St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 30TH OCTOBER 2019
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
09:40	2.	Apologies for Absence		Verbal	
	3.	Declaration of Interests		Verbal	
	4.	Minutes of the Previous Meeting held on 25th September 2019		Attached	
		4.1	Correct Record & Matters Arising	Verbal	
		4.2	Action Log	Attached	
Performance Reports					
09:45	5.	Integrated Performance Report		NHST(19) 83	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational Indicators		Nik Khashu OBO Rob Cooper
		5.3	Financial Indicators		Nik Khashu
		5.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10:00	6.	Committee Report – Executive		NHST(19) 84	Ann Marr
10:10	7.	Committee Report – Quality		NHST(19) 85	Val Davies
10:20	8.	Committee Report – Finance & Performance		NHST(19) 86	Jeff Kozer
10:30	9.	Committee Report – Audit		NHST(19) 87	Ian Clayton
10:40	10.	Committee Report – Charitable Funds *(incl Annual Accounts & Report)*		NHST(19) 88	Paul Growney
BREAK					

AGENDA			Paper	Presenter
Other Board Reports				
11:00	11.	Corporate Risk Register	NHST(19) 89	Anne-Marie Stretch OBO Nicola Bunce
11:10	12.	Board Assurance Framework	NHST(19) 90	Anne-Marie Stretch OBO Nicola Bunce
11:20	13.	Complaints, Claims & Incidents Report	NHST(19) 91	Sue Redfern
11:30	14.	Q1 2019/20 Learning from Deaths Update	NHST(19) 92	Rowan Pritchard-Jones
11:40	15.	Workforce Safeguards – Assurance Statement for Medical & Dental Staff & Allied Health Professionals	NHST(19) 93	Sue Redfern
11:50	16.	Infection Control Annual Report 2018/19	NHST(19) 94	Sue Redfern
Closing Business				
12:00	17.	Effectiveness of Meeting	Verbal	Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 27th November 2019		

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 September 2019 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 P Growney	(PG)	Non-Executive Director
	Miss L Knight	(LK)	Non-Executive Director
	Mrs G Brown	(GB)	Associate Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
	Mr R Pritchard-Jones	(RPJ)	Medical Director
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Mrs J Bussin	(JBu)	Responsible Officer *(for item NHST(19)82 only)*
	Mr I Clayton	(IC)	Non-Executive Director Designate *(Observer)*
	Ms L Gasson	(LG)	Reed Talent Solutions *(Observer)*
	Cllr A Lowe	(AL)	Halton Council *(Co-opted member)*
	Ms L Talbot	(LT)	Speech & Language Therapist *(for Patient Story only)*
	Mr M Weights	(MW)	Lay Member, St Helens CCG Governing Body *(Co-opted member)*
	Ms S Whelan	(SW)	Patient Experience Manager *(for Patient Story only)*
Apologies:	Mr J Kozer	(JK)	Non-Executive Director
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance

1. Employee of the Month

1.1. The Employee of the Month Award for August 2019 was presented to Cheryl Connor, Stroke Physiotherapist, Whiston Hospital.

1.2. The Employee of the Month Award for September 2019 was presented to James Parr, Operating Department Practitioner, St Helens Hospital.

2. Patient Story

2.1. SW was accompanied by Lucy Talbot (LT), a Trust Speech and Language Therapist, and introduced the story to Board on behalf of the patient. IB's story had been filmed, due to his dysarthria following multiple strokes.

2.2. IB was very happy with the holistic care he had received from the physiotherapy team, doctors and nurses and when asked what the Trust could do to improve the care for Stroke patients, he stated the Trust should just "carry on doing what is what doing".

2.3. LT added that despite there being a national shortage of Speech and Language Therapists, the Trust did not struggle to recruit due to the career opportunities it provided for staff to work in both an acute and community setting.

2.4. AM confirmed the Trust recognised how important it was to be able to provide support for newly qualified staff.

2.5. AM added Early Supported Discharge (ESD) was designed to enable the accelerated discharge of Stroke patients to their home, providing specialist rehabilitation and social support in a home setting rather than an acute hospital ward, however the service was not currently being commissioned consistently by all local commissioners.

2.6. IB had confirmed he would be happy for his story to be shared with commissioners in order to promote the service and Board members agreed the message was more powerful when coming from those people receiving care.

2.7. GB agreed ESD should not be regarded as a 'Cinderella service' and felt it was important to promote the film with commissioners, which demonstrated how it gave IB his life back after being so ill.

2.8. AL thanked the Trust for the service that he also had experience of, following an operation on his vocal chords. The Trust identified a Consultant specialising in rebuilding the voice box and AL was now able to speak with the use of silicone implants, which was only due to the service received from the Speech and Language Therapists.

2.9. RPJ updated members on initiatives around telehealth, which would enable the Trust to reach many more patients every day. RPJ mentioned an existing pilot on the Fylde coast and suggested he meet with LT outside the meeting to discuss this further. LT confirmed the Speech and Language Therapy team would welcome the opportunity to be involved.

2.10. CW explained that the current telehealth solution was being replaced by more modern technology that integrated directly into Medway, so that patients could cancel appointments without having to phone the Trust. Unfortunately, the migration to the new platform had been more problematic than expected, however, the technical issues had now been addressed and testing of the new solution was now underway and going well.

2.11. RF thanked SW and LT for bringing the story to the meeting and telling it with such passion and enthusiasm. He asked them to pass on the Board's thanks to IB for sharing his experiences.

3. Apologies for Absence and Introductions

3.1. Apologies were noted as above.

3.2. RF confirmed this would be Su Rai's last meeting and Ian Clayton would take up the vacant Non-Executive Director position.

3.3. RF welcomed Mrs Gill Brown (GB) and Mr Rowan Pritchard-Jones (RPJ) to their first Board meeting.

4. Declaration of Interests

4.1. GB declared that she continued to be a lay member of Southport & Formby CCG's Governing Body until the end of October 2019, although she had now attended her last Governing Body meeting.

5. Minutes of the previous meeting held on 31st July 2019

5.1. Correct Record

5.1.1. The minutes were accepted as a correct record once the following changes were made:

5.1.2. Minute 8.2: VD asked for the minute to be expanded as the concern she had raised in the meeting was two-fold, firstly in relation to the future capacity of staff to complete the Liberty Protection Safeguards assessments when they became law in 2020. Secondly, there was a general issue around current capacity of the safeguarding team to manage current demand and achieve the expected number of DoLs assessments. SRe informed the Board that a business case for increased specialist capacity had been developed and was currently under consideration by the Executive Committee.

5.1.3. In relation to minute 14.4, AMS confirmed an assurance report in relation to improving people practices would be presented to Board members when the new scrutiny group had met and agreed the action plan.

5.2. Action List

5.2.1. Action 2 (31.07.19, Minute 6.2.5) – This would be presented and discussed at Quality Committee. **ACTION CLOSED**. AM explained that the Trust had challenged the C.Diff 2019/20 tolerance level of 48 with the Department of Health (DoH) and NHSI infection control leads the previous week; the Trust was hopeful the tolerance figure may be increased.

5.2.2. Action 3 (31.07.19, Minute 6.3.16) – AM confirmed a letter had been sent to the Clinical Accountable Officer for St Helens CGG, Sarah

O'Brien, in relation to why St Helens was an outlier for activity and delayed discharges. AM confirmed the response would be shared with Board members, when received. **ACTION CLOSED**.

5.2.3. Action 4 (31.07.19, Minute 12.3) – RC would present the analysis to Quality Committee members. RC confirmed this linked back to the same point as Action 3 above regarding total delays. The previous 12 months had been analysed, which had been briefly discussed at this month's Quality Committee meeting and would be discussed in full at the meeting in October. **ACTION CLOSED**.

5.2.4. Action 5 (31.07.19, minute 13.4) – AMS confirmed there was ongoing dialogue with the Model Hospital team. She explained turnover and retention were 2 different things and she would bring a full explanation back for members. **Action: AMS**

5.2.5. Action 7 (31.07.19, Minute 13.9) - AMS was working with the Head of Communications in relation to the overall visibility of Directors, one element of which could be a buddy system. An update would be brought back to November's Board meeting. **Action: AMS**.

6. Integrated Performance Report (IPR) – NHST(19)72

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

6.2. **Quality Indicators**

6.2.1. RC presented the performance against the key quality indicators on behalf of SRe.

6.2.2. There had been no never events in August and none reported year to date.

6.2.3. There had been no MRSA reported in August and none reported year to date.

6.2.4. There were 5 C.Diff positive cases reported in August 2019 (5 hospital onset and 0 community onset). 7 of the previously reported cases had been successfully appealed in September. Year to date there had been 22 cases (20 hospital onset and 2 community onset). The annual tolerance assigned to the Trust by NHSE/I for 2019/20 was 48, which was currently being challenged as described in minute 5.2.1.

6.2.5. In response to RF's request for a projected year end figure to be included in the report, NB explained that this would be difficult to accurately predict, as many of the cases were appealed and there was always a lag between the RCA submission and the outcome of the appeal.

There were no grade 3 or 4 avoidable pressure ulcers reported for July or year to date.

6.2.6. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for August 2019 was 95.6% and year to date performance was 97.7%.

6.2.7. There had been no falls resulting in severe harm in July and 4 in the year to date.

6.2.8. Venous thromboembolism (VTE) assessment performance for July was 95.38%. Year to date performance was 95.27% against a target of 95%.

6.2.9. Year to date HSMR for 2019/20 was 99.7.

6.3. **Operational Indicators**

6.3.1. RC presented the update on the operational performance.

6.3.2. Performance against the 62-day cancer standard was above the target of 85.0% in July at 85.7%, year to date (YTD) was 87.8%.

6.3.3. The 31-day cancer target was achieved in month with 97.4% and YTD 97% performance against a target of 96%.

6.3.4. The 2-week rule target was not achieved with 87.5% in month and 87.8% YTD. The performance was directly related to specialist Breast Radiologist capacity and RC was pleased to report that interviews were scheduled for 30th September with a number of candidates being interviewed. Board members also noted the Trust had experienced an increase in 2-week referrals, due to the cessation of the service by other local providers.

6.3.5. A&E access time performance in August was 72.8% (type 1) and 69.7% YTD. The all-types mapped footprint performance for August was 86.4% and 84% YTD.

6.3.6. The Trust received 9,801 type 1 attendances in August and year to date growth was up 5.4% on the previous year.

6.3.7. Whiston A&E had the highest number of ambulance attendances in Cheshire & Merseyside and Greater Manchester in August, with 2,879 conveyances. The ambulance notification to handover target time was achieved with 12.41 minutes on average, against a target of 15 minutes.

6.3.8. Members noted the Trust was participating in an improvement programme with NWAS which would be tailored to address the Trust's specific issues and would be collaboratively delivered with partners from the Emergency Care Intensive Support Team (ECIST), the clinically led national NHS team that had been designed by clinicians to help health and care systems deliver high quality emergency care.

6.3.9. The Trust had been set a 40% reduction target in the number of super stranded patients (patients with a length of stay of greater than

21 days) by year end 2019/20. Working from the baseline figure of 154, a 40% reduction would equate to 92 patients, the average number in August was 132 (and 141 in July).

6.3.10. In relation to a query from SR, RC confirmed there was no financial penalty for not reaching the 40% reduction target in the number of super stranded patients, however failure to reduce the number of these patients had a negative impact on patient flow and the achievement of other waiting time targets, if sufficient beds were not available for patients to be admitted from A&E.

6.3.11. RC explained that to achieve the reduction target, it was essential there were sufficient numbers of appropriate beds available in the community to which patients could be discharged. This had been discussed at a recent Mid Mersey A&E Delivery Board (AEDB) meeting, where further work was required to match the capacity against the demand. In order to achieve the necessary progress , AM/RC were reviewing AEDB membership to ensure there was appropriate representation from across the health economy. **Action: AM/RC**

6.3.12. CW informed members that the Cheshire and Merseyside STP had been allocated £4m funds from the Health System Led Investment (HSLI) programme to extend system capacity management to improve hospital flow. The solution, which was being implemented across the STP, would hopefully be up and running in time to help with winter pressures. CW proposed discussing this at the next Mid Mersey AEDB meeting. **Action: CW**

6.3.13. PG asked whether other Trusts were achieving their super stranded targets. RC explained that all Trusts in the North West were struggling to achieve the reduction target. STHK was on an improving trajectory, however it was still extremely challenging and dealing with the needs of 4 CCGs added to the complexity. However, a set of national codes had recently been issued by NHSI/E, which provided a more consistent comparison, and would hopefully support the view that the Trust access to less than the required number of general nursing beds and packages of care.

6.3.14. PG asked how many patients were discharged home compared to residential care. RC confirmed people more people went home, with alternative pathways for people who could not go straight home, in accordance with the NHSE national standard. Most delays were because packages of care could not be put in place quickly enough.

6.3.15. PG asked whether the apprenticeship levy could be used to upskill staff to look after patients. RC confirmed the Trust was already doing this with its ‘discharge to assess’ and reablement workers.

6.3.16. IC asked whether the Trust had considered other initiatives, such as telehealth and ‘step up/down’ patients. RC confirmed the Trust had already recruited domiciliary care workers and was currently reviewing the Discharge to Assess (D2A) pathway.

6.3.17. GB asked whether the Trust had sufficient beds for dementia patients. RC acknowledged there was a shortfall in Elderly Mentally Impaired (EMI) beds in the health economy and the Trust was working to address the rising length of stay for this group of patients, so they could be discharged to specialist care in a timely way.

6.3.18. VD had recently attended a meeting with ED staff where it had been reported that Trust staff had been attending the ED department because of difficulty in accessing the Health and Wellbeing at Work (HWWB) services. Both RC and AMS were unaware of this; and AMS clarified that HWWB did not offer urgent care and like A&E was not a substitute for staff attending their GP. HWWB could be contacted if a member of staff had a crises at work and staff could attend ED if they had an injury or accident, but neither A&E nor HWWB should be used as a short cut for treatment. **Action: AMS to investigate whether there was any accuracy to the statement**.

6.3.19. The 18-week referral to treatment target (RTT) was achieved in July with 93.7% compliance and 93.7% YTD, against a target of 92%. The 6-week diagnostic target was achieved in August with 99.3% compliance and 99.4% YTD (target 99%). There had been no 52+ week waiters.

6.4. **Financial Indicators**

6.4.1. NK presented the update on the financial performance.

6.4.2. At the end of month 5, the Trust reported a deficit of £3.3m which was in line with agreed plans and assumed full achievement of this year's PSF funding. The Trust had utilised c£0.7m of non-recurrent funding to achieve the reported position. The Trust was forecasting to achieve a surplus of £3.9m including PSF funding.

6.4.3. An additional £0.5m relating to 2018/19 PSF had been allocated to the Trust following the redistribution of funds that were unachieved by other organisations. This had been included in the Trust's year to date and forecast position but excluded as a technical adjustment so there was no benefit in this financial year, as per guidance from NHSI.

6.4.4. Agency expenditure at month 5 was £2.7m which was £0.3m below the planned trajectory. NK commented that there had been a reduction in waiting list initiatives (WLIs) which was as a result of the NHS pension's taxation issue and was effectively reducing consultant capacity as had been feared.

6.4.5. The Trust was ahead of the CIP target of £3.6m by £1.3m. The Trust currently had £13.8m of transacted CIP with plans in place for the full £16.1m. NK commented on the great effort made by the Care Groups in proposing mostly recurrent schemes.

6.4.6. In response to SR's query relating to how the average length of stay (LOS) compared to the previous year, NK confirmed it had increased by approximately 0.5 day, which equated to approximately one ward of

additional patients in the hospital. RC explained that this was linked to the acuity of patients being admitted and the previously discussed issues with super stranded patients and the difficulties with discharge and packages of care.

6.4.7. LK asked whether the Trust undertook any streaming interventions and wondered if reasons for admission had been targeted. RC confirmed the Trust was already providing comprehensive care without admitting patients who came to A&E with conditions such as pneumonia or other breathing difficulties through same day emergency care (SDEC) services. These services prevented patients deteriorating from unnecessary admissions or long stays in hospital, freed up beds in hospital wards, and improved the flow of patients through A&E – allowing doctors and nurses to focus on those who needed the most urgent care.

6.4.8. Financial risks related to CQUIN achievement, activity changes and losing capacity as a result of the pension tax rules.

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on the workforce indicators.

6.5.2. Absence in August was 4.8%, which was 0.2% decrease from July. Qualified & HCA sickness was 5.8%. All qualified Nursing & Midwifery sickness was 4.3% for August, which is better than the 4.35% target.

6.5.3. The highest reported reasons for absence were stress and anxiety, which could reflect personal as well as work issues. AMS reported the Trust's programme of HWWB services supporting mental health issues continued to expand; the first group of mental health first aiders were now trained with more to follow. Any member of staff could approach these first aiders, even if it was just for signposting to where they could get support. AMS confirmed the Mental Health first aiders came from a whole spectrum of backgrounds/grades of staff across the Trust.

6.5.4. Mandatory training compliance was 81.8% (target = 85%) which was usual for August; however it would be monitored closely to ensure the position recovered quickly, following the holiday period. Appraisal compliance was 83.4% which was also below the target of 85% and all staff were to be reminded of the importance of their annual appraisal discussion.

7. Committee Report – Executive – NHST(19)73

7.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held in July and August 2019.

7.2. The Executive Committee had approved a Medical Care Group Consultant Staffing Business Case (partial approval only); the Radiology Services Staffing Business Case (approval in principle with final approval being sought from the Trust Board in the Closed Board meeting, as over the delegated limit for investment by the Executive); Medway Benefits Realisation -replacement of

paper forms project; proposals to develop a business case for using modular buildings to increase winter bed capacity; the final 2019/20 CNST Maternity Discount Scheme declaration, and a Cardiotocography(CTG) Centralised Monitoring Business Case for the delivery suite.

7.3. There were updates on other key Trust objectives, including: Medway upgrade preparations, BLS/ILS training, implications for the Trust of the collapse of the One to One Midwives service, and the industrial action taken by Unison in its pay dispute with Medirest.

7.4. The Executive Committee also considered regular assurance reports covering: appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register, safer staffing and shift shortfall monthly reports, and the Integrated Performance Report.

7.5. SR asked how the Trust benchmarked with others in relation to the Fair to Refer findings. AMS stated that there was currently no benchmarking data available but the Trust self-assessment had identified many of the same issues as highlighted by the national report.

7.6. CW reported that the planned Medway upgrade would go ahead on 28th September, subject to final approval of the readiness checks and business continuity plans at the Executive Committee on 26th September.

7.7. Board members noted the report.

8. Committee Report – Quality – NHST(19)74

8.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 17th September and the Patient Safety, Patient Experience, Workforce and Clinical Effectiveness Councils.

8.2. Matters escalated to the Board were; the further analysis of the Perinatal Mortality Review Report which had highlighted potential higher incidence for women receiving antenatal care in the community and then delivering at STHK. Committee had agreed that the report should be shared with Commissioners at the next CQPG meeting.

8.3. Increased number of incidents reported relating to errors in theatre checklists during Quarter 1. There had been no incidents resulting in harm to patients, but Committee had discussed the action plan to increase awareness of the importance of correctly completing pre-operative documentation. This was to be discussed at the Executive Committee with progress reported at the next Quality Committee meeting.

8.4. IC commented that it was good to see that this had been picked up quickly, the errors identified in theatre and action was being taken to prevent any harm to patients.

8.5. RC informed Board that the report had been written in July and there had been a significant reduction in the number of incidents reported in Quarter 2,

following implementation of the action plan.

8.6. The latest Medicine Storage audit results had been reported and although there had been an improvement overall there were still some areas which failed to achieve consistent compliance with the Trust policy.. The Committee had asked that the escalation procedure be reviewed.

8.7. Patient Experience Council reported an action plan was being developed for the Children and Young People Patient Survey, complaints performance was being maintained and summary of the National Inpatient Survey results which had been published in July 2018. A more detailed analysis of the results would be presented at the next meeting.

8.8. PG noted the outstanding dedication and passion he had observed from the MET team in very stressful conditions during a recent QWR. He also felt the support offered to patients after they had been in ITU was outstanding.

8.9. Board members noted the report.

9. Committee Report – Finance & Performance – NHST(19)75

9.1. DM presented the Chair's report to the Board on behalf of JK, which summarised key issues arising from the Finance & Performance Committee meeting held on 19th September, with assurance reports from the CIP and Procurement Councils.

9.2. DM explained that although the Trust had been asked to reduce its capital plan by c£0.7m, further guidance had now been received following government announcements which confirmed the reduction was no longer required. Therefore the original capital programme could continue to be delivered, as planned.

9.3. There was an increased cash risk because the Junior doctor pay award had to be paid in September, as Lead Employer this will have cash implications for the Trust of c£5m. The cash would be recoverable from the host Trusts. The Finance and Performance Committee had endorsed the need for a short term loan for October, and recommended approval of the loan application to the Trust Board. The application for a short term cash loan of £3.591m was approved.

9.4. Members had been assured about the action being taken to improve A&E access time performance by a presentation from the Assistant Director of Operations and Clinical Director for Emergency Care. The increase in attendances was discussed, particularly those from Warrington and Liverpool.

9.5. SR queried whether the Trust should plan for the possibility of 500 daily attendances, or whether it should plan for 400 and investigate other options. RC confirmed this linked in with ongoing work being done around urgent treatment centres and other alternatives to A&E.

9.6. RPJ believed diverting suitable patients away from A&E should be the objective, he felt that signposting the waiting times might help people to make good decisions. AM confirmed that the ambulance services were already

taking people to Urgent Treatment Centres (UTCs) where they felt this was appropriate. The rate of growth in activity from Halton and Knowsley had slowed this year but grown from St Helens and Liverpool, which illustrated the complex drivers influencing attendance patterns. The Board members recognised the excellent work being undertaken across the Trust to respond to these continued increases in activity.

9.7. NK commented that the significance of the CIP programme was that it demonstrated that the Trust can perform efficiently and take advantage of opportunities for collaboration and integration, whilst coping with the continued rise in demand.

9.8. The reduction in WLIs was a cause for concern as this reduced senior medical capacity. It was noted that a paper was being considered by the Remuneration Committee to consider how the Trust could respond to the NHS pension taxation issues in 2019/20, ahead of the outcome of the national consultation on changes for 2020 onwards..

9.9. Board members noted the report and approved a short term loan of £3.591m.

10. Committee Report – Audit – NHST(19)76

10.1. SR provided feedback on key issues arising from the Audit Committee on 2nd August.

10.2. All year end documentation had been submitted to the auditor as per national schedules.

10.3. The Annual Audit Letter was presented and members were advised there were no issues of concern for the committee. Committee accepted the report.

10.4. A number of internal audit reports were received, with a number of recommendations to be addressed.

10.5. Aged debt levels had increased, but were still low as a proportion of the annual cash turnover. It was recommended that this continued to be closely monitored.

10.6. Board members noted report and that the Audit Letter had been approved.

11. Statutory and Regulatory report – NHST(19)77

11.1. NB presented an update of external strategic developments that could impact the future direction of the Trust or regulatory requirements to maintain compliance with governance good practice.

11.2. A new oversight framework was published in August 2019, setting out how NHSE and NHSI would provide integrated oversight of the NHS. The new approach put more emphasis on systems rather than individual organisations and also set out the role of the new regional teams, working with Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) leadership in delivering the new framework. There were four new metrics included in the performance framework in support of the NHS People Plan.

11.3. The new conservative government had announced spending plans for 2020/21 in a "fast track" spending round on 4th September. A full 3-year spending review will not now take place until 2020 to set multi-year budgets for government departments.

11.4. NHSE/I had published a new Patient Safety Strategy, which would be interpreted and adopted by the Trust, although many of the actions were already encompassed within the Trust's agreed 2019/20 corporate objectives or care group plans.

11.5. A draft Board Development Programme for 2019/20 was presented to Board members. This ensured continued good governance of the Board and shaped development for the year. The programme was indicative as the Board would need to retain a measure of flexibility to respond to events as they occurred.

11.6. Board Members noted the report and the agreed the draft Board development programme.

12. EPRR Compliance Statement – NHST(19)78

12.1. NB on behalf of SRe presented the Trust's Statement of Compliance with national core standards for NHS Emergency Preparedness, Resilience and Response (EPRR) for 2019/20. The statement provided assurance to regulators and commissioners that the Trust could effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

12.2. This year's audit showed that the Trust was substantially compliant with 93.75%, which was a slight improvement on the previous year. The Trust was only partially compliant for chemical biological defence training; however an action plan was in place to ensure this was addressed.

12.3. An independent Mersey Internal Audit Association (MIAA) report had provided significant assurance.

12.4. Board members noted the Director of Nursing, Midwifery and Governance had signed the statement and were happy to ratify the report.

13. Workforce Race Equality Standard (WRES) Report and Action Plan – NHST(19)79

13.1. AMS provided an update on action taken to date in implementing the WRES, which was a requirement for NHS commissioners and NHS provider organisations.

13.2. The Trust was measured against 9 indicators; the first four measured staff experience over a 12-month period for harassment, bullying, or abuse from patients, relatives or the public. Another 4 indicators measured workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator 9 considered BME representation on executive boards.

13.3. AMS highlighted that the Trust was now below both the national and North West average for the relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (Indicator 3), with a lower score being positive. The Trust had appointed an

inclusion and diversity officer dedicated to increasing staff networks, as well as identifying what the Trust could do better; therefore further improvements in the scores were expected.

13.4. In relation to Indicator 5 - the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months, NK queried whether AMS could comment on why the figure for white staff had decreased in 2018 compared with 2017, whilst the figure for BME staff had increased by 3.5% to 30% in 2018 compared to 2017 and was also slightly above the national average of 29.8%. AMS could not comment with certainty as it was national data could not be interrogated, however, suggested it may be due more vigorous promotion of the WRES.

13.5. In relation to Indicator 6 – the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months, GB noted the huge improvement for BME staff between 2017 (26%) and 2018 (12.82%) and commented that the monthly scheduled ward rounds by the Assistant Director of Patient Safety was a great way to promote the Freedom to Speak Up (FTSU) process.

13.6. RF expressed surprise at the lack of awareness amongst staff when he wore his FTSU green badge at a recent Team Talk. AMS expected this to improve in October as it was National Freedom to Speak Up month and promotional material would be displayed around the Trust, including posters with the names and photographs of all Trust FTSU guardians.

13.7. AM noted the Trust had received the best results for “Does my organisation treat me fairly despite age, race, etc”, however believed it was not about being complacent; it was about always striving to do better.

13.8. The report was noted and the action plan approved

14. Workforce Disability Equality Standard (WDES) Report and Action Plan – NHST(19)80

14.1. AMS informed members this was the first year NHS organisations had been required to publish this information, similar to the WRES, therefore there was nothing for us to benchmark against at this stage.

14.2. One of the actions was to positively promote the WDES to encourage staff to view the standard in a positive, rather than negative, light. It was also acknowledged that there would be relatively small numbers of staff who had declared a disability currently.

14.3. The Trust would actively support staff with disabilities, to feel more engaged, valued and supported at work.

14.4. SR noted that the aim should be for staff to feel comfortable to declare any disability and feel they would not be discriminated against.

14.5. MW asked if the report was in a nationally mandated format, and AMS confirmed that this was the case.

14.6. GB acknowledged it was an extremely sensitive area and it was about being an inclusive organisation, where any member of staff felt comfortable to come forward. VD commented that she had attended the Disability Working Group and felt that there was a lot of good work being taken forward by the Trust to address the issues raised.

14.7. The report was noted and the action plan approved.

15. Workforce Safeguards Report – NHST(19)81

15.1. AMS presented the report on behalf of SRe.

15.2. The report set out best practice in relation to planning and how the Trust used its staff effectively. The report made 14 recommendations to strengthen workforce safeguards and each Trust would be assessed against these recommendations.

15.3. The Trust had completed a self-assessment and was currently compliant with 12 of the 14 recommendations for nursing staff, but more work was required to become fully compliant with the remaining 2. Actions to achieve full compliance were detailed in the report.

15.4. AMS confirmed a similar self-assessment was being undertaken for Medical and Allied Health Professionals (AHP) staff which would also be presented to the Board. **Action: SRe**

15.5. The Board agreed that it was not appropriate to expect the medical Director and Director of Nursing to sign off the staffing establishment and that this was a unitary Board responsibility.

15.6. The Board noted the content of the report and approved the actions to achieve full compliance for Nursing staff.

16. Medical Revalidation Annual Declaration – NHST(19)82

16.1. Jacqui Bussin (JBu), Responsible Officer, joined the meeting.

16.2. JBu explained the purpose of the paper was to provide feedback and assurance to Board members that the arrangements for Medical Appraisal and Revalidation were operating effectively at the Trust and in accordance with regulations.

