and do not exceed 5.0g saturated fat per 100g2	Monthly audits carried out by Trust monitoring team with Medirest staff in line with PFI Catering Performance Monitoring System. Daily / Adhoc audits carried out through the month by Monitoring Team and Medirest.	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19.
In year two (2018/19) a) 80% of drinks lines stocked must be sugar free (less than 5 grams per 100ml.)	Monthly audits carried out by Trust monitoring team with Medirest staff in line with PFI Catering	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting	

Dyan Clegg - Deputy Director of Estates and Facilities
Agreed:- February 2017
Updated:- April 2018

	Performance Monitoring System. Daily / Adhoc audits carried out through the month by Monitoring Team and Medirest. Updates reported at the PFI contract meeting. Medirest monitored externally in line with the planogram plan and action guide.	• Trust CQUIN meeting	
b) 80% of confectionery and sweets do not exceed 250kcal	Monthly audits carried out by Trust monitoring team with Medirest staff in line with PFI Catering Performance Monitoring System. Daily / Adhoc audits carried out through the month by Monitoring Team and Medirest. Updates reported at the PFI contract meeting. Medirest monitored externally in line with the planogram plan and action guide.	• Catering Audits • PFI Service Provider Contract meeting • Catering meeting • Trust CQUIN meeting	Continue with agreed monitoring and reporting regime for 18/19 and confirm any new targets at the Catering meeting
c) At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available		• Catering Audits • PFI Service Provider Contract meeting	Continue with agreed monitoring and reporting regime for 18/19 and

Dyan Clegg - Deputy Director of Estates and Facilities
Agreed:- February 2017
Updated:- April 2018

Estates & Facilities Management
CQUIN Summary 17/18

contain 400kcal (1680kj) or less per serving and do not exceed 5.0g saturated fat per 100g		• Catering meeting • Trust CQUIN meeting	confirm any new targets at the Catering meeting. Continue to monitor local progress regarding packaging of sandwiches.

Dyan Clegg - Deputy Director of Estates and Facilities
Agreed:- February 2017
Updated:- April 2018

Delivery of the C&M FYFV High BP action plan: Baseline survey for large NHS Provider organisations (Health and Wellbeing CQUIN 1b)

STHK Trust

Completed by (Name and job title): Joanne Welsby, FM & Patient Environment Manager

Date: 30 June 2017

1. Who in your organisation has lead responsibility for delivery of the HWB CQUIN 1b?
   Name: Dyan Clegg
   Job title: Interim Deputy Director of Facilities Management
   Email address: dyan.clegg@sthk.nhs.uk
   Telephone: 0151 430 1990

2. For 2016/17, please state if your organisation achieved the Health and Wellbeing CQUIN 1b 'Healthy food for patients, staff and visitors' in the following areas:

HWB CQUIN components 2016/17	Achieved? Y/N	Comments
a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS). The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets	Yes	
b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS)	Yes	
c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts	Yes	
d. Ensuring that healthy options are available at any point including for those staff working night shifts	Yes	

3. For 2017/18 please indicate if your organisation is on track to:

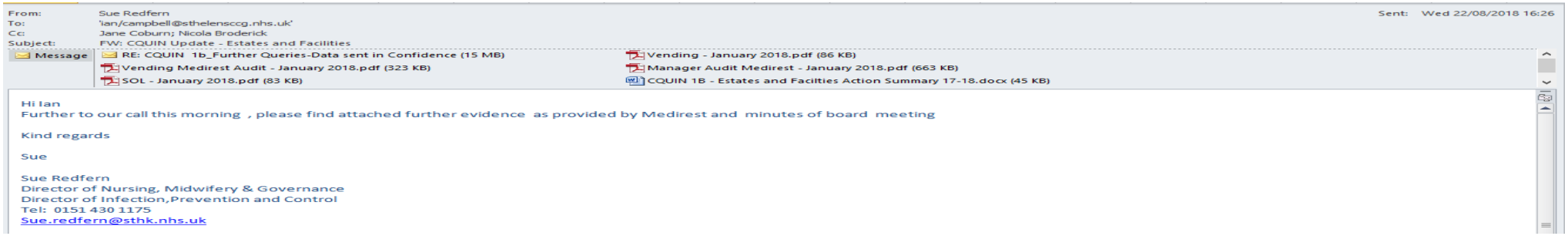
Maintain progress in the 4 changes required in the 2016/17 CQUIN:

HWB CQUIN components 2017/18 (Continued from 2016/17)	On track to maintain progress? Y/N	Comments
a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS). The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets	Yes	
b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS)	Yes	
c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts	Yes	
d. Ensuring that healthy options are available at any point including for those staff working night shifts	Yes	

And achieve three new changes to food and drink provision:

New HWB CQUIN components 2017/18	On track to achieve? Y/N	Comments
a.70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). *(This target will increase to 80% in 2018/19)*	Yes	Compass Group are currently on target
b.60% of confectionery and sweets do not exceed 250 kcal. *(This target will increase to 80% in 2018/19)*	Yes	Compass Group are currently on target
c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g *(This target will increase to at least 75% in 2018/19)*	Yes	Compass Group are currently on target

4. What additional support would help your organisation to meet the HWB CQUIN 1b as set out above?



From: Sue Redfern
To: 'ian/campbell@sthelensccg.nhs.uk'
Cc: Jane Coburn; Nicola Broderick
Subject: FW: CQUIN Update - Estates and Facilities
Sent: Wed 22/08/2018 16:26

Message
RE: CQUIN 1b_Further Queries-Data sent in Confidence (15 MB)
Vending Medirest Audit - January 2018.pdf (323 KB)
SOL - January 2018.pdf (83 KB)
Vending - January 2018.pdf (86 KB)
Manager Audit Medirest - January 2018.pdf (663 KB)
CQUIN 1B - Estates and Facilties Action Summary 17-18.docx (45 KB)

Hi Ian
Further to our call this morning , please find attached further evidence as provided by Medirest and minutes of board meeting

Kind regards

Sue

Sue Redfern
Director of Nursing, Midwifery & Governance
Director of Infection,Prevention and Control
Tel: 0151 430 1175
Sue.redfern@sthk.nhs.uk

Table 6: Exception Reports 2017/18.

Example of monthly Internal CQUIN meeting Agenda

CQUIN Monthly Review Meetings 2017/18

Monthly CQUIN review meetings have now been booked throughout the year - CQUIN leads are required to attend these meetings and report on progress against the quarterly milestones and/or identify any areas of concern.

Each CQUIN has a 20min reporting slots – please ensure you come to the meetings prepared with a succinct progress update.

Monday 26th March 2018 - Level 3, Seminar Room 1 Green; Whiston Hospital

Time Slot	CQUIN	CQUIN Leads
11:40	**1b)** Healthy Food For NHS Staff, Visitors & Patients (Maintaining the four changes that were required in the 2016/17 CQUIN & Introducing three new changes to food and drink provisions).	Dyan Clegg; Frank Carroll; Jane Mathers; Mark Hogg; Stuart Ackers (WHSmiths).

Example NHST(18)21 Executive Committee Chairs Report – Trust Board

5.6 CQUIN and Contract Update

The Head of Income and Contracting attended the meeting and presented the 2017 -18 quarter 3 update. The Trust had incurred contract penalties of £1.144m (mainly as a result of reduced STF for A&E performance) and achieved 100% of CQUIN income.

Example NHST(18)053 Trust Board Example of CQUIN Exception Reporting – Trust Board

Objective	Lead Director	Progress to date	Rating (RAG)
7.2 We will achieve local performance indicators including: a. CQUINS	DoOps	a. CQUINS have been achieved b. Contract indicators being delivered and no concerns	

Example IPR Executive Summary Reporting

St Helens and Knowsley Teaching Hospitals NHS Trust

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month at 85.1%. A small number of patients did not meet the 31 day standard resulting in failure against the 96% target at 94.6%. Actions are underway at specialty level to address this, including ongoing improvements in booking patients by day 7 to allow for patient related delays.

Continued high volume NEL activity and acuity of patients presenting in ED, alongside trust bed occupancy levels of over 98%, resulted in a continued underperformance against the A&E 95% standard which was 73.6% (type 1) and 87.2% (Mapped STHK Footprint - all types) in month. Staffing of additional escalation bed capacity continues to be a challenge, utilising additional hours from medical and nursing staff from within the organisation plus agency staff.

The Emergency Care Improvement Programme team continue to support the trust, with further improvement work related to key actions focusing on both the Emergency Department and the Inpatient wards.

Despite a continued reduction in the elective programme in month to support accommodation of NEL activity, RTT incomplete performance was maintained at 93.5% v target of 92.0%. Specialty level actions to maintain this achievement continue.

Financial Performance

Since December the Trust has continued to see very challenging operational pressures. This is over and above those supported by national winter money or estimated by the Trust. In summary adverse impacts have been seen in higher A&E attendances, greater acuity of patients requiring admission, elective programme reduction, challenges in discharges across the patch and worsening staff sickness levels. The Trust has endeavoured to maintain operational performance and financial management throughout this period whilst respecting the safety of our patients.

As at February 2018 (Month 11), the Trust is reporting an overall income and expenditure surplus of £3.5m (including all allowable STF worth £5.1m). Planned surplus was £7.5m, giving an adverse variance of £4m YTD to M11. This YTD adverse variance of £4m recognises £3m of STF now not allocated (not achieving A&E and financial performance) and exceptional net operational cost pressures from winter of £1m.

The Trust has delivered £11.4m of CIPs and is £2.4m behind the YTD plan which is reflected in the Trust's current financial performance. It is expected that the CIP plan will be in the region of £12.5m by year end, short of target by £3m.

Based on operational pressures, the Trust has reduced its forecast outturn to c£2.4m from our control total of £8.5m. £4m of this is the assumed non allocation of STF and the remaining £2m relating to the unprecedented net impact of winter, mainly through high pay costs. This means, excluding STF, the Trust is forecasting to have an adverse variance of £2m from its original control total of £0.6m. The YTD and Forecast financial position has been supported by the full utilisation of relevant reserves and balance sheet provisions.

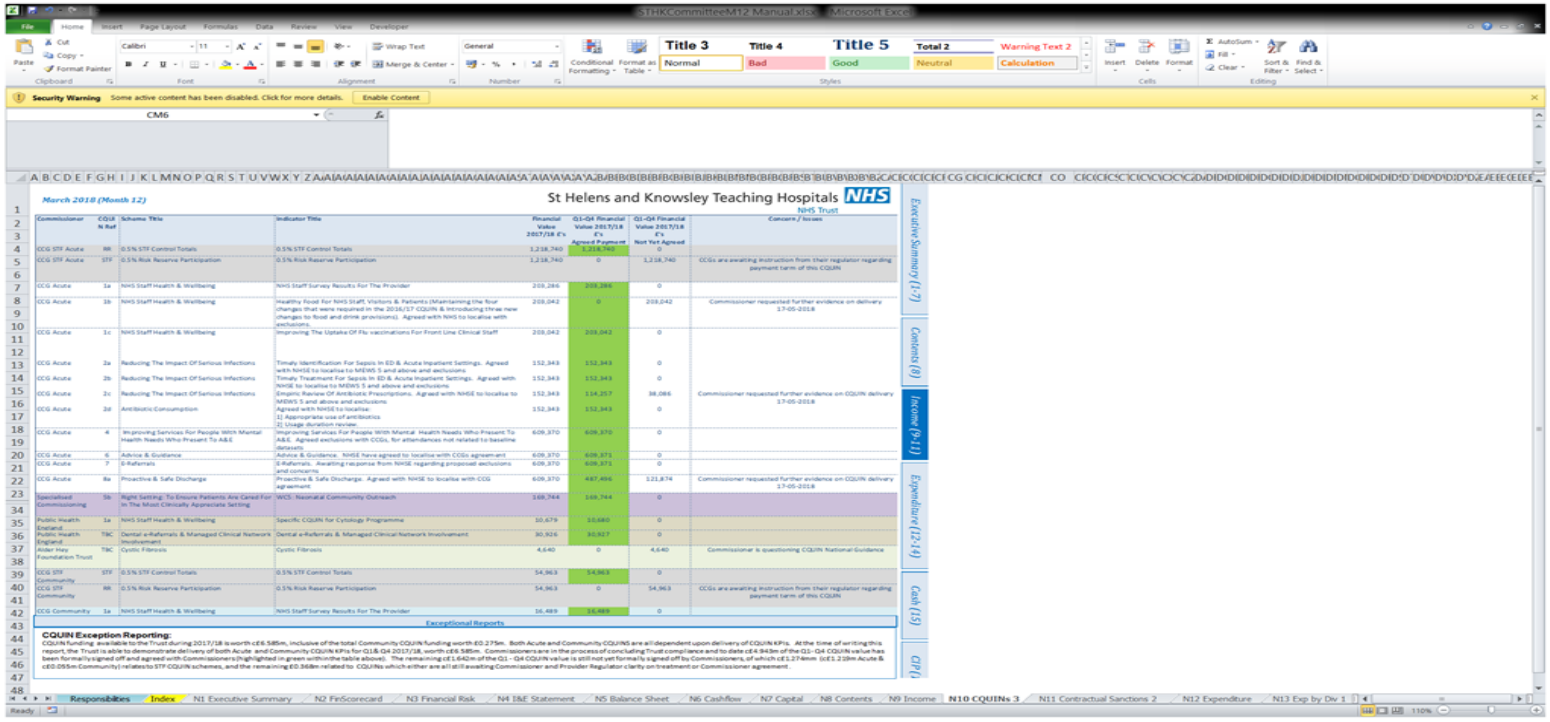
The Trust recognises the risks to achieving the revised surplus, which include remaining CIP achievement, exceptional costs of winter, continued contract and CQUINs challenges from Commissioners and adverse impact of HRG4+ to this position.

Example F&P Paper CQUIN Detail

Paper No:
Title of Paper: Financial Performance to March 2018
Purpose: To bring to the attention of the Finance Committee the Trust's Financial Performance for 2017/18.

CQUIN funding available to the Trust during 2017/18 is worth c£6.585m, dependant upon delivery of CQUIN KPIs. The Trust has delivered both Acute and Community CQUIN KPIs for Q1- Q4 2017/18.

Commissioners have formally signed off and agreed c£4.943m of this Q1 - Q4 CQUIN value, with the balance mainly £1.642m relating to either STF CQUINS (1.274m), Provider to Provider CQUINs (5k), which are awaiting Regulator clarity upon treatment or Commissioner agreement (£363k).



St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)85
Title of paper: A framework of quality assurance for Responsible Officers & Revalidation (Annex D & Annex E)
Purpose: The purpose of this paper is to provide feedback and assurance to the Board that arrangements for Medical Appraisal and Revalidation are operating effectively at the Trust and in accordance with regulations.
Summary: • Background • Governance Arrangements • Policies/Systems/Assurance/Individual Roles
Corporate objectives met or risks addressed: Assurance that the Trust as a designated body is adhering to the GMC revalidation & appraisal regulations.
Financial implications: None as a direct consequence of this paper
Stakeholders: Staff, the Trust, patients, regulators
Recommendation(s): The Board are asked to accept the report and to approve the 'statement of compliance' confirming that the organisation, as a designated body, is compliant with the regulations.
Presenting officer: Dr Terry Hankin, Responsible Officer and Deputy Medical Director
Date of meeting: 26th September 2018

A Framework of Quality Assurance for Responsible Officers and Revalidation

St Helens & Knowsley Trust Board – September 2018

Contents

1. Executive summary

Revalidation for all doctors practicing in the UK became a statutory obligation in December 2012. Revalidation is the process of renewing a doctor's license to practice and this occurs on a 5 year cycle. To ensure a doctor is up to date and fit to practice, they must take part in annual appraisals and be part of a governed system to ensure the quality of their practice. NHS England has the ultimate responsibility for the quality and delivery of Revalidation in England.

In 2017/2018 there were **370** doctors with a prescribed connection to St Helens & Knowsley Hospitals NHS Trust's Responsible Officer. Of these **327** doctors were fully appraised by the 31st March 2017 (**88.37%).**

2. Purpose of the Paper

This paper is presented to provide assurance to the Trust Board that the arrangements for Medical Appraisal and Revalidation have been operating effectively since the regulations came into effect. The format follows the Annual Board Report Template as provided by NHS England.

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

As a Designated Body, St Helens & Knowsley NHS Trust has appointed a Responsible Officer, Dr Terry Hankin. One of the key roles of the Responsible Officer is to make revalidation recommendations to the General Medical Council for each doctor with a prescribed connection to the Trust.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

4. Governance Arrangements

4.1: Individual doctors

Individual doctors are expected to take part in an annual appraisal, the process whereby they:

- Reflect on their practice (and in particular complaints and RCA's)
- Reflect on the supporting information they have gathered and what that information demonstrates about their practice
- Identify areas of practice where they could make improvements or undertake further development
- Demonstrate that they are up to date and fit to practice

This must encompass the whole scope of their medical practice. There are six types of supporting information that doctors will be expected to provide and discuss at their appraisal at least once in each five year cycle. They are:

- Continuing professional development (CPD)
- Quality improvement activity
- Significant events
- Feedback from colleagues
- Feedback from patients
- Review of complaints and compliments

4.2: Appraisers

A medical appraiser is a licensed doctor with knowledge of the context in which the doctor works. An appraiser will

- Be the most appropriate appraiser for the doctor, taking into account their full scope of work
- Understand the professional obligations placed on doctors by the GMC
- Understand the importance of appraisal for the doctor's profession
- Have suitable skills and training for the context in which the appraisal is taking place.

4.3 Responsible Officer (RO)

The Responsible Officer is accountable to the Trust Board for Medical Revalidation and appraisal, and for ensuring consistent quality assurance processes in line with

national guidelines. The Responsible Officer must ensure that appraisals are carried out by the Trust in line with the most recent GMC guidelines, and are fit for the purpose of Medical Revalidation. The Responsible Officer will be required to attend any recommended training to develop and maintain their skills within the role of Responsible Officer this will include attendance at the regional Responsible Officer Network Meetings. The Responsible Officer will also ensure that an annual report is presented to the Board / Quality Committee to provide assurance that the Trust is compliant.

4.4 Clinical Appraisal Lead

The Trust has recently recruited a new Clinical Appraisal Lead, Dr J Bussin who provides guidance and assurance to appraisers from within the Trust and Chairs the Appraisal Support Group. The Clinical Appraisal Lead's objectives include:

- Lead the on-going development and improvement of medical appraisal within the Trust and identify and implement good practice.
- Develop the skills of the Medical Appraisers.
- Represent the Trust at regional Lead Appraiser network meetings.
- Quality assures medical appraisals and coordinate appraisal audits.

4.5 Professional Standards Medical HR Manager

The Professional Standards Medical Workforce HR Manager supports the Responsible Officer in the management and quality assurance of the Trust's Medical Revalidation and appraisal policy and guidelines.

4.6 Appraisal & Revalidation Officer

The Revalidation Officer provides administrative support to the Professional Standards Medical HR Manager and co-ordinates the overall process of appraisal and revalidation for the Trust.

4.7 Policy and Guidance

The Trust has a Medical Revalidation and Appraisal Policy which has recently been reviewed and updated and is in line with the NHS England Framework of Quality Assurance. The policy includes guidance on the appraisal process, to include clearly defining the non-participation process, the role of the appraiser etc.

All mandatory report's and returns are completed in line with required deadline's which includes the Annual Organisational Audit which was completed and submitted to NHS England in August 2018.

4.8 Systems

The electronic system for appraisal and revalidation is provided by Premier IT 'PReP' and training is provided on a 1:1 basis by the Appraisal & Revalidation Officer.

The system is extremely effective in supporting the Trust in the appraisal and revalidation process and enabling the Responsible Officer to review and sign off the required assurance statements with regards to revalidation. The system is secure and encrypted, and allows for documents to be uploaded by the doctor and linked with the relevant GMC standards.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Of the **370** doctors with a prescribed connection to the Trust, **327** successfully completed medical appraisals by the 31st March 2018.

b. Appraisers

Within the appraisal year 2017 – 2018, the Trust had **90** trained appraisers across a variety of specialties and grades.

The Trust has arranged further Appraisal training which will include refresher training sessions for early 2019.

c. Quality Assurance

For the appraisal portfolio:

- The doctor is expected to complete the electronic appraisal portfolio in a timely manner to allow the appraiser sufficient time to review the content and if necessary request additional supporting evidence.
- Review of appraisal folders provides assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard.
- Review of appraisal outputs by the Responsible Officer provides assurances that any key items identified pre-appraisal as needing discussion during the appraisal are included.

For the individual appraiser:

- An annual record of the appraiser's participation in appraisal calibration events such as reflection on ASG (Appraisal Support Group) meetings is kept by the revalidation team
- Feedback from doctors for each individual appraiser is collected at the end of each appraisal meeting.

For the organisation:

- The PReP system allows the Revalidation team to track timescales for appraisals from the setting of appropriate appraisal dates to completion of the

process and a system of prompts and reminders culminating in a letter from the RO

- Trust Information Governance policies apply. Doctors are responsible for ensuring no patient identifiable information appears in their appraisal portfolio

- The appraisal process is confidential to the Responsible Officer, the Clinical Appraisal Lead and the Appraiser, the only exception to this would be if significant concerns were to arise as part of the appraisal and revalidation process or otherwise which relate to fitness to practice, or where patient safety is of a concern.

d. Access, Security and Confidentiality

Trust Information Governance policies apply. Doctors are responsible for ensuring no patient identifiable information appears in their appraisal portfolio. No breaches were identified in the year 2017 to 2018.

e. Clinical governance

Doctors are required to include reflection on any significant incidents and complaints within their appraisal portfolio, which could include an action as part of a disciplinary outcome. In addition, a pre-revalidation check of each doctor against the Trust risk management system ensures that the Responsible Officer has access to the relevant clinical governance information when making a recommendation.

6. Revalidation Recommendations

- Recommendations between April 2017– March 2018 = 19
- Recommendations completed on time / not on time =19
- Positive recommendations = 17
- Deferral requests = 2
- Non-engagement notifications = 0

7. Recruitment and engagement background checks

Robust policies are in place to govern the recruitment process for permanent and temporary medical staff, including the pre-employment checks that form part of these processes as per NHS Employer guidance and include the Revalidation Reference Check.

8. Monitoring Performance

Monitoring performance from a ‘fitness to practice’ point of view remains one of the most challenging aspects of the Responsible Officers role. At STHK we

continue to develop systems to gather 'intelligence' from a variety of governance sources such as –

- Patient Complaints.
- Colleagues and allied staff.
- Datix Incidents.
- Medical Directors litigation report.
- Claims.
- Claims outcome form.
- External Reports e.g. Health Service Ombudsman.
- SUI / RCA.

9. Responding to Concerns and Remediation

All concerns raised in relation to medical staff are managed in line with Trust Policy 'Handling Medical Concerns' and national guidance 'Maintaining High Professional Standards in the Modern NHS'.

A robust framework is in place to ensure that all concerns are managed appropriately and in a timely manner to include:

- Weekly case reviews with the Responsible Officer, Director of HR, Professional Standards Medical HR Manager and HR Advisor.

- Regular case reviews with Chief Executive Officer, Responsible Officer and Director of HR

- Quarterly Professional Standards meetings chaired by the Responsible Officer, are held with the Divisional Medical Directors and Medical Education Lead.

- Were appropriate, concerns relating to medical staff are managed within the Trust Remediation Policy which has recently been reviewed and updated; options include –

    i. Re-skilling
    ii. Rehabilitation

10. Risks and Issues

There are currently no issues identified for reporting to Trust Board.

11. Board Reflections

None at present.

12. Corrective Actions, Improvement Plan and Next Steps

The focus for the next year is to continue to strengthen the quality assurance process, increase compliance rates and introduce a communication and reporting process for Divisional Directors and their responsible areas.

13. Recommendations

The Trust Board are asked to accept the report and to approve the ‘statement of compliance’ confirming that the organisation, as a designated body, is compliant with the regulations. This report will be shared with the Higher Responsible Officer as part of the Trusts Annual Organisational Audit Submission.

End

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The executive management team of St Helens & Knowsley Teaching Hospitals NHS Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes – Dr Terence Hankin, Assistant Medical Director.

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

   Yes.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes, the Trust currently has 90 trained appraisers across a wide range of specialties and grades.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Yes, this is overseen by the designated Clinical Appraisal Lead in conjunction with the Responsible Officer and the Appraisal & Revalidation Officer.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Yes.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Yes.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes this is co-ordinated through the Resourcing Team.

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes. The Responsible Officer, Clinical Appraisal Lead and Appraisal & Revalidation Officer regularly meet to ensure the processes are adhered to; and make any improvements and amendments where necessary in line with current regulations and guidance which will include a robust action plan.

Signed on behalf of the designated body:

Deputy Chief Executive

Official name of designated body:

St Helens & Knowsley Teaching Hospitals NHS Trust

Name: Mrs Anne-Marie Stretch Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Role: Deputy Chief Executive/Director of HR

Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)86

Title of paper: Infection Prevention and Control Annual Report 2017/18

Purpose: To present the 2017/18 Infection Prevention and Control Annual Report, to provide assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Summary:

a. Infection prevention and control is a statutory duty of the Trust Board and an annual report must be made annually on performance in the previous year.
b. This report covers the 2017/18 financial year.
c. Health care acquired infections (HCAIs) are reported every month via the Integrated Performance Report (IPR) and the Board via the Quality Committee also gains assurance via regular in depth reports of the actions taken and lessons learnt.
d. During 2017/18 the IPC performance improved in comparison to the previous year and the following were reported:
    1. 19 cases of Clostridium difficile infection (CDI) against an objective of no more than 41.
    2. 2 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) 1 true bacteraemias (ie clinical infections) and 1 contaminant.
    3. 22 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases
    4. 66 E.coli bacteraemia cases.
    5. No cases of CPE bacteraemia.
e. Surgical site infection surveillance in orthopaedics:

April 2017 – March 2018	STHK	National
Hips 301/2 infections	0.7%	0.7%
Knees 415/2 infections	0.5%	1.3%

f. 12 outbreaks of infection: VRE colonisation (2), diarrhoea and vomiting (1), MDRP (2), flu (2), scabies (1), Norovirus (3), Pertussis (1). 127 bed days lost.
g. The annual report also sets out the planned improvements for 2017/18 and given the time of reporting comments on the progress in achieving these improvements.
h. Further improvement in performance has been achieved in 2017/18, and this was reported in the Quality Account.

Trust objective met or risk addressed: Assurance of robust reporting, training and governance for IPC to meet regulatory and contractual quality standards, and improve the safety of patient care.

Financial implications: None directly as a result of approving this report.

Stakeholders: Staff, patients and the public, regulators

Recommendation(s): To approve the 2017/18 IPC annual report.

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

Date of meeting: 26th September 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

Infection Prevention Annual Report 2017-2018

CONTENTS

EXECUTIVE SUMMARY

1 This is a two-part document; a report on the developments and performance related to Infection Prevention (IP) activities during 2017/18 and the work plan for 2018/19 to reduce the risk of healthcare associated infections (HCAIs) in Appendix 1. The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI for patients.

2 The annual report for Infection Prevention outlines the Trusts IP activity in 2017/18. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the IP team.

3 A zero tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IP practice is essential to ensure that people who use the Trust's services receive safe and effective care. Effective IP practices must be part of everyday practice and be applied consistently by everyone. The publication of the IP Annual Report, which is a requirement in accordance with The Health and Social Care Act (2008), should be publicly available on the website as outlined in 'Winning ways: working together to reduce healthcare associated infection in England' to demonstrate good governance and public accountability.

4 The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the risk of infections. Additionally the Trust continues to work collaboratively with a number of outside agencies as part of its IP and governance arrangements including:

- Clinical Commissioning Groups (CCG)
- Cheshire and Merseyside Public Health England (PHE)
- Community IP teams
- NHSI/NHSE

Summary of key performance indicators for 2017/18

- The Trust has remained registered with the Care Quality Committee (CQC) as having appropriate arrangements in place for the prevention and control of infections.

- There were 19 cases of Clostridium difficile infection (CDI) against an objective of no more than 41 cases for 2017-18. This was a reduction form 21 cases the previous year. In addition, there were nine cases which were agreed as unavoidable after review by CCG CDI appeals panel which was based on there being no lapses in care. The objective for CDI was therefore met. However, the learning outcomes from CDI Root Cause Analysis (RCA) indicated that stool specimens were not being sent for testing in a timely manner, resulting in several cases being Trust attributable. Following introduction of a stool collection algorithm there has been a downward trend in the number of CDI cases within the Trust. Use of the stool collection algorithm continues to be embedded across all wards through targeted training sessions.

- Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia is a key performance indicator with a target of zero tolerance set by NHS England.

  - The objective for MRSA bacteraemia has not been met. During 2017-18 the Trust reported 1 MRSA bacteraemia and 1 MRSA contaminant. (2 positive blood samples).

  - All cases of MRSA bacteraemia were subject to a multi-disciplinary Post Infection Review (PIR). The learning outcomes indicate a need for improvement in Aseptic Non-Touch Technique (ANTT) in junior doctors, patients screened on admission for existing wounds or skin breaks to have the sites swabbed for MRSA. PIVC to be re-sited after 72 hours unless otherwise clinically indicated. A Trust wide combined MRSA/MSSA Action Plan has been

generated and monitored through the Hospital Infection Prevention Group (HIPG), Patient Safety Council (PSC) and the Clinical Quality Performance Group (CQPG).

- There were a total of 22 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases in 2017/18.

- There were a total of 66 E.coli bacteraemia cases last year.

- There were no cases of CPE bacteraemia.

- Surgical site infection surveillance in orthopaedics:

April 2017 – March 2018	STHK	National
Hips 301/2 infections	0.7%	0.7%
Knees 415/2 infections	0.5%	1.3%

- Outbreaks: There were 12 outbreaks of infection: VRE colonisation (2), diarrhoea and vomiting (1), MDRP (2), flu (2), scabies (1), Norovirus (3), Pertussis (1). 127 bed days lost.

- Hand hygiene continues to be strongly promoted throughout the Trust. Monthly audits of hand hygiene were undertaken on all wards throughout the year. Covert hand hygiene surveillance has also been undertaken.

- Training**:** Infection control induction and mandatory training sessions were provided for all clinical staff.

- Infection Control Link Nurse training occurs every 2 months.

- Antibiotic prescribing: The Trust intranet interactive antibiotic guidelines were updated (intranet website and app) in August 2015. The antibiotic penicillin allergy chart was also updated. Numerous audits were undertaken including AMT ward rounds, point prevalence audits, missed dose audit, time to first dose of antibiotics, impact of ready-made antibiotics from the aseptic unit and joint replacement antibiotic prophylaxis . All ward pharmacists check patients MRSA, VRE, CPE and *Clostridium difficile* status against appropriateness of antibiotic therapy.

- The expansion of the aseptic unit to produce more ready-made IV preparations saves considerable time, money and reduces potential risk to patients. This service has been promoted to clinical and directorate leads.

- Communication**:** Infection Prevention messages were reinforced with the use of many different means of communication including global emails, intranet messages, screen savers, Team Brief, meetings, posters, additional training sessions, and personal communication. A comprehensive IP report is disseminated widely with all key learning from root cause analysis reviews.

- Successful collaboration with whole health economy with regards to all issues relating to infection prevention.

- Introduction of a MSSA Patient Group Directive (PGD) for all orthopaedic joint replacement patients identified as colonised with MSSA pre-operatively for suppression therapy prior to surgery.

- Information technology**:** The ICNet NG electronic infection prevention surveillance and case management system went live in December 2014. In the second phase of the project, in April 2015, ward reporting of data related to infection prevention was implemented. Clinical staff now have real time access to health care associated infection and audit data specific to their own clinical areas as well as for the rest of the Trust.

- Engagement at ward level**.** Twenty five consultants from all specialities are Consultant Leads in Infection Prevention for their own areas. Root cause analyses (RCA) of infections continue to be presented by consultants to the Executive Panel.

- All Gram negative bacteraemia including E coli bacteraemia have an RCA undertaken on all hospital cases.

Developments in 2017/18

- Zero tolerance of MRSAb and other avoidable blood stream infections.

- ANTT programme continues to ensure that Trust staff reaches the target of 85% annual compliance for ANTT competency. A peripatetic service has been introduced to reach staff who cannot be freed from clinical areas to attend the training days.

- Further roll out of the Trust Line Care Course using a new E-Learning package to ensure best evidence based practice and ensure patient safety;.

- To use information technology to facilitate best practice and improve current practice specifically in relation to CPE risk assessment/screening and Bristol Stool Chart monitoring by incorporating these into the electronics medical early warning score (eMEWs) system, Patientrack.

- To further embed the concept of 'One Together' programme for reducing risk of surgical site infection into the Trust in the surgical division and theatre department.

- Newton Community hospital and Marshall Cross GP services has been audited and actions taken to ensure they work within the STHK IP policies and guidelines.

- To explore the introduction of water coolers into non-augmented care areas of the Trust to improve patient experience whilst minimising risk of water born infection.

- Collaborate with the healthcare community on the implementation of a toolkit to reduce the risk of E.coli and other gram negative bacteraemia.

- Work alongside the sepsis team on the correct detection, reporting and management of sepsis.

- Continued input into refurbishment projects as required, together with Infection Prevention advice.

- Continued education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.

- The Trust has signed up to the NHSI Improvement UTI collaborative framework to reduce UTI by 5% by 2019.

BACKGROUND

1. Infection Prevention Arrangements

1.1. As recommended in the Health and Social Care Act 2008, there is a duly constituted Hospital Infection Prevention Group (HIPG) which meets bi-monthly. The HIPG is a sub-group of the Patient Safety Council (PSC) which reports to the Quality Committee (QC). The current Trust clinical management arrangement consists of Care Groups in which the IPT sits within the Corporate Care Group.

1.2 IP Governance

1.2.1. The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IP arrangements in the Trust.

1.2.2. The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Chief Nurse.

1.2.3. The DIPC is supported by the Assistant DIPC, IP Doctor, and the Trust Antimicrobial Pharmacist. The wider IPT structure is tabled below.

1.2.4. The DIPC delivers an Annual HCAI Reduction Report to the Board of Directors and the forthcoming HCAI Reduction Delivery Plan based on the national and local quality goals.

1.2.5. The Executive Committee and Care Group clinical leads receive monthly updates on patients with Clostridium difficile infections, MRSA and MSSA.

1.2.6. IP performance is reported monthly in the Integrated Performance Report presented at Team brief and all governance meetings.