16.3. JBu confirmed the Trust was 95% compliant for consultants but less so for other grades. Educational events for doctors regarding appraisal and revalidation were to be introduced and the non-engagement policy would be refreshed to make it more robust.

16.4. There had been a 20% increase in doctors at the Trust, therefore appraiser training had been scheduled for autumn 2019 and would be a priority for next year.

16.5. In terms of the GMC, JBu continued to meet the Liaison Adviser and attended regular RO meetings for updates. An advisory group met quarterly and

discussed revalidation.

16.6. RPJ thanked JBu and commented she had already transformed the role and added both he and the Deputy Medical Director would be undertaking the RO and appraisal training.

16.7. In relation to Q2 under Section 2, AM was keen to ensure that mediation had occurred in terms of education. JBu confirmed she was notified of every serious incident on Datix and if she felt further training/mediation was required, then she was able to add a note to an individual's record, so the issue would be discussed as part of the revalidation process.

16.8. TH asked whether GPs working in practices managed by the Trust were included in this process. NHS England currently have responsibility for the appraisal and revalidation of GPs, but the Board felt that the Trust should be involved if it was accountable for the delivery of care. **Action: AM asked JBu to investigate the Trust's responsibilities in relation to supporting GPs working in Trust medical practices**.

17. Effectiveness of Meeting

17.1. RF asked MW for his reflections on the meeting.

17.2. MW felt the Patient Story was always dealt with effectively by the Board, and demonstrated the ability and willingness to learn and improve, rather than treat it as a pat on the back. It was obvious the committee reports gave solid assurance to Board members. He referred to minute 16.9 and felt assured by the way in which the issue of GPs in Trust medical practices had been dealt with and even though they were appraised by NHS England, the Trust had acknowledged it had a duty to provide further support.

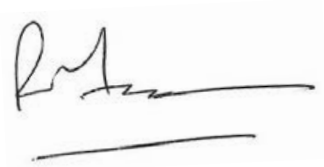
17.3. RF thanked MW for his observations and confirmed Board members wanted to hear both positive and negative patient stories, as both provided learning opportunities.

18. Any Other Business

18.1. None.

19. Date of Next Meeting

19.1. The next meeting will be held on Wednesday 30th October 2019 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.



Chairman: ……

30th October 2019

Date: ……

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 30TH OCTOBER 2019

No	Date of Meeting (Minute)	Action	Lead	Date Due
~~3~~	~~31.07.19 (6.3.16)~~	~~AM to meet with SOB/GA to understand why St Helens is an outlier for activity and delayed discharges.~~ **ACTION CLOSED**	~~AM~~	~~25.09.19~~
5	31.07.19 (13.4)	AMS to clarify difference between model hospital turnover vs retention figures. **Update 25.09.19: AMS to bring explanation of difference between turnover and retention (stability index) back to Board.**	AMS	30.10.19
6	31.07.19 (13.6)	AMS to report HR KPIs against BAME characteristics in the next HR indicators report.	AMS	29.01.20
7	31.07.19 (13.9)	AMS reviewing the overall visibility of the Board, the ward buddy system being one element of that. AMS to bring proposal back to Board for approval.	AMS	27.11.19
9	31.07.19 (14.6)	AMS to arrange a training and awareness session for Board members on what to consider when implementing a just culture for a future Board development session.	AMS	29.01.20
10	31.07.19 (15.3)	AMS to prepare an update on achievement of the Workforce Strategy actions.	AMS	27.11.19
11	25.09.19 (5.2.2)	If received by next meeting, AM to share SOB response to letter explaining why St Helens is an outlier for activity and delayed discharges.	AM	30.10.19
~~12~~	~~25.09.19 (6.3.11)~~	~~Following a discussion regarding delayed discharge/bed capacity at a recent Mid Mersey A&E Delivery Board meeting, AM/RC will review AEDB membership to ensure there is appropriate representation from the Mid Mersey health economy~~. **ACTION CLOSED.**	~~AM/RC~~	~~Executive Committee~~
13	25.09.19 (6.3.12)	CW to discuss £4m funds which had been allocated to the C&M STP from the Health System Led Investment (HSLI) programme to extend system capacity management to improve hospital flow, allocated to C&M STP, at the next Mid Mersey AEDB meeting.	CW	30.10.19
14	25.09.19 (6.3.18)	AMS to investigate whether there has been a spike in Trust staff attending A&E due to difficulty accessing the Trust's Health & Work Wellbeing (HWWB) services.	AMS	30.10.19
~~15~~	~~25.09.19 (15.4)~~	~~SRe to present an assessment for Allied Health Professionals, Medical and Dental staff groups to the October Board meeting~~. **ON AGENDA. ACTION CLOSED.**	~~SRe~~	~~30.10.19~~
~~16~~	~~25.09.19 (16.8)~~	~~Jacqui Bussin to investigate the Trust's responsibilities in relation to supporting GPs working in Trust medical practices with appraisals and revalidation~~. **MATTERS ARISING. ACTION CLOSED.**	~~JBu~~	~~30.10.19~~

Paper No: NHS(19)83
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

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

There were no Never Events in September 2019. (YTD =0)

There were no cases of MRSA in September 2019 (YTD=0)

There were 3 C.Difficile (CDI) positive cases reported in September 2019 (2 hospital onset and 1 community onset). YTD there have been 25 cases (22 hospital onset and 3 community onset). The annual tolerance for CDI for 2019-20 is 48. The new guidance now requires us to include hospital onset and any community cases that have been discharged from hospital in the previous 28 days.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2019 was 92.5%. YTD rate is 96.8%.

There were no grade 3 or 4 avoidable pressure ulcers in August 2019. (YTD = 0).

During the month of August 2019 there was 1 fall resulting in severe harm (Ward 2D). (YTD Severe harm fall = 5)

Performance for VTE assessment for August 2019 was 95.20% against a target of 95%. (YTD = 95.26%)

YTD HSMR (April -May) for 2019-20 is 103.7

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 19/20 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: 30th October 2019

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (August 2019) at 85.9%. YTD 86.8%. The 31 day target was achieved with 96.3% performance in month and YTD 96.9% against a target of 96%. The 2 week rule target was not achieved with 88.5% in month and 88.0% YTD against a target of 93.0%.

Accident and Emergency Type 1 performance for September 2019 was 77.8% and YTD 71.1%. The all type mapped STHK Trust footprint performance was 88.3% in month and 84.7% YTD. The Trust received 10223 Type 1 attendances in September 2019. Year to date growth in ED attendances is 6.0% up on 2018/19. The work streams, designed to increase performance against the 4 hour standard, continue to focus on driving forward the required improvement.

Ambulance notification to handover time was achieved in September 2019 with 12.02 mins/seconds on average (target 15 mins). There were 2801 ambulance conveyances (second highest in Cheshire and Merseyside)

The Trust has been set a 40% reduction target in the number of super stranded patients (length of stay 21day+) by year end 2019/20. Working from the baseline figure of 154, a 40% reduction would equate to 92 patients. The average number in September stands at 121 (was 132 in August). Medical and Surgical clinical /managerial teams and all CCG and local authority partners are actively engaged in the achievement of the reduction in super stranded. Progress and actions to address are monitored daily.

The 18 week referral to treatment target (RTT) was achieved in September 2019 with 92.3% compliance YTD 92.3% (Target 92%). There were no 52+ week waiters. The 6 week diagnostic target was achieved in September (99.97%) and YTD compliance 99.5% (Target 99%).

Financial Performance

At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved.
Key assumptions within the plan include:-
- Full achievement of CQUINs
- Activity within planned levels
- Achievement of CIPs (£16.1m)
- Agency spend within cap levels

Surplus/Deficit - At the end of Month 6 StHK has reported a deficit of £3.6m which is in line with agreed plans and assumes full achievement of this years PSF funding. The Trust has utilised c£1.8m of non-recurrent options to achieve the reported deficit. The Trust is forecasting to have a surplus of £3.9m including PSF funding.

An additional £0.5m relating to 2018/19 PSF has been allocated to the Trust following the redistribution of funds that were unachieved by other organisations. This has been included in our YTD and Forecast position but excluded as a technical adjustment so there is no benefit in this financial year as per guidance from NSHi.

The annual target for agency is £7.6m which is an increase of £0.3m on 2018/19. Agency expenditure at Month 6 is £3.9m which is £0.2m under our planned trajectory.

The Trust set a challenging CIP target of £16.1m in order to deliver the financial plan, this equated to c3.8% of the Trusts turnover and is in excess of the 1.6% target included within planning assumptions. At the end of Month 6 the Trust has delivered £6.4m which is £1.6m more than the YTD plan. The Trust currently has £15.3m of transacted CIP with plans in place for the full £16.1m.

Human Resources

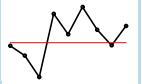
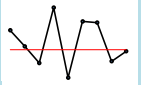
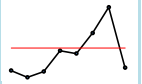
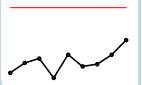
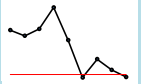
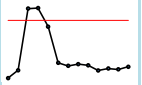
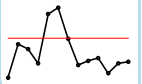
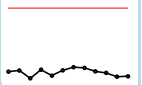
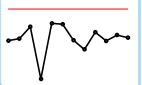
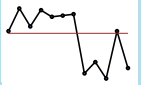
In September, sickness was 4.9%, which is a 0.1% increase from August . It is 0.55% higher than Q2 target of 4.35%. The YTD figure is 4.9% which is 0.1% below the 2018/19 outturn of 5.0%. Qualified & HCA sickness was 6.4%, a 0.6% increase since August. All qualified Nursing & Midwifery sickness was 5.6% for September which was an increase of 1.3% in month. Mandatory Training compliance is 82.1% (target = 85%). Appraisal compliance is 82.9%

The following key applies to the Integrated Performance Report:

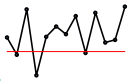
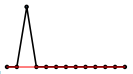
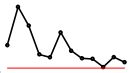
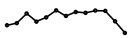
▲ = 2019-20 Contract Indicator
▲£ = 2019-20 Contract Indicator with financial penalty
● = 2019-20 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Sep-19

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

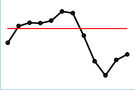
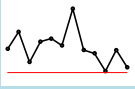
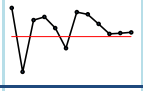
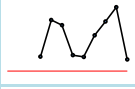
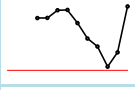
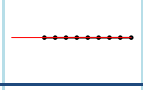
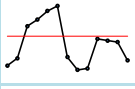
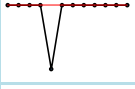
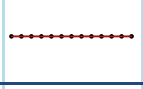
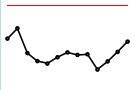
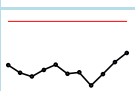
	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Sep-19	1.7%	2.2%	No Target	2.2%		SHMI (governments preferred measure) stable and consistently better than NW average. Following a reduction in the previous 2 months, HSMR has risen again in May. Weekend admission mortality is a 'noisy metric' because numbers are small.	Patient Safety and Clinical Effectiveness	The Board commissioned external review of Winter HSMR has been completed. Documentation of comorbidities is still below expected (which artificially increases HSMR) - action to improve electronic capture of comorbidities started in Oct-19.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Mar-19	1.04		1.00						
Mortality: HSMR (HED)	Q	▲	May-19	108.4	103.7	100.0	101.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	May-19	98.4	94.0	100.0	106.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Apr-19	96.5	96.5	100.0	98.3		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust continues to work internally and with healthcare partners to minimise unnecessary readmissions.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	May-19	94.0	92.6	100.0	90.4		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. This includes robust management of delayed patients and scrutiny of superstranded patients.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	May-19	99.0	100.3	100.0	111.5					
% Medical Outliers	F&P	T	Sep-19	0.3%	0.2%	1.0%	0.5%		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. There are currently no medical outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Sep-19	40.4%	39.5%	52.5%	45.7%		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. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Aug-19	71.3%	72.2%	90.0%	71.3%		eDischarge performance remains poor. Inpatient performance is stable and is not expected to improve until new (pending) electronic solutions are implemented. Outpatient performance and ED performance require investigation and remediation.		For IP an interim Discharge Notification is being developed by informatics and will be available for review by the end of November. This summary will be sent within 24 hours. Thereafter a full discharge summary will be sent within 14 days. For ED discharge summaries the NHS Number issue was resolved on 10th October and it is expected that following this fix we will achieve the target.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Aug-19	83.8%	83.3%	95.0%	85.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Aug-19	93.1%	93.4%	95.0%	96.3%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

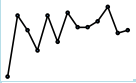
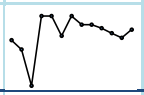
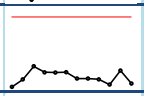
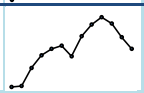
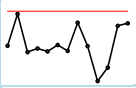
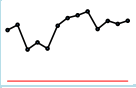
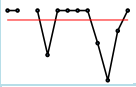
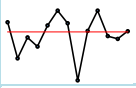
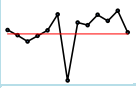
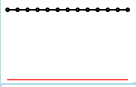
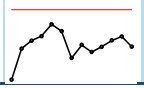
	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Sep-19	94.6%	89.0%	83.0%	85.7%		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	Continued achievement.	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲£	Sep-19	0	0	0	1		No never events reported YTD	Quality and patient safety	Safer surgery actions and checks in place to minimise the likelihood of never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Sep-19	98.7%	98.8%	98.9%	99.1%		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	Sep-19	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. This is supported by EPMA.	RPJ
Number of hospital acquired MRSA	Q F&P	▲£	Sep-19	0	0	0	1		YTD there have been 34 C Diff cases, of which 9 have been successfully appealed. Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The objective (i.e. target) for cases of CDI set for our Trust in 2019-20 by NHS Improvement (NHSI) is no more than 48 cases. From April 2019 onwards, the Trust's objective will include community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. All CDI cases are subject to an Exec RCA review	SR
Number of hospital onset and community onset C Diff	Q F&P	▲£	Sep-19	3	25	48						
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-19	3	19	No Target	31					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Aug-19	0	0	No Contract target	0		No grade 3 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	▲	Aug-19	1	5	No Contract target	18			Quality and patient safety	RCA is currently being undertaken. Bespoke improvement work in areas being undertaken.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Aug-19	95.20%	95.26%	95.0%	95.94%		VTE performance monitored since implementation of Medway and newly introduced ePMA. An electronic solution is in the IT pipeline. Performance remains above target.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending electronic solution (this can be challenging when new doctors start in August).	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Sep-19	1	12	No Target	26					
To achieve and maintain CQC registration	Q		Sep-19	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Sep-19	92.5%	96.8%	No Target	96.5%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Sep-19	2	2	No Target	0					

Sep-19

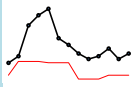
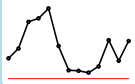
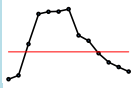
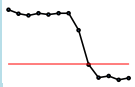
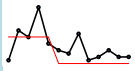
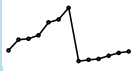
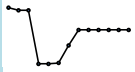
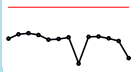
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Aug-19	88.5%	88.0%	93.0%	92.2%		2 week performance remains below standard with continued pressures on Breast Service and the ability to provide 1 stop service. 31 day Target achieved in month. 62 Day target met but pressures remain with Consultant workforce constraints. Radiological capacity in Breast and Dermatology patient rearrangements contributed to the performance.	Quality and patient experience	1. All DMs producing speciality level action plans to provide 2 week capacity 2. Capacity demand review on going at speciality level 3. Breast Radiologist recruited, to start ? January 2020. 4. Trust pilot site for SFIT lower GI which will improve cancer access and pathways. full roll out of pilot expected early 2020 5. Trust to commence Rapid Diagnostic Service early 2020	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Aug-19	96.3%	96.9%	96.0%	98.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-19	85.9%	86.8%	85.0%	88.3%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Sep-19	92.3%	92.3%	92.0%	92.4%		Impact of pension / tax rules on Consultant WLI activity resulting in increase in WL and wait times	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. ongoing pension / tax negotiations locally and nationally	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Sep-19	99.97%	99.5%	99.0%	99.9%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Sep-19	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-19	0.6%	0.7%	0.8%	0.8%		There was one breach of the 28 day re-list target in January due to difficulties in communicating with the patient.	Patient experience and operational effectiveness Poor patient experience	Proactive system in place to monitor, manage and prevent cancelled operations within the care group. Lessons learned from the 28 day re-list patient in January have been feedback to the relevant departments for learning and reflection.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Aug-19	100.0%	100.0%	100.0%	99.5%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Sep-19	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Sep-19	77.8%	71.1%	95.0%	74.3%		Accident and Emergency Type 1 performance for September 2019 was 77.8, increasing YTD performance to 71.1%. The all type mapped STHK Trust footprint performance was 88.3% in month and 84.7% YTD. The Trust received 10,223 Type 1 attendances in September 2019. Year to date growth in ED attendances is 5.9% up on 2018/19. The work streams, designed to increase performance against the 4 hour standard, continue to focus on driving forward the required improvement. Whiston ED had 2801 Ambulance conveyances in September 2019. Ambulance notification to handover time was achieved with 12.01 mins/seconds on average (target 15 mins).	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 New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily 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. Continue with daily AMU/ED huddles which is proving beneficial. COPD pilot in place from December continues with benefits realised of avoiding admission.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Sep-19	88.3%	84.7%	95.0%	87.1%					
A&E: 12 hour trolley waits	F&P	▲	Sep-19	0	0	0	0					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Aug-19	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	Sep-19	23	150	No Target	266		% new (Stage 1) complaints resolved in month within agreed timescales continues to remain above the 90% target. Slight increase in the number of new complaints received in September.	Patient experience	The Complaints Team continue to work hard to respond to complaints within agreed timescales and to proactively monitor each complaint that is likely to exceed this. The backlog of overdue complaints continues to remain extremely low as reported previously. To increase performance, weekly reminders are sent to Care Groups regarding complaint responses due a fortnight before to ensure improved performance is maintained. Additional actions to be taken to sustain the improved performance include messages to all staff via global email and Team Brief.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-19	16	152	No Target	241					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-19	93.8%	93.4%	No Target	92.1%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Aug-19	18	19	No Target	19		In August 2019 the average number of DTOCS (patients delayed over 72 hours) was 18.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Sep-19	322	339							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Sep-19	121	132							
Friends and Family Test: % recommended - A&E	Q	▲	Sep-19	88.7%	86.2%	90.0%	86.0%		The YTD recommendation rates remain above target for inpatients and postnatal, but slightly below target for ED, delivery and outpatients. Community postnatal continue to achieve 100% recommendation rates.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team, by attendance at ward meetings, the Patient Experience and Dignity Champions and monthly Team Brief. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. Improved performance was noted in August with a greater % of posters submitted. At least two members of staff have been identified in each area to take responsibility for production of the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides were issued to each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues. A random spot check audit was conducted during September to review performance in displaying posters. 79% (23/29) had a poster on display, with 65% of these displaying the latest month's data. The Patient Experience Council Chair has written to each area that has not displayed a current poster for the last three months.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Sep-19	95.4%	95.4%	90.0%	94.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Sep-19	85.7%	97.8%	98.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Sep-19	98.1%	97.5%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Sep-19	95.3%	97.2%	95.1%	94.8%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Sep-19	100.0%	100.0%	98.6%	98.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Sep-19	94.3%	94.4%	95.0%	94.2%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Sep-19	4.9%	4.9%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.0%		In September sickness was 4.9%, which is a 0.1% increase from August but 0.1% lower than 2018-19 position. It is 0.55% higher than Q2 target of 4.35%. Qualified & HCA sickness was 6.4%, a 0.6% increase since August. It is 1.1% above 2019-20 target.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The large scale review of the current HR policies and procedures continues inline with "Just Culture" including the Attendance Management policy with the aim of driving improvements in engagement levels, attendance and streamlining. The programme of wellbeing awareness events continue, including Mental Health First Aid Training and Mindfulness Sessions facilitated within the workplace. Case conference meetings are being held in October between HR and HWWB to review those long-term cases that may require further intervention to enable timely actions inline with policy. The Compassionate Leadership Culture development is being devised following NHSI course attendance by HR.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Sep-19	6.4%	5.9%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-19	82.9%	82.9%	85.0%	89.6%		Appraisal compliance in September is below target by 2.%. Mandatory training compliance is below the target by 2.9%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The HRBP's alongside Education, Training & Development and Workforce Planning teams continue to ensure improvements in compliance for Mandatory Training & work with managers to ensure on-going maintenance of compliance for Appraisals. Non-compliances 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	Sep-19	82.1%	82.1%	85.0%	95.3%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q1	96.2%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q3 survey is underway in the form of the National Staff Survey covering all areas of the Trust. The survey closes on 30th November with results expected in February 2020.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q1	84.6%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Sep-19	0.7%		No Target	9.2%		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	Sep-19	3.0	3.0	3.0	3.0		At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved. Key assumptions within the plan include:- - Full achievement of CQUINs - Activity within planned levels - Achievement of CIPs (£16.1m) - Agency spend within cap levels 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	Sep-19	6,425	6,425	16,100	14,978					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Sep-19	(3,602)	(3,602)	3,900	(597)					
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-19	4	4	2	5					
Capital spend £ YTD (000's)	F&P	T	Sep-19	1,957	1,957	7,872	9,642					
Financial forecast outturn & performance against plan	F&P	T	Sep-19	3,900	3,900	3,900	(597)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-19	88.6%	88.6%	95.0%	91.2%					

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-20 YTD	2019-20 Target	FOT	2018-19	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	88.9%	100.0%	100.0%	100.0%	100.0%	96.0%	83.3%	100.0%	100.0%	84.6%	73.7%	100.0%	89.7%	88.6%	85.0%		96.5%		
	Total > 62 days		1.5	0.0	0.0	0.0	0.0	0.5	2.5	0.0	0.0	1.0	5.0	0.0	2.0	6.0			5.0		
	Total > 104 days		1.5	0.0	0.0	0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					
Lower GI	% Within 62 days	▲£	92.3%	100.0%	36.4%	88.9%	100.0%	87.5%	72.7%	80.0%	94.4%	100.0%	88.9%	60.0%	60.0%	85.7%	85.0%		86.6%		
	Total > 62 days		0.5	0.0	3.5	1.0	0.0	1.0	1.5	1.0	0.5	0.0	0.5	3.0	2.0	4.0			10.5		
	Total > 104 days		0.5	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0					
Upper GI	% Within 62 days	▲£	62.5%	77.8%	66.7%	33.3%	63.6%	84.6%	88.9%	75.0%	88.9%	85.7%	83.3%	90.9%	100.0%	87.0%	85.0%		74.7%		
	Total > 62 days		1.5	1.0	0.5	1.0	2.0	1.0	0.5	1.5	0.5	1.0	1.0	0.5	0.0	3.0			12.0		
	Total > 104 days		0.0	0.0	0.5	0.0	0.5	0.0	0.0	0.5	0.0	0.0	0.0	0.5	0.0	0.5					
Urological	% Within 62 days	▲£	97.1%	80.6%	90.3%	75.0%	89.4%	85.2%	87.8%	90.9%	87.1%	91.3%	96.9%	87.5%	83.3%	90.1%	85.0%		86.0%		
	Total > 62 days		0.5	3.0	1.5	3.5	2.5	2.0	2.5	1.5	2.0	1.0	0.5	2.5	3.0	6.0			29.0		
	Total > 104 days		0.5	0.0	0.0	2.0	0.5	0.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	2.5					
Head & Neck	% Within 62 days	▲£	42.9%	83.3%	50.0%	80.0%	57.1%	25.0%	0.0%	100.0%	0.0%	25.0%	0.0%	16.7%	50.0%	16.7%	85.0%		57.1%		
	Total > 62 days		2.0	0.5	1.0	0.5	1.5	1.5	0.5	0.0	1.5	3.0	0.5	2.5	1.5	7.5			12.0		
	Total > 104 days		0.5	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5					
Sarcoma	% Within 62 days	▲£	100.0%	100.0%	0.0%	100.0%	100.0%			50.0%			100.0%		100.0%	100.0%	85.0%		85.2%		
	Total > 62 days		0.0	0.0	1.0	0.0	0.0			0.5			0.0		0.0	0.0			2.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0			0.0			0.0		0.0	0.0					
Gynaecological	% Within 62 days	▲£	72.7%	50.0%	62.5%	100.0%	81.8%	57.1%	88.9%	77.8%	66.7%	100.0%	40.0%	83.3%	40.0%	73.3%	85.0%		77.8%		
	Total > 62 days		1.5	0.5	1.5	0.0	1.0	1.5	0.5	1.0	2.0	0.0	3.0	1.0	3.0	6.0			10.0		
	Total > 104 days		1.0	0.0	0.5	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0					
Lung	% Within 62 days	▲£	100.0%	81.8%	66.7%	94.1%	100.0%	92.9%	81.8%	92.9%	71.4%	100.0%	88.2%	100.0%	100.0%	90.2%	85.0%		90.4%		
	Total > 62 days		0.0	1.0	2.0	0.5	0.0	0.5	1.0	0.5	1.0	0.0	1.0	0.0	0.0	2.0			8.0		
	Total > 104 days		0.0	0.0	1.0	0.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0					RC
Haematological	% Within 62 days	▲£	66.7%	90.9%	50.0%	85.7%	66.7%	50.0%	0.0%	83.3%	100.0%	80.0%	100.0%	50.0%	85.7%	84.0%	85.0%		76.7%		
	Total > 62 days		1.0	0.5	1.0	1.0	1.0	2.0	2.0	1.0	0.0	1.0	0.0	1.0	1.0	2.0			9.5		
	Total > 104 days		0.0	0.5	0.0	1.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					
Skin	% Within 62 days	▲£	98.1%	93.3%	84.6%	90.2%	98.0%	93.7%	88.1%	94.9%	95.0%	97.1%	94.4%	92.8%	95.0%	94.4%	85.0%		93.4%		
	Total > 62 days		0.5	3.0	4.0	2.5	0.5	2.0	2.5	1.0	1.0	0.5	1.5	2.5	1.5	5.5			20.5		
	Total > 104 days		0.0	1.0	1.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.0	0.5	3.0					
Unknown	% Within 62 days	▲£	75.0%	100.0%	100.0%	100.0%		100.0%	66.7%	100.0%	100.0%	50.0%	100.0%		100.0%	66.7%	85.0%		93.9%		
	Total > 62 days		0.5	0.0	0.0	0.0		0.0	0.5	0.0	0.0	1.5	0.0		0.0	1.5			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0		0.0	0.5	0.0	0.0	0.5	0.0		0.0	0.5					
All Tumour Sites	% Within 62 days	▲£	89.1%	90.9%	77.8%	88.4%	89.0%	86.7%	82.6%	90.0%	89.6%	87.6%	85.6%	85.7%	85.9%	87.0%	85.0%		88.3%		
	Total > 62 days		9.5	9.5	16.0	10.0	8.5	12.0	14.0	8.0	8.5	9.0	13.0	13.0	14.0	43.5			119.5		
	Total > 104 days		4.0	2.0	3.5	5.0	1.0	2.0	2.0	1.0	1.5	2.0	1.5	3.0	1.0	9.0					
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%				100.0%	66.7%		80.0%	85.0%		90.0%		
	Total > 31 days		0.0	0.0	1.0	0.0	0.0	0.0	0.0				0.0	0.5		0.5			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0				0.0	0.0		0.0					
Acute Leukaemia	% Within 31 days	▲£		0.0%	100.0%										100.0%	100.0%	85.0%		66.7%		
	Total > 31 days			1.0	0.0										0.0	0.0			1.0		
	Total > 104 days			0.0	0.0										0.0	0.0					
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)84
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during September 2019. There were a total of 3 Executive Committee meetings held during this period. The Executive Committee approved: • Modular Building proposals; • Windows 10 deployment strategy; • Medway upgrade go live decision. There were updates on BLS/ILS training, and the industrial action taken by Unison in its pay dispute with Medirest. The Committee also considered regular assurance reports covering: the Risk Management Council and Corporate Risk Register, the Integrated Performance Report and progress reports for a number of key projects.
Trust objectives met or risks addressed: All 2019/20 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: 30th October 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
October 2019

1. Introduction

There were 3 Executive Committee meetings in September 2019. The 19th September meeting was cancelled due to the number of apologies. At every meeting the committee reviews any bank or agency staff requests that would breach the NHSI cost thresholds.

2. 5th September 2019

2.1 Patient Flow Dashboard

The Director of Finance and Information introduced a demonstration of the patient flow dashboard that had been developed by the Service Improvement Team, as an interim bed management solution. The benefits of all ward areas using the dashboard to improve coordination and flow were acknowledged and the team were thanked for their work on this project.

2.2 Healthcare Safety Investigation Branch (HSIB) Report and Action Plan

The Director of Nursing, Midwifery and Governance introduced the report which summarised the outcome of the round table review of the five HSIB investigations that had been undertaken between February and June 2019. The action plan was reviewed and it was noted that all themes had been highlighted in the Trust 72 hour reviews that had taken place before the HSIB investigations, giving assurance that the internal organisational processes had already identified these issues.

2.3 Basic and Intermediate Life Support (BLS/ILS)Training Compliance

The Director of Nursing, Midwifery and Governance presented the report which detailed progress against the training compliance improvement trajectory. Although many additional staff had been trained a large number had also fallen out of compliance during the same time period so the overall compliance rates did not show a significant improvement. Further actions to improve attendance at the available training sessions were agreed and committee noted that the new mobile training mannequins would be in use from 1st October which would make training more accessible for staff.

2.4 Trust Board Agenda

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

2.5 SafeCare Allocate Implementation

The Director of Nursing, Midwifery and Governance presented the latest update on the implementation of the SafeCare Allocate system to monitor patient acuity and ward staffing. A steering and champion user group had now been established and the current staffing SOP was being revised to accommodate the system. The acuity and dependency data collected continued to be audited and training offered to staff.

2.6 HSJ Awards Nomination Presentation

The Deputy CEO/Director of HR outlined plans for the forthcoming HSJ awards judges visit to the Trust.

2.7 Medirest Industrial Action

The Director of Corporate Services confirmed that the Trust had been notified that Medirest staff were planning further industrial action in support of their pay claim on 20th, 21st and 22nd September. Business continuity plans were being put in place to maintain patient services.

2.8 Infection Prevention Control

The Director of Finance and Information led a discussion about the authorisation process required to approve ward deep cleans. It was agreed that the SOP should be reviewed to achieve the clarity needed.

3. 12th September 2019

3.1 Safeguarding Capacity Business Case

The Director of Nursing, Midwifery and Governance presented the business case outlining the increased demand for safeguarding and future changes to the regulations which will increase the responsibilities of the Trust. In light of the multiple pressures described it was agreed that more detail was needed to clarify the benefits expected from the requested investment.

3.2 Radiology Managed Equipment Service (MES)

The Director of Finance and Information presented an update on the MES contract variation and the strategic options open to the Trust for future equipment replacements. The Committee reviewed each of the options and agreed to the variation that retained maximum organisational flexibility. Benchmarking based on Carter at Scale and GiRFT data demonstrated that the Imaging function was performing well and the MES contract continued to offer value for money.

3.3 Command Centre Scoping Exercise

The Director of Finance and Information presented a proposal from the MES supplier to explore the feasibility of developing command centre technology for the imaging services. It was agreed that a scoping exercise could be undertaken and a formal proposal would be developed once this had been completed.

3.4 Risk Management Council and Corporate Risk Register

The Director of Corporate Services presented the assurance report from the Risk Management Council (RMC) meeting on 10th September, including risks that had been escalated to the Corporate Risk Register (CRR). There was also a summary of the feedback from the Information Governance Steering Group, the Claims Governance Steering Group and the Emergency Planning Group.

3.5 NEWS2 Implementation Progress Report

The Director of Nursing, Midwifery and Governance presented the report which detailed the impact of NEWS2 since its introduction in March 2019. The system was easy to use and there were high levels of compliance from staff. The impact on MET calls was being closely monitored following the introduction of NEWS2. A full benefits realisation report will be prepared to evaluate the impact on patient care.

3.6 Integrated Performance Report (IPR)

The Director of Finance and Information presented the IPR for August for review and agreement of the executive commentary. Improvements in the HSMR score, cancer 2 week wait performance and sickness absences were noted.

3.7 Cold Decontamination Replacement - Update

The Director of Corporate Services introduced the report which detailed the progress on the schemes being planned for both St Helens and Whiston Hospitals. The St Helens scheme is being progressed with a site and outline design agreed and the equipment specification finalised. For Whiston Hospital a suitable location option has now been identified and although still subject to feasibility studies and agreement with NewHospitals was agreed in principle by the committee.

3.8 Urgent Treatment Centres (UTC)

An update was given on discussions with St Helens CCG regarding the proposed transfer of the St Helens UTC contract to the Trust. Committee also discussed the latest developments concerning the intentions of Halton CCG in relation to the Widnes UTC.

3.9 Contract Review Board

The Director of Finance and Information gave an update on current discussions with commissioners on a range of contractual issues that could increase the income risk for the Trust.

4. 26th September 2019

4.1 Modular Ward Proposal

The Director of Operations and Performance presented a progress report on the development of the plans, including the site, potential layout and timescales. It was agreed that the facility should be developed as step down and decant capacity. The drivers to reduce super-stranded patients in acute beds, provide additional escalation capacity and decant facilities for life cycle works were compelling and it was agreed that the plans should now be further developed into a business case that would be taken to the Trust Board in October.

4.2 Windows 10 Deployment Strategy

The Director of Informatics presented the plans to transfer all Trust users to Windows 10 by March 2020, in line with national requirements. The sequencing of the roll out was approved.

4.3 Informatics annual work programme

The Director of informatics presented a revised Informatics work programme for 2019/20 and revised 5 year IT investment strategy. The in-year priorities had been reviewed in line with patient safety priorities, the Trust objectives and national policy requirements. The overall cost was the same and each individual project remained subject to business case approval. The changes to the work programme were agreed.

4.4 Medway upgrade go live decision

The Director of Informatics informed committee that all the technical and operational readiness tests for the upgrade had been completed and outlined the support and business continuity arrangements that had been put in place. The Committee approved the recommendation to proceed with the Medway upgrade on 28th September 2019.

4.5 Adult Community Services Contract

The Director of Integration reported that St Helens CCG had confirmed that the Adult Community Services contract was to be extended for a further two years from April 2020.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)85

Title of paper: Committee Report – Quality Committee

Purpose: To summarise the meeting papers from the Quality Committee meeting held on 22nd October and escalate any issues of concern.

Agenda Items Discussed:

- Integrated Performance Report – QC(19)120
  The committee focused on the Quality and Workforce KPIs, with the main areas of scrutiny being the increased incidence of CDI positive cases and the increase in avoidable grade 2 pressure ulcers. There was also an update on the progress of the flu vaccination programme, which had achieved 30% uptake so far.
- Update on the quality improvement priorities for 2019/21 – QC(19)121
  The report detailed the progress achieved to date against the quality improvement objectives for 2019/20 identified in the Quality Account; timely and effective assessment and delivery of care in ED; maximise the utilisation and effectiveness of new electronic systems; increase proportion of patients reporting they have received information to meet their needs. Committee discussed in detail the actions being taken to improve patient information and communication.
- Patient Safety Council Assurance Reports for September and October– QC(19)122
  Key issues highlighted from the reports were;
  - Safeguarding Q1 performance improvement
  - Investigation and actions being taken in response to the increase in grade 2 pressure ulcers
  - Changes to the controlled drugs policy resulting from the Gosport Hospital review recommendations
  - Results of the NEWS2 and Bristol Royal Infirmary Safety Checklist audits in ED
  - Reduction in falls and medication incidents reported by the Medical and Surgical Care Groups
- Safeguarding Quarterly Report – QC(19)123
  An increase in safeguarding activity and performance was reported. Concerns highlighted in relation to the number of DoLs being reported and the 2020 changes in regulations. It was noted that a business case to enhance the Trust Safeguarding team had been approved by the Executive. Progress in achieving the Prevent level 3 compliance target for Q3 was also reported.
- Infection Prevention Control Annual Report 2018/19 – QC(19)124
  The report met all the statutory requirements and was approved by the Quality Committee.
- CQC Action Plan Progress Report – QC(19)125
  Of the 50 actions 45 had now been completed, 4 were on track for completion by the agreed completion date and 1 remained at risk of not being achieved – ED 4 hour access target achievement, although it was noted that performance had stabilised.

- Patient Safety Council Assurance Report – QC(19)126
  Key issues were; work with Medirest to ensure patients were offered all the available meal choices; increases in spiritual care activity highlighted; the Trust team being shortlisted for the National Dementia Awards
- National Inpatient Survey 2018 Action Plan - QC(19)127
  The report detailed the National Inpatient Survey Results from the responses of patients who had their inpatient stay in July 2018. The Trust compared better than other Trusts in 5 questions and worse in 1. For the remaining questions the responses were "about the same" as other Trusts. There was a statistically significant fall in the scores between 2017 and 2018 for the Trust in 6 areas. All areas of concern had been incorporated in the action plan, with the main focus being on patient communication and information. A dedicated Project Manager had been recruited to lead this work.
- Complaints, Concerns and Claims Q2 Report – QC(19)128
  Performance and themes across the majority of areas was consistent with previous reporting periods. An increase in inquests was noted and this was attributed to the different working practices of the new Coroner. Committee asked for additional benchmarking information and trend analysis in relation to clinical negligence claims.
- Friends and Family Test Q2 Report – QC(19)129
  Patient satisfaction scores remained consistently high although response rates continued to be variable. Changes to FFT reporting guidance will offer different opportunities to obtain real time feedback from patients. Patient comment themes included discharge medication, Marshalls Cross Health Centre and waiting times in the Emergency Department.
- Clinical Effectiveness Council Assurance Report – QC(19)130
  Issues highlighted to the Quality Committee were the results of the recent Respiratory Service GiRFT review and the National Emergency Laparotomy Audit (NELA), both of which were being reviewed by the Executive Committee.
- Clinical Audit Programme Progress Report - QC(19)131
  Six months into the year 203 projects were active and 69 had been completed of the proposed 330 project programme which was a 98% compliance rate. A further 36 projects were in the planning phase to be completed by year end.
- NICE Guidance Compliance Report – QC(19)132
  In Q1 55 pieces of NICE guidance had been issued, of which 40 were applicable to the Trust. For 26 the Trust was reporting full compliance and partial compliance for a further 4. 2 pieces of guidance had not yet been allocated and 8 were awaiting a compliance response. Committee were concerned that there were outstanding responses from 2018/19 and asked that the escalation and monitoring process be reviewed.
- Safer Staffing Report September 2019 – QC(19)133
  The overall RN fill rate was 92.46% and HCA fill rate was 112.29%. There were no patient harm incidents that could be linked to staffing levels.
- Nurse Staffing Establishment Review – QC(19)134
  The audit to inform the review had taken place in August, this had identified some discrepancies between the funded establishment and the Shelford/SafeCare audit results, however using professional judgement and taking account of the situation at the

time of the audit no changes to establishment were recommended at this time. The audit will continue to be undertaken on a rolling basis with a further formal establishment review in February 2020 to inform budget setting for 2020/21.

- Mandatory Training Compliance – BLS/ILS – QC(19)135
  The report outlined the actions that had been undertaken to improve compliance and the introduction of the mobile Resuscitation Skills Stations. Further actions were discussed to ensure that 85% compliance was achieved across all clinical areas.

Matters for Escalation:

- Increased incidence of CDI
- Increase in avoidable grade 2 pressure ulcers
- Review of the NICE Guidance compliance monitoring process
- The actions being taken to achieve 85% compliance with BLS/ILS training

Corporate objectives met or risks addressed: Effectiveness, Experience, Safety and Workforce.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff, regulators and commissioners

Recommendation(s): It is recommended that the Board note this report.

Presenting officer: Val Davies, Non-Executive Director and Chair of Committee

Date of meeting: 30th October 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)86

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 24th October 2019

Summary:

Agenda Items

For Information

- DoF verbal update – NK gave an update on a number of issues for the Committee's attention. These included:
  - STP position – The financial position for the Cheshire and Mersey STP at month 6 is £78.1m deficit against a plan of £51.2m deficit. Pro rata position would indicate an outturn deficit of c£187m against a current planned deficit of £16m which is clearly a risk. (Outturn is influenced by CIP/QIPP/PSF profile).
  - The Trust has received a letter from the Treasury confirming the funding of £4m for Ambulatory Care which will be phased over the next three years.
  - The Executive team had a system meeting with NHSE&I and CCG partners which focussed on quality, finance and winter planning. There was some discussion around the financial recovery of the local system and whether this could be achieved through multi-year plans.

- Integrated Performance Report
  - The Committee discussed the HSMR score, this will need to be validated by the Medical Director and brought back to the Committee.
  - The performance of E-Discharges was highlighted as this has been below target for a number of months. RC assured the Committee that actions are being taken in a number of areas but as different areas required difference solutions it had taken a while to resolve.
  - The Committee also discussed the performance in relation to thrombolysis of stroke patients and while some patients didn't receive this within one hour all patients had been thrombolysed. Further information is to be brought to the next Committee.

- Finance Report
  - The Trust is reporting a £3.6m deficit YTD which is in line with plans. £1.8m of non-recurrent resources were utilised to achieve this position, an increase of £1.1m from last month.
  - Capital resources of £2.0m have been utilised year to date and the Trust has plans for the entire programme.
  - The Trust delivered a UoR of 3 in line with plan.
  - The financial position includes Provider Sustainability Funding (PSF) of £2.3m; this is excluding the £0.5m of PSF relating to 2018/19.
  - The Trust had a cash balance of c£5m at the end of October which equates to 4 days of operating expenses.

- The challenge from CCG's regarding the zero day length of stay audit has now been withdrawn.
- NK summarised the financial risks currently being managed, they were:-
    - Over-performance for Halton & Warrington CCG's relating to 2017/18.
    - NEL admission conversion rates given A&E growth. Bed capacity has meant this is below plans YTD. In October a c21 beds have been closed due to Norovirus but were due to be open by the 25th October 2019.
    - Clinical income achievement given pensions tax impact and doctors not taking up WLIs or additional payments for extra duties. More work is needed to understand how the Trust can improve the uptake of additional sessions for some specialities.

- Budget Setting 2020/21
    - A provisional timetable for 2020/21 Budget Setting process has been shared with the Committee, this assumes full guidance and draft tariffs to be received in early December with returns due to NHSi in January, February and a final full plan in April, this timetable will be updated as more information is available.
    - A guide for Budget Holders has been produced to clarify the process for budget setting including indicative dates. The Management Accounts team will share this guidance and commence meetings with budget holders from November.
- National Cost Collection
    - The Committee noted the successful submission of the National Cost Collection in August. The outcome of the costing exercise will be brought to the Committee once this has been published at the end of the year.
- Briefings were accepted from:
    - Capital Planning Council

For Approval

- LTP
    - GL took the Committee through a presentation of the Long Term Plan which is due to be submitted to the STP in early November.
    - The underlying inflation rates were discussed alongside the risks to cash, capital and the delivery of continued growth.
    - It was proposed to achieve a breakeven position in 2020/21 with surpluses building in later years. The Committee approved this approach.

For Assurance

- A&E Performance
    - The Committee reviewed the presentation from the ADO and CD for Emergency Care.
    - JF presented a breakdown of stroke patients arriving at the department including those that were confirmed and non-confirmed strokes..
    - Actions to improve the 4 hour target were presented including a focus on GP streaming within the department, while streaming has improved there is still work needed to cover weekends.
- CIP Programme update
    - The Committee noted the £15.3m of CIP plans which have already been transacted this year and were notified that high risk schemes have now been moved into 2020/21 to form part of next year's CIP plans.
    - The Committee were assured around the governance arrangements of CIPs having tested a scheme at random but were advised there was still some work to be done to ensure both quality and equality assessments were being completed.
- CIP Programme update – SCG

- The ADO for Surgical Care presented an updated on their CIP performance to date including details on the process within the division of how CIPs are identified and the plans so far for 2020/21.
- The projects ongoing with the Service Improvement team were noted and should be able to contribute to efficiencies next year. NK thanked the SCG team for their contribution towards the overall CIP programme.

Risks noted/Items to be raised at Board

- NEL and admissions due to closure of beds for October and management going forward
- General activity risk due to doctors not willing to take up additional work because of pension tax impact.
- Aged debt increase of c£13.5m (and therefore cash management) but recognising that cash turnover is now c£1bn

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: 30th October 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)87

Title of paper: Committee Report – Audit

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

Summary:
A meeting of the Audit Committee was held on 9th October 2019. The following matters were discussed and reviewed:

External Audit

- **Progress and Sector Update Report** – GT presented a progress report on delivery of their responsibilities as the Trust's external auditors and also referred to issues of interest in the sector (eg. GT publications, insights from NHS sector specialists, reports of interest and accounting and regulatory updates). All proceeding to plan at present.

Internal Audit

- **Progress Report** – This report by MIAA included detail on the latest finalised reports (Tender and Quotation Waivers (substantial assurance) and Data Quality: Did Not Attends (limited assurance). An update on the latter report was presented by an officer of the Trust and the Audit Committee were assured with the management action plan and progress to date.

Anti-Fraud

- **Progress Report** - This report by the Trust Local Anti-Fraud Specialist from MIAA included detail on anti-fraud and investigation work carried out on behalf of the Trust and progress against plan. The report was discussed and accepted.

Standing Items

- **Audit Log** – Report was accepted and triangulated with MIAA internal audit update received.
- **Losses, Write-offs & Compensation –** Report was discussed and accepted.
- **Aged Debt –** Overdue debt as at 30th September 2019 has risen to £13.4m. This was reflective of the cash challenges within the NHSI but also that against a cash annual turnover of c£1bn this would be expected to grow proportionally. All aged debt has been escalated accordingly.
- **Tender Waivers Report –** Compliance with policy and report was noted with assurance.

Governance & Assurance (including Quality Committee) Update

- The Director of Nursing's report took the Committee through key updates of current quality, governance and assurance issues. This included Safer Staffing, CQC action plan, Saving Babies Lives, CNST, Perinatal Mortality report, Healthcare Safety Investigation Branch (HSIB) Maternity, Infection Control, Pre-operative Error Checking Incidents, Safeguarding, Quality Spot Check Review (Newton), Medicine Safety and Storage, and Complaints. Assurance was received regarding progress and compliance. The shortlisting of the "Trust as Trust of the Year" for the HSJ Awards was also referred to.

Issues/Risk to be escalated to Board

- **Aged Debt –** It is recommended the Board and F&P committee continue to consider the risks to cash given financial challenges of other organisations and shared service growth.

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 this update

Presenting officer: Ian Clayton, NED and Chair of Audit Committee

Date of meeting: 30th October 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19) 88

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 22nd October 2019.

Summary

1. Action Log
    - Discussion to increase/replace clinical representation at the committee meetings
    - Joining a cash lottery is not going to be pursued at this stage.

2. Financial position - The Committee noted the level of investments and recent income and expenditure.

3. Fundraising update
    - Recruitment to a part time Community Fundraiser to raise the profile of the charity locally.
    - A discussion also took place around how fundraising could be managed in the future, for example targeted fundraising.

4. Any other business –
    - The Annual Accounts and Report 2018-19 were approved by the Committee on behalf of the Trustee (ie the Trust Board) after the independent examiner's report done by Grant Thornton, external auditors.
    - Christmas monies – the Committee agreed £5.00 per patient to be spent on Christmas gifts, plus biscuits/sweets for visitors.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Paul Growney, Chair Charitable Funds Committee

Date of meeting: 30th October 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)88b
Title of paper: Charitable Funds Accounts and Annual Report
Purpose: For Board members to note the approval of the Charitable Funds Annual Accounts and Annual Report 2018/19 by the Charitable Funds Committee at their meeting held 22nd October 2019.
Summary: The Charitable Funds Annual Accounts and Annual Report 2018-19 were approved by the Charitable Funds Committee on behalf of the Trustee (ie the Trust Board) after the independent examiner's report done by Grant Thornton, external auditors. The accounts show that for the year 2018/19, Income was £279.8k with expenditure of £348.5k giving an in year net movement of funds of £60.5k (loss). Brought forward into 2018/19 was a positive balance of £655.7k, giving a 2018/19 year-end balance of £595.1k. A copy of the annual report and accounts can be made available on request.
Corporate objectives met or risks addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): Ratify the approval of the Charitable Funds Annual Accounts and Annual Report 2018-19
Presenting officer: Nikhil Khashu, Director of Finance
Date of meeting: 30th October 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)89

Title of paper: Corporate Risk Register

Purpose: To inform the Board of the risks that have currently been escalated to the Corporate Risk Register (CRR) from the Care Groups via the Trust's risk management systems.

Summary:

The CRR is reported to the Board to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council (RMC), which reports to the Executive Committee providing assurance , that all risks;

- Have been identified and reported
- Have been scored in accordance with the Trust risk grading matrix.
- Any risks initially rated as high or extreme have been reviewed by a Director
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level

This report covers all the risks reported and reviewed in September 2019 and is a snap shot, rather than a summary of the quarter. A comparison with the previous Board report in July is included to illustrate the movement in risks during the period. The report shows;

- The total number of risks on the risk register is 779 compared to 753in July
- 46% (360) of the Trusts risks are rated as Moderate or High compared to 46% (350) in July
- 14 risks that scored 15 or above had been escalated to the CRR (there 10 risks escalated in July 2019),

The spread of CRR risks (Appendix 1) across the organisation is;

- 3 in the Medical Care Group
- 0 in the Surgical Care Group
- 4 in Clinical Support Care Group
- 7 in Corporate Services
- 0 in Primary Care and Community Services Care Group

The risk categories of the CRR risks are;

- 11x Patient Care
- 2 x Money
- 1x Governance
- 0x Staff

The report also includes comparisons between the quarterly reports and against the

same period in October 2018(Appendix 3 and 4).
Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Commissioners, Regulators.
Recommendation(s): The Trust Board notes the risk profile of the Trust and the risks that have been escalated to the CRR
Presenting officer: Anne-Marie Stretch on behalf of Nicola Bunce, Director of Corporate Services
Date of meeting: 30th October 2019

CORPORATE RISK REGISTER – OCTOBER 2019

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/10/2019	Previous Reporting Period 02/09/2019	Previous Reporting Period 01/08/2019
Number of new risks reported	18	15	24
Number of risks closed or removed	6	17	5
Number of increased risk scores	3	3	2
Number of decreased risk scores	2	4	8
Number of risks overdue for review	32	84	45
Total Number of Datix risks	**779**	**768**	**772**

*based on 776 scored risk, 3 new not scored at the time the report was taken

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
56	**53**	**20**	**119**	**11**	**157**	**58**	**131**	**35**	**122**	**4**	**10**	**0**	**0**
129 = 16.62%			**287 = 36.98%**			**346 = 44.59%**				**14 = 1.80%**			

2.1 Surgical Care Group - 220 risks reported 28.35% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**13**	**7**	**41**	**4**	**45**	**15**	**50**	**8**	**31**	**0**	**0**	**0**	**0**
26 = 11.82%			**90 = 40.91%**			**104 = 47.27%**				**0**			

2.2 Medical Care Group - 188 risks reported 24.22% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
27	**24**	**1**	**30**	**0**	**35**	**7**	**22**	**13**	**26**	**1**	**2**	**0**	**0**
52 = 27.66%			**65 = 34.57%**			**68 = 36.17%**				**3 = 1.60%**			

2.3 Clinical Support Care Group - 90 risks reported 11.60% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**7**	**1**	**7**	**0**	**12**	**11**	**13**	**10**	**20**	**2**	**2**	**0**	**0**
13 = 14.44%			**19 = 21.11%**			**54 = 60%**				**4 = 4.44%**			

2.4 Primary Care and Community Services Care Group - 39 risks reported 5.02% of the Trust total

Very Low Risk	Low Risk	Moderate Risk	High/ Extreme Risk

1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**1**	**0**	**10**	**1**	**5**	**4**	**5**	**4**	**9**	**0**	**0**	**0**	**0**
1 = 2.56%			**16 = 41.03%**			**22 = 56.41%**				**0**			

2.5 Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR and Medicines Management) -

239 risks reported 30.80% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
18	**8**	**11**	**31**	**6**	**60**	**21**	**41**	**0**	**36**	**1**	**6**	**0**	**0**
37 = 15.48%			**97 = 40.58%**			**98 = 41%**				**7 = 2.93%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	1	17	5	0	23
Estates and Facilities Management	0	5	13	7	25
Nursing, Governance, Quality & Risk	1	14	8	8	31
Finance	2	7	18	11	38
Medicines Management	0	17	37	8	62
Human Resource	3	37	16	3	59
Information Governance	0	1	0	0	1
Total	7	98	97	37	239

3. The Trusts Highest Scoring Risks – Corporate Risk Register

Risks of 15 or above (Appendix 1) are added to the CRR.