1.2.7. The Trust has 25 Consultant Infection Prevention Leads (‘Consultant Champions’) and 70 link nurses.

1.2.8. The IPT also works closely with the Matrons, Infection Prevention Link Professionals and Facilities Management.

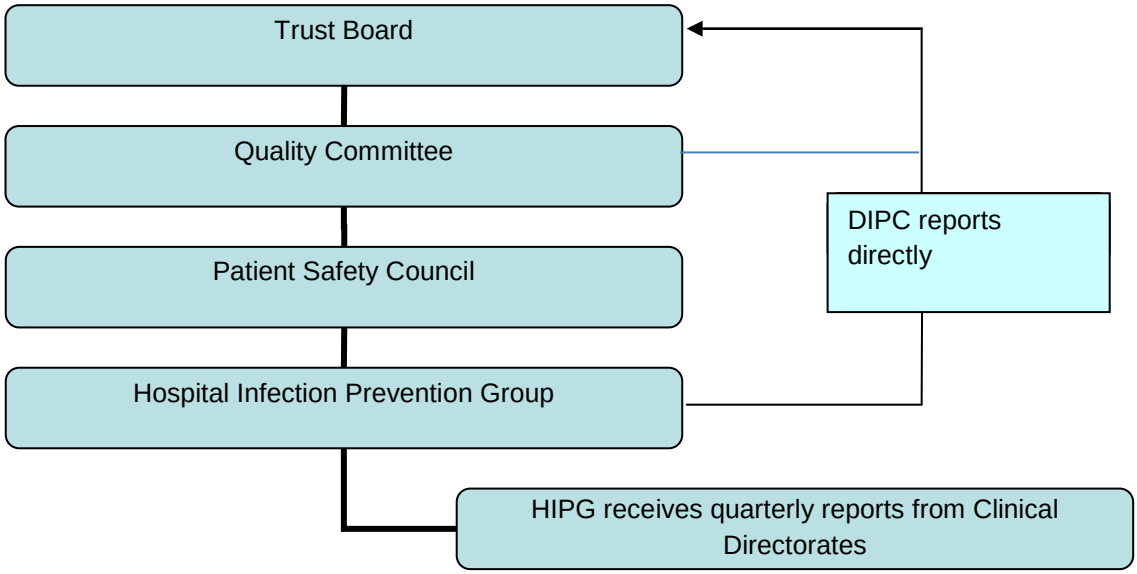
1.2.9. The Trust returns a monthly Assurance Framework to the Cheshire and Merseyside Commissioning Support Unit; this framework outlines performance against a number of key performance indicators (KPIs). This in turn is used as part of a performance pack for the relevant CCGs.

1.2.10. Infection Prevention Standards and Assurance - The annual reduction aspirations were agreed by the Trust Board in the trust objectives 2017/18 and the Clinical and Quality Strategy Annual Delivery Plan for 2017/18.

1.2.11. The Trust continues to undertake a number of interventions in relation to infection prevention as detailed within the HCAI Reduction Plan 2017/18. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Infection Prevention Doctor.

1.3 Hospital Infection Prevention Group (HIPG)

1.3.1 The Hospital Infection Prevention Group reporting line to the Trust Board is shown below:



1.3.2 The Terms of Reference are reviewed annually and were amended in 2018.

1.3.3 The Infection Prevention Team (IPT) consisting of nurses, doctors, assistant practitioner, audit and surveillance assistant and a secretary to support delivery of the IP strategy and action plan. The IPT is located on the Whiston Hospital site but attend the St Helens and Newton sites on a regular basis.

1.3.4 Infection Prevention is an essential component of care and one of the Trust's key clinical priorities.

1.3.5 The IPT's objectives are to protect patients, visitors and staff from the risks of healthcare associated infections. Infection prevention is the responsibility of every member of staff and the role of the IPT is to support and advise them to ensure that high standards are maintained consistently across all sites.

1.3.6 Isolation facilities

The current proportion of single rooms is 50% which supports the prompt isolation of patients with suspected or confirmed infections.

The target time for isolating patients with unexplained (and potentially infectious diarrhoea) is less than four hours.

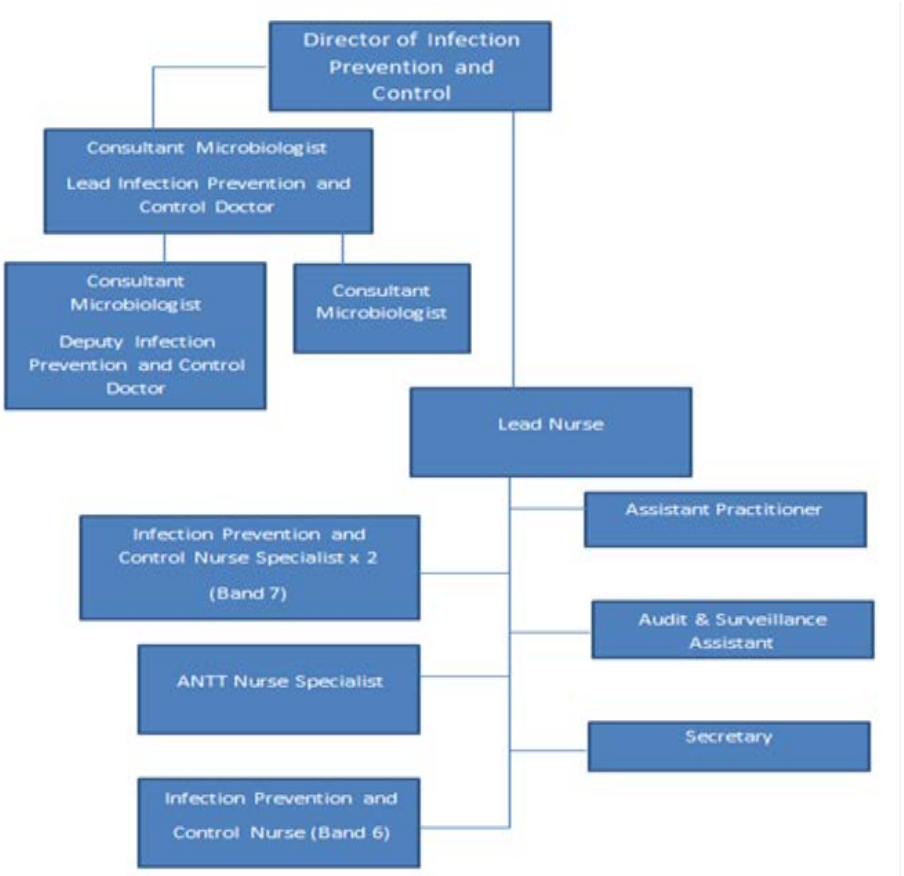
Each ward/clinical department maintains an isolation plan and the IPT send out a Trust wide side room plan daily. This identifies who is managed in a side room and the reason for their isolation. This is used by the wards and the site team to enable the correct placement of patients.

1.3.7 The core members of the IPT consist of:

- Director of IPC (DIPC) - Director of Nursing, Midwifery and Governance
- Lead Infection Prevention Doctor
- Deputy Infection Prevention Doctor - recently appointed to
- 8B Lead Nurse IP (1.0 WTE)
- Band 7 Specialist IP Nurses (2.0 WTE)

- Band 7 ANTT Specialist Nurse (0.5 WTE)
- Band 6 IP Nurses (1.0 WTE)
- Band 4 Assistant Practitioner (1.0 WTE) (currently on part time student nurse apprenticeship)
- Band 4 IP Secretary (1.0 WTE)
- Band 3 Audit and Surveillance Assistant (0.6 WTE)
- Antimicrobial Management Pharmacists - 0.5 WTE band 8b and 0.5 WTE band 8A

1.3.8 IP organisational structure



1.3.9 In addition, the IPT has a Link Nurse programme of over 70 personnel with study days/ meetings planned on a bi-monthly basis.

1.3.10 The IPT meets bi-weekly to discuss and minute progress, and map actions against the Annual Work Programme. Representatives from other Departments attend as required including the Antimicrobial Pharmacist.

1.3.11 The IP team continue provide a 5 day service and an on call microbiology service is available out of hours.

1.4 Committee representation by members of the IPT:

- Hospital Infection Prevention Group
- Patient Safety Council
- RCA Executive Review Panel Meetings
- Health Economy Healthcare Associated Infection Group (Knowsley)
- Health and Safety Group
- Sharps Safety Group
- Water Safety Group

- Drugs and Therapeutics Group
- Decontamination Group
- Medical Device Group
- Matrons' Infection Prevention and Facilities Meeting
- Cheshire and Merseyside Public Health England Healthcare Associated Infections (HCAI) Group
- Trust IV Access and Therapy Group
- St Helens and Knowsley NHS Trust Major Incident Planning
- North West Antibiotic Pharmacy Group
- North West IV Forum Group
- Cheshire and Merseyside Antimicrobial Resistance Group
- Medical and Surgical Care Group Governance Meetings

2. Healthcare Associated Infections

2.1 Healthcare associated infections (HCAIs) are infections that are acquired as a result of health care interventions. Surveillance of HCAIs infections allows the continuous monitoring of diseases in a population so that data can be analysed and trends identified in order to introduce and maintain effective mechanisms to facilitate patient safety and care. High quality information on infectious diseases, HCAIs and antimicrobial resistant organisms is essential for monitoring progress, investigating underlying causes and applying prevention and control measures.

2.2 Since April 2001, it has been mandatory for all acute NHS Trusts in England to report all cases of bacteraemia caused by S aureus as well as the proportion of these cases due to MRSA. Mandatory surveillance of MRSA and C difficile was introduced in 2004. Since April 2007, all NHS Trusts in England are required to participate in the Department of Health's mandatory CDI reporting system and to report all cases of Clostridium difficile infection (CDI) in patients over 2 years of age. Escherichia coli bacteraemia was added to the enhanced mandatory data reporting from June 2011.

2.3 All HCAI surveillance and reporting has been carried out in line with the NHS England and Public Health England mandatory reporting requirements.

2.4 The IP Team visit all patients at regular intervals according to their infection or possible infection, such infections/conditions are listed below:

Target/Alert Organisms

- MRSA
- Clostridium difficile
- Group A Streptococcus
- Salmonella species
- Campylobacter species
- Mycobacterium tuberculosis
- Glycopeptide resistant Enterococci
- Multi - resistant Gram negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers; multi-drug resistant pseudomonas
- Carbapenemase-producing Enterobacteriaceae (CPE)
- Neisseria meningitides
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

Alert Conditions

- Scabies
- Chickenpox and shingles
- Influenza
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

2.5 Meticillin-resistant Staphylococcus aureus (MRSA)

2.5.1 MRSA can cause substantial morbidity e.g. wound infections, line infections, bacteraemia, chest infections, urinary tract infections, osteomyelitis.

2.5.2 Since 2004, the Department of Health has set objectives for all Hospital Trusts to reduce their MRSA bloodstream infection rates e.g. by 60% by 2007/2008 against the 2003/4 baseline.

2.5.3 Since 2013/2014 there has been a zero tolerance target for MRSA nationally. The objectives for this Trust are shown below:

Year	Actual MRSA Bacteraemia	Objective
The following objectives apply to hospital-acquired cases only		
2010/11	8	5
2011/12	5	5
2012/13	10	3
2013/14	4	0
2014/15	2	0
2015/16	0	0
2016/17	2	0
2017/18	1 and 1 contaminant	0

2.6 The 2 cases of Trust acquired MRSA bacteraemia underwent thorough multi-disciplinary root cause analysis and were reviewed by the Executive Root Cause Analysis Panel. One case as a skin contaminant hence deemed avoidable. The second case was deemed unavoidable by the Trust PIR panel and this decision was supported by the relevant CCG. However, when submitted to the NHS England Arbitration Panel, that Panel deemed the case should still be apportioned to the Trust as there were gaps in the peripheral cannula monitoring documentation (although the bacteraemia was not related to a cannula site infection) and there was incomplete documentation on information on wound care (although the bacteraemia was clinically not related to a wound infection but an aspiration pneumonia).

2.6.1 RCA findings of the cases:

- Patient admitted with fractured neck of femur; past history of stroke and poor swallow (although non-compliant with Speech and Language Therapy advice which was to remain nil by mouth) admitted from own home and no previous history of MRSA. NHSE arbitration panel stated there was insufficient evidence of actions carried out the gain the compliance of the patient and relatives with regards to reducing risk of aspiration when admitted to hospital. Due to this, as well as gaps in VIP documentation (although the patient had no evidence of cannula site infection hence this was not a contributory factor in the bacteraemia), the case was attributed to the Trust.

- Patient screened appropriately on admission (screen was negative), given appropriate antibiotic prophylaxis for hemi-arthoplasty, reviewed in a timely manner

when deteriorated with sepsis following likely aspiration, blood cultures taken in a timely manner by ANTT trained doctor and appropriate antibiotics given. All devices used appropriately and inserted by ANTT competent staff. Patient placed on end of life care pathway shortly afterwards. No MRSA isolated from any other samples from this patient including repeat full MRSA screen taken when blood culture was found to be MRSA positive. All staff involved with care of this patient screened for MRSA as well as all other patients on the ward. No staff screens positive. Two other patients on ward found to be MRSA positive (one with a known history and one new) - isolates sent for typing the results of which indicate that the bacteraemia was caused by a unique strain.

- Skin contaminant. Patient with extensive dermatitis/pemphigoid. Blood culture taken by ANTT competent staff however patient was not co-operative during the procedure. Patient not known to be MRSA positive previously and negative on nose and throat swabs done on admission however a Grade 2 sore on left leg and a sacral sore were not screened. A full body survey was not done on admission hence was not possible to state definitively whether these skin breaks were present on admission. Subsequent screening (after the positive blood culture result was available) revealed MRSA colonisation in sacral wound, groin and perineum. Non-contributory factors - incomplete VIP documentation and cannula kept in for > 72 hours without an indication; one cannula inserted by an FY1 who was not ANTT competent.

2.6.2 Lessons identified were:

- Review patients for wounds/skin breaks on admission and document details in patient's clinical notes (e.g. using body map).
- Patients presenting with wounds or skin breaks must have those sites swabbed as a part of the MRSA screen (regardless of whether there are clinical features of infection) in order to detect potential MRSA colonisation. NB this is a recurrent theme from previous MRSA bacteraemias including some from 2016-2017.
- Peripheral cannulae must be re-sited at the latest every 72 hours. However, if there is a clinical indication to leave a cannula in for longer (e.g. patient with very difficult IV access), ensure that the rationale is clearly documented in the patient's clinical notes. In addition, continue to observe the site of the cannula for at least 48 hours post removal and document VIP score at least once every shift for evidence of infection.
- All doctors within the Trust who undertake clinical duties must be ANTT trained (theory assessment as one-off requirement) and must undertake annual practical competency assessment to be done by the Key Trainer in their clinical area. New starters must complete the practical competency assessment within 2 weeks of starting.

2.6.3 A trust-wide action plan owned by the care groups was implemented to address the issues identified.

2.7 MRSA Screening

2.7.1 The Trust continues to use a robust approach to screening the majority of patients, either pre operatively or on admission.

2.7.2 Screening compliance is monitored on a monthly basis. It is based on all admissions who are screened on day 0, 1 or 2 (day 0 being day of admission).

2.7.3 The contractual target for MRSA screening is 100% of eligible patients requiring screening.

2.7.4 The Trust has achieved 100% compliance throughout 2017/18.

2.8 Clostridium difficile toxin infection (CDI)

2.8.1 Targets for CDI were introduced in 2008/2009.

2.8.2 The CDI NHS England target for 2017/18 was no more than 41 cases.

2.8.3 In total there have been 19 cases of CDI, excluding 9 cases which have been successfully appealed as having no lapses in care and therefore are not included in the year-end performance figure.

2.8.4 There continues to be a decrease in the overall number of patients with Trust apportioned CDI.

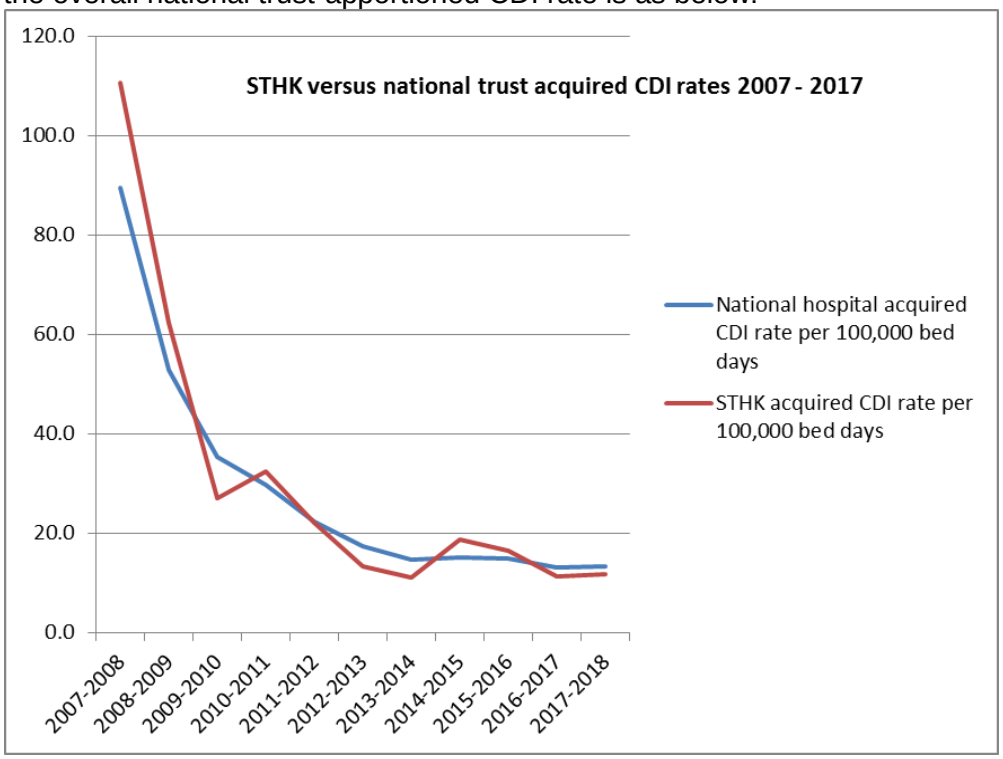
2.8.5 Each case has been investigated by the clinical teams using a standardised post-incident review (PIR) process and fed back to all clinical areas. Any lapses in care are discussed and actions agreed and their delivery monitored through Hospital Infection Prevention Group. If there are no lapses in care, the case is heard by the CCG CDI Appeals Panel with a view to removing the case for performance purposes.

2.8.6 The table below demonstrates year on year reduction:

Baseline data	334		
	Targets	**Actual**	
2008/09	302	170	
2009/10	235	75	
2010/11	169 (DOH target) 71 (PCT target)	74	
2011/12	65	52	
2012/13	37	31	
2013/14	31	26	
2014/15	19	35	avoidable cases (excluding 9 cases which were deemed unavoidable by the CCG CDI appeals panel)
2015/16	41	26	avoidable cases (excluding 13 which were deemed unavoidable by the CCG CDI appeals panel)
2016/17	41	21	avoidable cases (excluding 6 cases which were deemed unavoidable by the CCG CDI appeals panel)
2017/18	41	19	avoidable cases (excluding 9 cases which were deemed unavoidable by the CCG CDI appeals panel)

2.9 STHK apportioned CDI rate per 100,000 bed days remained stable compared with 2016/17 (11.4 versus 11.9 cases per 100,000 bed days in 2016/17 and 2017/18. This mirrors the overall national trend of stabilisation in Trust acquired CDI rates (13.2 versus 13.3 cases per 100,000 bed says in 2016/17 and 2017/18 respectively). Comparison with

the overall national trust-apportioned CDI rate is as below:



2.9.1 Lessons identified from RCA:

- If a patient has type 5 to 7 stool on the Bristol Stool Chart which is not explicable by any other reason, stool specimen must be sent for C difficile testing at the earliest opportunity.
- If there is a clear explanation as to why a patient is having diarrhoea (e.g. laxatives, constipation with overflow) there is no indication to send a stool sample for C difficile testing.
- Avoid long term antibiotic prophylaxis to prevent urinary tract infection in patients with long term urinary catheters or on-going foci of potential infection such as colovesical fistula as this will invariably select out organisms which are resistant to the agent given (which when they then cause infection will usually be also more difficult to treat).
- Isolate any patient with diarrhoea (type 5 to 7 on the Bristol Stool Chart) in a single room promptly and if patient has no other reason for diarrhoea, send stool specimen for C.difficile testing without delay.
- Adhere to Trust Antibiotic Policy and review previous positive microbiology results when prescribing any antibiotic. Document the indication for the antibiotic in the patient's medical records.
- Review all prescriptions IV antibiotics within a maximum of 24-72h of starting to see if patient can be stepped down to oral antibiotics or whether antibiotics can be stopped, if clinically appropriate.
- Before prescribing any antibiotic, review other antibiotic therapy already prescribed already to ensure that other agents are not continued unnecessarily.
- When communicating changes in antibiotic therapy, ensure that the full name of the drug is used both in verbal and written communication e.g. 'cef and met' is not acceptable; 'cefuroxime and metronidazole' is.
- If relatives providing personal care for patient, educate relatives on the importance of informing staff on the patient's bowel habit and document this advice in the patient's medical record.
- Document patient's bowel habit on Bristol Stool Chart (BSC) at least once daily.
- Ensure that BSC is documented correctly for patients who may use the toilet independently.

- Ensure that when transferring patients, handover between the clinical teams should include patient's bowel habit and whether patient is having diarrhoea (i.e. type 5 to 7 stool) on the BSC.
- When documenting a patient's bowel habit, ensure that Bristol Stool type (i.e. 1 to 7) rather than subjective descriptions (e.g. 'loose' or 'jelly-like') are used on the Bristol Stool Chart.
- Stool for C difficile testing can be taken from an incontinence pad or even if mixed with urine.
- If a patient has risk factors for and symptoms consistent with CDI, do not delay treatment whilst awaiting results of stool sample testing.
- If a patient is clinically suspected to have C difficile infection, treatment for this must also commenced without awaiting laboratory results.
- Do not send repeat stool samples for C difficile testing from patients with a diagnosis of CDI already, on treatment and improving clinically.
- Urine for culture can be obtained using a Newcastle pad from a patient who is suspected of having a urinary tract infection who is incontinent of urine.

2.9.2 Lessons learnt have been disseminated Trust wide using multiple modalities including Infection Prevention Monthly Report, Team Brief, Infection Prevention Link Professional Educational Days, Infection Prevention Consultant Champions' meetings and teaching for medical/non-medical prescribers and nursing staff.

2.9.3 Outbreaks of CDI:

- There was one outbreak of CDI confirmed in 2017/18 on ward 2D (ribotype involving 2 patients (ribotype 002). The ward was deep cleaned and the IPT performed weekly high impact intervention audits until compliance with the required care elements achieved >90%.

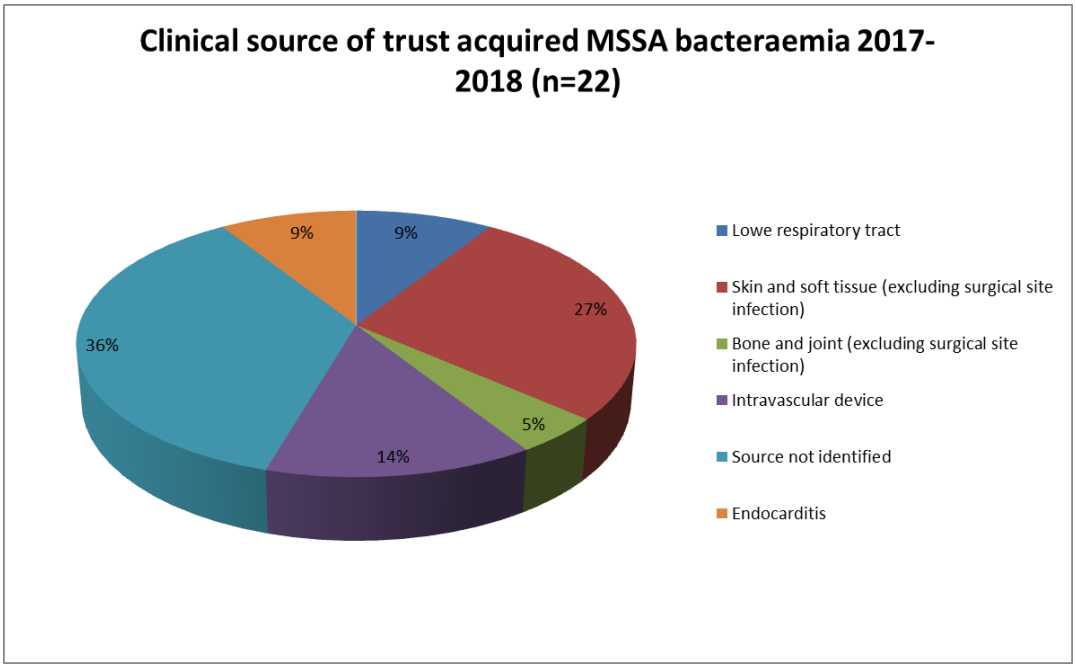
2.10 Meticillin-sensitive Staphylococcus aureus (MSSA)

2.10.1 MSSA bacteraemia mandatory surveillance commenced in January 2011, but national objectives have not yet been set.

2.10.2. There were 22 cases of Trust acquired MSSA bacteraemia in 2017/18 compared with 17 cases 2016/2017 and 28 in 2015/16.

2.10.3. All cases of MSSA bacteraemia using the Post Infection Review Framework. Clinical Teams present each case to the executive root cause analysis review panel.

2.10.4. The clinical source of infections associated are identified below.



Following root cause analysis investigation 12 of the 22 cases were deemed avoidable.

2.10.5 Lessons identified from RCA:

- Peripheral cannulae must be re-sited at the latest every 72 hours. However, if there is a clinical indication to leave a cannula in for longer (e.g. patient with very difficult IV access), ensure that the rationale is clearly documented in the patient's clinical notes.
- Screen for sepsis in any of the following groups of patients:
- Every patient attending to ED except minors and trauma
- All referrals to AMU / GPAU / SAU / SCBU / Maternity ward
- All acute admission (medical / surgical) including children and pregnant women
- All inpatients who suddenly deteriorate and or not improving
- All MET calls
- If a patient fulfils criteria for sepsis screening, blood cultures must be taken before starting antibiotics (which need to be administered within 1 hour of the diagnosis of sepsis).
- Document details of staff taking blood culture on the blood culture request card.
- Document details peripheral cannulae on VIP chart (at insertion, of monitoring at least once per shift and on removal). When the cannula is removed, the site needs to be continued to be monitored at least once per shift for at least another 48 hours, in order to detect in a timely manner, any evidence of infection post-removal. This must also be documented on the last page of the VIP chart.
- Each peripheral cannula must have a separate VIP chart commenced at the time of insertion.
- All doctors within the Trust who undertake clinical duties must be ANTT trained (theory assessment as one-off requirement) and must undertake annual practical competency assessment to be done by the Key Trainer in their clinical area. New starters must complete the practical competency assessment within 2 weeks of starting.
- Ensure that when a plan has been made to start a patient on antibiotics, this is not only documented in the medical notes but the drug(s) is prescribed on the medication chart and the requirement to give the patient the new medication in a timely manner is communicated with nursing staff in order to avoid any delays in commencing treatment.
- If a patient requires repeated/multiple peripheral IV cannulation, consider early referral for PICC.

2.10.6 The key areas for focus in 2017/18 included:

- Improving Aseptic No Touch Technique (ANTT) practices;
- ANTT Cascade Trainers were launched and it was included as part of the Quality Care Accreditation Tool (QCAT) assessment criterion;
- Development of an Intravenous Line Care Course, incorporating Peripheral and Central line care and Blood Culture requirements commenced for staff on the wards;
- Maintaining the quarterly aseptic non-touch technique (ANTT) Key Trainer programme. Since July 2015 the number of Key trainers in the Trust has risen from 24 to 196;
- ANTT (aseptic non-touch technique) training and annual competency assessments have been promoted throughout the Trust.

2.11 Gram negative bacilli bacteraemia (Escherichia coli/Klebsiella species/Pseudomonas aeruginosa)

In 2017-2018, the Trust continued to carry out RCA review of all Trust acquired E coli bacteraemias and implemented the same for all Trust acquired Klebsiella and Pseudomonas aeruginosa bacteraemias. In addition, as per Department of Health/PHE requirements, we also commenced reporting of risk factor information for these cases on the PHE Data Capture System (DCS).

Gram negative bacteria such as E coli and Klebsiella species are frequently found in the intestines of humans and animals. While some of these organisms live in the intestine quite harmlessly, others may cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intra-abdominal infection such as biliary infection. Bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood. E coli is the commonest cause of bacteraemia nationally.

Pseudomonas aeruginosa is commonly found in the environment e.g. in water and soil and may transiently colonise humans. It normally causes in infection in vulnerable patients e.g. those who are immunocompromised or those with indwelling devices.

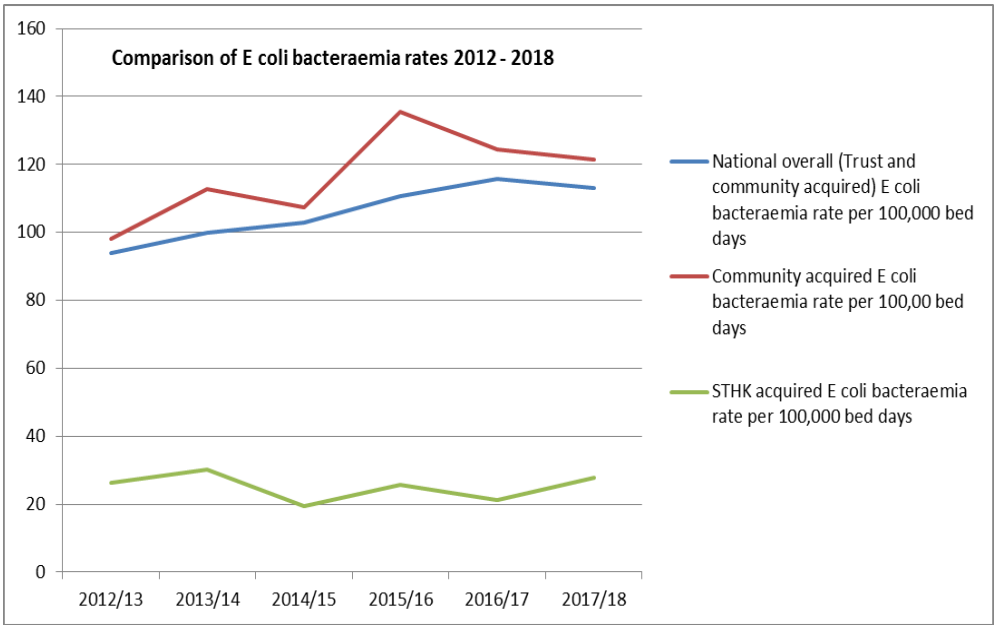
E coli

2.11.1 E coli bacteraemia mandatory surveillance commenced in April 2011. For 2017-2018, there was a healthcare-economy wide target of 10% reduction of cases compared with a 2015-2016 base line. Whilst there is no national reduction target specific to acute trusts, we extrapolated the CCG-wide reduction target to give the Trust a trajectory of no more than 54 Trust acquired cases in 2017-2018 (as there were 61 Trust acquired cases in 2015-2016). The Trust has been part of the healthcare economy-wide E coli bacteraemia group led by St Helens CCG.

2.11.2 The Trust has been undertaking RCA for E coli bacteraemia since January 2017.

2.11.3 In 2017-18 there were 66 cases compared to 50 in the previous year. Of these 46 cases where deemed unavoidable after RCA.

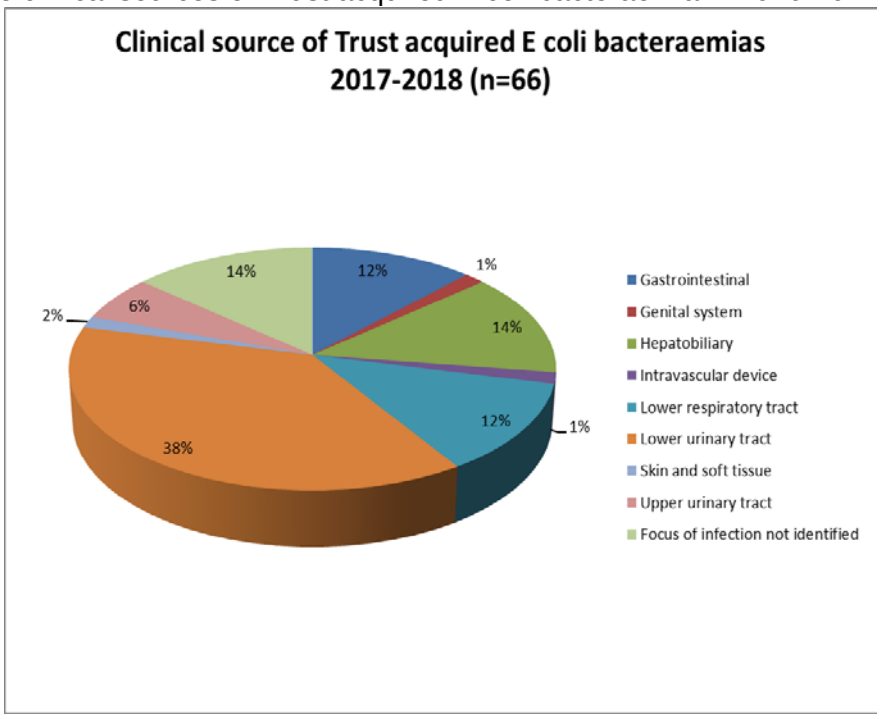
2.11.4 STHK apportioned E coli bacteraemia rate per 100,000 bed days in comparison with the overall national E coli bacteraemia rates and rate for community acquired cases identified in our Trust are as below:



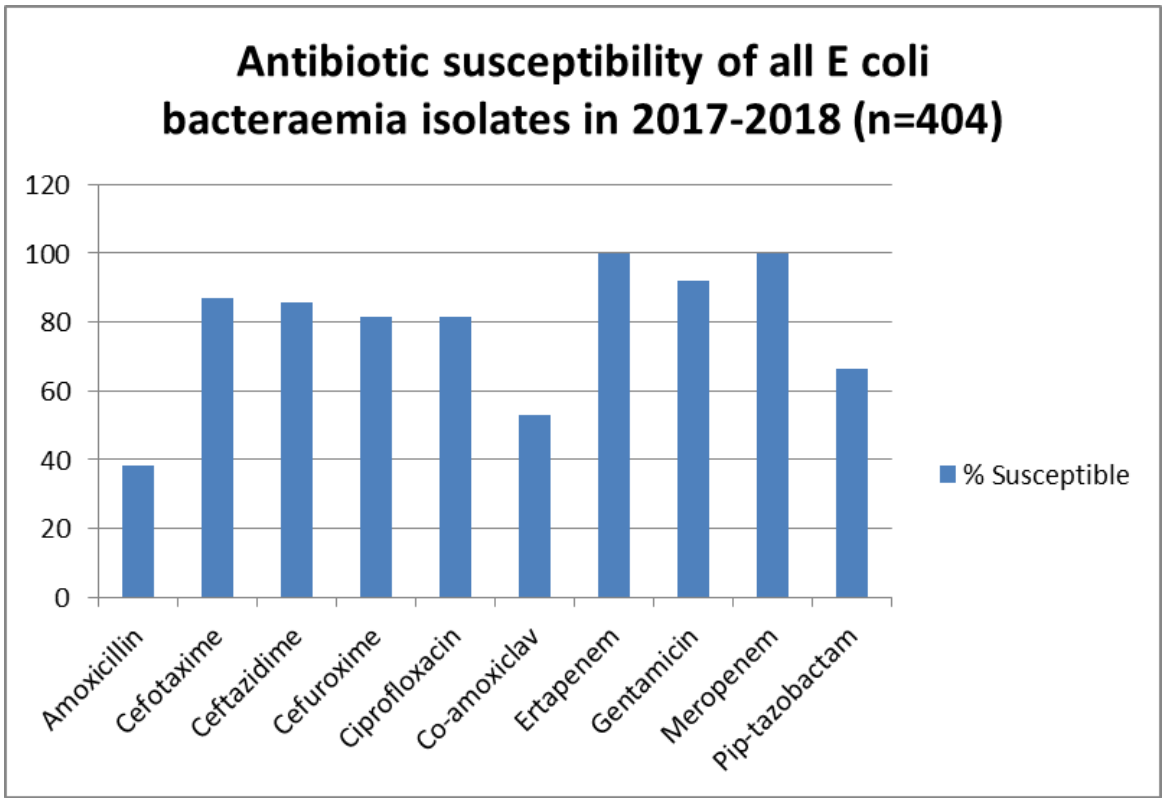
2.11.5 UCAM (Urinary Catheter Assessment and Monitoring) was introduced in 2011 in order to reduce urinary catheter associated urinary tract infection. All urinary catheter care is documented with the aim of:

- Preventing unnecessary catheterisation
- Prompting daily review of patients with catheter to encourage the earliest possible removal of catheter
- Providing evidence of quality of patient care (insertion and ongoing care) as per High Impact Intervention No.6 catheter care bundle (Saving Lives)
- Teaching sessions for urethral catheterisation are available through Learning and Development
- A Trust wide UCAM audit is conducted on an annual basis by the IPT and the Continence Nurse
- An evidence based Trust policy on Urinary Catheter Management on the best practice in relation to all aspects of urinary catheter management was produced and published in 2017-2018
- The Urinary Catheter Passport has been implemented within the Trust

2.11.6 The clinical sources of Trust acquired E coli bacteraemia in 2016-2017 are as below:

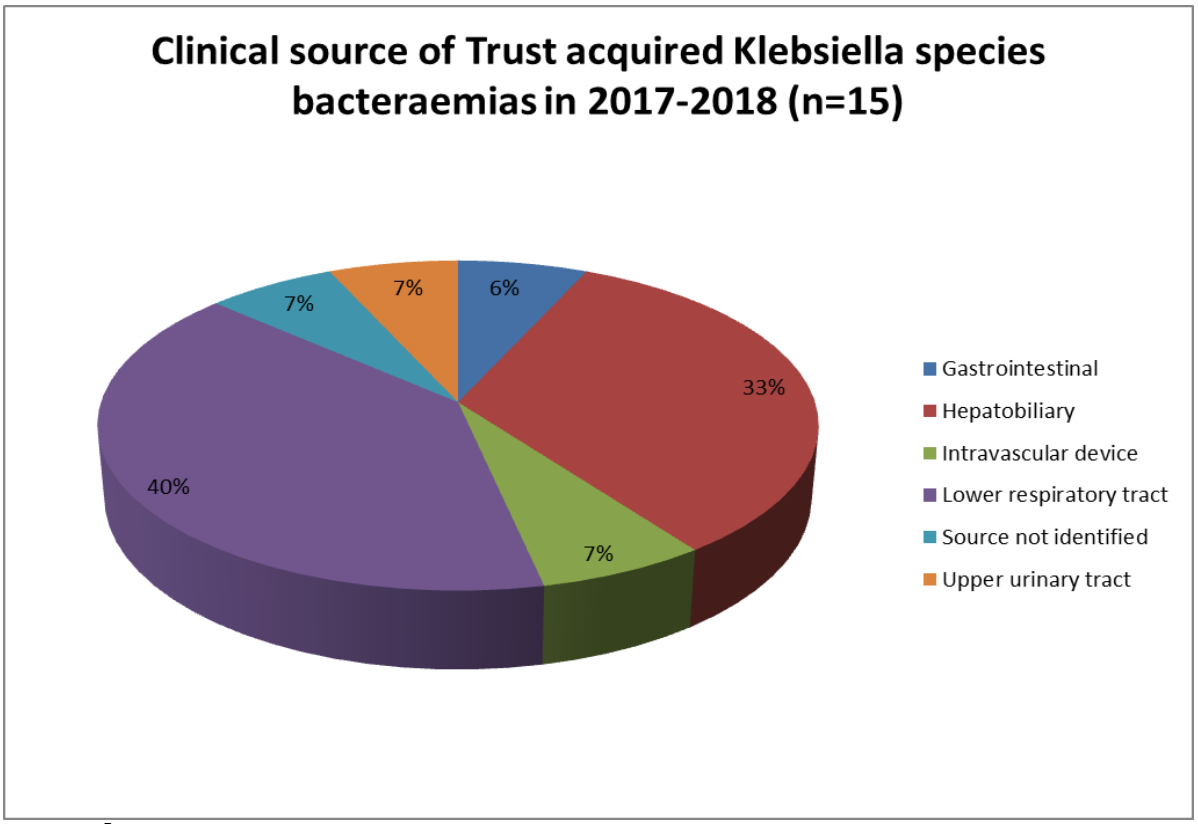


2.11.7 The overall antibiotic susceptibilities for all E coli bacteraemia (i.e. community and Trust acquired) identified at the Whiston Hospital Microbiology Laboratory in 2017-2018 are as below:



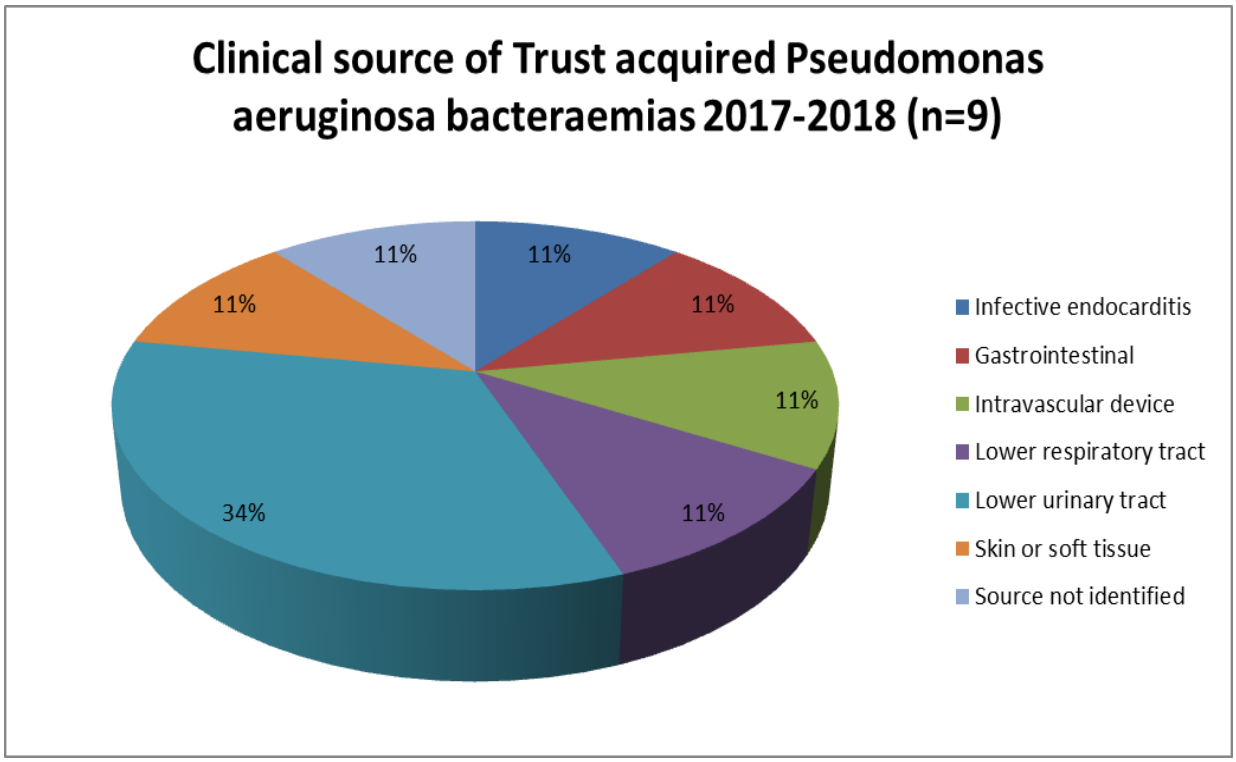
Klebsiella species bacteraemia

- This was the first year Klebsiella bacteraemia was included in Department of Health Mandatory reporting. There were 15 cases of Trust acquired Klebsiella bacteraemias in 2017-2018. Of these, 13 were deemed unavoidable after RCA review.



Pseudomonas aeruginosa

- This was the first year Pseudomonas aeruginosa bacteraemia was included in Department of Health Mandatory reporting. There were 9 cases of Trust acquired Pseudomonas aeruginosa bacteraemias in 2017-2018. Of these, 6 were deemed unavoidable after RCA review.



Lessons identified from RCA for cases of Trust acquired Gram negative bacteraemias:

- Nitrofurantoin must not be used for UTI in patients with a creatinine clearance of less than 30mL/min/1.73m2. This is because nitrofurantoin only accumulates to a useful/therapeutic concentration in the lower urinary tract via renal clearance.
- Patients on intravenous aminoglycosides must be monitored regularly (i.e. therapeutic dose monitoring/levels and renal function) for evidence of toxicity (as stated in the Trust antibiotic policy). When abnormal results are communicated to the ward by the laboratory, ensure that these are communicated to the member of staff caring for the patient so that they can be acted upon in a timely manner.
- Screen for sepsis (as well as other potential causes) in a patient who is admitted with delirium; if the patient fulfils criteria on sepsis screening, blood cultures must be taken before starting antibiotics (which need to be administered within 1 hour).
- Document details urinary catheters on UCAM chart (at insertion and of monitoring at least once per shift).
- Only prescribe antibiotics when there is an appropriate clinical indication for antibiotic treatment.
- Ensure that an indication is documented on the medication chart or patient's medical notes for every course of antimicrobials prescribed.
- Adhere to Trust Antibiotic Policy when prescribing antibiotics – piperacillin tazobactam ('Tazocin') is not an appropriate treatment for sepsis of unknown origin.
- Ensure that a review date (within 48h of starting) or a stop date is documented on medication chart and/or medical notes for every prescription of an antimicrobial.
- Review empirical antibiotic therapy in light of results from microbiological and other investigations – if infection is excluded, stop antibiotics.

- Use the automated calculated linked from the Trust antibiotic website or Mersey Micro app to determine the correct dose for once daily gentamicin dosing and vancomycin dosing.
- ALL unplanned admissions presenting with ascites due to decompensated chronic liver disease must have a diagnostic ascitic tap within 6 hours of presentation irrespective of the reason for presentation
- If a patient is diagnosed with sepsis, antibiotics must be administered within 1 hour of diagnosis. Prescribing a stat dose(s) and informing nursing staff caring for the patient to administer the antibiotic(s) facilitates this.
- CVAT chart must be in place for any central venous line which should be monitored at least once per shift and outcome documented on CVAT chart.
- Take blood cultures and other relevant samples for culture in a timely manner (and whenever possible before starting antibiotics) in patients with sepsis: Follow Trust Blood Culture Policy including checking the correct patient identifiers before taking specimens.
- Document details of staff taking blood culture and where the specimen was taken from (e.g. line, if so which type, or peripheral) on the blood culture request card.
- Ensure that appropriate/adequate clinical details are given on blood culture request in order to able to interpret the results accurately.
- Document details peripheral cannulae on VIP chart (at insertion and of monitoring at least once per shift).
- Repeat blood cultures should be taken from patients who deteriorate whilst inpatient even if BC taken on admission if sepsis is again suspected.
- Urine for culture can be obtained using a Newcastle pad from a patient who is suspected of having a urinary tract infection who is incontinent of urine.
- Document details peripheral cannulae on VIP chart (at insertion, of monitoring at least once per shift and on removal). When the cannula is removed, the site needs to be continued to be monitored at least once per shift for at least another 24 hours in order to detect in a timely manner, any evidence of infection post-removal. This must also be documented on the last page of the VIP chart.
- Record all clinical documentation legibly.
- When a patient has a urinary catheter inserted, ensure that the residual volume is documented.
- Ensure that when a patient who is deteriorating has a clinical review, evidence of the review is documented in the medical notes.
- Whilst prophylaxis for urethral catheter insertion is not routinely indicated, if the patient has had a history of sepsis after previous catheter insertion/change or known history of difficult/traumatic catheterisation in the past, prophylaxis should be given as per the Trust Antibiotic Policy.
- Be aware that it is sometimes possible for patients to have bacteraemia without necessarily displaying overt signs of sepsis especially in the early stages of infection. Consider taking blood cultures if one or more of the following clinical symptoms/signs are present and there is a clinical suspicion of infection:
  - Fever (core temperature greater than $38^{o}C$) or hypothermia (core temperature less than $36^{o}C$)
  - Raised or very low peripheral white cell count (<4 $x10^{9}$/L or >12 $x10^{9}$/L)
  - Tachycardia >90 beats/min, hypotension systolic BP <90 mmHg and/or raised respiratory rate >20 breaths/min
  - Focal signs of infection
  - Rigors or chills
  - Acutely altered conscious level or mental state
  - Blood glucose >7.7mmol/L in a non-diabetic patient

- Escalate patients with repeated positive urines/UTIs for senior/specialist review to determine appropriate future management plans.
- If a patient who develops sepsis has a pre-existing PICC (or other central line), blood cultures should be sent from line as well as peripherally to determine whether the line is the source of infection.

2.12 Vancomycin-resistant enterococcus (VRE)

2.12.1 VRE is multi-drug-resistant enterococcus (usually Enterococcus faecalis or Enterococcus faecium). Enterococci live in intestines and on skin, usually without causing problems. But they can cause serious infections, especially in patients who are more vulnerable e.g. following surgery, multiple antibiotics, invasive devices etc. Infections include urinary tract infection, intra-abdominal infection and line infection.

2.12.2 As VRE are resistant to many antibiotics, these infections are more difficult to treat. Therefore ppatient's found to be colonised with these organisms are isolated to avoid transmission of infection.

2.12.3 There has been a nationwide increase in the number of patients with VRE. It has been postulated that this may be related to VRE in the food chain e.g. meat from animals exposed to antibiotics.

2.12.4 The proportion of isolates showing vancomycin resistance among all Enterococcus species from bacteraemia in England and Northern Ireland increased each year from 12% in 2012 to 17% in 2015 before decreasing to 15% in 2016 [Laboratory surveillance of Enterococcus spp. bacteraemia in England, Wales and Northern Ireland: 2016; Public Health England, Health Protection Report, Volume 11 Number 15 Published on: 21 April 2017].

2.12.5 In 2017-2018, 12% of enterococcal isolates from blood cultures at STHK were resistant to vancomycin (which is an increase of 3% compared with 2016-2017).

2.12.6 There were 2 outbreaks due to VRE in 2017-2018. There were 4 cases of Trust acquired VRE bacteraemia and 2 community acquired VRE bacteraemias.

2.12.7 There were 77 hospital acquired cases of VRE (non-bacteraemia) most of which were asymptomatic colonisation detected on screening as well as 77 cases of community acquired non-bacteraemia cases of VRE.

2.12.8 VRE rectal screening (on admission and then weekly) was continued on 4D, 4E and 2A. In the absence of national guidance on extending VRE screening further, the HIPG in 2017 agreed to continue with current practice with regards to VRE screening.

2.12.9 Carbapenemase-producing enterobacteriaceae (CPE)

2.12.10. CPE are a growing concern, nationally and regionally due to their resistant to a wide range of antibiotics including the very broad spectrum carbapenem class of antibiotics.

2.12.11 The Trust CPE policy is in line with the DH CPE Toolkit issued in 2013 and been reviewed, building on our learning experiences and those from other local Trusts.

2.12.12 The guidance concentrates on prevention, isolation of high-risk individuals and screening being of particular.

2.12.13 There was one community acquired and no hospital acquired CPE bacteraemias in 2017-2018.

2.12.14 There were 2 cases of hospital acquired CPE (i.e. CPE detected in a sample taken >48h after admission in a patient without pre-existing risk factors for CPE). In these cases, contacts were managed as per the PHE CPE Toolkit including screening.

No cases of onward transmission were identified. There were also 25 cases of community acquired CPE detected during the same time period.

3. Outbreaks and Incidence of Periods of Increased Incidence (PII)

3.1 There were 13 confirmed outbreaks in 2017/18:

Month	No of outbreaks	Organism	Ward/Unit and Number of cases	No of bed days lost
2017				
Apr	0			
May	1	Possible scabies	1A (4 staff and 1 patient)	0
Jun	0			
Jul	1	VRE	3D (2 patients)	0
Aug	0			
Sep	2	Multi-drug resistant pseudomonas (continuation of previous outbreak)	2 patients	24
		CDI	2D (2 patients)	0
Oct	2	Pertussis	3F/4F (2 staff)	0
		VRE	3E Medicine (3 patients)	0
Nov	2	Norovirus	3B (14 cases with symptoms: 3 patients and 3 staff confirmed as positive for norovirus)	21
		Norovirus	Newton Community Hospital Inpatient Ward (19 cases with symptoms: 7 patients and 3 staff confirmed as positive for norovirus)	31
Dec	2	Norovirus	5C DMOP (5 cases with symptoms: 1 patient confirmed as positive for norovirus)	2
		Diarrhoea and vomiting – no pathogen identified	1A (10 patients and 11 staff with symptoms)	35
2018				
Jan	0			
Feb	1	Influenza A	5C DMOP (3 patients)	0
Mar	1	Influenza A	Newton Community Hospital Inpatient Ward (13 patients and 1 staff)	14
Total	**12**			**127**

3.1.2. The IP team during the winter period attend the bed meeting twice daily to support the wards in management of patients with suspected infections such as norovirus and influenza.
3.1.3. During the period between December 207 to March 2018 the IPC team implemented a safari ward round to ensure all patients admitted with symptoms related to influenza were promptly assessed to ensure full compliance with IPC practice, review of treatment plan and to support discharge planning.

3.2 Multi drug resistant Pseudomonas aeruginosa (MDRP)

3.2.1 The management of the multi-drug resistant pseudomonas outbreak on the Mersey Regional Burns Unit (Ward 4D) involved significant multi-disciplinary input from not only the Trust IPT and the ward clinical team but also other relevant colleagues within and outside of the Trust including from Medirest, Vinci Facilities and Public Health England (PHE).