Appendix 2 - Summary of the Corporate Risk Register – October 2019

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

Risk Category	Datix Ref	Risk	Current Risk Score I x L	Date of last review	Executive Lead	Target Risk Score I x L	Action plan in place	Governance
Patient Care	762	If the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	13/05/2019	Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Quality Committee
Money	1152	If there is an increase in bank and agency then there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	03/04/2019	Anne-Marie Stretch	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1358	If the Cheshire and Mersey PACs system experiences system issues, then there is a risk to patient safety	4 x 4 = 16	23/08/2019	Rob Cooper	4 x 1 = 4	Action plan in place	Executive Committee
Patient Care	1605	If the Trust is unable to fill gaps on the SpR rota then there is a risk to patient safety	4 x 4 = 16	16/08/2019	Sue Redfern	3 X 1 = 3	Action plan in place	Quality Committee
Governance	1772	If there is a malicious cyber-attack on the NHS then there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	30/09/2019	Christine Walters	4 x 3 = 12	Action plan in place	Executive Committee
Patient Care	2083	If inpatient bed occupancy levels are over 95% then this will negatively adversely affect the admission of medical patients from the ED	3 x 5 = 15	02/08/2019	Rob Cooper	2 x 2 = 4	Action plan in place	Executive Committee
Patient Care	2334	If the Medway migration issues in PBS are not resolved then there is a risk to efficient service delivery across the Trust	4 x 4 = 16	12/08/2019	Rob Cooper	4 x 2 = 8	Action plan in place	Executive Committee
Patient Care	2428	If the breast imaging service cannot recruit staff to cover the vacancy arising following retirement of the previous post holders, then capacity to deliver this specialist service will be reduced	4 x 3 = 15	16/07/2019	Anne-Marie Stretch	3 x 3 = 9	Action plan in place	Executive Committee
Patient Care	2502	If there is a no deal Brexit then there could be an adverse impact on the supply of medical consumables and devices.	4 x 4 = 16	12/09/2019	Nik Khashu	3 x2 = 6	Action plan in place	Finance and Performance Committee
Patient Care	2708	If a large number of senior medical staff are adversely impacted by the NHS pension tax rules then the Trust could experience reduced senior clinical capacity	4 x 4 =16	04/07/2019	Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Remuneration Committee
Money	2746	If the Trust does not achieve its activity plans then the planned income may not be achieved	4 x 4 = 16	23/08/2019	Nik Khashu	4 x 3 = 12	Action plan in place	Finance and Performance Committee
Patient Care	2750	If there are national PDS spine data mismatch errors following the implementation of Medway then diagnostic imaging results could be affected.	5 x 3 = 15	04/09/2019	Rob Cooper	5 x 2 = 10	Action plan in place	Executive Committee

Patient Care	2759	If there is not sufficient medical cover on ward 4E then patients will not receive the required standard of care	4 x 4 = 16	17/09/2019	Rob Cooper		Action Plan in place	Quality Committee
Patient Care	2565	If there is not sufficient capacity or capability in the Safeguarding Team the Trust may not be able to fulfil its statutory obligations	5x3=15	25/09/2019	Sue Redfern	2x2=4	Action Plan in place	Quality Committee

*****Risks escalated since the July Board report

Risks that have been de-escalated from the CRR since the April Board report are;

Risk Category	Datix Ref	Risk
Patient Care	2370	If critical care cannot recruit sufficient consultant medical staff then there is a risk to the level of medical cover for the service Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C

Appendix 2

Trust Risk Profile – July 2019

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
50	50	20	116	11	150	59	125	36	120	1	9	0	0
120 = 16.06%			277 = 37.08%			340 = 45.52 %				10 = 1.34%			

Trust Risk Profile – October 2018

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
53	64	25	135	14	154	54	121	40	109	1	7	3	0
142 = 18.2			303 = 38.8%			324 = 41.5%				11 = 1.41%			

Appendix 3

CRR – October 2018

The risks highlighted remain on the CRR

Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Target Risk Score I x L	Action plan in place
Governance	222	Risk of failure to ensure delivery of national performance targets	4 x 4 = 16	4 x 4 = 16	24/04/2017 Rob Cooper	4 x 2 = 8	Action plan in place
Governance	1772	Risk of Malicious Cyber Attack	3 x 4 = 12	3 x 5= 15	09/11/2016 Christine Walters	3 x 3 = 9	Action plan in place
Money	1555	Risk of not receiving apprenticeship levy payments for Lead Employer Doctors in Training.	3 x 5 = 15	3 x 5 = 15	01/04/2016 Anne-Marie Stretch	3 x 4 = 12	Action plan in place
Money	1152	Risk to the quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 3 = 8	Action plan in place
Patient Care	1569	Risk to consultant recruitment for Clinical Support Services, due to national staff shortages	5 x 2 = 10	5 x 3 = 15	17/11/2016 Anne-Marie Stretch	5 x 2 = 10	Action plan in place
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C	4 x 5 = 20	4 x 5 = 20	15/08/2017 Sue Redfern	4 x 1 = 4	Action plan in place
Staff	762	Risk that if the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 2 = 8	Action plan in place
Patient Care	2080	Risk of avoidable harm to A&E patients being cared for in the corridor at times of escalation when there is insufficient bed capacity	5 x 4 = 20	5 x 4 = 20	27/12/17 Rob Cooper	5 x 2 = 10	Action plan in place
Patient Care	2283	Risk that replacement biochemistry blood analysers cannot be procured by December	4 x 4 = 16	4 x 4 = 16	11/05/18 Rob Cooper	4 x 2 = 8	Action plan in place

Staff	2370	Consultant vacancies in Critical Care	4 x 4 = 16	4 x 4 = 16	21/08/18 Kevin Hardy	4 x 2 = 8	Action plan in place
Patient Care	2502	Impact of Brexit “no deal” on the supply of medical consumables and devices	4 x 4 = 16	4 x 4 = 16	21/09/18 Nik Khashu	4 x 2 = 8	Action plan in place

TRUST BOARD

Paper No: NHST(19) 90
Title of paper: Review of the Board Assurance Framework (BAF) – October 2019
Purpose: For the Trust Board to review the BAF
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in July 2019. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Recommended changes** The following changes should be considered: • Increase the score of risk 1 to 10 to reflect the bed pressures and difficulties in securing discharge for super stranded patients
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Anne-Marie Stretch on behalf of Nicola Bunce, Director of Corporate Services.
Date of meeting: 30th October 2019

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

Mission: To provide high quality health services and an excellent patient experience

BAF Ref	Long term Strategic Risks	Strategic Aims					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	✓		✓		✓	✓
3	Sustained failure to maintain operational performance/deliver contracts	✓	✓		✓	✓	✓
4	Failure to protect the reputation of the Trust			✓			✓
5	Failure to work in partnership with stakeholders	✓	✓	✓	✓		✓
6	Failure to attract and retain staff with the skills required to deliver high quality services	✓				✓	✓
7	Major and sustained failure of essential assets, infrastructure	✓	✓	✓			✓
8	Major and sustained failure of essential IT systems	✓	✓	✓			✓

Alignment of Trust 2019/20 Objectives and Long Term Strategic Aims

2019/20 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Risk Scoring Matrix

Impact Score	Likelihood /probability				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible (very low)	1	2	3	4	5

Likelihood – Descriptor and definition
Almost certain - More likely to occur than not, possibly daily (>50%)
Likely - Likely to occur (21-50%)
Possible - Reasonable chance of occurring, perhaps monthly (6-20%)
Unlikely - Unlikely to occur, may occur annually (1-5%)
Rare - Will only occur in exceptional circumstances, perhaps not for years (<1%)
Impact - Descriptor and definition
Catastrophic – Serious trust wide failure possibly resulting in patient deaths / Loss of registration status/ External enquiry/ Reputation of the organisation seriously damaged- National media / Actual disruption to service delivery/ Removal of Board
Major – Significant negative change in Trust performance / Significant deterioration in financial position/ Serious reputation concerns / Potential disruption to service delivery/Conditional changes to registration status/ may be trust wide or restricted to one service
Moderate – Moderate change in Trust performance/ financial standing affected/ reputational damage likely to cause on-going concern/potential change in registration status
Minor – Small or short term performance issue/ no effect of registration status/ no persistent media interest/ transient and or slight reputational concern/little financial impact.
Negligible (very low) – No impact on Trust performance/ No financial impact/ No patient harm/ little or no media interest/ No lasting reputational damage.

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Safety thermometer • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy	To Board; • IPR • Patient Stories • Quality Board Rounds • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	~~5x1 = 5~~ 5 x 2 = 10	~~Routine reporting of quality and performance of community and primary care services delivered by the Trust~~	Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate changes in behaviour to achieve a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, inquests and mortality reviews	Implementation plans for the four key 7-day service standards by 2020 ~~Risk assessment of critical suppliers and development of contingency plans for EU exit.~~ Continue to monitor closely the impact of EU Exit on critical healthcare supplies and costs Undertake a review of patient communication and information to improve accessibility and understanding (Revised to March 2020) Continue to work with commissioners to complete the consultation process and implement the preferred location for the Eastern Sector Cancer Hub Introduce six monthly workforce safeguards reports for all clinical staff groups (March 2020)	5 x 1 = 5	R P-J/ SR

Risk 2 –Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	4x3=12	~~Develop 2019 -20 detailed CIP plans and strengthen QIA monitoring to mitigate additional risk~~ Continue collaboration across C&M to deliver transformational CIP contribution Monitoring of management plans to deliver GiRFT recommendations	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Cash flow and prompt payment of invoices from other NHS providers Cash requirements to service capital costs for committed PFI UP charges and other essential capital demands for patients care from 2020/21.	Develop a 5 year plan with the local Place based systems to deliver the NHS long term plan with C&M partners for final submission in November 2019 Secure maximum PSF funding in 2019/20 to achieve revised forecast outturn Via the St Helens Cares Finance and Contract group develop proposals for financial allocations and funding flows for the system (Draft September 2019 and final submission in November 2019) Seek all possible sources of capital funding including national bids to support capacity planning	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	4 x 4 = 16	Implementation of routine capacity and demand modelling	Achievement of targets to reduce DTOC and super stranded patients, by working effectively with health system partners ~~Review the effectiveness of the 2018/19 health economy winter plans and learn lessons to inform the plans for 2019/20~~ Detailed 2019/20 winter plan proposals Resolve residual Medway and operational issues with OP patient booking systems	Delivery of the Urgent and Emergency Care Summit improvement programme (On going) Work with Halton CCG to achieve implementation of the agreed frailty pathway model following the allocation of STP transition funding (November 2019 for CCG plans to be finalised) ~~Mitigation plan to improve access to Breast Imaging (September 2019).~~ Understand changes in reported activity and increased A&E attendances and admissions (October 2019) Implement contract changes for Community Services and UECs in St Helens and Halton (March 2020)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSI Segmentation Rating	4 x 2 = 8	Regular media activity reports , including social media, to the Executive Committee	~~Action plan to improve understanding of patients and carers' views (Revised to September 2019)~~	Update Trust internet site Delivery of the updated inpatient survey action plan (July 2020) ~~Assess the impact of the combined NHSE/I accountability framework (September 2019)~~ Delivery of the staff survey action plan (Revised to March 2020)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Health and Care Partnership governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN • Annual staff engagement events programme	4 x 3 = 12		C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks	Participation in One Halton Programme Board Membership of the Knowsley Health and Care Executive Group to develop plans for integrated place based care Membership of St Helens Cares Board and chair of the Provider Board Continue participation with the Collaboration at scale board and work streams Continue working with the C&M H&SCP to agree final 5 year plans for the locally delivery of the NHS Long Term Plan (November 2019)	4 x2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES and WDES reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream	5 x 3 = 15		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Monitoring of take up of the UK Settlement Scheme by EU staff Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3	Development of a C&M collaborative staff bank (Revised p Proposals accepted September 2019 for implementation by March 2020) ~~Develop workforce strategy in relation to new roles e.g. Nurse Associates to maximise potential – September 2019~~ ~~Revise the Workforce Strategy to align to the workforce objectives in the NHS Long Term Plan and interim people plan (July 2019)~~ Implement 2019/20 NHS Pension Taxation Flexibilities for staff impacted (March 2020)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M STP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.		NHSI approval of Same Day Ambulatory care /bed capacity business case (Now expected October 2019) Commence 3 year capital programme to deliver the Same Day Ambulatory care capacity, once business case approval received and funding confirmed (January 2019) Develop proposals for additional winter capacity beds (October 2019) Revise Estates and accommodation strategy (November 2019) Operational plans to accommodate 10 year lifecycle works with minimal service disruption (September 2019 in progress) Review business continuity plans to protect service delivery during periods of disruption (November 2019)	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports (5YFV) • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval Annual Corporate Governance Structure review Staff Development Plan Technical Development Annual programme of audit NHS Digital Unified Cyber Risk Framework	ISO27001 Cyber Essentials Plus Service Improvement Plans Communications Strategy Digital Maturity Assessment Complete investigation and review of controls and business continuity resilience following IT outage in January	ISO27001 (August 2020) Cyber Essentials Plus (National deadline revised to July 2020) Medway benefits realisation programme delivery (revised to March 2020) ~~HIMSS assessment completed (Sept 2019)~~ ~~Delivery of Penetration Test Action Plan (August 2019)~~ Information security management framework (Revised to December 2019) PA Consulting external cyber security gap analysis and technology baseline assessment (December 2019)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)91

Title of paper: Complaints, Claims and Incidents – Quarter 2 2019-20

Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 2 2019-20 (Q2).

Summary

Incidents

- 3988 incidents reported in Q2, with 13 incidents reported to StEIS and 42 categorised as moderate harm, severe harm or death. In comparison, during Q 1 there were 3946 incidents reported with 9 reported to StEIS and 58 categorised as moderate or above.

Complaints

- 76 1st stage complaints were received and opened in Q2; 2 more than the previous quarter
- 91.9% of 1st stage complaints were responded to within the agreed timescales in Q2
- Clinical treatment was the primary cause of complaint

Concerns

- 0.79% increase in PALS contacts compared to the previous quarter
- Clinical treatment is the main reason for enquiries to PALS
- 3.3% of PALS contacts converted to a complaint

Claims

- 53 new clinical negligence claims were received in Q2 an increase of 12.7% in comparison to Q1
- Failure to diagnose or delay in diagnosis was the primary cause of clinical negligence claims
- 7 clinical negligence claims were settled with damages
- 3 new insurance claims (Employment Liability & Public Liability) were received in Q2, the same as Q1
- 6 insurance claims were closed with no damages
- 20 new Inquests were opened in Q2 an increase of 110% compared to Q1
- No inquests were concluded in Q2 2019-20

Corporate objectives met or risks addressed: Care and safety

Financial implications: None as a direct consequence of this paper

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

Recommendation(s): Members are asked to consider and note the content of the report

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

Date of meeting: 30th October 2019

1. Introduction

The Trust uses the same Datix system to record incidents, complaints, PALS enquiries and claims. This allows the Trust to link any related occurrences. This report highlights if there are any trends and the learning derived from incidents, complaints, claims and PALS enquiries received by the Trust. The information includes all reported incidents, complaints, PALS and litigation (claims and inquests).

The top category in each of the areas has been consistent for the last four quarters and the other reasons for each area have also remained in the top five, except for claims, where there is some fluctuation due to the small numbers. The table below shows that the most common themes across all areas are clinical care, communications, waiting times, patient care/nursing care and values and behaviours (staff).

Top 5 reasons for complaints, concerns and claims in Q2 2019-20

Incidents	Q2 2019-20	Complaints	Q2 2019-20	Concerns	Q2 2019-20	Clinical Negligence Claims	Q2 2019 20
Accident that may result in personal injury	928	Clinical treatment	32	Clinical treatment	140	For all specialities failure to diagnose or delay in diagnosis	21
Implementation of care or ongoing monitoring/review	734	Values and behaviours	13	Communications	117	Fail/delay treatment	8
Access, Appointment, Admission, Transfer, Discharge	385	Patient care/nursing care	7	Appointments	114	Failure to recognise complications of treatment	3
Clinical assessment (investigations, images and lab tests)	360	Admissions and discharges	6	Patient care/ nursing care	102	Falls	3
Medication	323	Waiting times	5	Waiting Times	67	Intra-operative problems	3

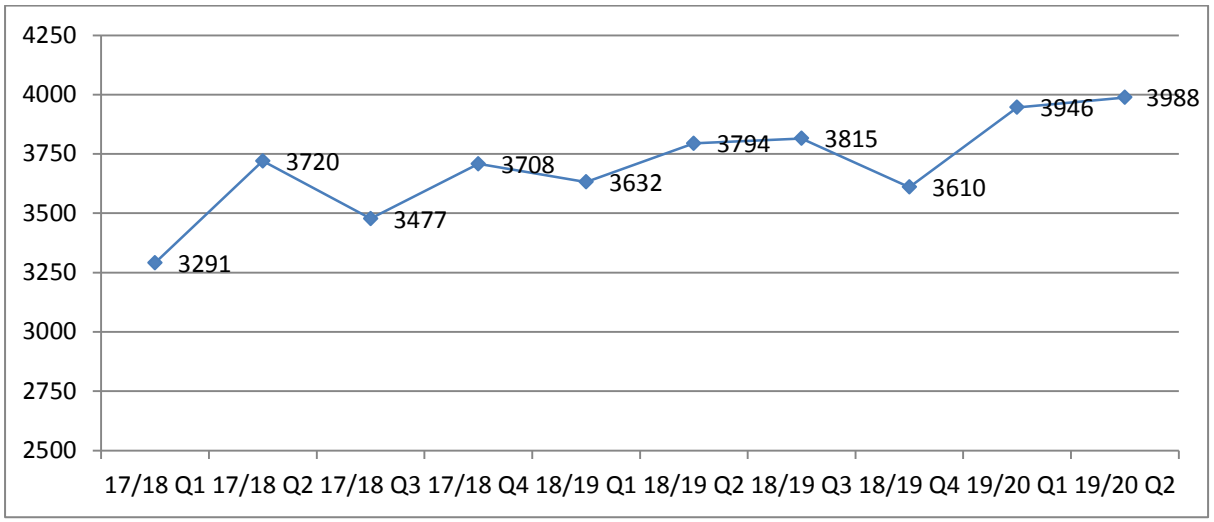
Key to table above

Clinical Treatment
Waiting times/appointments
Communications
Values and behaviours (staff)
Patient care/nursing care
Admissions and discharges

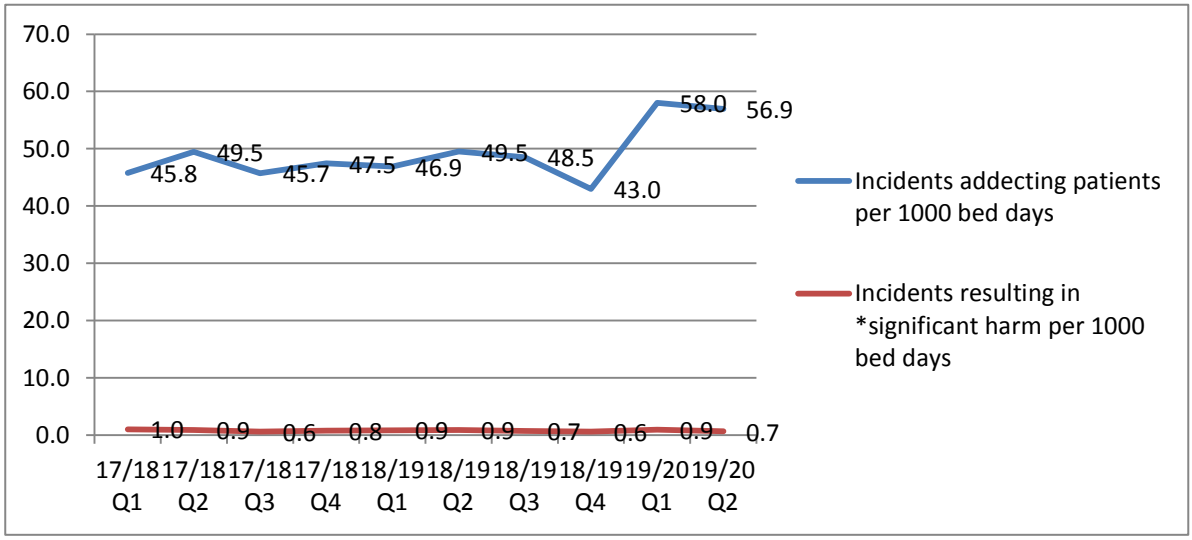
2. Incidents Quarter 2 2019-20

During Quarter 2 2019/20 there were 3988 incidents reported by staff, with 13 incidents reported to StEIS and 42 categorised as moderate harm, severe harm or death. In comparison, during Quarter 1 2019/20 there were 3946 incidents reported with 9 reported to StEIS and 58 categorised as moderate or above.
The charts below show the Trust's incident reporting activity from Q1 2017-18 to Q2 2019-20. This shows an increase in incident reporting but a downward trend in levels of significant harm resulting from the incidents. This indicates an improving culture of reporting.

Total incidents



Rate of incidents affecting patients per 1000 bed days



National Reporting and Learning System (NRLS) benchmarking

	Oct 2016-Sept 2017		Oct 2017-Sept 2018	
	Trust %	National %	**Trust %**	National %
No harm	**83.6%**	73.8%	**86.1%**	74.7%
Low	**14.5%**	22.9%	**12.4%**	22.1%
Moderate	**1.5%**	2.8%	**1.3%**	2.6%
Severe	**0.3%**	0.3%	**0.2%**	0.3%
Death	**0.1%**	0.2%	**0.1%**	0.2%

The table above 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.

2.1. Thematic analysis of incidents reported to StEIS in Q2 2019-20

In Q2 the Trust reported 13 incidents to StEIS while in Q1 there were 9 incidents reported. The table below give brief detail of all incidents reported to StEIS during Q2. 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.

Themes of StEIS reported incidents Q2 2019-20

Category	Number
Slips, trips, falls and collisions	5
AAA rupture	1
Contrast Induced Nephrotoxicity	1
Alleged abuse on patient by HCA	1
Missed opportunity to escalate deteriorating patient	1
Failure to recognise sepsis	1
Suicide	1
Delay to Endoscopy	1
Dressings incident	1

2.2. Actions taken as a result of serious incidents

A root cause analysis investigation is undertaken following each serious incident, with recommendations and an action plan produced to reduce the risk of a reoccurrence.

Examples of the actions taken include:

- Development of an emergency laparotomy pathway
- Embed new falls risk assessment in Emergency Department
- Training needs analysis for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training
- Implementation of ED medical staffing e-roster
- Updated Head Injury Policy to provide appropriate guidance from Consultant Haematologist on patients who present with a head injury and suspected coagulopathy focussing on low platelet counts
- CQuIN of 3 high impact changes of the National Stand Firm Initiative implemented on the ward

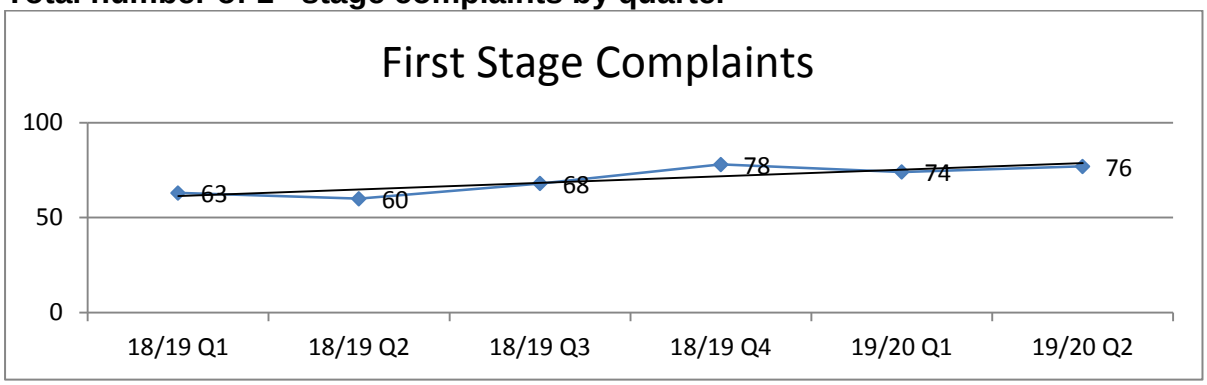
Lessons learned from incidents are shared via the bi-monthly safety bulletin included in Team Brief, via Ward Manager and Matrons' meetings, as well as through each Care Group's governance meetings.

3. Quarter 2 2019-20 - Complaints Activity

3.1. First stage complaints received

There were 76 new 1st stage complaints opened in Q2 2019-20 compared to 74 received in Q1 2019-20, an increase of 2.7%.

Total number of 1st stage complaints by quarter



100% of complaints received in Q2 were acknowledged within three working days, as the Complaints Team have maintained consistent performance year to date.

There were six 2nd stage complaints received and opened for investigation in Q2 2019-20, 4 less than Q1, which is a 40% decrease.

3.2. First stage complaints received by Care Group Q2 2019-20

The table below highlights that there was an increase in the number of complaints received in the Medical Care Group in Q2 2019-20 in comparison to the previous quarter, 2018-19, with a 27.2% increase. The Surgical Care Group had the second highest number of complaints, although there was a 17.1% decrease in comparison to the previous quarter.

First stage complaints by Care Group by quarter

Care Group	19/20 Q1	19/20 Q2	Total
Medical Care Group	33	42	75
Surgical Care Group	35	29	64
Clinical Support Services	3	3	6
Facilities (Medirest/TWFM)	1	1	2
Nursing, Governance, Quality & Risk	1	0	1
Medicines Management	1	0	1
Community Services	0	1	1
Total	74	76	150

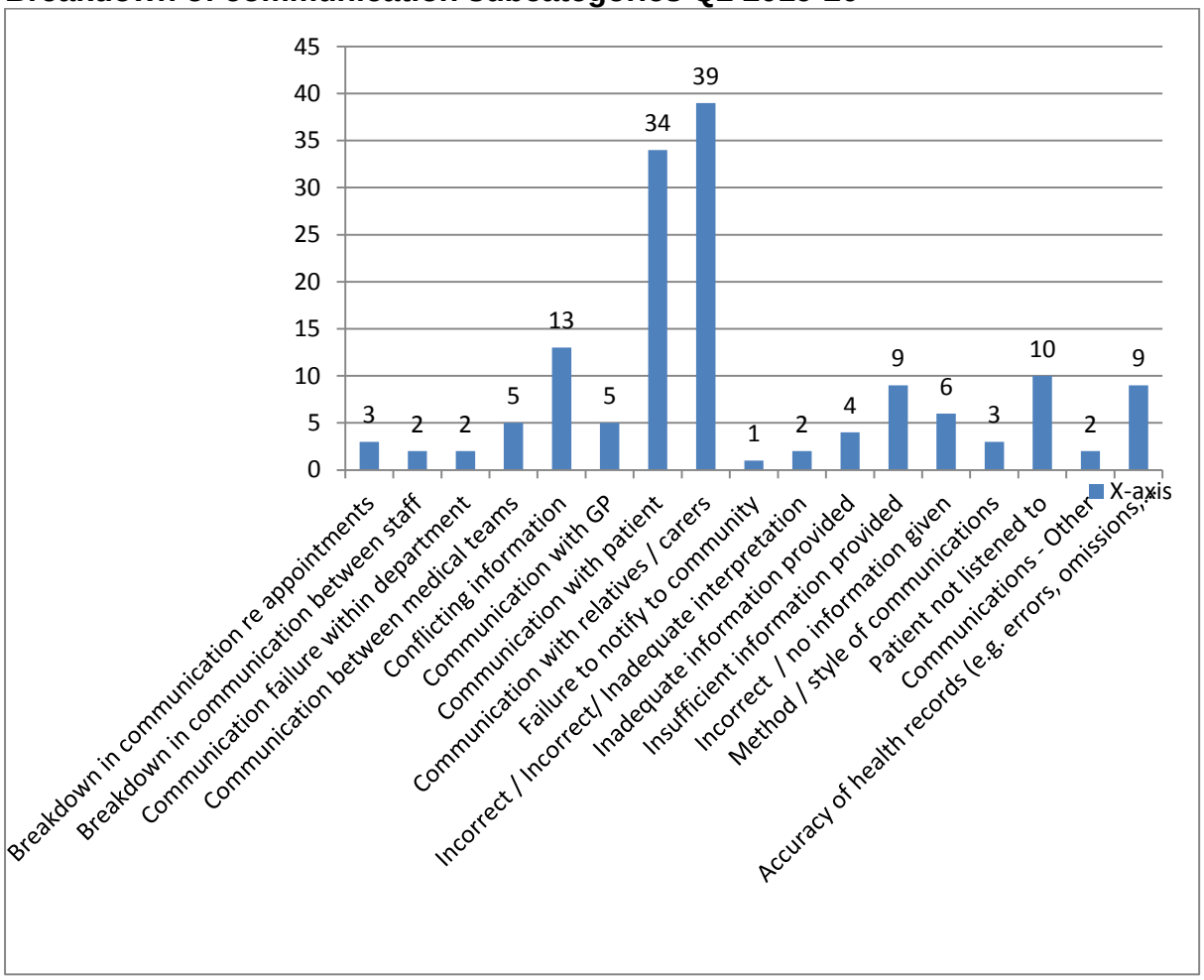
Top reasons by Care Group for Q2 2019-20

	Medical Care Group	Surgical Care Group	Clinical Support Services	Facilities (Medirest/ TWFM)	Community Services	Nursing Quality & Risk	Total
Clinical Treatment	18	13	1				32
Patient Care/ Nursing Care	5	2					7
Appointments		4					4
Values and Behaviours (Staff)	4	7	1	1			13
Communications	3	1					4

End of Life	1						1
Facilities		1					1
Trust Admin/Policies/Procedures (inc. Patient Record Management)	1		1		1		3
Admissions and Discharges (excl. delayed discharge re care package)	6						6
Waiting times	4	1					5
Total	42	29	3	1	1	0	76

The table above highlights that the top reason for complaints in the Medical Care Group and Surgical Care Group was clinical treatment. The second highest reason for complaints in Q2 2019-20 was values and behaviours (staff).

Breakdown of communication subcategories Q2 2019-20



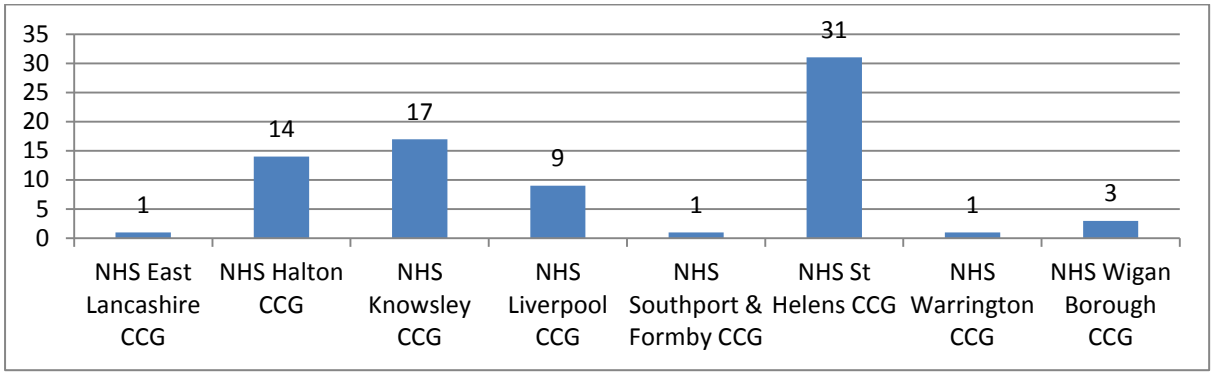
The chart above provides a further breakdown of the communications sub-category to further understand the issues that cause dissatisfaction with communications. There are a number of actions being taken to improve communications, including training and discussion at ward meetings and a focus on person-centred care.

3.3. Complaints by Clinical Commissioning Group Q2 2019-20

The Clinical Commissioning Group for each of the 76 1st stage complaints received during Q2 2019-20 is detailed in the chart below, highlighting that the highest was NHS St Helens CCG with 31 complaints which is three less than the previous

quarter. There is a decrease of 15% in the complaints received from Knowsley CCG in Q2 2019-20 in comparison to the previous quarter when 20 complaints were received.