3.2.2 The outbreak originated from the index case who was colonised with the strain on admission at the time of an inter-hospital transfer from abroad in November 2015. Following this, there were 7 further cases in burns patients up to the end of March 2017 (one of which is a cross transmission outside the Trust in a care home setting from a patient who was discharged who was known to be colonised with the

organism prior to discharge). Two new cases of the same organism was identified in 2017-2018 on ward 4D.

3.2.3 The source is likely to be environmental contamination (including the specialised burns bath as well as water drains which was confirmed by extensive environmental sampling). An enhanced cleaning/descaling regime for the bath was implemented and decision made to procure a replacement bath. Water outlets and drains on the ward were reviewed to ensure there was no risk of contamination of the water outlets via splash back or blockage of drains. Hydrogen peroxide decontamination equipment was procured by the ward and decontamination implemented in collaboration with Medirest including planned preventative decontamination.

4. Aseptic Non-touch Technique (ANTT)

4.1 Trust-wide ANTT continues to monitor compliance and for 2017-2018 is just below the trajectory of 85%. Actions are in place to improve this:

- ANTT: Each ward and department has a key trainer who is responsible for cascading training to all staff in their areas. Responsibility for training has been undertaken by the ANTT Nurse and assisted by the nominated lead from the IPT and the Lead Nurse for IP.

- ANTT practical competencies - since August 2015 these competencies are mandatory assessed by the Key trainers on an annual basis and are monitored by the ANTT Nurse Specialist.

- ANTT stickers, which are attached to the staff name badge, have been introduced since August 2016 to identify who has been assessed as competent in ANTT procedures and when their annual competency assessment is due.

- New cannulation packs, non-ported cannula, needle free devices and giving sets have been introduced in the Trust.

- IV Access and Therapy Group are held on a monthly basis and co-chaired by the Lead Nurse IP and Medical Emergency Team Consultant Nurse. The aims of the group are to:
  - To ensure that the use of intravenous devices complies with best evidenced based practice and is cost effective within the Trust

  - To facilitate and lead a Trust wide multidisciplinary approach to improvements in IV access and therapy

  - To provide a forum for collaboration across Directorates and specialities, monitoring of quality indicators and facilitate the development of Trust wide Intravenous guidelines.

5. Infection Prevention policies/publications

5.1 No new IP policies have been required.

5.2 The existing IP policy and SOPs have been reviewed in line with Trust policy.

6. Education and training

6.1 Staff Education

All staff, including those employed by support services, must receive training in prevention and control of infection. Infection Prevention is included in induction programmes for new staff, including support services. There is also a programme of on-going education for existing staff, including update of policies, feedback of audit results, with examples of good practice and action required to correct deficiencies, and Root Cause Analysis (RCA) reviews and lessons learned from the process and findings. Records are kept of attendance of all staff who attend Infection Prevention training/teaching programmes.

6.2 Training Sessions/Courses

- Trust Induction
- Infection Prevention Mandatory Update
- The IPT also provide training sessions on the Band 5 and HCA rolling education programme
- The IPT also provide training for Student, Cadet and Bank Nurses
- The Team also provide additional ad hoc education sessions held in seminar rooms in main hospital building. These sessions address current HCAI problems identified within the Trust. Topics have included MRSA, CDI and CPE
- FFP3 Face Fit testing The IPT provides a rolling programme of Fit testing that all staff have access to.

6.3 Link Personnel Programme

Link personnel meetings were held bi-monthly. An education session, usually from a guest speaker is incorporated into the meeting. Numerous topics were covered, including hand hygiene, CDI, MRSA, CPE, ANTT etc. In addition the link personnel have been encouraged to continue to undertake their own ward audits. New audit Indicators were introduced in January 2017 to address specific IP concerns on the wards /departments.

6.4 Hand hygiene

The Trust continues to strongly promote optimal hand hygiene practices. Covert surveillance from outside companies continued on an annual basis. Wards, Matrons and Link personnel are also encouraged to audit each other.

Compliance with “bare below the elbows" dress code is continually monitored by the IPT, Matrons and Senior Management.

Monthly observational audits are conducted of hand-washing to determine compliance with the Infection Prevention Manual Hand Decontamination Policy.

6.5 Infection Prevention Quiz

An interactive, locally-developed (jointly with IT) quiz is available http://iicquiz.shk.nhs.uk/ on the Infection Prevention intranet website under Infection Prevention training section. There is instant feedback on the results of each question and a score provided at the end of each section. The questions are devised to get across key messages in infection prevention and control.

6.6 Training Activities for Infection Prevention Specialists

The IPT have attended national meetings, eg Infection Prevention Society (IPS), ANTT and various meetings/study days throughout the year, including meetings of North West Infection Control Group (NORWIC).

7. Information Technology

7.1 The ICNet NG electronic infection prevention surveillance and case management system was implemented in December 2014 which has enabled the IPT to review and manage a much broader range of cases in a timely and time efficient manner.

7.2 In 2016, ICNet NG was successfully upgraded to version 7.4 which will strengthen the surveillance utility within the software in relation patient and ward specific audit.

7.3 Due to the current delay in the GE Opera Theatre Management System implementation, the expected interface with that system and ICNet had been on hold however although Opera is now live. However, Informatics Department has identified that there is no funding to configure the Opera-ICNet interface from an Opera point of view (although there is funding available to configure the ICNet side of this interface). Therefore the ICNet-Opera interface has been shelved for now pending launch of the electronic patient record (EPR) in 2018 which may be able to support some of the functionality required for surgical site infection surveillance.

7.4 Patientrack electronic Bristol Stool Chart (BSC) and CPE assessments.

7.4.1 Over the last 18 months, work has been carried out by the IPT to support the incorporation of the BSC and CPE risk/screening assessments onto the Patientrack system which records electronic patient observations within the Trust for inpatients.

7.4.2 It is anticipated that by making the forms electronic with automated/algorithm based scheduling and advisory prompts for staff will improve reliability of documentation and aid correct and timely patient management. The forms are expected to be launched in the latter half of 2017 after development and testing have been completed.

8 Audits and Surveillance

8.1 Surveillance: The Infection Prevention Team (IPT) undertakes continuous surveillance of target organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

8.2 Audits

8.2.1 Environmental audits using the IPS audit tools are carried out unannounced by the IP&C Practitioners and where possible accompanied by a member of departmental staff.

8.2.2 There is an extensive IP Audit plan in place which includes audits undertaken by the clinical staff on their wards and also audits undertaken by the IP team. The results are feedback to the Divisions on a monthly basis.

8.2.3 Monthly ward audits continue and continue to demonstrate good compliance. However some of that compliance can be questioned due to bias.

8.2.4 Audits by Infection Prevention Team

The following annual Trust-wide audits were carried out by the IPT:

- Sharps audit – undertaken by sharpsmart, results produced monthly
- Peripheral cannula (PIVC) trust wide audit – March 2018
- Compliance with IP precautions audits monthly during 2017-18
- Leaflet audit – Sept and Nov 2016; March 2017
- UCAM audit – November 2017
- Deep clean audits – June 2017
- Alcohol gel audits - May 2017
- Blood Culture Request audit – May 2017

In addition, the following audits were carried out monthly by the IPT:

- Commodes audit
- Mattresses audit - Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity this is led by the tissue viability team and supported by IPT. There is a system in place for the provision and storage of replacement mattresses across the Trust. The IP team work with the external supplier to ensure compliance with standards
- MRSA screening compliance
- Hand Hygiene Audits and Compliance - Compliance rate varies for 80-100%.

8.3 Mandatory Surgical Site Infection Surveillance (SSI)

8.4 PHE requires surveillance to be performed for at least one type of procedure (total hip replacement, hip hemiarthroplasty, total knee replacement and open reduction of long bone fracture) for at least one quarter of the year.

8.5 Mandatory surveillance covers the period up to discharge or 30 days following the procedure, whichever comes first. Additionally with surgery where a device is inserted follow-up is required after 12 months.

8.6 A summary of the infections of total hip and knee replacements and actions completed by the multi-disciplinary team (Orthopaedics, Infection Prevention and Control, Theatres, Tissue Viability and Pharmacy).

8.7 2017/18 data indicated that:

- There were 327 Hip operations performed of which 2 infections were noted (0.7% compared to 1.0% national average)
- There were 415 Knee replacements completed of which 2 infections were reported (0.5% compared to 1.3% national average)

8.8 April 2016 – March 2017 data indicates:

	STHK	National
Hips 301/2 infections	0.7%	1.0%
Knees 415/2 infections	0.5%	1.3%

8.9 Actions completed:

- RCA documentation has been revised to include the number of points taken from NICE guidance and One-Togetherness Toolkit
- To ensure a proper senior attendance, regular root cause analysis meetings now conducted in the Executive Boardrooms every month which is attended by the Consultant Orthopaedic Surgeons, Microbiologist, Ward Team and Infection Control Team
- Audit on Antibiotic prescription and delivery for total joint replacements performed and findings presented in the Audit Meeting.

9. Antimicrobial Stewardship

Key Achievements:

- Recruited new Band 7 Antimicrobial Pharmacist - Ben Logan.
- Continued weekly antimicrobial orthopaedic, urology, general surgery and plastics ward rounds. Also continued C.diff ward rounds with IPC nurses.
- Continued weekly site-wide antimicrobial stewardship ward rounds focused on carbapenems, piperacillin/tazobactam and other priority agents.
- Quarterly audits of antimicrobial use in sepsis carried out for the CQUIN.
- Repeatedly reviewed the Antibiotic Policy at short notice due to many significant drug shortages.
- Reviewed antibiotic renal dose adjustment policy and prepared an app which integrates this information with a CrCl calculator.
- Began development of e-learning package for clinicians to undertake every 3 years focused on prudent antimicrobial prescribing.
- Began development of OPAT database to track patient progress and improve quality/quantity of reporting.

Key challenges/issues:

- Antibiotic Policy and Antimicrobial Stewardship Strategy due for review.
- New CQUIN targets confirmed at very short notice and local contractual agreement delayed.
- Frequent shortages of key antimicrobial agents generating much extra work.
- EPMA remains outstanding limiting our stewardship reach.
- Lack of a funded OPAT service means that OPAT provision is ad-hoc with significant variation in quality/safety/follow up.
- Growing ward and managerial commitments from pharmacy greatly limit availability for both clinical work and service development.

Actions taken to overcome challenges and issues:

- Worked jointly with Southport and Ormskirk to update Antibiotic Policy and will shortly be disseminating draft document for consultation.
- Commissioned antibiotic review stickers to prompt CQUIN compliance.
- OPAT business case in progress.
- Andrew Brush enrolled in non-medical prescribing qualification.

Forward plan 2018/2019:

- Gain access to crystal reports and prepare for EPMA rollout.
- Begin an additional 'sepsis' ward round to aid CQUIN compliance.
- Work with pharmacy procurement to improve stock management.
- Develop further educational resources for staff.

9.1 Antibiotic Management Group (AMG) – the AMG meets and reviews all aspects of antimicrobial use throughout the Trust. The antimicrobial management team (AMT) includes antimicrobial pharmacists and clinical microbiologist(s) who are all members of the AMG. The team update and maintain the Trust's antimicrobial formulary, the stewardship strategy/policy and raise agenda items to be discussed at the AMG.

9.2 The AMG reports to Drug and Therapeutic Group (DTG) and Hospital Infection Prevention Committee (HIPG).

9.3 Following the launch of the Trust interactive antibiotic guideline on the intranet site in early 2013 the site has continued to be developed. The guideline has been hyperlinked to information sources such as online British National Formulary (BNF) and drug company data sheets (SPC).

9.4 The antibiotic policy has been updated regularly in 2017/18 in line with updated national guidance and local requirements and is due a full review in August 2018. The intranet base has been update in 2017 and will hopefully be launched in mid-2017 improve the speed and ease of access to policies and guidelines including the antibiotic guideline.

9.5 Trust Clinical and Quality Strategy Action plan and also the Nursing and Midwifery Strategy were launched in 2014 continues to run till 2018. The goal is to reduce Hospital Acquired Infections (HAIs) and promote a culture of safety throughout the Trust. The strategy is on the intranet under antimicrobial stewardship strategy.

9.6 Throughout 2016 the AMT continued to respond to NICE guidance 15 updates – Antimicrobial stewardship: systems and processes for effective antimicrobial use. The goal is to implement this action plan over 2016 period resources allowing.

9.7 The Trust-wide antibiotics point prevalence audits continued in 2017/18. Audits continued to include completion of course length/review date endorsement, documentation of antibiotic indication, % missed doses and due to Trust CQUIN targets a senior practitioner review of patients antibiotic therapy was added within the first 72 hours of treatment.

9.8 All data was analysed trust wide and subdivided into medical and surgical directorates.

9.9 The data findings indicated that there was:

- 97% compliance documented review within 72 hours (adherence to Trust policy/microbiology advice being 92%)
- Documentation of indication was 99%.

9.10 Throughout 2017 smaller antibiotic point prevalence audits were conducted and reported on a monthly basis as a part of the Trust's Infection Prevention performance framework and submitted to the CCGs as part of the CQUIN program contract variation.

9.11 OPAT (outpatient parenteral antibiotic therapy) services for Halton and St. Helens continued to grow in 2016. Utilising the OPAT service activity in 2016 has increased on the 2015 figures.

9.12 The successful completion rate of therapy under OPAT to the desired outcome over 7 years' audits has continued to be over 90%. Over this period more than 1300 patients have been referred to OPAT with more than 22,300 bed days saved.

9.13 The landscape for OPAT therapy has seen considerable shifts in both types of patient referrals and therapies utilised. More intravenous (IV) ceftriaxone and teicoplanin have been used. In addition more patients have been referred for OPAT as part of ambulatory care services and also admission avoidance directly from clinics.

9.14 The Consultant Microbiologists have continued to be integral to the Antimicrobial Management Team (AMT) and developing and maintaining the interactive antibiotics guideline and developing the Mersey Micro application. AMT ward rounds will continue to expand resources allowing focusing on areas of high use antibiotics, increased rates of healthcare associated infection or areas that were performing poorly in point prevalence audits.

9.15 In 2017/18, the AMT continued contributing to the Executive Root Cause Analysis Review Panels for significant HCAIs, specifically reviewing the use and appropriateness of antimicrobial therapy.

9.16 In 2017 the Trust took part in the European Antibiotic Awareness Day (EAAD). This included an educational stand for both staff and patients to come and meet the antimicrobial management team. There were posters of Trust related initiatives such as antimicrobial resistance, Trust initiatives including the Mersey Micro app, antibiotic guardianship was promoted and education resources from Public Health England (PHE) distributed with the goal to promote good antimicrobial stewardship. The stand was attended by a high number of both staff and patients and was advertised on global emails and team brief. There has also been a good following on social media sites such as Facebook and Twitter.

9.17 This Trust achieved the AMR and Sepsis CQUIN in 2017/18.

10. Health, Work and Wellbeing (including Sharps)

10.1 The Health, Work and Well-being (HWWB) provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff. There is also a recall system in place in which staff are recalled (if appropriate) for vaccinations when due to ensure that they are kept up to date and our compliant.

10.2 The service has also supported advice and treatment in the event of outbreaks or incidents requiring staff screening or treatment. The Trust Health & Wellbeing Department report monthly to the IPC including vaccination updates.

10.3 Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on measles, chicken pox, HIV and hepatitis C have been incorporated for all 'new starters' and a catch up exercise is in place for staff already employed. The IPT supports the Health & Wellbeing Team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

10.4 The HWWB team leads the seasonal flu vaccination campaign. The flu campaign commenced September 2017 with the aim of completing the campaign by the end February 2018.

10.5 **Key Achievements:**

- Flu uptake – 87.2% highest uptake of flu vaccination for front line healthcare workers achieved by the organisation.

- On line pre-employment health questionnaire which has helped to provide assurance with regards to new starters occupational immunisation assurance.

10.6 **Key challenges/issues:**

1. Hepatitis B vaccination not been available for almost 2 years, limited stock only to be used for emergency e.g. inoculation injuries. The look back exercise has identified approximately 900 staff requiring Hepatitis B.

2. Mantoux and BCG vaccination still unavailable.

10.7 **Actions taken to overcome challenges and issues:**

1. Hepatitis B look back exercise commenced and staff will be called to attend for vaccine in September when we will also provide the flu vaccination.

2. Staff advised of the re: signs and symptoms of TB and risk assessment recommended for high risk areas.

10.8 **Forward plan 2018/2019:**

- Achieve higher uptake of flu vaccination for front line healthcare workers**.**

- A campaign to reduce the incident of inoculation injuries e.g. needlestick injuries.

When Mantoux and BCG vaccination available look back exercise will be completed and a plan will be developed to vaccine those staff currently not vaccinated, identifying high risk groups in the first instance.

11. Decontamination

11.1 Decontamination audits are organised and carried out by the Decontamination Manager/ Trust lead for Decontamination in accordance with an annual work plan which is agreed by the Decontamination Group. The results are discussed at the Trusts Decontamination Group, which in turn reports to the HIP Group.

11.2 All decontamination and sterilisation of reusable medical devices is carried out off site by the Trust sterile services partner (Synergy Health PLC).

11.3 Central decontamination and high level disinfection of flexible endoscopes; there are two small satellite units which operate to local SOP's and are audited bi-annually as part of the decontamination managers work plan.

11.4 **Key Achievements:**

Interim Decontamination Unit signed off by AED for further twelve months. The recent JAG audit carried out by the AED was also passed.

Senior staff attended City and Guilds – Endoscope Managers Decontamination Course over three days. All the candidates passed.

Project Manager appointed for the cold decontamination projects together with a project team and project group. Regular meetings are now taking place and relevant feasibility studies are progressing for both hospitals.

Weekly residual protein testing has been implemented by the Quality Manager to comply with the current guidelines.

11.5 **Key challenges/issues:**

Implement a number of points highlighted by the most recent AED annual audit in June 2018. The points raised by the AED have taken into the account the limitations of the existing old equipment and the fact that new projects are being planned.