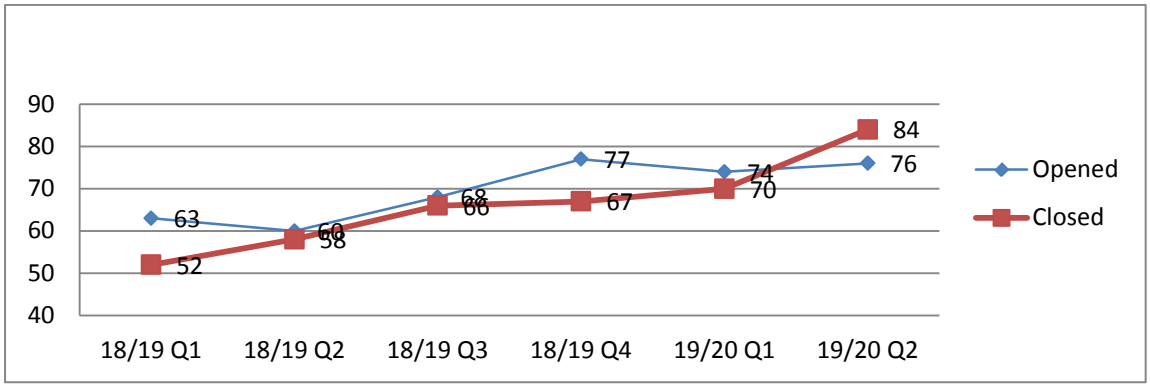
Complaints by Clinical Commissioning Group Q2 2019-20



3.4. First stage complaints closed by quarter

The Trust resolved more complaints than it received in Q2 2019-20 as shown in the chart below. This indicates that the Trust is dealing with complaints in a timely manner as they are received with no significant backlog of complaints building up.

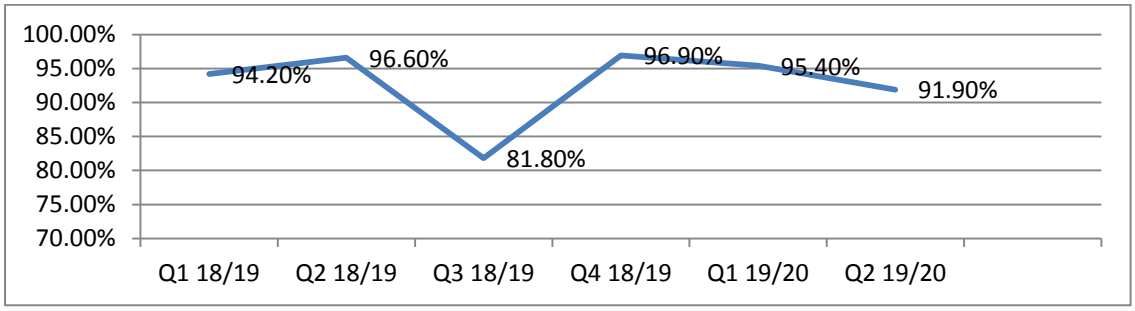
Stage 1 closed complaints by quarter



An audit of the current complaints in the system showed that risk rating is recorded once the complaints are opened. Similarly, risk rating is recorded on closure on Datix. A review of the risk assessment did not identify any risks that need to be recorded on the risk register.

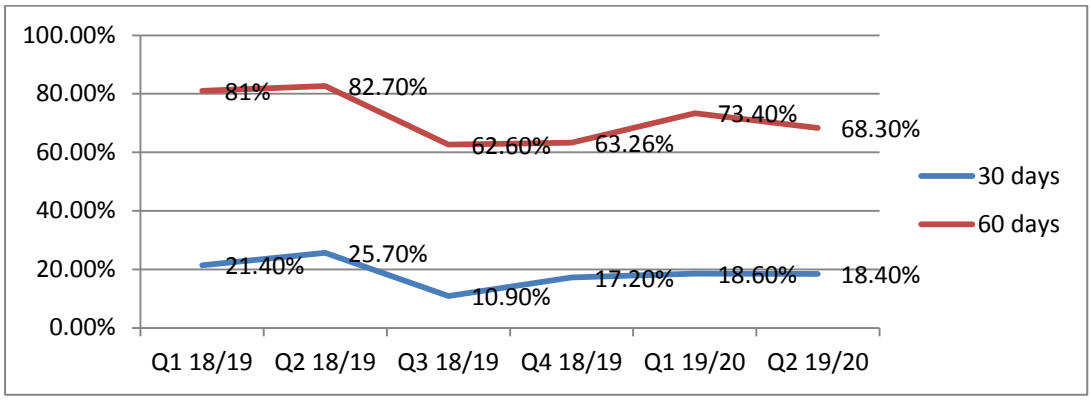
3.5. Responses within agreed timescales by quarter

The Trust responded to 91.9% of 1st stage complaints within agreed timeframes during Q1 2019-20. This represents a slight decrease compared to Q1 when 95.4% of 1st stage complaints were responded to within timeframes; however it remains above the 90% target.



There was one overdue complaint at the end of Q2. The total number of open complaints increased to 68 at the end of Q2 2019-20.

3.6. Responses within 30/60 days



There are occasions when the initial timeframes have been extended with agreement from the complainants. These extensions are usually for a number of reasons, namely, delays in getting statements back from witnesses; witnesses not providing sufficient information to draft a response; complaint more complex and involving a number of departments or organisations; consent issues; staff leave; delay in quality assurance process and more recently clinicians taking advice from their defence organisation. In these circumstances, exception reports are completed for sign off by the Complaints Manager. This has an impact on the 30/60 days response times shown in the chart above.

3.7. Decisions, Actions and Learning

The table below details the outcome of complaints closed in Q2 2019-20. It shows that 63.1% of complaints closed were not upheld; 14.3% upheld and 22.6% partially upheld.

Outcome of closed complaints

	Medical Care Group	Surgical Care Group	Clinical Support Services	Facilities (Medirest/ TWFM)	Nursing, Governance, Quality & Risk	Medicines Management	Total
Not Upheld Locally	35	15	1	1	1	0	53
Partially Upheld	8	6	4	0	0	1	19

Locally							
Upheld Locally	7	4	1	0	0	0	12
Total	50	25	6	1	1	1	84

3.8. Actions taken following the closure of the 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 complaints across the Trust is shared at the monthly Patient Experience Council 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 learned from complaints and to embed any actions taken to improve the quality of patient care. The following are examples of actions from Q2 2019-20.

Communications

- Palliative care will review documentation for the individualised care and communication record (ICCR) regarding the use of oxygen for symptom management to ensure there is no misunderstanding by patients and or their relatives
- Staff were reminded on the ward to tell relatives visiting times when asked.
- Plan of care to be explained to patient at each contact

Patient Care/Nursing Care

- Importance of food chart monitoring was discussed at ward meeting
- Aid magnets will be introduced in the ward 5C to alert staff to patients with sensory problems
- Staff reminded of the importance of ensuring that when medication is unable to be administered, it is discussed with the medical staff and pharmacist to ensure that there is no alternative route for administration

Clinical Treatment

- Staff remained to provide patients with analgesia at the point of triage in ED
- Sonographers and support workers in the ultrasound department have been reminded to provide strict instructions to patients on how much water should be consumed to speed up bladder filling prior to pelvic scan

4. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

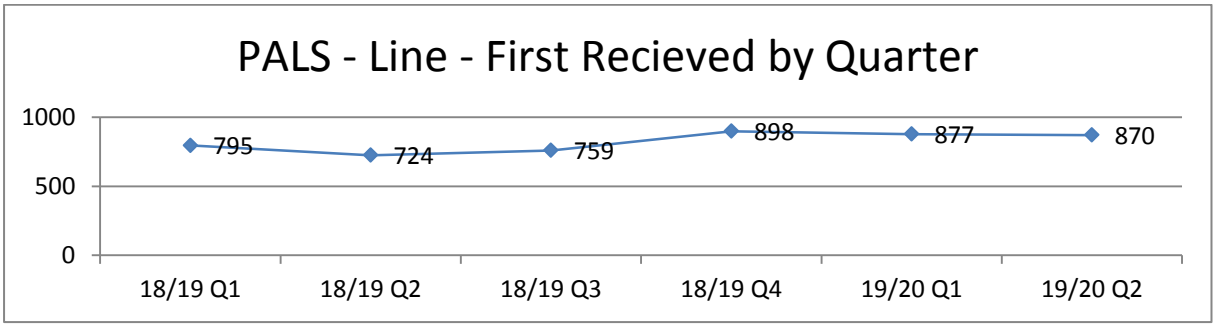
There were no new PHSO cases in Q2 2019-20.

5. Concerns

5.1. PALS enquiries by quarter – Q2 2019-20

There were 870 PALS contacts during Q2 2019 -20, a 0.79% decrease compared to Q1. 14.8% (129) of contacts were sign posting and the remainder concerns. 29 PALS contacts were converted to a complaint which represents 3.3% of PALS contacts.

Total PALS contacts by quarter



Clinical treatment was the highest cause of contact with PALS in Q2 2019-20 and communications were the second highest cause.

PALS by Care Group and theme

Category	Medical Care Group	Surgical Care Group	Clinical Support Services	Facilities (Medirest/TWFM)	Nursing, Governance, Quality & Risk	Medicines Management	Community Services	Total
Access to Treatment or Drugs	2	7	1	0	0	0	2	12
Admissions and Discharges (excl.delayed discharge re care package)	32	15	1	0	4	0	1	53
Appointments	26	73	8	1	4	0	2	114
Clinical Treatment	56	78	4	0	2	0	0	140
Commissioning	0	2	0	0	1	0	0	3
Communications	63	41	5	0	8	0	0	117
Consent	1	0	0	0	0	0	0	1
End of Life Care	14	0	0	0	2	0	0	16
Facilities	2	3	0	3	0	0	0	8
Integrated Care (incl. delayed discharge re care package)	1	0	0	0	0	0	1	2
Mortuary	1	0	1	0	0	0	0	2
Patient Care/ Nursing Care	68	28	0	1	5	0	0	102
Prescribing	5	1	0	0	0	1	1	8
Privacy and Dignity	4	1	0	0	1	0	0	6
Transport (Ambulances)	0	2	0	0	1	0	0	3
Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	2	5	1	0	7	0	0	15
Values and Behaviours (Staff)	11	5	0	1	2	0	0	19
Waiting Times	8	57	0	0	2	0	0	67
Other (e.g. abuse/behaviour/Theft/Benefits)	13	13	0	0	4	0	1	31
No details	0	0	0	0	0	0	0	151
Total	309	331	21	6	43	1	8	719

6. Clinical Negligence Claims

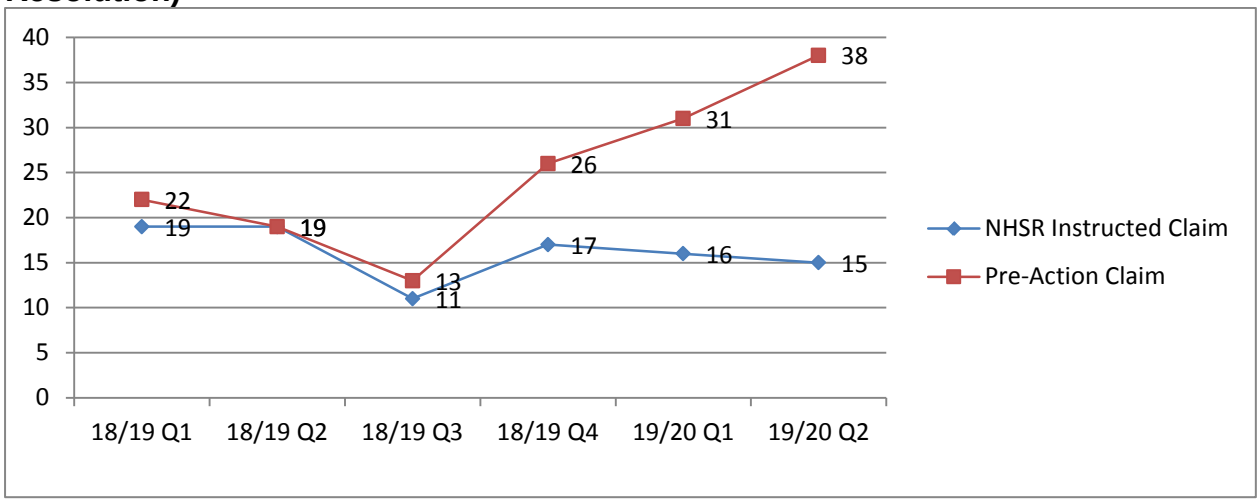
6.1. New clinical negligence claims received in Q2 2019-20

The Trust had 343 active clinical negligence claims as of 1st October 2019. This represents an increase of 9.2% from the previous quarter, when the Trust had 314 open clinical negligence claims.

6.2. New clinical negligence claims received

In Q2, the Trust received 53 new claims of which 38 were pre-action claims whilst 15 were formal claims. This represents an increase of 23.4% in comparison to Q1 2019-20 when only 47 claims (both pre-action and formal claims) were received.

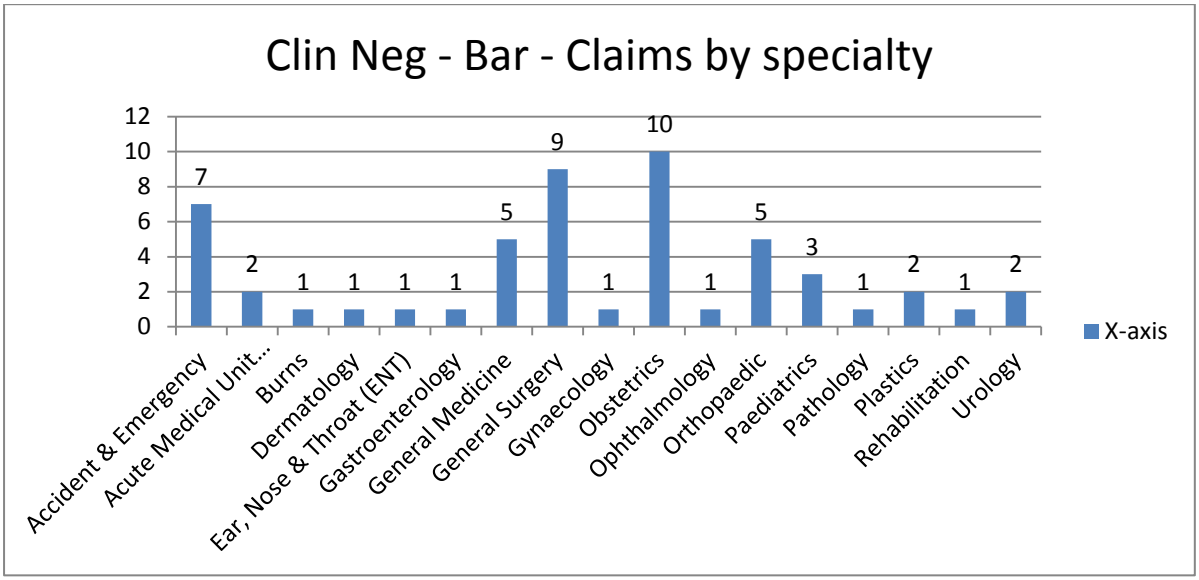
Clinical negligence claims received by month (by pre-action and NHS Resolution)



6.3. Breakdown of the clinical negligence claims received in Q2 by Directorate

The Surgical Care Group received the highest numbers of claim with 32 claims (26 pre-action and 6 formal claims) in Q2 2019-20. Medical Care Group received 20 claims (11 pre-action and 9 formal claims). Clinical Support Services received 1 pre-action claim and no formal claims.

Breakdown of the new clinical negligence claims opened in Q2 2019-20 by specialty



Obstetrics received the highest number of claims with 10 claims, whilst General Surgery received the second highest number of claims with 9 claims.

Breakdown of new clinical negligence claims received in Q2 2019-20 by subject

	19/20 Q2
Failure to diagnose pre-eclampsia	1
Failure to recognise complication of treatment	3
Failure to warn (informed consent)	2
For all specialities failure to diagnose or delay in diagnosis	23
Infusion problems	1
Intra-operative problems	3
Medication errors	1
No details of allegations yet received	5
Performance of operation that is not indicated	1
Fail/ Delay Treatment	8
Failure to make timely response to abnormalities in FHR	1
Removal & Retention of Organs	1
Falls	3
Total	53

The above table indicates that failure to diagnose or delay in diagnosis is the top reason for clinical negligence claims whilst failure or delay in treatment is the second highest reason for clinical negligence claims in Q2. This is consistent with previous quarters.

Outcome of clinical negligence claims closed in the period Q2 2019-20

	Upheld	Not Upheld	Closed after file review	Total
NHSR Instructed Claim	7	5	3	15
Pre-Action Claim	0	1	6	7
Total	9	4	9	22

The table above provides a breakdown of closed claims in Q2. The seven claims upheld were settled with damages; five claims were closed by NHSR following the Trust's defence of the claims.

6.7 Lesson learning/actions

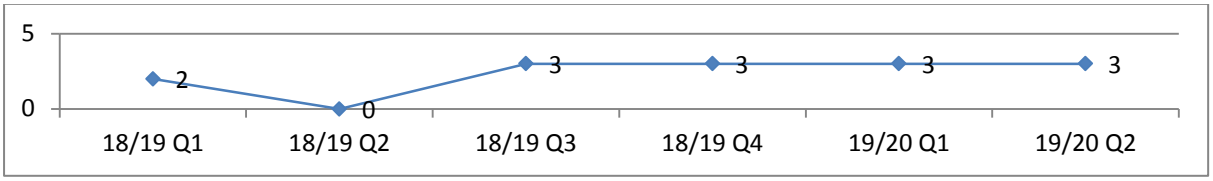
Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of claims in Q2 2019-20

Incident	Learning and actions
The patient's human epidermal growth factor receptor 2 (HER2) positive results from 2015 testing were not discussed with her until October 2016. Had the result been discussed in the October 2015 MDT then chemotherapy and Herceptin could have been considered which have statistically proved to reduce the recurrence of HER breast cancer.	The case highlighted the need to review how supplementary reports are actioned. The Trust now brings all supplementary reports back to the MDT. Histological reports that have further work being done now show as 'pending' and will be reviewed at MDT when complete. Also Histology reports are now only sent to the Consultant's Secretary rather than multiple sites.
Following a caesarean section in June 2013, the patient's bowel was sutured to the abdominal wall resulting in peritonitis.	The case highlighted the need for a more informed consent process and the need for senior consultant involvement for complex cases.
No documentary evidence to show that the necessary investigations were carried out regarding urinary retention	The case identified the importance of record keeping and as such various seminars were arranged.
The patient should have been diagnosed with a malignant melanoma in 2009. This was not picked up until 2015.	The case highlighted the need for double reporting on histology to gain a second opinion.

7. Insurance claims

Three new insurance claims were received in Q2 2019-20, same as the previous quarter.

New insurance claims received by quarter



Number of insurance claims by quarter (Employment Liability & Public Liability)

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q219/20
Employees Liability	36	32	12	12	14	13
Public Liability	8	7	6	7	7	6
Total	44	39	18	19	21	19

The Trust currently has 19 open insurance claims, a decrease compared to Q1 2019-20 when there were 21 open insurance claims.

Reasons for claims currently open

	Confirmed
Injury/harm to others by patient	1

Manual handling	1
Slip trip fall	9
Needle-stick	2
Other (data breach & faulty equipment)	6
Total	19

The table above highlights that the primary cause of insurance claims is due to slips, trips or falls (47.3%)

Outcome of insurance claims closed in Q2

Reasons for Closure	Total
Settled with payment of damages	0
Defended or repudiated	5
Closed after file review	1
Total	6

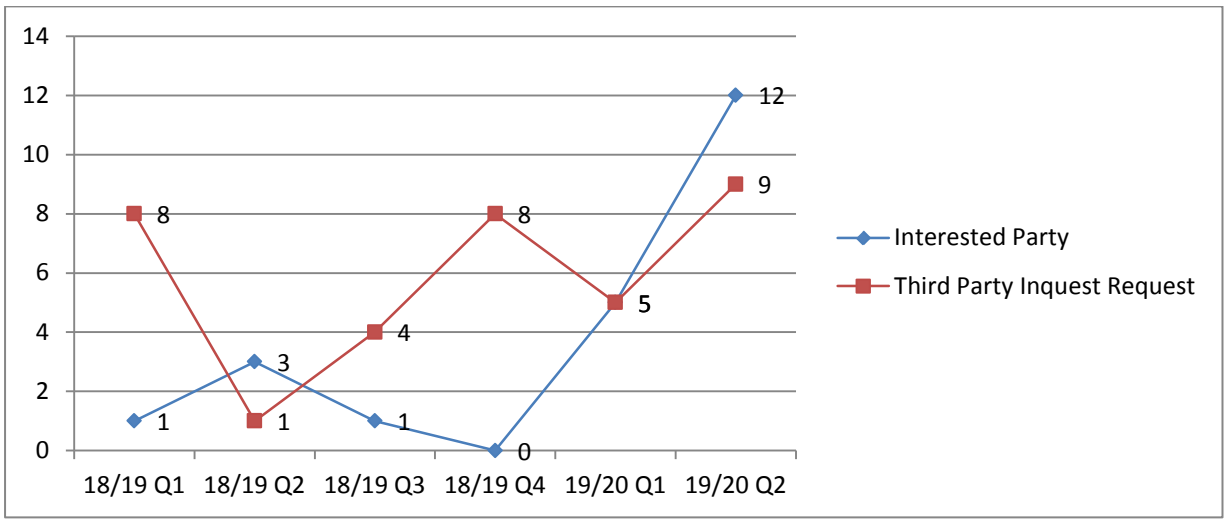
In Q2, 5 insurance claims was closed. One was closed after file review and the others were withdrawn after a successful investigation by the Trust legal team.

8. **Inquests**

The Trust 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 Team are also kept informed if there is any potential for media interest and therefore a risk to the organisation's reputation.

21 Inquests were opened in Q2 2019-20 an increase of 11 compared to Q1 2019-20 when 10 inquests were received. However, the Trust is an interested party in 12 of these new inquests whilst the remaining 9 open inquests relate to a third party (where the Trust is not directly involved). The increase in inquests is possibly due to having a new coroner who has a different approach to the previous one.

Inquests opened by quarter



In Q2 2019-20, no inquests were concluded or closed.

9. Recommendations

It is recommended that the Board note the report.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)92
Title of paper: Learning from Deaths Quarterly Report 2019/20 Q1
Purpose: To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths, and key learning has been disseminated throughout the Trust.
Summary: Data is given for Quarter 1 2019/20 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, policy and good practice guide
Presenting officer: Mr Rowan Pritchard-Jones, Medical Director
Date of meeting: 30th October 2019

STHK Learning From Deaths Board Report 2019/20

		Specified Groups										
	Deaths in Scope [1]	Learning Difficulties Death	Severe Mental Illness Death [2]	Child Death	Neonatal Death or Stillbirth	Maternal Death	CQC Alert Death	Diagnosis Group Death [3]	Post-Op Death	SIRI Death	Concern Death [4]	Total [5]
Apr-19	129	2	1	0	0	0	0	6	7	0	3	18
May-19	145	5	2	0	0	0	0	3	8	0	3	20
Jun-19	134	1	3	0	0	0	0	2	7	1	4	17
Grand Total	408	8	6	0	0	0	0	11	22	1	10	55

	Specified Groups			Non-Specified Groups		
	Total [5]	Reviewed	% Reviewed	Total	Reviewed	% Reviewed (Target 25%)
Apr-19	18	18	100.0%	111	29	26.1%
May-19	20	20	100.0%	125	33	26.4%
Jun-19	17	17	100.0%	117	30	25.6%
Grand Total	55	55	100.0%	353	92	26.1%

	% of Reviews with RAG Rating [6]			Total % Reviewed
	Total RAG Reviewed	Total Reviewed	% RAG Reviewed	
Apr-19	46	47	97.9%	36.4%
May-19	51	53	96.2%	36.6%
Jun-19	44	47	93.6%	35.1%
Grand Total	141	147	95.9%	36.0%

	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	Grand Total
Apr-19	44	2	0	46
May-19	46	5	0	51
Jun-19	43	1	0	44
Grand Total	133	8	0	141

	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
Apr-19	95.7%	4.3%	0.0%
May-19	90.2%	9.8%	0.0%
Jun-19	97.7%	2.3%	0.0%
Grand Total	94.3%	5.7%	0.0%

[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 2019/Q1

2019/Q1 Key Priorities

(1) Encouraging staff in all disciplines to identify vulnerability in a patient and engaging with the safeguarding team as soon as it is recognised, to assist in fact finding and future planning.

(2) Using a card communication scheme to facilitate timely joint conversations between consultants and patients and their families/carers. This is especially poignant in deteriorating or dying patients and discussion of uDNACPR.

Assurance

Sharing: (Current Q-1) 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:

_____

_____

Effectiveness: (Current Q-1) Audit of DATIX ☐, SIRIs ☐, Complaints ☐, PALS ☐, Litigation ☐, Mortality Reviews for evidence of failure to deliver these priorities ☐.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)93a
Title of paper: Workforce Safeguards – safe and effective staffing
Purpose: To provide assurance that the Trust is compliant with the Workforce Safeguards standards introduced by NHS Improvement from 2019/20 for Allied Health Professionals
Summary: In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing*. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also sets out guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. The paper included 14 recommendations to strengthen workforce safeguards and each Trust will be assessed against these recommendations. Following the paper relating to Nursing staff presented to the Board in September, the self –assessment against the recommendations for the Allied Health Professional (AHP) staff group has been completed which identified that for 8 of the 14 we are currently complaint but the remaining 6 require more work for the organisation to be fully compliant. The actions to achieve full compliance are detailed in the report.
Corporate objective met or risk addressed: Provide high quality personalised care
Financial implications: None as a direct result of this report
Stakeholders: Trust Board, Staff, NHSE/I, CQC, Commissioners, Patients, members of the public
Recommendation(s): The Board notes the current position against the Workforce safeguards standards for the AHP staff group.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Meeting date: 30th October 2019

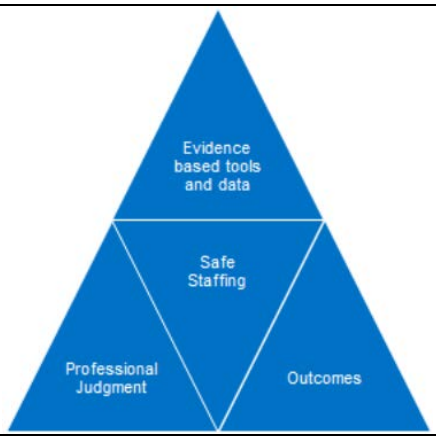
1. Overview of Standards

In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing* paper. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also sets out guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. It also described the regulatory requirement for NHS Improvement (Now NHSE/I) to assess the effectiveness of workforce safeguards annually. The paper included 14 recommendations to strengthen workforce safeguards and the NHS commitment to safe, high quality care, to help Trusts manage common workforce problems and make informed, safe and sustainable workforce decisions.

Trusts will be assessed on their compliance with the 'triangulated approach' to deciding staffing requirements described in National Quality Board's (NQB) 2016 guidance Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

The guidance is applicable to **all** clinical staff.

There are 14 recommendations as follows:

<table>
<tr><td>1</td><td colspan="2">Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.</td></tr>
<tr><td>2</td><td>Trusts must ensure the three components are used in their safe staffing processes:
evidence-based tools (where they exist)
professional judgement
outcomes
NHSI will check this in their yearly assessment.</td><td> 
</td></tr>
<tr><td>3</td><td colspan="2">Assessment will be based on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.</td></tr>
<tr><td>4</td><td colspan="2">NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.</td></tr>
<tr><td>5</td><td colspan="2">As part of this yearly assessment NHSI will also seek assurance through the Single Outcomes Framework (SoF), in which a provider's performance is monitored against five themes.</td></tr>
<tr><td>6</td><td colspan="2">As part of the safe staffing review, the Director of Nursing and Medical Director <u>must</u> confirm in a statement to their board that they are satisfied with the</td></tr>
</table>

	outcome of any assessment that staffing is safe, effective and sustainable.
7	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

2. Trust Assessment

This paper outlines Allied Health Professionals (AHP) current compliance with the 14 safeguard recommendations and identifies areas for improvement.

This demonstrated that we are fully compliant, for the AHP staff group, against 8 of the recommendations and partially complaint against the remaining 6.

Metrics for other elements of the NHS workforce are being developed by Model Hospital – for example, clinical hours to contact (CHtC) and cost per contact for non-ward based settings and once in use will also be incorporated into the Trusts workforce governance processes.

No	Recommendation	Lead	Performance Update	Compliance
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Director of Nursing	There are 3 main expectations from the NQB 2016 guidance relating to safe staffing regarding the right people with the right skills are in the right place at the right time. **Safe, Effective, Caring, Responsive and Well-Led Care** **Measure and Improve** - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback - - Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing - **Expectation 1** — **Right Staff** 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers **Expectation 2** — **Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention **Expectation 3** — **Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency The Executive Committee and Board receive information on mandatory training compliance levels and vacancies within the organisation through the Trust's Integrated Performance Report (IPR) and Staffing Dashboard. This enables the Board to identify concerns at an early stage and develop strategies to mitigate risks. Staffing for the AHP workforce is informed initially through the annual business planning and job planning processes and on an operational basis using professional judgement regarding	Partially Complaint

			the demands of the specific service. The Trust is currently six months into a two year project to implement activity based rostering in all specialties which takes service demand templates, job planning (for Medical & Dental, Allied Health Professionals and other groups as required) and rostering tools to build a service level oversight of staffing. This is built on the skills required to undertake the required work within the specialty. It is intended that this project will be completed by 31 March 2021. As part of the above process bi-annual establishment reviews will be extended to all staff groups as they will be completed at a specialty level.	
2	Trusts must ensure the three components are used in their safe staffing processes: • evidence-based tools (where they exist) • professional judgement • outcomes NHSI will check this in their yearly assessment.	Director of Nursing	There is currently no validated tool available for the assessment of safe staffing levels for the AHP profession. Due to this professional judgement is utilised to ensure the Trust has safe staffing in place across all clinical areas. There are national plans in place under the “AHP Workforce Improvement Programme” in line with the NHS People Plan from NHS England & Improvement to introduce an AHP acuity tool. A scoping exercise has been completed which encompasses workforce redesign, workforce deployment and safe staffing tools. (See Appendix 1) The Trust has already completed Job Plans for the AHP workforce and we await the staffing tool guidance in order to progress this. A review of other available guidance will take place and, where appropriate, be implemented within the Trust. NHS Improvement receives the annual operational plan and	Partially Complaint

			the Trust annual report. NHS Improvement has raised no concerns with the Trust about the level of AHP staffing.	
3	NHSI will base their assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.	Director of Corporate Services	Annual governance statement completed and is published within the 2018/19 Annual Accounts. An external audit has taken place into our governance framework including the annual governance statement and no issues or concerns were identified. **Workforce Strategy and Workforce Safeguards** The Board has a workforce strategy with agreed objectives for ensuring that the Trust can attract and retain the right number of staff with the necessary skills to deliver high quality patient care, and who are fully engaged and offered opportunities to develop their careers within the organisation. This strategy is currently being refreshed to ensure that it aligns with the workforce aspirations set out in the NHS Long Term Plan. The Board approves the high level workforce plan each year as part of the annual operational planning cycle, which takes into account projected activity growth or change and agreed service developments. The Trust utilises electronic software systems to roster staff, plan activities and monitor staffing on a day to day basis. These systems are being implemented for the Medical & Dental workforce as part of a roll-out project which is due to be completed in March 2021.	Fully Complaint

			There are detailed workforce key indicator reports presented to Board twice a year which include recruitment, vacancy and turnover information. The Trust has a guardian of safe working who reports twice a year on the working hours and shift patterns of Doctors in training.	
4	NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	Director of Corporate Services	see 3 above	Fully Complaint
5	As part of this yearly assessment NHSI will also seek assurance through the SOF, in which a provider's performance is monitored against five themes. *The assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual Trusts. These will be available from 'board to ward' and sourced*	Director of Finance	The following 5 themes are monitored at Trust Board: - Quality of Care - Finance and Use of Resources - Operational Performance - Strategic Change - Leadership and Improvement Capability Board receive the Trusts Integrated Performance Report (IPR) on a monthly basis which covers all of the above areas. The IPR is discussed at the open board meeting each month. These 5 themes are also monitored at the Quarterly performance Meetings with NHSI (see point 3 above) and the Trust has for a number of years been categorised as	Fully Complaint

	from ESR, e-Rostering and financial systems as well as a quality dashboard reviewed by the Trust Board.		segmentation level 2.	
6	As part of the safe staffing review, the Director of Nursing and Medical Director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Director of Nursing and Medical Director	There is currently no validated tool available for the assessment of safe staffing levels for the AHP profession. Due to this professional judgement is utilised to ensure the Trust has safe staffing in place across all clinical areas. A tool is currently in development nationally and will be implemented in due course. As part of this the Trust will, moving forward, include a statement in this report confirming the Director of Nursing and Medical Director are satisfied with the outcome of the assessment around staffing being safe, effective and sustainable.	Partially Complaint
7	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.	Director of HR	See section 3 The narrative operational plan for 2019/20 was approved by the March Trust Board meeting. In July 2019 the Trust Board approved a workforce strategy and received a detailed HR indicators report which included information on hard to recruit posts/specialities and the actions being taken by the Trust to improve recruitment and retention	Partially Complaint
	Establishment setting must be done annually		There is currently a finance led establishment review undertaken as part of budget setting. This informed the workforce plan that is included in the annual operational plan and the opening budgets that are approved by the Trust Board in March each year.	

			Bi-annual establishment reviews will be extended to all staff groups once activity based rostering is implemented as they will be completed at a specialty level.	
	A mid-year review of establishment should take place		There is currently a finance led establishment review undertaken as part of budget setting. This informed the workforce plan that is included in the annual operational plan and the opening budgets that are approved by the Trust Board in March each year. Bi-annual establishment reviews will be extended to all staff groups once activity based rostering is implemented as they will be completed at a specialty level.	
	Establishment reviews should take account of: • *patient acuity and dependency using an evidence-based tool* • *activity levels* • *seasonal variation in demand* • *service developments* • *contracts commissioning* • *service changes* • *staff supply and experience issues* • *where temporary staff have been required above the set planned establishment*		Establishment review meetings will be amended to incorporate the following: • *patient acuity and dependency using an evidence-based tool* Shelford, SafeCare, • *activity levels* Bed occupancy, patient attendances • *seasonal variation in demand* Taking a reflective review of the previous 6-12 months • *service developments / contracts commissioning / service changes* Any new services or service redesign supported by business cases • *staff supply and experience issues* Review of recruitment activity and success also preceptorship etc for new staff to ensure they stay • *where temporary staff have been required above the set planned establishment*	

	• *patient and staff outcome measures* *Data should be utilised from a number of sources:* • *ESR* • *Evidence based decision support tools* • *E-Rostering system* • *E-JobPlan system* • *Financial systems* • *Model hospital (I.e. CHPPD, CHtC)*		Temporary workforce data on bank and agency requests and filled including reasons for requests, with a regular report to the Executive Committee. • *patient and staff outcome measures* Friends and Family Test, complaints, harms, staffing shortfalls, safeguarding, rostering performance KPIs The establishment reviews will be undertaken in specialties and will encompass all staff groups including Medical & Dental and AHP. During the annual staff job planning reviews performance information is provided to senior clinicians and operational managers (we have a wider workforce than Medical & Dental that have job plans e.g. Specialist Nurses and ANPs) in order for the job planning process to be monitored efficiently and effectively. Job plans are then fed into the software for areas that utilise "activity based rostering". It is the intention of the Trust to have rolled this out to all specialties by 31 March 2021. A suite of activity based rostering KPIs will be developed to enable the Trust to monitor the performance of specialties.	
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard.	Director of Nursing and Medical Director	The Trust utilises benchmarking data to provide assurance on its quality performance via a range of reports to the Board and its Committee's, however Model Hospital data is not reported in the IPR because of the time lag in the national data being reported Please see section 3	Partially Complaint

	Trusts should report on this to their board every month. *Individual Trusts are expected to collate and review data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures – as a whole and not in isolation from each other. We also expect evidence of continuous improvement across all these areas. To optimise allocation of workforce resources and improve outcomes, boards should implement the NQB (2016) and Carter recommendations together with the information available from Model Hospital.*			
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This	Director of Nursing	N/A	Fully Complaint

	must also be linked to professional judgement and outcomes.			
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Director of Nursing	N/A	Fully Complaint
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.	Service lead/ADO	The Trust has an established QIA process that is used to review any significant service changes.	Fully Compliant
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	Service lead/ADO	QIA has been developed based on NHSI template. The Assistant Director of Workforce Development supports departments in completing a QIA for new roles being considered within the Trust. A QIA is currently being undertaken for the introduction of Physicians Associates.	Fully Compliant

13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Director of Nursing	Professional judgement is used on a daily basis to review staffing levels within the various specialties. Business continuity plans are in place for all AHP teams which are utilised for unpredicted reduction in staffing or increase in demand which cannot be managed in the existing rostered workforce. There is also an overarching plan for the wider Therapies team should a serious workforce issue arise. Staffing below the optimum levels is reported as an incident.	Partially Compliant
	An organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis.		A prioritisation matrix is utilised to address short term workforce issues and this feeds into the business continuity plan should the issues continue.	
	A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated. Within this associated thresholds need to be developed with frontline staff to inform and trigger concerns about safe staffing deployment. This includes clear escalation approach describing the steps that may			

	be required to ensure safe staffing levels to meet every patient's needs on each shift.			
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Director of HR	Staffing risks are escalated to Board via Executive Committee via the established risk management process. Minutes are taken of Executive Committee and reports to Board where issues are raised and actions taken. The corporate risk register is reported to the Board 4 times and year. There is also a Board Assurance Framework which identifies staffing levels as a strategic risk for the organisation	Fully Compliant

3. Next Steps and Timetable

Review of partially complete standards for AHP and create action plans to strengthen the workforce safeguards governance as described.

4. Assurance

The Trust has formal systems in place for reviewing AHP staffing including utilising professional judgement.

The Trust will continue to implement a range of systems as they are developed nationally and in line with the Nursing workforce to improve real time oversight of the AHP workforce to continue to ensure safe and effective levels of staffing.

END

Appendix 1

High impact actions for AHPs
Key area 3: Enabling the workforce to deliver and grow

Ambition	Action	Stage of development [Scoping/scaling up/delivery]
Support development	**Supporting Workforce Redesign** (21st Century care workstream)	An interim report with findings from the scoping work for tabling at the September 2019 Allied Health Professions (AHP) Workforce & Education Strategic Oversight Forum. This will include suggestions for the future development of this work.
Support development	**AHP Leadership** (Leadership workstream) Develop and sustain the capacity and capability of AHP leadership across systems	Delivery of: - increasing the prevalence of AHPs applying for and participating on national NHS Leadership academy programmes by 10%, from current levels, bridging the gap between operational and strategic leadership capability - provide evidence, guidance and package of support to providers, systems and challenged trusts Aim is to ensure 100% of provider organisations have an identified Chief AHP
Effective deployment	**AHP Releasing Time for Care** - (RTfC HIA6) - To deliver the RTfC efficiency & productivity gain, by ensuring trusts measure and benchmark their AHP productivity, trusts optimise their AHP workforce, and trusts access the Model Hospital to compare performance metrics with peers and identify unwarranted variation.	Scaling up and delivery - the efficient and effective deployment of AHP staff including productivity opportunities (reducing unwarranted variation) whilst scoping the consistent approach across all systems. It has also shown that it improves staff satisfaction. 1.AHP Job Planning [NHS People plan area 3, ambition 4 / Carter rec. 2 / NHS LTP 4.48, 6.17i] 2. Clinical Hours to Contact (CHtC) deployment metric 3. AHP Safe Staffing tools - AHP Optimisation Staffing Tool (AHPOST) 4. Support workers - NO CURRENT PROGRAMME
Retention	**National Retention Programme** To promote the active inclusion of AHPs in the national retention programme	This programme delivers impact from the evidence to date. Expansion of the National Retention programme to include AHPs currently underway. There is a national Chief AHPs event in October whereby the national retention team will be presenting to increase awareness and engagement from provider trusts.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)93b
Title of paper: Workforce Safeguards – safe and effective staffing
Purpose: To provide assurance that the Trust is compliant with the Workforce Safeguards standards for Medical and Dental Staff.
Summary: In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing*. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also sets out guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. The paper included 14 recommendations to strengthen workforce safeguards and each Trust will be assessed against these recommendations. Following the paper relating to Nursing staff presented to the Board in September, the self –assessment against the recommendations for the Medical and Dental (M&D) staff group has been completed which identified that for 8 of the 14 we are currently complaint but the remaining 6 require more work for the organisation to be fully compliant. The actions to achieve full compliance are detailed in the report.
Corporate objective met or risk addressed: Provide high quality personalised care
Financial implications: None directly as a result of this report
Stakeholders: Trust Board, Staff, NHSE/I, CQC, Commissioners, Patients, members of the public
Recommendation(s): The Board notes the current position against the Workforce safeguards standards for M&D staff
Presenting officer: Rowan Pritchard-Jones, Medical Director
Meeting date: 30th October 2019

1. Overview of Standards

In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing* paper. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also sets out guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. It also described the regulatory requirement for NHS Improvement (Now NHSE/I) to assess the effectiveness of workforce safeguards annually. The paper included 14 recommendations to strengthen workforce safeguards and the NHS commitment to safe, high quality care, to help Trusts manage common workforce problems and make informed, safe and sustainable workforce decisions.

Trusts will be assessed on their compliance with the 'triangulated approach' to deciding staffing requirements described in National Quality Board's (NQB) 2016 guidance Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

The guidance is applicable to **all** clinical staff.

There are 14 recommendations as follows:

<table>
<tr><td>1</td><td colspan="2">Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.</td></tr>
<tr><td>2</td><td>Trusts must ensure the three components are used in their safe staffing processes:
evidence-based tools (where they exist)
professional judgement
outcomes
NHSI will check this in their yearly assessment.</td><td> 
</td></tr>
<tr><td>3</td><td colspan="2">Assessment will be based on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.</td></tr>
<tr><td>4</td><td colspan="2">NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.</td></tr>
<tr><td>5</td><td colspan="2">As part of this yearly assessment NHSI will also seek assurance through the Single Outcomes Framework (SoF), in which a provider's performance is monitored against five themes.</td></tr>
<tr><td>6</td><td colspan="2">As part of the safe staffing review, the Director of Nursing and Medical Director <u>must</u> confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.</td></tr>
<tr><td>7</td><td colspan="2">Trusts must have an effective workforce plan that is updated annually and signed</td></tr>
</table>

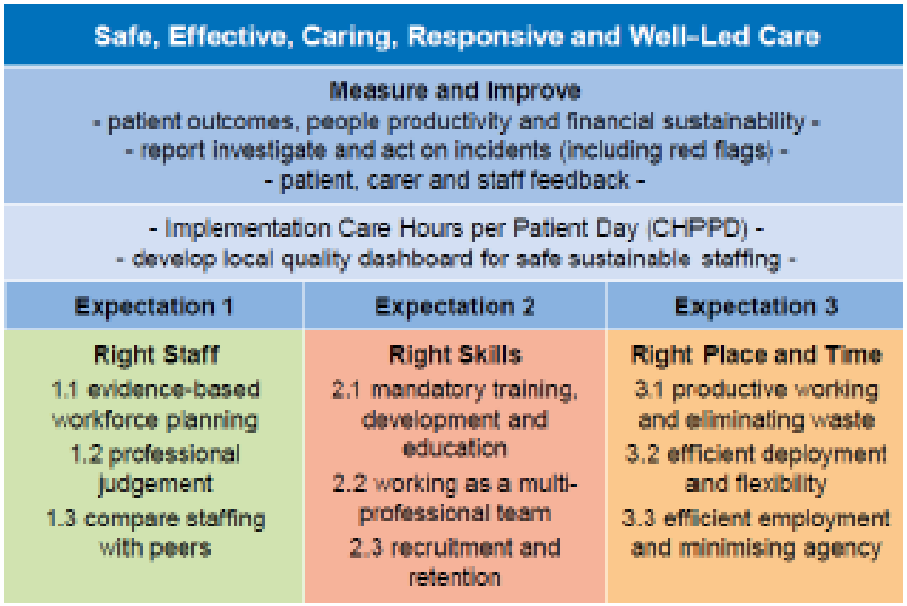
	off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

2. Trust Assessment

This paper outlines Medical & Dental's current compliance with the 14 safeguard recommendations and identifies areas for improvement.

This demonstrated that we are fully compliant, for the Medical & Dental staff group, against 8 of the recommendations and partially complaint against the remaining 6.

Metrics for other elements of the NHS workforce are being developed by Model Hospital – for example, clinical hours to contact (CHtC) and cost per contact for non-ward based settings and once in use will also be incorporated into the Trusts workforce governance processes.

No	Recommendation	Lead	Performance Update	Compliance
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Medical Director	There are 3 main expectations from the NQB 2016 guidance relating to safe staffing regarding the right people with the right skills are in the right place at the right time.  The Executive Committee and Board receive information on mandatory training compliance levels and vacancies within the organisation through the Trust's Integrated Performance Report (IPR) and Staffing Dashboard. This enables the Board to identify concerns at an early stage and develop strategies to mitigate risks. Staffing for the Medical & Dental workforce is informed initially through the annual operational planning and job planning process and on an operational basis using professional	Partially Complaint

			judgement regarding the demands of the specific service. The Trust is currently six months into a two year project to implement activity based rostering in all specialties which takes service demand templates, job planning (for Medical & Dental, Allied Health Professionals and other groups as required) and rostering tools to build a service level oversight of staffing. This is built on the skills required to undertake the required work within the specialty. It is intended that this project will be completed by 31 March 2021. As part of the above process bi-annual establishment reviews will be extended to all staff groups as they will be completed at a specialty level.	
2	Trusts must ensure the three components are used in their safe staffing processes: • evidence-based tools (where they exist) • professional judgement • outcomes NHSI will check this in their yearly assessment.	Medical Director	There is currently no validated tool available for the assessment of safe staffing levels for the Medical & Dental profession. Due to this professional judgement is utilised to ensure the Trust has safe staffing in place across all clinical areas. The Royal College of Physicians published the *Guidance on safe medical staffing* working party report to help those planning and organising core hospital medical services with safe medical staffing levels. All Royal College guidance is used when planning the Medical and Dental workforce and agreeing staffing structures and rotas. The Trust is also subject to a number of external reviews, such as GiRFT which include a review of M&D staffing levels. This guidance will continue to be taken into account when developing the Trusts workforce plans and future service developments. NHS Improvement receives the annual operational plan and	Partially Complaint

			the Trust annual report. NHS Improvement has raised no concerns with the Trust about the level of Medical & Dental staffing.	
3	NHSI will base their assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.	Director of Corporate Services	Annual governance statement completed and is published within the 2018/19 Annual Accounts. An external audit has taken place into our governance framework including the annual governance statement and no issues or concerns were identified. **Workforce Strategy and Workforce Safeguards** The Board has a workforce strategy with agreed objectives for ensuring that the Trust can attract and retain the right number of staff with the necessary skills to deliver high quality patient care, and who are fully engaged and offered opportunities to develop their careers within the organisation. This strategy is currently being refreshed to ensure that it aligns with the workforce aspirations set out in the NHS Long Term Plan. The Board approves the high level workforce plan each year as part of the annual operational planning cycle, which takes into account projected activity growth or change and agreed service developments. The Trust utilises electronic software systems to roster staff, plan activities and monitor staffing on a day to day basis. These systems are being implemented for the Medical & Dental workforce as part of a roll-out project which is due to be	Fully Complaint

			completed in March 2021. There are detailed workforce key indicator reports presented to Board twice a year which include recruitment, vacancy and turnover information. The Trust has a guardian of safe working who reports twice a year on the working hours and shift patterns of Doctors in training.	
4	NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	Director of Corporate Services	see 3 above	Fully Complaint
5	As part of this yearly assessment NHSI will also seek assurance through the SOF, in which a provider's performance is monitored against five themes. *The assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual Trusts.*	Director of Finance	The following 5 themes are monitored at Trust Board: - Quality of Care - Finance and Use of Resources - Operational Performance - Strategic Change - Leadership and Improvement Capability Board receive the Trusts Integrated Performance Report (IPR) on a monthly basis which covers all of the above areas. The IPR is discussed at the open board meeting each month. These 5 themes are also monitored at the Quarterly	Fully Complaint

	These will be available from 'board to ward' and sourced from ESR, e-Rostering and financial systems as well as a quality dashboard reviewed by the Trust Board.		performance Meetings with NHSI (see point 3 above) and the Trust has for a number of years been categorised as segmentation level 2.	
6	As part of the safe staffing review, the Director of Nursing and Medical Director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Director of Nursing and Medical Director	There is currently no validated tool available for the assessment of safe staffing levels for the Medical & Dental profession. Due to this professional judgement is utilised to ensure the Trust has safe staffing in place across all clinical areas. The Trust will continue to review of all staffing guidance published by the Royal Colleges and other bodies, when developing its workforce plans. As part of this the Trust will, moving forward, include a statement in this report confirming the Trust Board is satisfied with the outcome of the assessment around staffing being safe, effective and sustainable.	Partially Complaint
7	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.	Director of HR	See section 3 The narrative operational plan for 2019/20 was approved by the March Trust Board meeting. In July 2019 the Trust Board approved a workforce strategy and received a detailed HR indicators report which included information on hard to recruit posts/specialities and the actions being taken by the Trust to improve recruitment and retention	Partially Complaint
	Establishment setting must be done annually		There is currently a finance led establishment review undertaken as part of budget setting. This informed the workforce plan that is included in the annual	

			operational plan and the opening budgets that are approved by the Trust Board in March each year. Bi-annual establishment reviews will be extended to all staff groups once activity based rostering is implemented as they will be completed at a specialty level.	
	A mid-year review of establishment should take place		There is currently a finance led establishment review undertaken as part of budget setting. This informed the workforce plan that is included in the annual operational plan and the opening budgets that are approved by the Trust Board in March each year. Bi-annual establishment reviews will be extended to all staff groups once activity based rostering is implemented as they will be completed at a specialty level.	
	Establishment reviews should take account of: • *patient acuity and dependency using an evidence-based tool* • *activity levels* • *seasonal variation in demand* • *service developments* • *contracts commissioning* • *service changes* • *staff supply and experience issues* • *where temporary staff*		Establishment review meetings will be amended to incorporate the following: • *patient acuity and dependency using an evidence-based tool* Shelford, SafeCare, • *activity levels* Bed occupancy, patient attendances • *seasonal variation in demand* Taking a reflective review of the previous 6-12 months • *service developments / contracts commissioning / service changes* Any new services or service redesign supported by business cases • *staff supply and experience issues* Review of recruitment activity and success also	

	have been required above the set planned establishment • *patient and staff outcome measures* *Data should be utilised from a number of sources:* • *ESR* • *Evidence based decision support tools* • *E-Rostering system* • *E-JobPlan system* • *Financial systems* • *Model hospital (I.e. CHPPD, CHtC)*		preceptorship etc for new staff to ensure they stay • *where temporary staff have been required above the set planned establishment* Temporary workforce data on bank and agency requests and filled including reasons for requests, with a regular report to the Executive Committee. • *patient and staff outcome measures* Friends and Family Test, complaints, harms, staffing shortfalls, safeguarding, rostering performance KPIs The establishment reviews will be undertaken in specialties and will encompass all staff groups including Medical & Dental and AHP. During the annual staff job planning reviews performance information is provided to senior clinicians and operational managers (we have a wider workforce than Medical & Dental that have job plans e.g. Specialist Nurses and ANPs) in order for the job planning process to be monitored efficiently and effectively. Job plans are then fed into the software for areas that utilise "activity based rostering". It is the intention of the Trust to have rolled this out to all specialties by 31 March 2021. A suite of activity based rostering KPIs will be developed to enable the Trust to monitor the performance of specialties.	
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix	Director of Nursing and Medical Director	The Trust utilises benchmarking data to provide assurance on its quality performance via a range of reports to the Board and its Committee's, however Model Hospital data is not reported in the IPR because of the time lag in the national data being reported	Partially Complaint

	with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month. *Individual Trusts are expected to collate and review data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures – as a whole and not in isolation from each other. We also expect evidence of continuous improvement across all these areas. To optimise allocation of workforce resources and improve outcomes, boards should implement the NQB (2016) and Carter recommendations together with the information available from Model Hospital.*		Please see section 3	
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a	Medical Director	N/A	Fully Complaint

	year, in accordance with NQB guidance5 and NHS Improvement resources. This must also be linked to professional judgement and outcomes.			
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Medical Director	N/A	Fully Complaint
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.	Service lead/ADO	The Trust has an established QIA process that is used to review any significant service changes.	Fully Compliant
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would	Service lead/ADO	QIA has been developed based on NHSI template. The Assistant Director of Workforce Development supports departments in completing a QIA for new roles being considered within the Trust. A QIA is currently being undertaken for the introduction of Physicians Associates.	Fully Compliant

	be considered a service change and must have a full QIA.			
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Medical Director	Professional judgement is used on a daily basis to review staffing levels within the various specialties. This, in some areas, is supported by data such as ED attendances, theatre lists etc Staffing below the optimum levels is reported as an incident.	Partially Compliant
	An organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis.		A standard operating procedure will be introduced to support the day to day staffing review process.	
	A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated. Within this associated thresholds need to be developed with frontline staff to inform and trigger concerns about safe staffing deployment. This includes			

	clear escalation approach describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift.			
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Director of HR	Staffing risks are escalated to Board via Executive Committee via the established risk management process. Minutes are taken of Executive Committee and reports to Board where issues are raised and actions taken. The corporate risk register is reported to the Board 4 times and year. There is also a Board Assurance Framework which identifies staffing levels as a strategic risk for the organisation	Fully Compliant

3. Next Steps and Timetable

Review of partially complete standards for AHP and create action plans to strengthen the workforce safeguards governance as described.

4. Assurance

The Trust has formal systems in place for reviewing AHP staffing including utilising professional judgement.

The Trust will continue to implement a range of systems as they are developed nationally and in line with the Nursing workforce to improve real time oversight of the AHP workforce to continue to ensure safe and effective levels of staffing.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)94

Title of paper: Infection Prevention and Control Annual Report 2018/19

Purpose: To present the 2018/19 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:

1. 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.
2. This report covers the 2018/19 financial year.
3. 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.
4. During 2018/19 the IPC performance improved in comparison to the previous year and the following were reported:
   a. 13 cases of Clostridium difficile infection (CDI) against an objective of no more than 40 (of which were classified as unavoidable);
   b. 1 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) positive sample which as contaminant;
   c. 31 cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia;
   d. 62 Hospital Acquired E coli bacteraemia;
   e. Zero cases of CPE bacteraemia;
   f. 4 surgical site infections following surveillance of 716 procedures in orthopaedics;
   g. There were 10 outbreaks of infection: resulting in 58 lost bed days
5. The annual report also sets out the planned improvements for 2019/20.
6. Improvement in performance has been achieved in 2018/19, which 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.

Stakeholders: Staff, patients and the public, regulators

Recommendation(s): To note the 2018/19 IPC annual report has been approved by the Quality Committee.

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

Date of meeting: 30th October 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

Infection Prevention Annual Report 2018-2019

CONTENTS

EXECUTIVE SUMMARY

1 The Infection Prevention Annual Report is a two-part document, Part 1 outlines the developments and performance related to Infection Prevention (IP) activities during 2018/19 and Part 2 (Appendix 1) is the annual work plan for 2019/20 which aims to reduce the risk of healthcare associated infections (HCAIs). The report identifies the achievements and challenges faced in-year and the Trust's approach to reducing the risk of HCAI for patients.

2 The annual report identifies 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.

4 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.

5 There are national contractual reduction objectives for MRSA blood stream infections (BSI) and Clostridium difficile infections (CDI) in addition there are seven infections which are subject to mandatory reporting to Public Health England listed below. These will be included in the report.

- Methicillin Resistant *Staphylococcus aureus* (MRSA) BSI
- Clostridium *difficile* infections
- Meticillin Sensitive *Staphylococcus aureus* (MSSA) BSI
- *Escherichia coli* (*E.coli*) BSI
- *Klebsiella* sp BSI
- *Pseudomonas aeruginosa* BSI
- Vancomycin Resistant Enterococcal (VRE) Bacteraemia

6 The IPC forward plan relates to the 10 criteria outlined in the Health and Social Care Act 2012; Code of Practice on the prevention and control of infections and related guidance.

7 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 2018/19

- The Trust has remained registered with the Care Quality Committee (CQC) as having appropriate arrangements in place for the prevention and control of infections. During 2018/19 the Trust was rated Outstanding by the CQC.