Maintaining chemically disinfected RO water plants to the correct standard so that the processing of endoscopes can take place to the correct standard.

11.6 **Actions taken to overcome challenges and issues:**

Continued regular meetings with key suppliers to monitor performance with relation to daily operational issues/routine service/validation of ageing capital equipment.

Continued regular training updates and attending relevant study days.

11.7 **Forward plan 2018/2019:**

Current planning is mainly centred around the new cold decontamination projects and this includes understanding the latest guidelines and standards. Researching the current marketplace for the latest decontamination equipment and associated products.

12. Estates, Facilities, Waste Management and Water Safety

12**.1 Key Achievements:**

The Estates and Facilities Management team and their PFI (private finance initiative) partners: NewHospitals, Vinci FM and Medirest continue to work closely with the Infection Prevention and Control team to ensure statutory obligations are met and a safe, clean and quality environment is maintained for patient's, staff and visitors within the Trust. The services delivered include Facilities performance management, estates, pest control, utilities, waste management, domestic services, catering, linen and laundry, portering, car parking, security and helpdesk services.

The teams have continued to comply with the required legislation, service specifications and develop all services in line with the ever changing requirements of today's healthcare environments.

As a result of this and in response to the key infection control challenges presented the team has achieved the following:-

- Excellent PLACE scores for both 2017 and 2018 inspections with condition and appearance, infection control and cleaning categories all achieving 100% compliance in the 2017 inspection (scores for 2018 to be confirmed).
- Introduced Sharpsmart in trial areas in regards to the disposal of sharps both at Whiston and St Helens Hospitals to improve the compliance and reduce the number of waste breaches.
- Conducted ward redesign works with minimal impact to the ward environment.
- Provided specific water safety training to augmented care units and continued the monitoring of ward staff compliance with water safety control systems at ward level.
- Continued with multidisciplinary managerial environmental monitoring in high risk clinical areas.
- Revised and redesigned training programme on waste segregation for clinical staff.
- Achieved excellent food hygiene ratings on both hospital sites following environmental health inspections.
- Continued monitoring of the hospital ventilation maintenance systems and theatre gas scavenging systems to provide assurance of compliance with HTMs.
- Undertakes Hydrogen Peroxide fogging within the Burns Unit to support the deep clean process.

12.2 **Key Challenges:**

- Correct categorisation and disposal of waste at ward level
- Space utilisation, hospital redesign and configuration works
- Water safety within augmented care areas
- Cleaning access within theatre areas where operating lists have extended
- Maintaining PLACE standards
- Maintenance of the hospital ventilation system and theatre gas scavenging systems to provide assurance of compliance with HTMs
- Improve the Trusts response to and assist in the reduction of HCAI's
- The alignment of services at Newton Community

12.3 **Action Taken to Overcome Challenges:**

- Introduced a trial of the Sharpsmart system for the disposal of sharps which has demonstrated a significant reduction of waste breaches in the areas undertaking the trial. A proposal has been put forward to implement the system across all Trust sites.
- Ongoing number of hospital redesign and configuration projects to the internal environment since the hospitals opened. Established user groups to ensure design complies with infection control requirements and works are undertaken in such a way as to minimise the impact and disruption at ward level.
- The Water safety group continue to refine systems to ensure water safety at ward level, in particular within augmented care areas. The estates team provide bespoke training for clinical teams to monitor little used outlets and identifying non-compliance with systems.
- To continue to provide assurance of standards in theatre areas with managerial environmental checks in collaboration with Facilities Managers and Infection Prevention Nurses. This is undertaken using the PLACE principles in order to provide additional assurance that High risk clinical environments are safe and fit for purpose.

- Continue to provide assurance that the required maintenance of the hospital ventilation system takes place a new monitoring system has been developed to demonstrate the planned and reactive maintenance works completed.

12.4 **Forward Plan 2018/2019:**

The Estates and Facilities Management team will continue to work closely with infection prevention colleagues to review and develop services to achieve and maintain a safe, clean and quality environment. The team will continue to provide assurance that the hospital environment is fit for the clinical services delivered. Work streams will include:-

- Improve audit tools for the monitoring of minor and major construction work onsite.
- Enhance the multi-disciplinary user groups for major works to ensure safe infection prevention systems are put in place.
- Continue to work with wards staff to conduct training on the correct use of the ward sluice masters to reduce the number of blockages.
- Ensure safe systems of operation to enable the implementation of chilled water within all ward areas.
- Review the performance monitoring regime across all facilities management services to ensure they align with all corporate objectives by introducing KPI's.
- Review waste segregation at Whiston Hospital.
- Implement the Sharpsmart across the 3 sites – Whiston, St Helens and Newton.
- Continue to review training systems across all facilities management teams to ensure the standard of training delivered reflects the Trusts objectives via the PMS.
- Conduct a feasibility study into the implementation of UV decontamination equipment to support the deep clean process at ward level.
- New computerised monitoring system for domestic supervisors.
- Review cleaning products and hygiene products.

13. Burns Unit Report. Ward 4D

13.1 **Key Achievements:**

Eradication of a multi-resistant pseudomonas strain that had resulted in an outbreak from the unit. Co-authored journal article for Journal of Hospital Infection in collaboration with PHE on this experience.

Participated in task and finish group for infection control – northern burns network (chaired by K.S).

Exceptional levels of cleanliness and IP practice on burns unit.

13.2 **Key challenges/issues:**

This patient group is inevitably colonised by resistant organisms which is challenging.

Staffing levels and relative imbalance of junior staff vs senior. Limited opportunities for CPD, training and education.

Burns Unit bath requires upgrading, currently reviewing available replacements.

13.3 **Actions taken to overcome challenges and issues:**

Strict barrier nursing.

Nurse educator role presence on burns unit expanded.

Staff room upgraded to seminar room (pending).

Infection prevention/burns unit collaborative effort to source a new bath for the unit.

Integration of lead microbiologist into the burns weekly MDT meetings.

14. Intensive Care Unit

14.1 **Key Achievements:**

Environmental audit April 2018 96%, MRSA screening compliance 100%.

RCA all completed and lessons learned disseminated to all staff.

Matching Michigan, 0% incidence of line sepsis**.**

14.2 **Key challenges/issues:**

Completion of risk assessments on patient trac.

Staff shortage, potential impact on infection prevention.

Screening for patients at risk of CPE impacts on available side rooms.

14.3 **Actions taken to overcome challenges and issues:**

Paper copies completed but ensure that all staff are made aware to complete patient trac.

Staff vacancies advertised and now fully recruited.

Discussion with microbiology to prioritise the use of cubicles.

15. Glossary of abbreviations

AMT	Antibiotic Management Team
ANTT	Aseptic non-touch technique
AQ	Advancing Quality
BBE	Bare below the elbow
CAP	Community-acquired pneumonia
CCG	Clinical commissioning group
CDI	Clostridium difficile infection
CQC	Care Quality Commission
CVAT	Central Venous Access Assessment Tool
DDD	Defined daily dose
DOH	Department of Health
DTC	Drugs and Therapeutics Committee
ED	Emergency Department

HII	High impact intervention
HIPG	Hospital Infection Prevention Group
IPT	Infection Prevention Team
IV	Intravenous
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
MET	Medical Emergency Team
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OPAT	Outpatient parenteral antibiotic therapy
PGD	Patient Group Directive
PPE	Personal protective equipment
PFI	Private Finance Initiative
PLACE	Patient-led assessments of the care environment
PPI	Proton pump inhibitor
RCA	Root cause analysis
SSI	Surgical site infection
TTFD	Time to first antibiotic dose
UCAM	Urinary catheter assessment and monitoring
VIP	Visual infusion phlebitis
WHO	World Health Organisation

Appendix 1 – Infection Prevention Work plan 2017/18

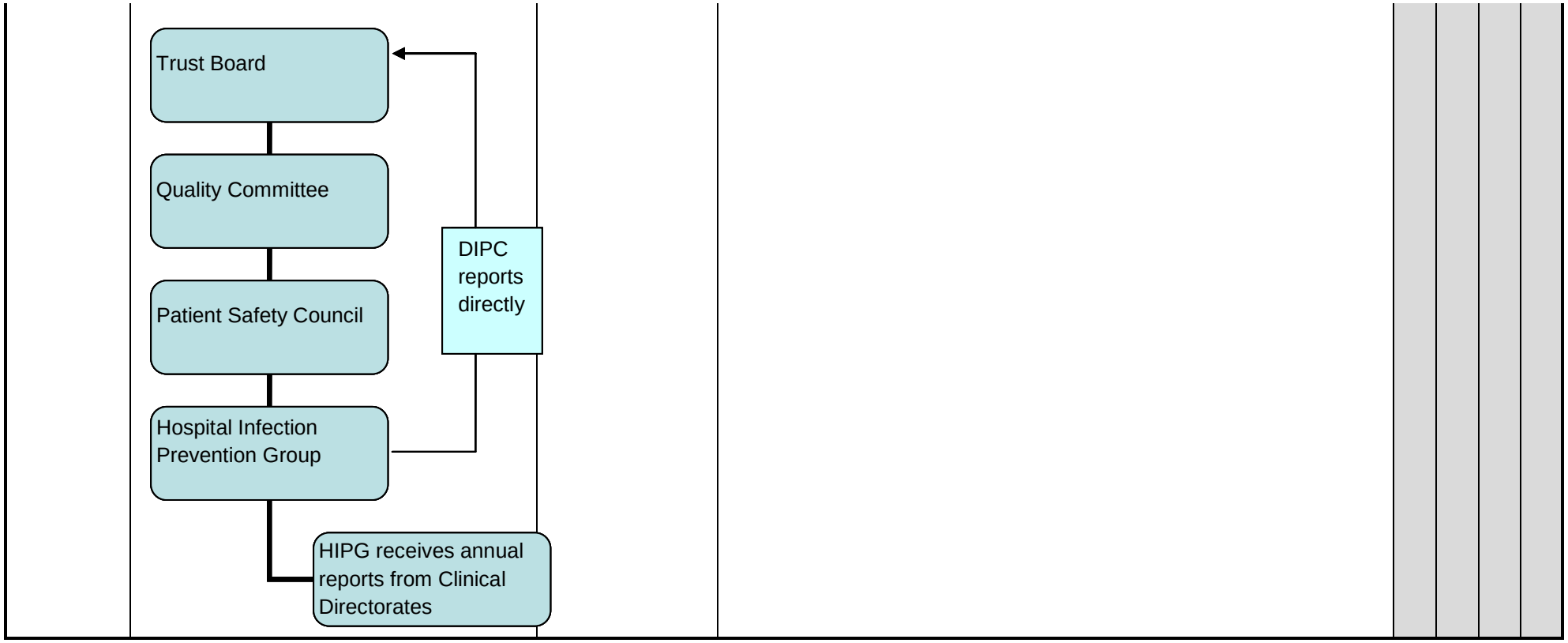
Infection Prevention Work Programme 2018/2019							
IP Code and Trust Objectives	**Plan and Priority Activities 2017/18**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6,9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**12. Interface with relevant groups** IP to attend and provide expert opinion for topics related to IP. Escalate issues to DIPC as necessary. To review new equipment/environmental utilisation.						
	Patient Safety Council	KM (Lead Nurse to deputise)	To provide on a monthly basis an update of IP surveillance and safety issues via a monthly report and attendance at Patient Safety Council.				
	Decontamination	MF and Lead IP Nurse	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Waste	JG	To attend scheduled meetings. To provide expert advice and support as required.				
	Water Safety	KM/OM	To attend all WSG meetings. To provide expert advice and support as required.				
	Built Environment	IPT Nominated Matron from Care Groups)	To attend meetings as required.				
	Estates and Facilities	IPT	To provide expert advice and support as required.				

	Health, Work & Well-being	IPT	To provide expert advice and support as required. To attend and represent IP at Trust Sharps Safety Meetings.				
	Medical Devices	MK	To provide expert advice and support as required.				
	Mattresses	IPT	To be involved in the renewal of contract relating to bed frames and mattress decontamination				
	Health & Safety	IPT	To provide expert advice and support as required.				
	Emergency Planning	IPT	To provide expert advice and support as required.				
	Care Group governance meetings	IPT	To provide expert advice and support as required.				
	Trust Team Brief	OM	To attend and disseminate information given out at Trust Team Brief.				
	Ad Hoc meetings	IPT	To provide expert advice and support as required.				

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q 1	Q 2	Q 3	Q 4
IP Code: 1, 3, 4, 8 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**1. Infection Prevention Team Staffing**						
	DIPC - Director of Nursing, Midwifery and Governance	Sue Redfern (SR)					
	Infection Prevention (IP) Doctor – Consultant Microbiologist	Dr Kalani Mortimer (KM)					
	Deputy IP Doctor – Consultant Microbiologist	Dr Michael Fisher (MF)					
	Lead Nurse IP	Oonagh McGugan (OM)					
	2 x IP Specialist Nurses (Band 7)	Julie Grimes (JG) Maureen Kendrick (MK)					
	0.5 x ANTT Specialist Nurse (Band 7)	Emily Ellis (EE)	Two secondees appointed for two 6 month placements to cover maternity leave				
	1 x IP Nurse (Band 6)	Alice Cruz (AC)					
	1 x Assistant Practitioner (Band 4)	Tracey Kelly (TK)	Action:TK Commenced Nursing Apprenticeship in October 2017, this leaves the IPT with 0.5WTE AP				
	1 x IP Secretary (Band 4)	Joy Davidson (JD)					
	0.6 Audit & Surveillance Assistant	Jackie Crute (JC)					

	Antimicrobial Management Pharmacists. (Pharmacy budget)	Andy Lewis (AL) Andrew Brush (AB) Ben Logan(BL)					
	The Trust Antimicrobial Management Team (AMT) consists of AL, AB, KM & MF						
	Hospital Infection Prevention Group (HIPG)						
	The IPT reports to the Board via the HIPG. The HIPG meets 6 times per year. The reporting line to the Trust Board is shown below. The Terms of Reference(TOR) were reviewed and amended in June 2018		TOR reviewed at HIPG Q1 2018				


Trust Board
Quality Committee
Patient Safety Council
Hospital Infection Prevention Group
HIPG receives annual reports from Clinical Directorates
DIPC reports directly

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q 1	Q 2	Q 3	Q 4
IP Code: 1, 3, 4 and 5 **Trust Objectives :** Care, Safety, Pathways, Systems and Communication	**2. Surveillance**						
	Alert Organisms	Microbiology and IPT	To maintain and alert Trust staff to any potential risks from pathogenic organisms. To provide IPC advice and support in order to minimise the risks to patients, staff and visitors.	Ongoing			
	Mandatory Reporting - It is a mandatory requirement for the Trust to report a variety of pathogenic organisms/infections to PHE for monitoring purposes			**Q 1**	**Q 2**	**Q 3**	**Q 4**
	MRSA/MSSA/VRE/E-COLI/Klebsiella/ Pseudomonas aeruginos Bacteraemia	Microbiology and IPT and Executive Review Panel, AMT	To identify, communicate and instigate investigations by the clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through the Executive Review Panel and to disseminate lessons learned for the process. Lessons learned are shared through the organisation via the monthly IP report, this report is available to all clinical staff	Ongoing			

	Clostridium difficile/PTP	Microbiology and IPT	To identify, communicate and instigate investigations by the clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through the Executive Review Panel and to disseminate lessons learned for the process. The IPT in conjunction with Microbiology undertake a weekly CDI ward round reviewing all active CDI and specifically identified PTP cases within the Trust. All hospital acquired CDI RCA reviews are sent to the CCG's for review regardless whether they are going forward for appeal or not.	Ongoing			
	CPE	Microbiology and IPT	To monitor the screening of identified risk patients (as per Trust policy) and to ensure that appropriate action is taken. To identify, communicate and instigate appropriate actions when the organism is identified.	Ongoing			
	Matching Michigan - ICU (4E)	ICU Consultant (JW)	Data collected by the ICU team is presented in the monthly IP report To discuss data and trends at the Patient Safety Committee. (PSC) To monitor results and instigate investigation if required.	Ongoing			

	Surgical Site Infection (SSI) surveillance for Orthopaedics	Microbiology, IPT Orthopaedic Team and Executive Review Panel	To support the investigation and presentation of incidences of SSI through the RCA process at the Executive Review Panel meetings and to support the dissemination of lessons learned to the relevant staff. To collect and submit data for SSIs in orthopaedics. To disseminate reports to the relevant clinical staff. To include data and reporting in IP Monthly Report. To provide a report for the HIPG every 2 months	Ongoing			
	Multi Drug Resistant Pseudomonas (MDRP)	Microbiology and IPT Burns team	To report and investigate all incidences of MDRP. Continue to work with the Burns Unit/Ward to ensure that practices and medical devices procured are conducive to preventing MDRP. A patient bath which is safe, effective and easily cleaned to be sourced by the burns team and the IPT	Ongoing			
	Candida auris bacteraemia	Microbiology, IPT, CCDC	To review updated PHE Guidance on candida auris and formulate Trust Policy. National guidance discussed at HIPG - awaiting further information from PHE via CCDC to clarify exact screening criteria .				

Infection Prevention Work Programme 2018/2019							
IP Code and Trust Objectives	**Plan and Priority Activities 2017/18**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**3. Hand Decontamination**						
	Introduce new hand decontamination sign posting for the Trust	IPT,Sylvia Sinclair (SS) Deputy General Manager (Medirest), Diversey and Gojo representatives	Determine what resources are available, assess their suitability and roll out throughout the trust				
	Introduce new hand decontamination education tool to wards and departments which incorporates an audit facility	IPT, Gojo rep	All wards and departments will have their hand hygiene technique assessed and audited, All wards and departments will focus on areas identified as requiring improvement				

Infection Prevention Work Programme 2018//2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**4. Policies and Patient Information Leaflets**						
	Review and update Infection Prevention Policies as required	*DIPC*	*Sharps, TB policies have been to HIPG waiting for approval from PSC. GI, hand decontamination and bed management will be complete by the end of Q1.Policy programme will be reviewed at the bi weekly IPT meetings*				
	System to be devised and implemented to remind nominated policy reviewers of when policies are due	*JD*	*Electronic system in place to inform nominated policy reviewer of timing of policy review.*				
	To provide advice and support on policies where IP is an integral component	*IPT*	*Participation in updating relevant IP related policies*				
	To review and update current patient leaflets. *To devise further patient leaflets as required*	*IPT*	*All patient leaflets have been updated and sent for printing to an external company*				
	To format policies and patient leaflets in Trust Format	*JD*					

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Monitor Trust wide compliance and increase compliance rates.	EE and secondee	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training	EE and secondee with support from Learning & Development	Key Trainer Training half day sessions are provided 4 times a year. The aim would be to increase this number to 6 times per year. However, this is dependent on facilitator and room availability. Extra sessions are provided as required by peripatetic ANTT staff to areas where compliance is low and where staff cannot be freed to attend the training days				
	Liaise with ANTT experts to review and refine existing processes	EE	EE to attend annual ANTT Conference. EE/OM to attend North West IV Forum Meetings.				
	To act as an advisory role for vascular access and therapy related issues.	EE, ANTT lead Nurse Consultant ICU	To provide expert advice on matters relating to vascular access and therapy. Provide report to the HIPG every two months. Lead IP Nurse to co-chair along with Nurse Consultant ICU, the Intravenous Access & Therapy Group on bi-monthly basis.				
	Monitor and communicate all cases of vascular access device related infections	EE	To identify, communicate and instigate investigations by the clinical teams for PIVC and CVC line infections. Provide report to the HIPG every two months				

	Produce and e-learning package for clinical staff	IPT	Content of e-learning package has been produced by KM. This has now to be converted into a web based education programme that will have a test element added to it. Education and learning to provide the resource for this				

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 3, 4, 5, 6 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**6. Training**						
	Ensure that IP staff are kept updated with IP evidence based practice	DIPC Lead IP Nurse	To ensure that a member of the IP Team attends the North West Infection Prevention Society (IPS) meetings at least once per year. 13.09.18 Cumbria, 13.12.18 Chorley To regularly attend local HCAI whole health economy meeting To attend local and National IP/relevant conferences as the service will allow				
	To ensure that Trust staff are kept updated with IP evidence based practice **Please see plan below:**						
	Induction	IPT	Twice a month				
	Mandatory	IPT	For all staff annually, sessions are 2-3 times weekly.				
	Preceptorship	IP Team Antimicrobial Management Pharmacists (AL, AB)	6 times per year				

ANTT Key Trainers	EE	>4 times per year				
Line Care Course	EE	>6 times per year				
Link Personnel	IPT	6 times per year				
Fit Testing Key Trainers	IPT	Monthly				
UTI collaborative	IPT and key trust staff					
IP antibiotic prescribing	Antimicrobial Management Pharmacists/Consultant Microbiologists	AMU Junior Doctor training; Surgical Junior Doctor teaching (both minimum twice yearly); Fourth year Medical Student teaching (6 times per year); all medical staff inductions; Grand Rounds as required; pharmacist clinical meetings at least updates every month and clinical education sessions twice per year. Pharmacist teaching for FY1 and FY2 Junior Doctor cohorts each at least twice per year.				
Ad hoc training to include: Volunteer Student Cadet Fundamental Training	IPT	As required, 2-3 times a year Monthly				

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 3, 4, 5, 6 7, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**7.Audit**						
	To provide assurance to the Board and relevant committees of adherence to high quality IP practices. All findings are communicated to the relevant clinical staff and reported via the IP monthly report and the HIPG. All lessons learnt are disseminated to the relevant staff and other agencies as appropriate in a timely manner.	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and PSC				
	The IPT follow the audit plan that was revised and commenced in January 2018. Audit Programme revised annually.	IPT	All clinical areas are audited on a monthly basis and action plans produced. Any area with a suboptimal score are revisited until issues are addressed and the area is compliant				
	Further audits are undertaken by the IP Team as set out in the work plan and as the service requires	IP Team	Commodes and Dirty Utility (monthly), Flushing Audit (augmented areas), Sharpsmart Audit, Enteral Feeding, Ward Kitchen audit, Hand Sanitiser placement audit bi annually, Blood Culture Audit monthly, Deep Clean Audit, Trust wide sharps audit annually				

	Wards and identified Departments	IP Team	Audits undertaken on an annual basis and are re-audited/re-visited dependant on concerns/scores.				
	Peripheral Intravenous Vascular Catheters (PIVC) and Central Vascular Catheters (CVC). Visual Infusion Phlebitis (VIP) Scoring	EE Matrons & Link Personnel	Annually - reported to the HIPG and Clinical Leads. VIP audits are undertaken if issues are identified through RCA Monthly reporting via IP audit indicators				
	UTI collaborative initiative requires several audits to be undertaken to provide baseline date which will inform the improvement programme. Catheter prevalence audit. UCAM forms audit. UTI prevalence audit. Review catheter passports, incontinence product suitability. Appropriate treatment with antibiotics to be audited. Baseline of UTI/CAUTI. The focus for this work will initially be on the care of the elderly ward	IPC Team, DIPC Continence Nurse specialist. Urology ward manager, AKI nurse specialist. AB pharmacist. Consultant in care of the elder person	Involved in a series of breakthrough improvement collaboratives for system wide improvement, focusing on interventions to reduce healthcare associated Urinary tract infections (UTI) /catheter associated UTIs. This clinically-led programme is a joint venture with NHS England and has been developed using Quality Improvement methodology. commenced May 2018.				
	Compliance with IP precautions, including isolation, care plans, PPE etc.	JC	Quarterly				
	MRSA Pathway	JC	Quarterly				
	CPE assessment and screening.	IPT	Reported monthly in the IP report and bimonthly to the HIPG				
	Bristol Stool Chart	IPT	BSC are completed electronically on Emews. Compliance reported monthly in the IP report and bimonthly to the HIPG				

	Blood Culture Contamination Rates	KM JG	ED rates reported weekly and communicated to Clinical Leads via e mail. Trust rates reported on a monthly basis via IP Monthly report to clinical Leads.				
	Mattresses	TK/JC	Mattresses on the warded areas are audited once a month. Air mattress cleaning (externally managed) is audited on a bi-annual basis at Drive Wigan				

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 3, 4, and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**8. Antibiotic Prescribing**						
	Participate in CQUIN program for antimicrobial resistance strategies	AMT	Reported monthly to executive leads and quarterly to HIPG and DTG				
	Undertake AMT ward rounds on Plastics, general surgical and orthopaedic wards	AMT	Immediate feedback provided on wards rounds to staff and areport twice yearly to directorate, HIPG and DTG				
	Twice yearly antibiotic point prevalence audits focusing on policy adherence, missed doses, review of antibiotics within 72 hours of commencement and appropriate course length	AL / AB	Audit updates circulated Trust wide monthly as part of the IP monthly report. Full Trust wide point prevalence audit reported back to Trust Clinical Leads twice yearly.				
	Participate in OPAT audit	AL / AB	To be circulated Trust wide annually				
	Presentation of antimicrobial expenditure information	AL / AB	Quarterly to HIPG and DTG				

	Maintenance and development of the Trust antibiotic guideline. The integration of Smart device app calculators within the intranet based guideline	AMT	Sessions provided to each CCG yearly				

Infection Prevention Work Programme 2018/2019							
IP Code and Trust Objectives	**Plan and Priority Activities 2017/18**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IP Monthly Report	IP Team and AMT	Unified IP monthly report, combining monthly reports for the Medical and Nursing staff.				
	Communication with other Trusts and agencies such as Public Health England (PHE)	IP Team	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IP investigations.				
	Trust intranet	IP Team	To maintain and update the Trust intranet site with relevant and up to date information for Trust staff.				
	Mersey Micro smart device app	AMT	To maintain and update the Mersey Micro app in line with changes to Trust antibiotic policy				

	Administration	JD	To provide administrative support to the IP Team to include: Co-ordination of relevant IP Meetings Diary management. Data collection for monthly reports. Co-ordinate RCA meetings and documentation. Signposting for wards and departments telephoning for IP advice. Taking and distribution of minutes for relevant IP meetings Co-ordination of IP documentation, e.g. audit programme, education programme. ESR administration, ICNet administration				

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 3, 4, 5, 8 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**10. Information Technology** To interface with new technology, including Pharmacy alerts.						
	ICNet	IPT KM	To continue to work with the ICNet system Interface with the HCAI DCS being introduced; to be tested Q2 To introduce further functions to the system as they become available via ICNet - next version (1.5) - which includes audit and surveillance. To maintain ICNet administration				

Electronic prescribing	KM/AL/MF	To help develop the functionality of the JAC 2016 EPMA system. To add alerts to the JAC system.				
Develop e-learning package for appropriate antimicrobial prescribing	AMT	To develop packages in 2017-2018 into ESR for IP and antibiotic prescribing for staff development - currently in development; limited by human resources and time available as no support available from IT.				
Interactive Trust antibiotics policies	AMT	To develop and maintain Trust intranet antibiotic policy and Mersey Micro App - both have been kept up to date according to changes in policy necessitated by antibiotic shortages. The AMT have also checked and validated the transfer of the antibiotic web pages from the old to new intranet.				

Infection Prevention Work Programme 2018/2019							
IP Code and Trust Objectives	**Plan and Priority Activities 2018/19**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6,	**11. IP Engagement at Ward and Department Level** To continue to communicate, advise, support and educate all staff within the Trust on IP related issues.						

9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	Link Personnel	IPT	To continue to communicate, support, advise and educate IP Link Personnel via Bi-monthly meetings and ad-hoc training. To ensure that Link Personnel are aware of responsibilities. To monitor the timely submission of the monthly audit indicators from wards and in departments and indicate non-compliance with submissions in HCAI monthly report.				
	Visit ward and patient when mandatory alert organism identified	IPT	To review the patient to ensure appropriate, safe care. Commence the RCA alongside the ward staff to provide a comprehensive history of the patients pathway and to identify any issues that may have contributed to the infection				
	Work collaboratively with ward and department staff	IPT	To identify IP issues in a timely manner and supporting staff in resolving these issues. A specific member of the IP Team (as identified in the audit programme) will support staff in that area on IP issues).				

Infection Prevention Work Programme 2018/2019

IP Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 3, 4, 5, 6,9 and 10	**12. Interface with relevant groups** IP to attend and provide expert opinion for topics related to IP. Escalate issues to DIPC as necessary. To review new equipment/environmental utilisation.						

Trust Objectives: Care, Safety, Pathways, Systems and Communication	Patient Safety Council	KM (Lead Nurse to deputise)	To provide on a monthly basis an update of IP surveillance and safety issues via a monthly report and attendance at Patient Safety Council.				
	Decontamination	MF and Lead IP Nurse	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Waste	JG	To attend scheduled meetings. To provide expert advice and support as required.				
	Water Safety	KM/OM	To attend all WSG meetings . To provide expert advice and support as required.				
	Built Environment	IPT Nominated Matron from Care Groups)	To attend meetings as required.				
	Estates and Facilities	IPT	To provide expert advice and support as required.				
	Health, Work & Well-being	IPT	To provide expert advice and support as required. To attend and represent IP at Trust Sharps Safety Meetings.				
	Medical Devices	MK	To provide expert advice and support as required.				
	Mattresses	IPT	To be involved in the renewal of contract relating to bed frames and mattress decontamination				
	Health & Safety	IPT	To provide expert advice and support as required.				
	Emergency Planning	IPT	To provide expert advice and support as required.				

	Care Group governance meetings	IPT	To provide expert advice and support as required.				
	Trust Team Brief	OM	To attend and disseminate information given out at Trust Team Brief.				
	Ad Hoc meetings	IPT	To provide expert advice and support as required.				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)AOB
Title of paper: Learning from Deaths Quarterly Report 2017/18 Q4
Purpose: To present the Board with an updated report to that presented at July's Board, showing the two key learning points for Q4 and the audit of dissemination of the learning points from Q3.
Summary: Data is given for 2017/18 and key learning described
Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, communication
Financial implications: None
Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners
Recommendation(s): To approve the report
Presenting officer: Prof Kevin Hardy, Medical Director
Date of meeting: 26th September 2018

STHK Learning From Deaths Board Report

	Deaths in Scope [1]	Specified Groups									
		LD Deaths	SMI Deaths [2]	Child Deaths	Neonatal Deaths & Stillbirths	Maternal Deaths	CQC Alert Deaths	Diagnosis Group [3] Deaths	SIRI Deaths	Concern [4] Deaths	**Total [5]**
Apr-17	121	0	1	0	3	0	0	10	0	3	**17**
May-17	133	1	0	0	3	0	0	11	1	2	**17**
Jun-17	132	0	0	0	2	0	0	9	1	0	**12**
Jul-17	143	1	1	0	0	0	0	12	1	1	**16**
Aug-17	130	2	2	0	2	0	0	8	0	1	**14**
Sep-17	150	1	3	0	5	0	0	11	1	1	**22**
Oct-17	128	1	0	1	3	0	0	14	0	4	**23**
Nov-17	130	2	1	0	2	0	0	12	0	1	**18**
Dec-17	149	0	0	0	1	0	0	9	0	2	**12**
Jan-18	213	1	0	0	2	0	0	24	1	0	**28**
Feb-18	154	0	0	0	1	0	0	13	0	0	**14**
Mar-18	149	2	1	0	2	0	0	8	0	0	**13**
Total	**1,732**	**11**	**9**	**1**	**26**	**0**	**0**	**141**	**5**	**15**	**206**

	Specified groups			Non-Specified groups		
	Total [5]	Reviewed	**% Reviewed**	Total	Reviewed	**% Reviewed (Target 25%)**
Apr-17	17	17	100.0%	104	30	28.8%
May-17	17	17	100.0%	116	37	31.9%
Jun-17	12	12	100.0%	120	32	26.7%
Jul-17	16	16	100.0%	127	34	26.8%
Aug-17	14	14	100.0%	116	37	31.9%
Sep-17	22	22	100.0%	128	23	18.0%
Oct-17	23	23	100.0%	105	28	26.7%
Nov-17	18	18	100.0%	112	29	25.9%
Dec-17	12	12	100.0%	137	40	29.2%
Jan-18	28	28	100.0%	185	47	25.4%
Feb-18	14	14	100.0%	140	35	25.0%
Mar-18	13	13	100.0%	136	34	25.0%
Total	**206**	**206**	**100.0%**	**1,526**	**406**	**26.6%**

	% of reviews with RAG review [6]		
	Total Reviewed	RAG Reviewed [6]	**% RAG Reviewed**
Apr-17	47	42	**89.4%**
May-17	54	48	**88.9%**
Jun-17	44	41	**93.2%**
Jul-17	50	46	**92.0%**
Aug-17	51	45	**88.2%**
Sep-17	45	33	**73.3%**
Oct-17	51	44	**86.3%**
Nov-17	47	41	**87.2%**
Dec-17	52	46	**88.5%**
Jan-18	75	72	**96.0%**
Feb-18	49	48	**98.0%**
Mar-18	47	34	**72.3%**
Total	**612**	**540**	**88.2%**

	Outcome of RAG Reviewed deaths			Outcome % of RAG Reviewed deaths		
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death – refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI Investigation	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death – refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI Investigation
Apr-17	41	1	0	97.6%	2.4%	0.0%
May-17	41	7	0	85.4%	14.6%	0.0%
Jun-17	40	1	0	97.6%	2.4%	0.0%
Jul-17	39	6	1	84.8%	13.0%	2.2%
Aug-17	40	5	0	88.9%	11.1%	0.0%
Sep-17	31	2	0	93.9%	6.1%	0.0%
Oct-17	41	3	0	93.2%	6.8%	0.0%
Nov-17	35	6	0	85.4%	14.6%	0.0%
Dec-17	41	5	0	89.1%	10.9%	0.0%
Jan-18	67	3	2	93.1%	4.2%	2.8%
Feb-18	45	2	1	93.8%	4.2%	2.1%
Mar-18	33	1	0	97.1%	2.9%	0.0%
Total	**494**	**42**	**4**	**91.5%**	**7.8%**	**0.7%**

[1] This includes all inpatient deaths at STHK and all stillbirths. If a patient was transferred and died at another provider then they are out of the scope of this data - even if the cause of death relates to care at STHK.

[2] For the purpose of this report SMI is defined as DOLs or patients under the Mental Health Act during the spell.

[3] Diagnosis groups under internal monitoring.

[4] Any death associated with a complaint, PALs or an expression of concern by a member of staff.

[5] If a patient is attributed to more than one specified group, the Total will only count each patient once.

[6] Some nationally specified review processes don't include RAG rating.

Learning & Sharing 2017/18

Q4 Key Priorities

(1) Clear and accurate records are essential for clinical decision making and high quality patient care. Document each patient interaction as soon as possible. The record should capture what happened during a consultation and inform colleagues who see the patient subsequently, supporting continuity of care;

(2) Older people are more susceptible to sepsis than younger adults. The initial clinical presentation may be non-specific, so clinicians should have a higher index of suspicion and lower threshold for treatment in older people.

Assurance

Sharing: (Current Q-3) Board (mins) ■, Quality Committee (mins) ■, F&P (mins) □, CEC (mins) □, PSC (mins) □, PEC (mins) ■ , MCG Governance (mins)■, SCG Governance (mins) □, Grand Rounds (mins) ■, ED Teaching (record) ■, FY Teaching (record) ■, Team Brief (record) ■, Intranet Message Board (record) ■, Global Email (record) ■, Directorate meetings (mins) ■. List any policies/procedures or guidelines changed:

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Effectiveness: (Current Q-3) Audit of DATIX □, SIRIs □, Complaints □, PALS □, Litigation □, Mortality Reviews for evidence of failure to deliver these priorities □.

Comments: We are working with DATIX team and Information to build an electronic repository within DATIX that will allow electronic thematic analysis of the above.