- The Trust Clostridium difficile infection (CDI) objective for 2018/19 was no more than 40 cases. The Trust reported 25 positive samples of which twelve cases were agreed as unavoidable after review by CCG CDI appeals panel, this was based on there being no lapses in care. The

total number of Trust attributable CDI cases in year was 13 .The objective for CDI was achieved.

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

- During 2018/19 the Trust reported 1 MRSA bacteraemia. This was a contaminant and no harm occurred to the patient.

- The case of MRSA bacteraemia was subjected to a multi-disciplinary Post Infection Review (PIR) and was deemed unavoidable. Lessons learnt were disseminated and an action plan was develop, which is monitored via the Hospital Infection Group (HIPG).

- During 2018/19, there were a total of 31 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases, of which 22 were unavoidable as not health care related

- During 2018/19,there were a total of 62 E.coli bacteraemia cases

- There were no cases of hospital acquired Carbapenemase Producing Enterobacteriaceae **(**CPE).

- Surgical site infection (SSI) surveillance in orthopaedics: the Trust was below the national average for SSI for knee infections and slightly above the national average for hip infections.

April 2017 – March 2018	**STHK**	**National**
Hips 301/2 infections	1.2%	0.9%
Knees 415/2 infections	0.5%	1.3%

- Outbreaks: during 2081-19 there were 10 outbreaks of infection: VRE colonisation (7), Flu (1), Norovirus (1), MRSA (1) which resulted in 85 lost bed days.

- 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 prevention induction and mandatory training sessions were provided for all clinical staff.

- Infection Control Link Nurse training occurs every 2 months.

- 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 every month including 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. The system was upgraded this year to improve the reporting function

- 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.

Developments in 2018/19

- Continued 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 that 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.
- The use of 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 new electronic system which will be available on Vitalpac.
- 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.
- The introduction of water coolers into non-augmented care areas of the Trust to improve patient experience. These are being monitored by the water safety group to prevent 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.
- Participated in the NHSI UTI collaborative network to reduce the incidence of E.coli bacteraemia and to reduce UTI by 5%. Several initiatives developed including "to dip or not to dip", urinalysis and urine sampling algorithm for suspected urinary tract infection.
- 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.
- Bi-weekly unannounced infection prevention and environmental inspections undertaken by the IPT, Estates and Facilities Team and Medirest (Soft FM services provider) to wards and clinical areas.

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 IPT is within the nursing and quality corporate services

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 Director of nursing, Midwifery and Governance.

1.2.3. The DIPC is supported by the IP Doctor, the IPT 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 HCAI Reduction Delivery Plan based on 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 and gram negative bacteraemia.

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.

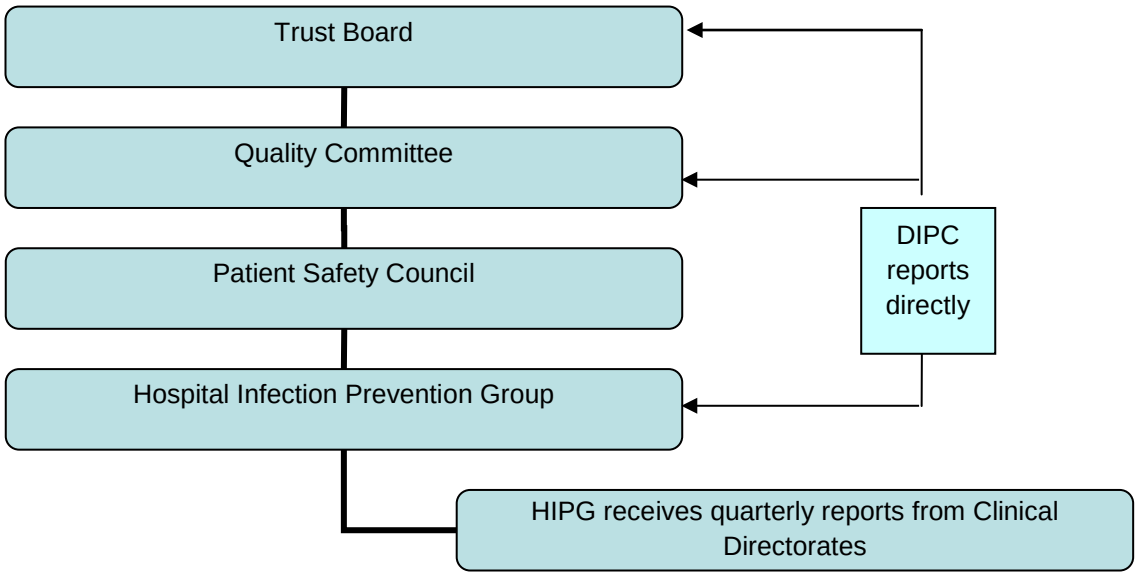
1.2.9. The Trust returns a monthly Assurance Framework to the Cheshire and Merseyside Commissioning Support Unit; this framework outlines performance against a number of key performance indicators (KPIs). This in turn is used as part of a performance pack for the relevant CCGs.

1.2.10. Infection Prevention Standards and Assurance - The annual reduction aspirations were agreed by the Trust Board in the trust objectives 2018/19 and the Clinical and Quality Strategy Annual Delivery Plan for 2018/19.

1.2.11. The Trust continues to undertake a number of interventions in relation to infection prevention as detailed within the HCAI Reduction Plan 2018/19. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Infection Prevention Doctor and lead nurse IPT.

1.2 Hospital Infection Prevention Group (HIPG)

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



1.2.2 The Terms of Reference are reviewed annually and were amended in March 2019.

1.2.3 The Infection Prevention Team (IPT) consists of specialist nurses, Medical Microbiology doctors, an assistant practitioner, audit and surveillance assistant and a secretary to support delivery of the IP strategy and action plan. The IPT are located on the Whiston Hospital site but attend the St Helens hospital, Newton hospital and Marshall Cross site on a regular basis.

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

1.2.5 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.

1.2.6 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 symptoms or conditions) is less than four hours.

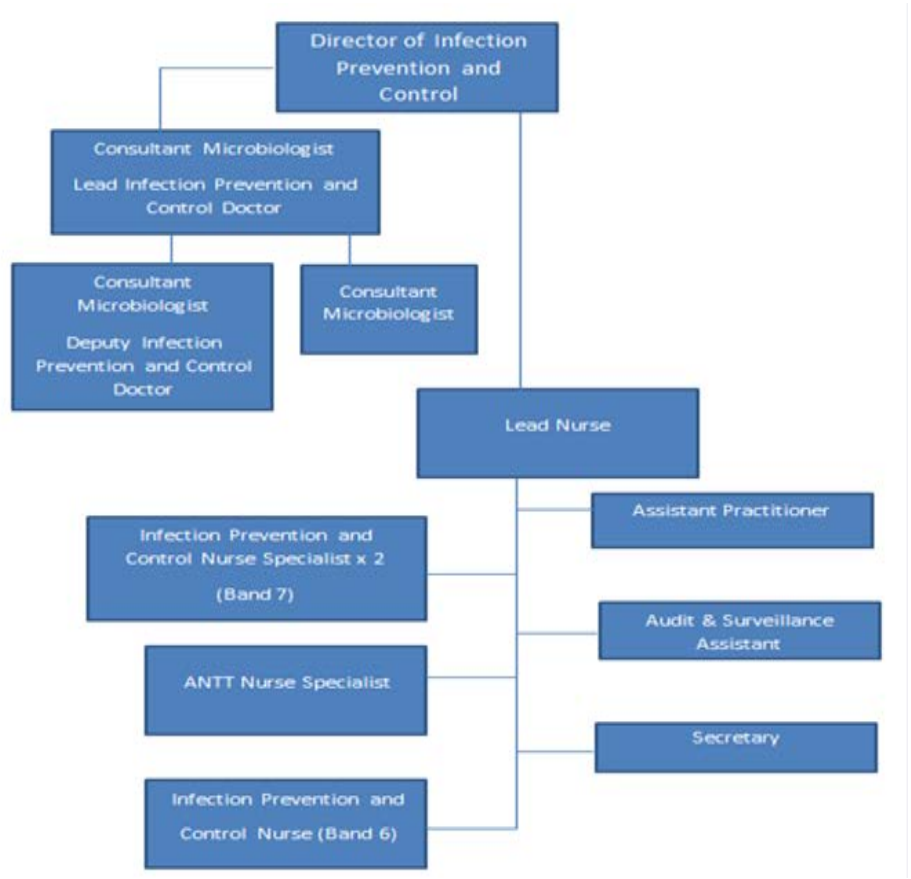
Each ward/clinical department maintains an isolation plan and the IPT send out a Trust wide side room plan daily during the winter months. This identifies who is managed in a side room and the reason for their isolation. This is used by the wards and the site team to enable the correct placement of patients.

1.2.7 The core members of the IPT consist of:

- Director of IPC (DIPC) - Director of Nursing, Midwifery and Governance
- Lead Infection Prevention Doctor
- 8B Lead Nurse IP (1.0 WTE)
- Band 7 Specialist IP Nurses (2 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

1.2.8 IP organisational structure



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

1.2.10 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.

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

1.3 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 The IPT undertakes continuous surveillance of target organisms and alert conditions. 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.

2.3 The IPT receive notification of alert micro-organisms isolated in the microbiology and virology laboratories continuously throughout the day electronically into an infection prevention and control system ICNET which is linked to the trust's patient administration system.

2.4 These alerts include positive *Clostridium difficile*, new CPE colonisations, all blood stream infections and MRSA colonised patients, additionally test results which indicate potential for cross infection and a need to alert ward staff and conduct follow up visits are highlighted. All in-patients identified for follow up are visited and records are reviewed by the team. The IP consultant conducts weekly Antimicrobial ward rounds.

2.5 The Trust submits data on MRSA, MSSA, E. *Coli, Klebsiella, Pseudomonas aeruginosa,* VRE and *Clostridium difficile* infections (CDI) by the 15th day of each month to Public Health England via an online Health Care Associated Infection Data Capture System. HCAI data is also submitted each month for the Trust Integrated Performance Report (IPR)

2.6 All isolates of Carbapenemase Producing Enterobacteriaceae (CPE) are routinely notified to Public Health England. The Trust also submits enhanced surveillance data to Public Health England and has participated in Regional Network Meetings.

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

2.8 The IP Team visit all patients with confirmed or potential infections at regular intervals to provide education and support.

HCAI Target/Alert Organisms include:

- 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

2.9. Meticillin-resistant Staphylococcus aureus (MRSA)

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

Since 2013/2014 there has been a zero tolerance target for MRSA nationally. The table below objectives indicates the number of Trust cases from 2010 to date:

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
2018/19	1 conta minant	0

During 208/19 the Trust reported one positive MRSA sample, which following a robust multi-disciplinary root cause analysis which was reviewed by the Executive Root Cause Analysis Panel. The case was deemed to be a contaminant, the patient did not have a MRSA bacteraemia and this did not result in any patient harm. However, there were a number of lessons identified:

- All long stay patients (>1 month) should be screened for MRSA at one month from admission and then monthly until discharge. The monthly screen should

include nose, throat, plus swabs from any wounds and if applicable, sputum if patient has a productive cough as well as CSU if the patient is catheterised.

- All staff within the Trust who under take clinical duties must have ANTT training and valid competency
- 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).

A trust-wide action plan owned by the care groups was implemented to address the issues identified. This was presented to the Patient Safety Committee.

2.10 MRSA Screening

The Trust continues to use a robust approach to screening the majority of patients, either pre operatively or on admission. Screening compliance is monitored on a monthly basis.

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

The Trust has achieved 100% compliance throughout 2018/19.

2.11 Clostridium difficile toxin infection (CDI)

The Trust CDI assigned by NHS England target for 2018/19 was no more than 40 cases.

In total there have been 25 postive cases of CDI, excluding 12 cases which have been successfully appealed as having no lapses in care and therefore are not included in the year-end performance figure. The Trust reported 13 CDI postive cases against a traget of 40 which is a 31.5% reduction from 19 cases the previous year.

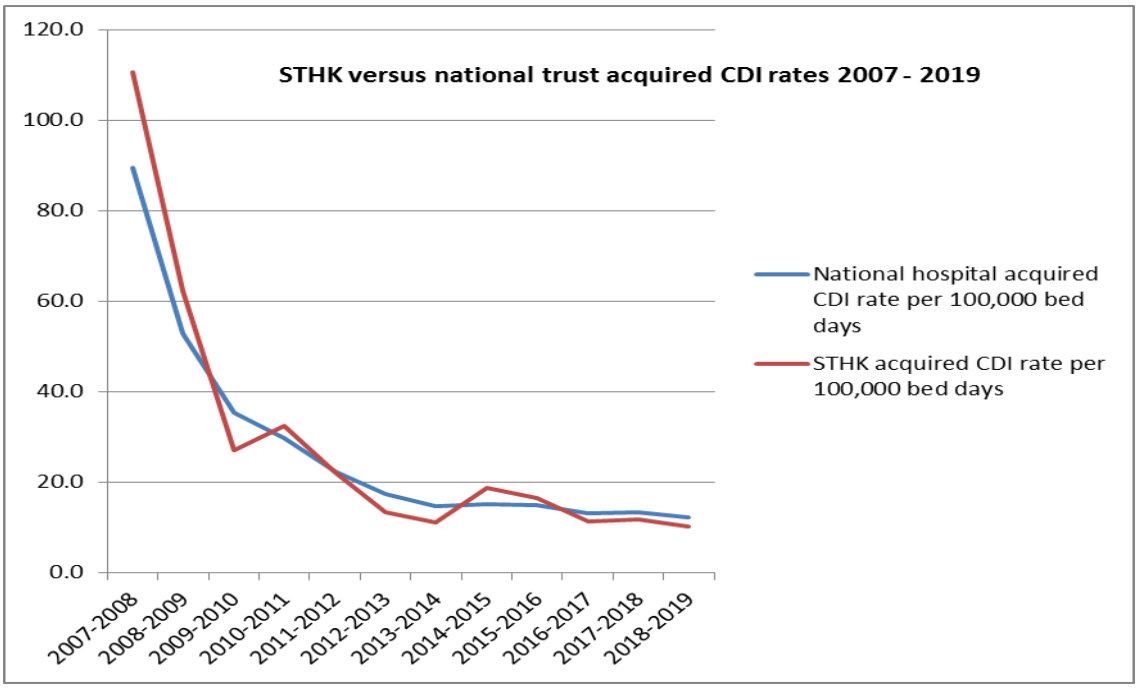
Each case has been investigated by the clinical teams using a standardised post-incident review (PIR) process and fed back to all clinical areas. Any lapses in care are discussed and actions agreed and their delivery monitored through Hospital Infection Prevention Group. If there are no lapses in care,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

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 During this year CDI appeals were introduced	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)
2018/19	40	13	avoidable cases (excluding 12 cases which were deemed unavoidable by the CCG CDI appeals panel)

STHK apportioned CDI rate per 100,000 bed days improved from 11.9 in 2017/18 to 10.22 in 2018/19.



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.

Outbreaks of CDI: There were no outbreaks of CDI confirmed in 2018/19.

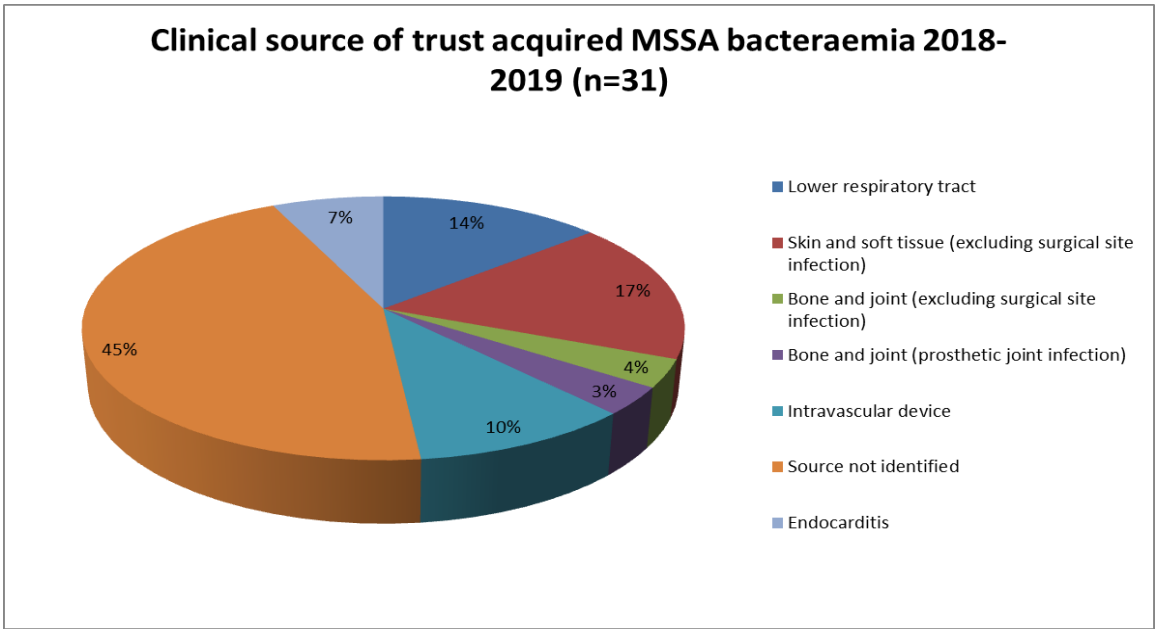
2.12 Meticillin-sensitive Staphylococcus aureus (MSSA)

There were 31 cases of Trust acquired MSSA bacteraemia in 2018/19

All cases of MSSA bacteraemia are subject to an Executive led Root Cause Analysis Review Panel. 28 of the 35 cases were deemed unavoidable

Of the 7 avoidable cases lessons were identified and action plans developed for shared learning.

The clinical source of infections associated with the MSSA cases is identified below:



The key areas for focus in 2018/19 included:

- 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.

2.13. Gram negative bacilli bacteraemia (Escherichia coli/Klebsiella species/Pseudomonas Aeruginosa).

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 infection in vulnerable patients e.g. those who are immunocompromised or those with indwelling devices.

In 2018-2019, the Trust continued to carry out RCA review of all Trust acquired E. coli, 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).

2.14 E. coli

In 2018/19 there were 62 cases compared to 66 in 2017/18 and 50 in 2016/17. Of these 62 cases, 7 were deemed avoidable after RCA.

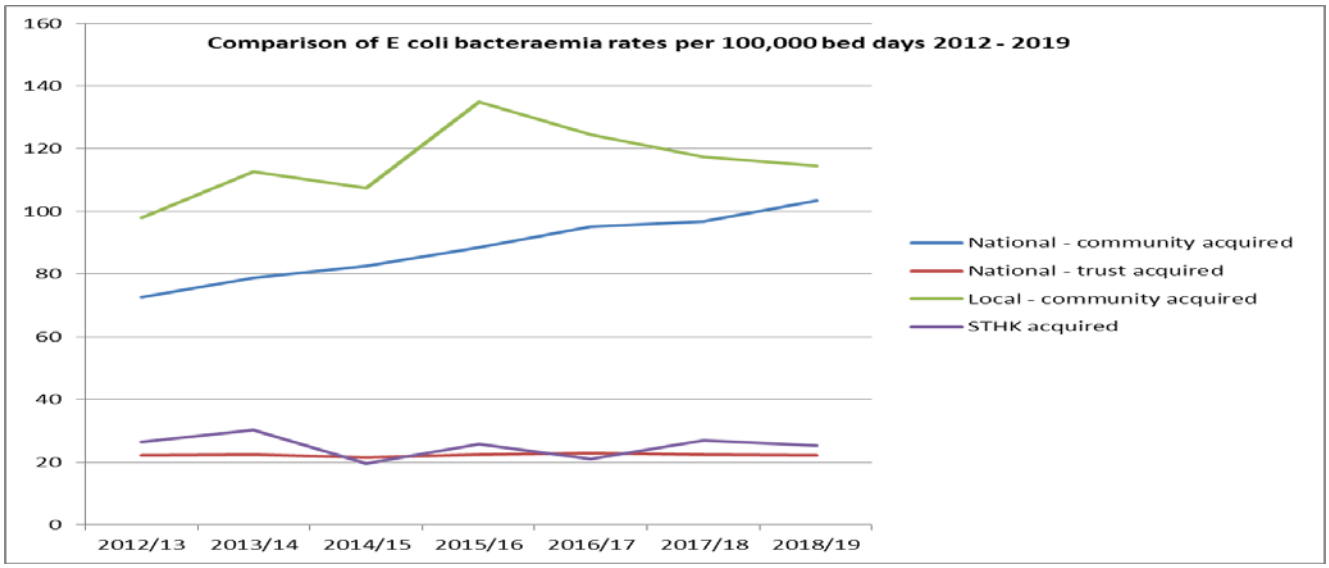
The Clinical Commissioning Group has been encouraging a whole health economy approach to reduce the total numbers of cases by 10%. The Trust has been involved in the working groups and set a reduction target during the year on previous cases. A slight reduction (0.9%) was seen within the year however the surveillance data indicated that the majority of cases were unavoidable with no clear lessons learnt for the Trust. The Trust IPCT has maintained education concerning the management of devices and ANTT throughout the year. This focus will continue.

Catheter Associated Urinary Tract Infections (CAUTI) and Documentation- All microbiologically positive catheter specimens of urine are compared to the blood cultures to identify CAUTI's. This information is collated monthly and is compared with the patient safety thermometer data and reported monthly.

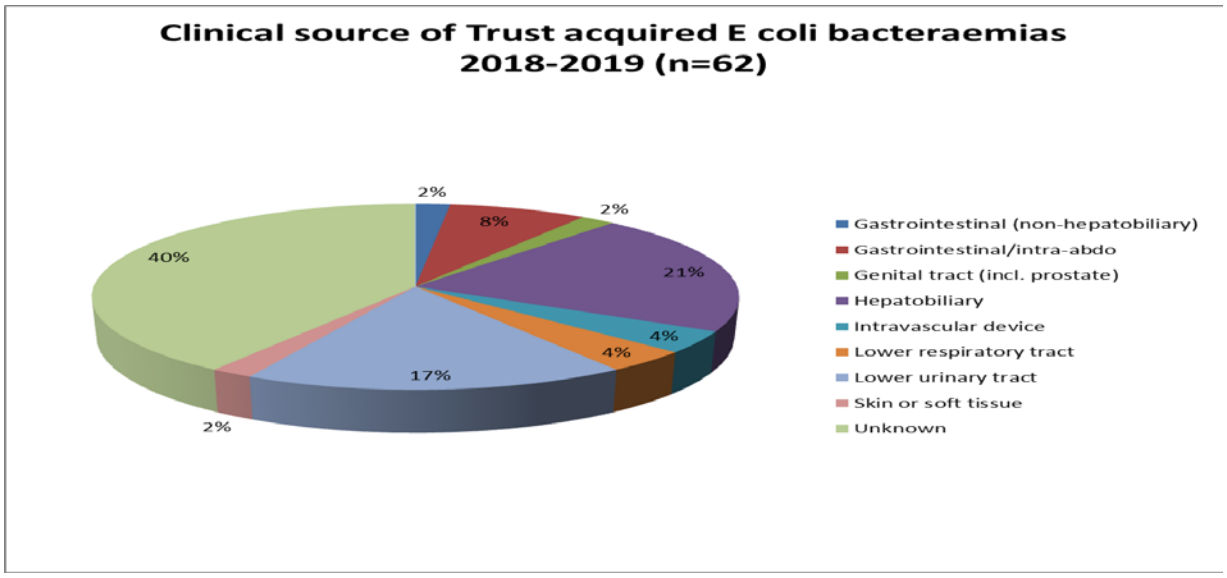
UCAM (Urinary Catheter Assessment and Monitoring) was introduced in 2011 in order to reduce urinary catheter associated urinary tract infection. All urinary catheter care is documented with the aim of:

- 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.

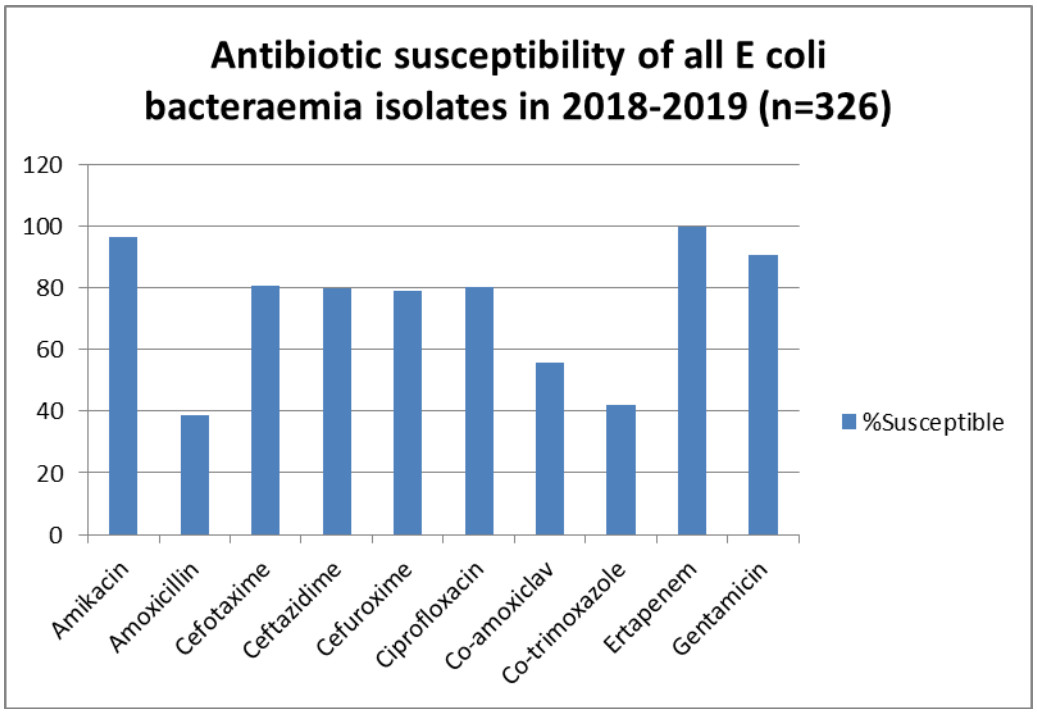
STHK apportioned E coli bacteraemia rate per 100,000 bed days in comparison with the overall national E coli bacteraemia rates and rate for community acquired cases identified in our Trust are as below. The Trust acquired E coli bacteraemia rates reduced from 26.98 in 2017/18 to 25.35 in 2018/19.



The clinical sources of Trust acquired E coli bacteraemia in 2018/2019 are as below:

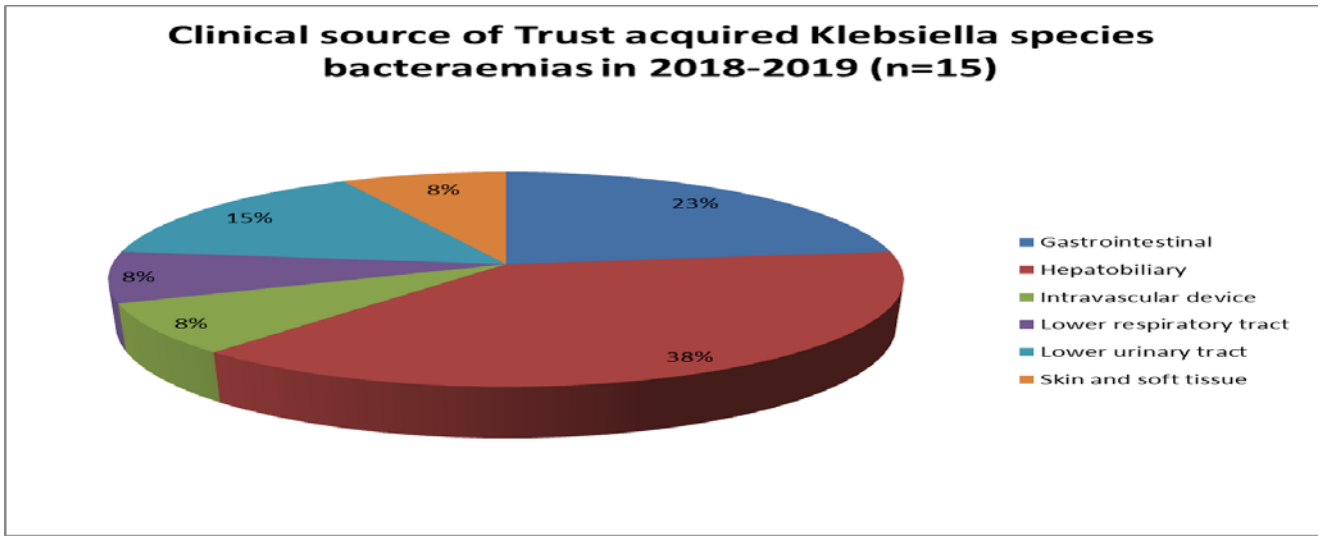


The overall antibiotic susceptibilities for all E coli bacteraemia (i.e. community and Trust acquired) identified at the Whiston Hospital Microbiology Laboratory in 2018/2019 are as below:



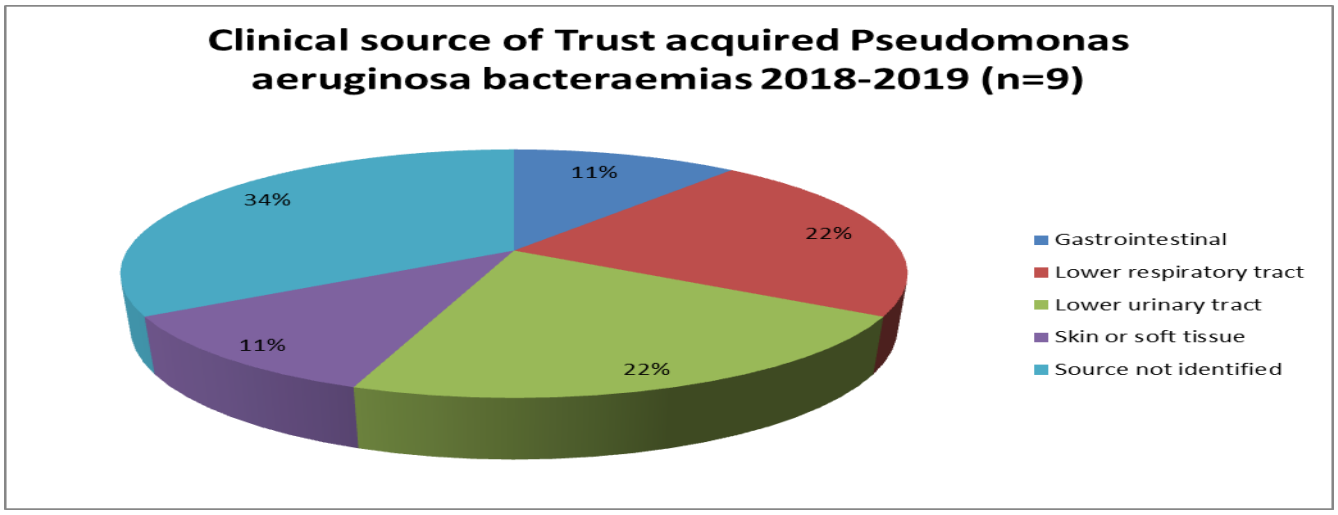
2.15 Klebsiella species bacteraemia.

There were 22 cases of Trust acquired Klebsiella bacteraemias in 2018/19 compared with 15 in 2017/18. Of these, 2 were deemed avoidable after RCA review.



2.16 Pseudomonas aeruginosa

There were 9 cases of Trust acquired Pseudomonas aeruginosa bacteraemia in 2018/19 compared with the same number of cases in 2017/18. Of these, none were deemed avoidable after RCA review.



2.17 Vancomycin-resistant enterococcus (VRE)

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.

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.

There has been a nationwide increase in the number of patients with VRE although there is limited information on population prevalence

In 2018/2019, there were 6 Trust acquired VRE bacteraemias. 11% of all enterococcal isolates from blood cultures at STHK were resistant to vancomycin (which is a decrease of 1% compared with 2017/2018). There were no community acquired VRE bacteraemias in 2018/2019 (compared with 2 in 2017/2018).

There were 6 outbreaks due to VRE colonisation in 2018-2019 compared with 2 in 2017/2018 (see section 3.1 for further details)

There were 136 hospital acquired cases of VRE (non-bacteraemia) compared with 77 in 2017/2018. Most of these were asymptomatic colonisation detected on routine screening as well as 134 cases of community acquired non-bacteraemia cases of VRE (compared with 77 in 2017/2018).

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, as agreed by HIPG in 2017 with current practice with regards to VRE screening was continued.

2.18 Carbapenemase Producing Enterobacteriaceae (CPE)

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.

CPE are multiple antibiotic resistant strains of bacteria which are carried harmlessly in the bowel e.g. Escherichia coli, Klebsiella, Enterobacter. These bacteria can cause infections if transferred to another site on the body e.g. urinary tract or blood stream. The antibiotics available to treat such infections are limited which increases the risk of treatment failure.

The Trust CPE policy is in line with the DH CPE Toolkit issued in 2013. The guidance concentrates on prevention, isolation of high-risk individuals and screening being of particular.

There were no CPE bacteraemias in 2018-2019 (hospital or community acquired).

There were 3 cases of hospital identified 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 19 cases of community acquired CPE detected during the same time period.

2.19 Lessons identified from RCA for cases of Trust acquired MSSA/Gram negative bacilli and VRE bacteraemias (includes lessons which were not contributory to bacteraemia):

- 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, the rationale is clearly documented in the patient's clinical notes.
- Consider whether fractured PICC lines should be replaced if the patient has sufficient alternative venous access rather than repaired hence reducing line manipulation.
- Document details urinary catheters on UCAM chart (at insertion and of monitoring at least once per shift).
- Review indication for catheterisation in patients admitted with long term catheters and considers alternative means of management of continence would be more appropriate.
- Consider antibiotic prophylaxis for urinary catheter change in patients with a history of sepsis after previous catheter insertion/change or known history of difficult/traumatic catheterisation in the past.

- Sepsis screening if a patient fulfils criteria for sepsis, blood cultures must be taken before starting antibiotics (which need to be administered within 1 hour of the diagnosis of sepsis).
- In patients with central/PICC lines with more than one lumen, when line infection is clinically suspected, blood cultures must be sent from each lumen of the line.
- Ensure that a review date (within 24 – 72h of starting) or a stop date is documented for every prescription of an antimicrobial; when reviewing prescriptions, document in medical notes what the outcome of review.
- Long term prophylaxis for urinary tract infection inevitably leads to selection of organisms resistant to the antibiotic(s) used. Such prophylaxis must be reviewed on a regular basis and if organisms resistant to the antibiotic used as prophylaxis have been isolate, the agent should be discontinued.
- Tap water is not appropriate for oral hygiene in augmented care areas – sterile water should be used.
- Water for patient washing in augmented care areas should not be taken from the clinical hand washing sinks.

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

3.1 There were 10 confirmed outbreaks in 2018/19:

Month	No of outbreaks	Organism	Ward/Unit and Number of cases	No of bed days lost
2018				
Apr	1	VRE	1C (2 patients)	0
May	0			
Jun	1	VRE	4E/ICU (1 patient: likely cross transmission from a patient who was already positive for VRE on admission to 4E)	0
Jul	0			
Aug	0			
Sep	1	VRE	4D/Burns Unit (3 patients)	0
Oct	1	VRE	2C (3 patients)	0
Nov	0			
Dec	2	VRE	3alpha (3 patients)	0
		MRSA	3C (2 patients with new colonisation)	0
2019				
Jan	2	Norovirus	Newton Community Hospital Inpatient Ward (14 patients and 4 staff)	43
		Pseudomonas aeruginosa bacteraemia	4E/ICU (2 patients with unrelated strains one of whom had the same strain as isolated from tap water in the hand wash sink of the same bed space)	0
Feb	1	Influenza A	2C (11 patients and 1 staff)	0
Mar	1	VRE	3D (20 patients including 2 patients with VRE bacteraemia and 18 detected on screening - Typing results indicated that the 2 bacteraemias were strains distinct from each other; there were several different strain types with two being predominant).	14
Total	**10**			**85**

The IP team during the winter period attend the bed meeting daily to support the wards in management of patients with suspected infections such as norovirus and influenza. In addition, the DIPC in conjunction with the nominated consultants in Respiratory medicine conduct a daily a safari ward round to review all patients with confirmed Influenza.

4. Aseptic Non-touch Technique (ANTT)

Trust-wide ANTT continues to monitor compliance and for 2018/2019 is meeting the trajectory of 85%. Actions are in place to further improve compliance are:

- 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.

5 Infection Prevention policies/publications

No new IP policies have been required during the 2018/19.

The existing IP policy and SOPs have been reviewed in line with Trust policy and are compliant with national guidance.

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. Infection Prevention Mandatory Training continues to be provided by the IPNs, there are modules, a clinical and a non-clinical. The trust percentage for mandatory training is 96%

6.3. Training Sessions/Courses

- Trust Induction
- Infection Prevention Mandatory Update
- The IPT provide training sessions on the Band 5 and HCA rolling education programme
- The IPT 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.

6.4. 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.

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

7. Hand hygiene

7.1. 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.
7.2. Compliance with “bare below the elbows" dress code is continually monitored by the IPT, Matrons and Senior Management.
7.3. Monthly observational audits are conducted of hand-washing to determine compliance with the Infection Prevention Manual Hand Decontamination Policy. The overall percentage for hand hygiene compliance is 98%

8. Information Technology

8.1 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. In 2017/18, ICNet NG was successfully upgraded to version 7.6 this addressed issues related to accessibility of the reports function related to previous versions.

8.2 In April 2018 the Trust implemented a new Patient Administration System (PAS) – Medway from which all patient demographics will feed through to ICNet. ICNet was interfaced with Medway ADT which is the Admissions, Discharges and Transfers element of the PAS that tracks the patient as they move through the hospital, ensuring that clinicians can see exactly where the patient is currently located. Since the go-live of Medway, the two developments below have been awaited:

- Development of a bidirectional interface between ICNet and Medway in order to automate the updating of infection prevention alerts on Medway from ICNet (currently done manually by IPT) – progress update awaited from Informatics Department.

- Incorporation of bed/bay numbers from Medway into ICNet in order to enable timely and efficient outbreak investigations and contact tracing – progress update awaited from Informatics Department.

- Currently, BSC and CPE assessments are continuing to be recorded on Patientrack although that system is expected to be discontinued in 2019. Hence work is ongoing to develop a CPE assessment form in VitalPac.

- The strategy for surgical site infection surveillance was revisited during 2018/19 as the hospital develops further its EPR solution

- Mersey Micro app – the updated Trust Antibiotic Policy was implemented in March 2019. an options appraisal is currently being undertaken regarding a suitable replacement for Mersey Micro.

- Following the implementation of electronic prescribing (JAC) in the Trust in 2018-2019, as a routine part of clinical case management, the IPT commenced adding infection prevention related alerts to inpatient records on JAC to support selection of appropriate antibiotic therapy.

9. Audits and Surveillance

9.1 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.

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

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 Care groups on a monthly basis.

Monthly ward audits are ongoing and continue to demonstrate good compliance.

9.2 Audits undertaken by the Infection Prevention Team:

- Sharps audit – undertaken by Sharpsmart, results produced monthly
- Peripheral cannula (PIVC) trust wide audit – March 2018
- Compliance with IP precautions audits throughout 2018/19

In addition, the following audits were carried out monthly by the Infection Prevention Team:

- 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%.
- Environmental and audits are undertaken throughout the year and reported on the monthly trust wide report

9.3 Mandatory Surgical Site Infection Surveillance (SSI)

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.

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.

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);

2018/19 data indicated that:

- There were 333 Hip operations performed of which 4 infections were noted (1.2% compared to 0.9% national average)

- There were 409 Knee replacements completed of which 2 infections were reported (0.5% compared to 1.3% national average)

- Following extensive RCA only one was deemed a true infection but potentially unavoidable.

9.4 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.

10. Antimicrobial Stewardship.

10.1. Antimicrobial Stewardship is a key component of Infection prevention. The IP consultant and Antimicrobial pharmacist continue to provide**:**

- Weekly antimicrobial orthopaedic, urology, general surgery and plastics ward rounds.
- C.Diff ward rounds.
- 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.
- Developed an e-learning package for clinicians to undertake every 3 years focused on prudent antimicrobial prescribing.
- Developed an Outpatient antibiotic therapy (OPAT) database to track patient progress and improve quality/quantity of reporting.

10.2. 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.

10.3. The AMG reports to Drug and Therapeutic Group (DTG) and Hospital Infection Prevention Committee (HIPG).

10.4. 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).

10.5. 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.

10.6. Throughout 2018-19, the AMT continued to respond to NICE guidance 15 updates – Antimicrobial stewardship: systems and processes for effective antimicrobial use.

10.7. The Trust-wide antibiotics point prevalence audits continued in 2018/19. 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.

10.8. All data was analysed trust wide and subdivided into medical and surgical directorates.

10.9. 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%.

10.10. Throughout 2018-19 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.

10.11. 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 referred to OPAT with more than 22,300 bed days saved. have been

10.12. 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.

10.13. 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.

10.14. In 2018/19, the AMT continued contributing to the Executive Root Cause Analysis Review Panels for significant HCAIs, specifically reviewing the use and appropriateness of antimicrobial therapy.

10.15. This Trust achieved the AMR and Sepsis CQUIN in 2018/19.

10.16. Actions taken to overcome challenges and issues

- Commissioned antibiotic review stickers to prompt CQUIN compliance.
- OPAT business case in progress.
- Andrew Brush antimicrobial Pharmacist enrolled on non-medical prescribing qualification.
- Commence an additional 'sepsis' ward round to aid CQUIN compliance.
- Work with pharmacy procurement to regarding Antimicrobial stock.
- Develop further educational resources for staff.

11. Health, Work and Wellbeing (including Sharps)

11.1. 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.

11.2. 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.

11.3 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.

11.4. The 2018/19 saw changes to the flu campaign

- Over 100 flu clinics set up across the three clinical sites and Alexandra park
- Introduction of Peer vaccinators, 16 trained, 9 engaged throughout the campaign.
- Live information was streamed to HWWB from microbiology so HWWB could target staff in areas where flu patients were being nursed.
- Data collected for PHE on staff that refused the vaccine and reasons given for refusal.
- Trajectory targets were issues and weekly data on flu vaccine uptake was fed to the board.
- Total of 95.4 % clinical staff received the vaccine during this campaign.

11.5 Moving forward: 2019/20 Campaign

- Flu campaign in progress
- Increased Peer vaccinators have increased from 18 to 23.
- A campaign to reduce the incident of inoculation injuries e.g. needle stick 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.

11.6 Key challenges/issues:

- Hepatitis B vaccination not been available for almost 2 years, limited stock only to be used for emergency e.g. inoculation injuries.
- Mantoux and BCG vaccination still unavailable.

12. Decontamination

12.1 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.

12.2 All decontamination and sterilisation of reusable medical devices is carried out off site by the Trust sterile services partner (Synergy Health PLC).

12.3 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.

12.4 Key Achievements:

- Interim Decontamination Unit approved by AED for further twelve months. The recent JAG audit carried out by the AED was also achieved.
- 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.

13 Estates, Facilities, Waste Management and Water Safety

13.1 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.

13.2. 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. Achieving:

- Excellent PLACE scores (best in the NHS) for both 2018 and 2019 inspections with condition and appearance, infection control and cleaning categories all achieving 100% compliance in the 2018 inspection.
- Introduced Sharpsmart for 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.

13.3. Water safety group

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.

Continues 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.

Continues 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.

The Estates and Facilities Management team 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 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.
- Review the performance monitoring regime across all facilities management services to ensure they align with all corporate objectives by introducing KPI's.
- Continue to review training systems across all facilities management teams to ensure the standard of training delivered reflects the Trusts objectives via the PMS.
- New computerised monitoring system for domestic supervisors.
- Review cleaning products and hygiene products.

14. Risk Register

There a number of low level risks on the risk register, the most significant infection risks on the Trust's risk register is the identification of patients within the Trust colonised with multidrug resistant bacteria and pandemic flu.

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

St Helens and Knowsley Teaching Hospitals NHS Trust

St Helens & Knowsley Teaching Hospitals NHS Trust
Infection Prevention Annual Work Plan 2019/2020

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008 (revised 2015). This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. This work programme below has been linked to these codes and to the Trust's Objectives 2018-2019.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of passing on the infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Infection Prevention Work Programme 2019/2020

IP Code and Trust Objectives	Plan and Priority Activities 2019/2020	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
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 Redfen (SR)					
	Infection Prevention (IP) Doctor – Consu	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, t No longer additional support provided for ANTT as CNS resumed work				
	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 approximatey 0.				
	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 2019				
	Trust Board Quality Committee Patient Safety Council DIPC reports directly Hospital Infection Prevention Group HIPG receives annual reports from Clinical Directorates						

Infection Prevention Work Programme 2019/2020

IP Code and Trust Objectives	Plan and Priority Activities 2019/2020	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
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			Q1	Q2	Q3	Q4
	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 regardles 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. This data is no longer being collected by the ICU. It was discontinued by the ICU Consultants in October 20-18.This has been approved by the Medical Director. It is not mandatory to collect this data.	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 To proved a report for the PSC every month	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			
	Flu and RSV	Microbiology and IPT	Throughout the Flu/RSV season, the IPT produce a Flu and RSV report daily and disseminate to Trust Strategic Operational teams and present to the daily bed management meetings.Daily report of all Trust side room usage and isolation requirements is produced and sent to Trust Strategic Operational teams.				
	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 .CCDC has contacted the national experts for information and is currently waiting feedback				

Infection Prevention Work Programme 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/2020**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**3. Hand Decontamination**						
1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	Introduce new hand decontamination sign posting for the Trust	IPT, Deputy General Manager (Medirest),	Determine what resources are available, assess their suitability and roll out throughout the trust				
	Review current products and dispensers and investigate the possibility of upgrading to hand free dispensers for soap product.	Soap provider rep and procurement					

Infection Prevention Work Programme 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/2020**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**4. Policies and Patient Information Leaflets**						
1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	Review and update Infection Prevention Policies as required	DIPC	Polcies for review are discussed at biweekly IP team meetings and timeframes agreed.				
	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 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/2020**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**5. ANTT/Intravascular Access and Therapy**						
1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	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				
	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-montly 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 clini	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 2019/2020

IP Code and Trust Objectives	Plan and Priority Activities 2019/2020	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. Provide dates for 2019/20 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. 12 month mandatory training is provided via an online video for clinical staff. 3 yearly mandatory training update for non clinical staff is via e-learning				
	Preceptorship	IP Team Antimicrobial Management Pharmacists (AL, AB)					
	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				
	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	IPT	As required, 2-3 times a year				
	Fundamental Training		Monthly				

Infection Prevention Work Programme 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/20**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**7.Audit**						
1, 2, 3, 4, 5, 6 7, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	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 2019. 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	Trust wide audit of PIVC care will be audited this year by the IPTAnnually - reported to the HIPG and Clinical Leads. VIP audits are undertaken if issues are identified through RCA Monthly reporting via IP audit indicators				
	Compliance with IP precautions, including isolation, careplans, PPE etc.		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 bi-monthly. Air mattress cleaning (externally managed) is audited on a bi-annual basis at Drive Wigan				

Infection Prevention Work Programme 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/20**	**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. Weekly pip/taz and meropenen ward rounds as part of the trust AMR strategy.	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/BL	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/BL	To be circulated Trust wide annually				
	Presentation of antimicrobial expenditure information	AL / AB/BL	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				
	Participate in CQUIN program for Antifungal Stewardship (AFS)	AMT	Reported monthly to executive leads and quarterly to HIPG and DTG				
	Develop antimicrobial elearning package for Trust clinical members of staff	AL / AB / BL	Trust staff to undertake every 3 years when completed				
	Working closely with GPs to reduce all gram negative infections by 10% each year across the health economy	AMT	Twice yearly sessions				
	Pharmacy to explore the possibility of ready made intravenous antibiotic preparations for use on the ward	AL / AB / BL	Quarterly to HIPG and DTG				
	To Develop EPMA antibiotic data extraction for drug use audit and targeted ward rounds	AL / AB / BL	Quarterly to HIPG and DTG				
	Develop OPAT business case for formalise service provision	MF / AL	Quarterly to HIPG and DTG				
	Develop and implement teicoplanin dosing chart for ward use by clinicians on ward	AL / AB / BL	Quarterly to HIPG and DTG				

Infection Prevention Work Programme 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/20**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**9. Communications**						
1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	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 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/20**	**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: configuration still ongoing - expected to be completed end of Jan 2019 and tested in Feb/March 2019. To introduce further functions to the system as they become available via ICNet - which includes audit and surveillance. To maintain ICNet administration.				
	Electronic prescribing	KM/AL/MF	To help develop the funtionality of the JAC EPMA system. To add alerts to the JAC system.				
	Develop e-learning package for appropriate antimicrobial prescribing	AMT	To develop packages 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 upto date according to changes in policy necessiated by antibiotic shortages. The AMT have also checked and validated the transfer of the antibiotic web pages from the old to new intranet.				

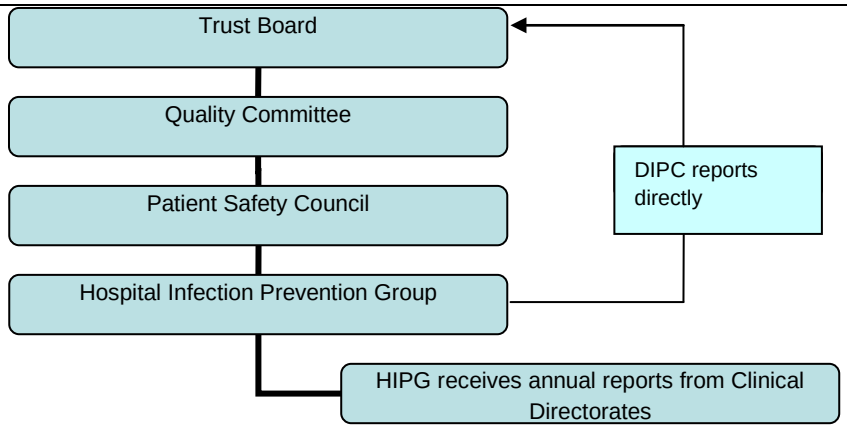
Infection Prevention Work Programme 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/20**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**11. IP Engagement at Ward and Department Level** To continue to communicate, advise, support and educate all staff within the Trust on IP related issues.						
	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 along side 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 2019/2020							
IP Code and Trust Objectives	**Plan and Priority Activities 2019/20**	**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	OM	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		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		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		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.				
	Huyton CCG meetings	OM	To attend and provide assurance to CCG on IP issues				
	Mid Mersey	MF	To provide medcines management support and training in Antimicrobial Stewardship				
	Ad Hoc meetings	IPT	To provide expert advice and support as required.				

St Helens and Knowsley Teaching Hospitals NHS Trust

Terms of Reference	NAME: HOSPITAL INFECTION PREVENTION GROUP (HIPG) FINANCIAL YEAR: 2019
Authority	To ensure that St Helens and Knowsley Teaching Hospitals Trust has effective systems in place to prevent and control hospital acquired infections and to provide assurance to the Trust Board. To maintain an overview of infection prevention priorities within the Trust, and link this into the clinical governance and risk management processes.
Terms of Reference	1. To identify key standards for infection prevention as part of the Trust's clinical governance programme. 2. To ensure that programmes for the control of infection, including education, are in place and working effectively. 3. To ensure that appropriate infection prevention policies and procedures are in place, implemented and monitored. 4. To ensure that robust plans for the management of outbreaks of infection are in place and to monitor their effectiveness. 5. To monitor surveillance of infection results e.g. mandatory surveillance, post-operative infection rates. 6. To highlight priorities for action in infection prevention management. 7. To agree the annual infection prevention audit programme, and monitor its implementation. 8. To approve the annual infection prevention report, prior to its submission to the Trust Board, and to monitor its progress. 9. To ensure that national guidance and best practice in infection prevention is implemented within the Trust. 10. To ensure the delivery of national infection prevention objectives e.g. NPSA alerts / NICE guidelines /CQC reports/ High Level Enquiries. 11. To appraise innovative products with regard to infection prevention 12. To monitor antimicrobial/disinfectant usage & expenditure patterns.
Review	In the fourth quarter of the financial year, the HIPG will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Terms of Reference.
Membership	**Core members** • Director of Infection, Prevention & Control (Chair) • Lead Nurse Infection Prevention • Consultant Microbiologists & Infection prevention doctor • Infection Prevention Nurses • ANTT Nurse Specialist • Head of Quality for Surgical Care(matron to deputise if not in

	attendance) • Head of Quality for Medical Care (matron to deputise if not in attendance) • Senior clinicians for: o Medicine o Surgery o Paediatrics • PFI Contract and Performance Manager • Decontamination Manager • Operational Services representative – Head of Patient Flows • Antimicrobial Management Pharmacist • Health Work & Well-being representative • Vinci Maintenance Services Manager • Consultant in Communicable Disease Control **In attendance** It is anticipated that the following senior officers will regularly attend: • Community Infection Prevention Nurses • Director of Facilities and Contract • Health & Safety Advisor • Finance Manager Infection Prevention • Infection prevention assistant practitioner • Infection prevention audit and surveillance assistant The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. In addition to formal members the group shall be able to require the attendance of any other member of staff. Microbiology trainees are invited to attend the group as observers. Director of Nursing, Midwifery & Governance/ Director of Infection Prevention and Control chairs the group. In the absence of the Chairman, the Deputy Chair shall be the Lead Infection Prevention Doctor/ Consultant Microbiologist or Lead Nurse Infection Prevention. In the absence of both the Chair and Deputy Chair the remaining members present shall elect one of themselves to chair the meeting.
Attendance	It is expected that Core Members (or appropriate deputies) attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership (or appropriate deputies) must be present. To include at least one Infection Control specialist"
Accountability & Reporting.	The Hospital Infection Prevention Group was established by and is responsible to the Trust Board via the Patient Safety Council:



.

Meeting Frequency

6 times a year

Agenda Setting and Minute Production and Distribution.

Agenda

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Group and any other person required to attend prior to the meeting. Supporting papers shall be sent to Group members and to other attendees as appropriate, at the same time.

Regular reports received by HIPG.

Quality indicator report	Frequency of report	Reported by
Mandatory surveillance: a. MRSA bacteraemia b. C difficile infection c. MSSA bacteraemia d. Gram negative (E coli/Klebsiella/Pseudomonas aeruginosa) bacteraemia e. SSI orthopaedics	At each meeting	Lead IPN
Local surveillance results	As available.	Infection Prevention Nurses
External inspection reports and action plan progress (e.g. CQC)	As required (subject to reports being issued by external agencies)	Lead IPN
Antimicrobial Management Team report (to include audit results and action plans, policy compliance and review)	At each meeting	Consultant Microbiologist and Antibiotic Pharmacist
Annual Report	Annual	DIPC or deputy
Reports from Medical & Surgical Directorates.	At each meeting	Heads of Quality/ Senior Clinicians for Medicine and Surgery/

			Matron representatives
	Reports from community	At each meeting	Community Infection Prevention Nurses
	Audits a. Ward audits since last meeting b. Other audits	At each meeting	Infection Prevention Nurses
	Outbreaks	At each meeting	Infection Prevention Nurses
	Report from Decontamination Lead	At each meeting	Decontamination Lead or Deputy
	Report for Water Safety Lead	At each meeting	Water Safety Group Representative
	Report from Waste Management Group	At each meeting	Waste Management Group representative
	Report from Sharps Safety Group	At each meeting	Sharps Safety Group representative
	Report from HWWB	At each meeting	Lead Nurse HWWB
	Report from public health	At each meeting	Consultant in Communicable Disease Control
	Minute Production and Distribution. The Secretary shall minute the proceedings and resolutions of all meetings of the Group, including recording the names of those present and in attendance. Minutes of Group meetings shall be circulated promptly to all members of the Group.		
Document Tracking/Control	Documents submitted to the group should be identifiable by using a standard report cover sheet and structure (Appendix1).		
Policy Management.	Policies approved by the committee must adhere to the overall guidance document “Document Control Policy” (Trust Policy on Policies). The Director of Infection, Prevention & Control is responsible for ensuring that the Policy Checklist is completed in respect of each policy approved. All policies approved by HIPG will be taken, by DIPC or deputy, to Patient Safety Council for ratification prior to distribution.		

Appendix 1
Summary for Submission of
Paper to the Hospital Infection Prevention Group (HIPG)

Paper number:
Subject:
Purpose:
Summary:
Corporate objectives met or risk addressed:
Financial Implications: *Any direct costs associated with this paper that need approving.*
Stakeholders:
Recommendation(s):
Review Date:
Authors :
Presenting Manager:
HIPG date: