Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 25TH NOVEMBER 2020
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
09:40	2.	Patient Story		Verbal	
10:00	3.	Apologies for Absence		Verbal	
	4.	Declaration of Interests		Verbal	
	5.	Minutes of the Previous Meeting held on 28th October 2020		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(20) 75	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Nik Khashu
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10:30	7.	Committee Report – Executive		NHST(20) 76	Ann Marr
10:40	8.	Committee Report – Quality		NHST(20) 77	Gill Brown
10:50	9.	Committee Report – Finance & Performance		NHST(20) 78	Jeff Kozer
BREAK					
Other Board Reports					
11:10	10.	Research & Development Annual Report and Research & Development Annual Capacity Statement		NHST(20) 79	Rowan Pritchard-Jones
11:30	11.	Trust Board Meeting Arrangements for 2020/21		NHST(20) 80	Nicola Bunce

AGENDA			Paper	Presenter
11:35	12.	Approval of Quality Account 2019/20	NHST(20) 81	Sue Redfern *(Anne Rosbotham-Williams in attendance)*
11:50	16.	Infection Prevention Control Annual Report 2019/20	NHST(20) 82	Sue Redfern
Closing Business				
12:00	17.	Effectiveness of Meeting	Verbal	Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 27th January 2021		

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 28th October 2020 in the Boardroom, Whiston Hospital and via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs L Knight	(LK)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Pritchard-Jones	(RPJ)	Medical Director
In Attendance:	Ms E Alexander	(EA)	HR Graduate Management Trainee *(Observer)*
	Ms S Amesu	(SA)	Insight NED Development Programme Placement *(Observer)*
	Mr G Appleton	(GA)	Chair, St Helens CCG Governing Body *(Co-opted member)*
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Mrs K Hughes	(KH)	Head of Media, PR & Communications *(Observer)*
	Mr K Lomas	(KL)	Local Democracy Reporter, St Helens Star *(Observer)*
Apologies:	Mr R Cooper	(RC)	Director of Operations & Performance
	Mrs C Walters	(CW)	Director of Informatics
	Cllr A Lowe	(AL)	Halton Council

1. Employee of the Month

1.1. The Employee of the Month for October 2020 was awarded to Anne Rosbotham-Williams, Deputy Director of Governance.

2. Apologies for Absence

Apologies were noted as above.

3. Declaration of Interests

There were no new declarations of interest.

4. Minutes of the previous meeting held on 30th September 2020

4.1. Correct Record

4.1.1. The minutes were approved as a correct record, once the following amendments were made:

- Page 5, minute 6.4.3 – year to date position at end of month should be month 5 not month 4;
- Page 11, minute 11.5 – LK clarified that the Employee Relations Oversight Steering Group *had previously* met, however meetings were currently suspended due to COVID.

4.2. Action List

No actions were due for the meeting. RPJ commented that in relation to action 41, the seven-day service reporting remained suspended and a re-set would not be possible whilst services continued to be disrupted because of the pandemic. It was agreed that the action should be closed.

5. Integrated Performance Report (IPR) – NHST(20)061

5.1. The 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

5.2. Quality Indicators

5.2.1. SR presented the performance against the key quality indicators.

5.2.2. There were no never events in September, YTD 3.

5.2.3. There were no cases of MRSA in September, YTD 0.

5.2.4. There were 4 C.Difficile (CDi) positive cases reported in September 2020 (2 hospital onset and 2 community onset). YTD there have been 18 cases (8 hospital onset and 10 community onset), compared to 34 by September in 2019. The annual tolerance for CDi for 2020/21 had not yet been published therefore the 2019/20 tolerance level of 48 was being used.

5.2.5. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2020 was 93.3%. YTD rate is 94.4%.

5.2.6. There were no grade 3 avoidable pressure ulcers reported in August. Reducing the number of Trust-acquired avoidable pressure ulcers, including category 2, continued to be a quality priority for the year following the increases observed in 2019/20.

5.2.7. There were 3 falls resulting in severe harm in August, YTD 16. A robust action plan was in place to ensure patients were risk assessed on admission and preventative measures put in place.

5.2.8. The reporting of VTE assessments remained suspended nationally because of COVID-19.

5.2.9. Year to date HSMR (April to June) for 2020/21 was 111.9. RPJ reminded the Board that as discussed in September the HSMR model was still adjusting to the impact of COVID and the Trust was utilising a range of other measures to assess mortality, which provided assurance that it was not an outlier.

5.3. **Operational Indicators**

5.3.1. NK presented the update on the operational performance on behalf of RC.

5.3.2. The 62-day cancer standard was above the target of 85% in August 2020 at 92.7%.

5.3.3. The 31-day cancer target was achieved in August with 98.1% performance against a target of 96%.

5.3.4. The 2-week cancer standard was achieved in August with 94.5% in month, against a target of 93%.

5.3.5. The A&E access time performance for all types mapped for September was 89.2%, YTD 89.4%. The Trust was seeing attendance levels flatten in September, with the average daily attendance being the same as August (307). Total attendance for September was 9,219.

5.3.6. There were 2,435 ambulance conveyances in September compared to 2,565 in August and the ambulance turnaround time averaged 27 minutes against the standard of 30 minutes.

5.3.7. The average daily number of super stranded patients (length of stay of greater than 21 days) in September 2020 was 62 compared with 121 in September 2019.

5.3.8. The 18-week referral to treatment target (RTT) was not achieved in August 2020 with 60.5% compliance against a target of 92%.

5.3.9. There were 137 52+ week waiters.

5.3.10. The COVID pandemic had had a significant impact on RTT and diagnostic performance as all routine operating, outpatient and diagnostic activity had to be cancelled. Activity had now restarted in all areas, albeit at a reduced capacity compared with pre-COVID, due to social distancing and infection control measures. All patients had been, and continued to be, clinically triaged to ensure urgent and cancer patients remained a priority for treatment.

5.3.11. Community nursing activity levels had returned to a typical level of activity pre-COVID. The services provided by specialist nursing, district nurses and community matrons were being monitored to ensure there was no waiting list. St Helens Urgent Treatment Centre had

approximately 140 daily attendances.

5.3.12. VD commented on the improving RTT performance and achievement of the cancer standards and felt this provided substantial assurance that the Trust was treating the sickest patients. She reported that this had been discussed at the recent CCG Governing Body and she had received feedback from Cllr Marlene Quinn of St Helens Council, who had observed that St Helens Urgent Treatment Centre performance had improved since the Trust had taken over the provision of the service.

5.4. **Financial Indicators**

5.4.1. NK presented the update on the financial performance.

5.4.2. As a result of the COVID-19 pandemic, the NHS financial regime for 2020/21 was put on hold and a system introduced to ensure all Trusts remained in financial balance April to September 2020. Payment by Results (PBR) was replaced with block payments on account, with any additional expenditure above this value reimbursed in a retrospective top up, including costs incurred because of COVID -19.

5.4.3. The Trust had therefore reported a balanced YTD position at the end of Month 6 in line with the emergency financial guidance. This assumed full reimbursement of COVID-related costs and additional expenditure incurred year to date (£16.3m). The Trust had received confirmation that expenditure for months 1 to 4 had been approved.

5.4.4. The agency ceiling issued by regulators for 2020/21 was £7.8m, which was a £0.2m increase on 2019/20. Year to date spend was £3.9m which was £0.2m below the agency cap and slightly above the previous year’s spend.

5.4.5. The requirement for CIP was currently on hold under the block payment arrangement.

5.4.6. At the end of month 6, the cash balance was £47.0m. The closing balance continued to be high due to the changes in funding arrangements related to COVID-19, where the Trust received block payments one month in advance.

5.4.7. RF asked whether the changes to the financial arrangements had been helpful and the Trust had received all the funding it needed to respond to the pandemic. NK believed the block payment arrangement had been reasonable for months 1 to 6. He was however concerned that this arrangement had now ended, and the Trust had been asked to restart all its normal activities and would be allocated a budget for the remainder of the year. NK had fed back his concerns to the national team regarding the likelihood of a 2nd wave of the pandemic and the fact the Trust was in a Tier 3 area.

5.4.8. NK confirmed that the Trust was also ensuring that suppliers were paid promptly to support the wider economy.

5.5. Workforce Indicators

5.5.1. AMS presented the update on the workforce performance.

5.5.2. Sickness absence for September was 6.1%, which was an increase and reflected the increased incidence of COVID-19

5.5.3. Appraisal compliance in September was 64.5%, which was below the target of 85% by 20.5%. AMS confirmed that the 2nd wave of COVID-19 was impacting the ability to release time for appraisals and training but managers had been asked to check in with staff on a regular basis even if they could not undertake a full appraisal, which was being well received.

5.5.4. Mandatory training compliance was 78.7% and remained below the target of 85%. Although recovery plans had been developed it was unlikely the situation would improve significantly whilst the Trust was responding to another surge in COVID-19 cases.

5.5.5. RF had attended a regional Chairs' meeting with Anthony Hassell, Regional Chief People Officer, NHSE/I regarding the high levels of absence being seen in the North West. RF felt that the presentation had not reflected the different infection rates across the North West, which was bound to be reflected in staff sickness. AMS commented that there were significant variations in sickness, which did seem to mirror the COVID hotspots and the Trust was currently facing a significant staffing challenge.

5.5.6. Board members noted the report.

6. Committee Report – Executive – NHST(20)062

6.1. AM summarised issues considered by the Executive Committee at meetings held during September 2020.

6.2. The Executive Committee approved resources to support the delivery of the 2020 flu vaccination programme, additional SAS Grade Anaesthetic cover, and re-establishment of the COVID incident command and control structure following the increase in patient admissions.

6.3. Acute Kidney Injury (AKI) Action Plan - a Hydration Steering Group had been formed and was meeting regularly. AM commented that she felt good progress was now being made on this issue and the right actions were in place. VD asked what the Trust could do to support those patients admitted with existing renal disease. RPJ explained that early assessment and intervention were essential and the Trust was fortunate to have an AKI Nurse Specialists and had now recruited a Renal Physician, which meant that more patients could be treated at the Trust and would not need to be transferred to the renal unit at Liverpool University Foundation Trust (LUFT).

6.4. AM highlighted that the committee had approved the business case in relation to increased out of hours anaesthetic cover.

6.5. AM also drew the Board's attention to the progress report on the development of the acute medial model, which aimed to streamline the assessment and admission processes. This was one of the corporate objectives for 2020/21, and the opening of Bevan Court had already improved the position for the frail elderly cohort of patients.

6.6. GB commented that it was interesting to see how Marshalls Cross Health Care Centre had responded to the pandemic, and good to see the progress that had been made with recruitment. GB was particularly interested in the army nurses undertaking placements in the practice. AMS explained that the Trust had established a close working relationship with the army medical division, and although this had stalled a bit during COVID-19, she was hopeful that it would continue to develop, as there were mutual benefits.

6.7. Board members noted the report.

7. Committee Report – Quality – NHST(20)063

7.1. GB presented the report, which summarised the key issues considered at the Quality Committee meeting in October.

7.2. GB reported that there had been a very full agenda but there had been time for robust discussion. She thanked the Executive for distributing the papers earlier.

7.3. Committee received the regular assurance reports from Patient Safety Council, Patient Experience Council, and Clinical Effectiveness Council and had reviewed the integrated performance report in relation to the quality and safety performance indicators.

7.4. GB highlighted that the committee had received the report summarising the pandemic review meetings, and GB felt this had been a very worthwhile exercise, as there were several lessons that had been learned.

7.5. Issues that the committee wished to bring to the Boards attention were; the need for further scrutiny and assurance in relation to the actions being taken to reduce pressure ulcers. GB reported that she was meeting with SR and NB to review the governance processes in relation to pressure ulcers. Also highlighted was the improved compliance reported following the recent medicines storage audits, and the excellent progress made in delivering the extensive clinical audit programme, despite the pandemic.

7.6. Additionally, GB provided assurance that the committee was monitoring mandatory training delivery and had endorsed the prioritisation of core clinical training, at the current time.

7.7. Committee had reviewed and approved the infection prevention annual report 2019/20 for presentation to the Trust Board in November.

7.8. The report was noted.

8. Committee Report – Finance & Performance – NHST(20)064

8.1. JK presented the Chair's report to the Board which summarised key issues discussed at the Finance & Performance Committee meeting in October.

8.2. Committee had reviewed the integrated performance report in respect of the finance and performance indicators.

8.3. Committee had noted that the % of Did Not Attends (DNA) for outpatient appointments was reducing, which reflected the public's growing confidence in being able to attend hospitals for planned appointments.

8.4. The committee had discussed how the Board could receive assurance in relation to nosocomial infections and other indicators of how the Trust had performed during COVID-19, in line with the expectations of Boards set out in the letter from Bill McCarthy. The Executive has been asked to review the reporting arrangements to ensure all the necessary information was flowing to the Board. RF reported that following the recent Chairs meeting with Bill McCarthy he was assured that there were no concerns from NHSE/I about the Trust's response.

8.5. The Committee had discussed the approach to cost improvement programme (CIP) for 2021/22, including the commitment to quality impact assessments (QIA) to ensure that there would be no detrimental impact on the quality of patient care. VD asked if the QIAs for 2019/20 had continued to be reviewed and NK confirmed that this was the case, and the CIP report had included detail of the CIPs being tracked for review.

The Committee had received a presentation on the offer made to the Trust by Cheshire & Merseyside Health Care Partnership (HCP) and the forecast outturn position this would create. The Committee discussed the risks within the forecast and the steps that would need to be taken by the Trust and HCP to reduce the system gap. The Committee had supported the approach and recommended the Board be briefed on the position.

8.6. The committee reviewed a proportion of the COVID expenditure schemes that have been approved by the Executive Committee. The committee was assured that there was a robust approval process in place and the schemes were reviewed on a regular basis.

8.7. NK confirmed that this review of COVID initiatives completed action 43 from September's Public Board meeting.

8.8. The report was noted.

9. Committee Report – Charitable Funds NHST(20)065

9.1. PG presented the report, which summarised the provided feedback on the key issues discussed at the Charitable Funds Committee in October.

9.2. The Committee had noted the level of investments and recent income and expenditure, together with the delays to planned events due to the pandemic. PG commented on the excellent efforts of the Charities Manager and

Communications Team in liaising with local businesses.

9.3. The Trust had received grants from NHS Charities Together and discussed options for how use these donations which were for the benefit of NHS staff.

9.4. The Committee agreed £5.00 per patient to be spent on Christmas gifts. Agreement was to be reached regarding enhancing patients' experience over Christmas if the current visiting arrangements were still in place.

9.5. The Annual Report and Accounts 2019/20 were approved by the Committee on behalf of the Trust Board, subject to the independent examiner's report completed by Grant Thornton UK LLP, the Trust's external auditor.

9.6. GB commented that it inspiring to see how the charitable donations were being spent to achieve benefits for patients and staff.

9.7. JK had attended the meeting and commented on the enthusiasm and professionalism of the team, he had been very impressed.

9.8. Board members ratified the approval of the Charitable Funds Draft Annual Accounts and Annual Report 2019/20.

10. Corporate Risk Register – NHST(20)066

10.1. NB presented the CRR to provide inform the Board of the risks that had currently been escalated to the Corporate Risk Register (CRR) from the care groups via the Trust's risk management systems.

10.2. The report covered all risks reported and reviewed until the end of September and was a snapshot of the position in September, with comparisons to the previous Board report in July.

10.3. It was noted that Risk 2866 on page 6 of the report should be shaded blue to reflect it had been reported after the previous report in July.

10.4. VD queried whether 154 risks overdue for review in the current reporting period was cause for concern. NB confirmed that the number of overdue risks was monitored very closely by the Risk Management Council and each Care Group and Service reporting on any risks that had not been reviewed were monitored every month and a snapshot taken on a specific date. However quite often, the lack of review was a timing issue e.g. the reporting date was a Monday and by the time the monthly Risk Management Council meeting took place risks had been reviewed, however staff absence and operational pressures also had an impact.

10.5. LK queried whether the dates in the 'last review due' column on page 5 were correct. NB confirmed that some risks did not need to be reviewed every month; this was determined by the action plan and the review date was set by the risk owner.

10.6. Regarding the risk relating to EU Exit (Risk 2520) VD queried whether the rating of 16 was still appropriate given the potential for a 'no deal' outcome. NK confirmed the Trust was heavily involved in discussions and had management plans in place regarding consumable goods procurement. He explained preparations for the COVID pandemic had helped to ensure the Trust was prepared pre-Brexit. SR also confirmed that the DHSC and NHSE/I were

issuing guidance to Trust on the measures they needed to take to prepare for the UK EU exit and the organisation was fully compliant with all the actions required at Trust level.

10.7. Regarding Risk 2932 relating to fluid balances, VD asked for clarity around whether the risk related to fluid balances not being recorded accurately, or whether it was the bigger risk of patients not being given enough to drink. RPJ explained the recording of fluid balances was moving to the e- vitals platform which would help in providing, prompts, accurate and timely recording and monitoring which would prevent de-hydration. This was part of the Acute Kidney Injury (AKI) action plan.

10.8. Board members noted Risk 2641 regarding new laptops Community midwives had now been de-escalated as new equipment had been issued.

10.9. The report was noted.

11. Board Assurance Framework (BAF) – NHST(20)067

11.1. NB presented the quarterly review of the BAF.

11.2. No changes to the risk scores were proposed for this quarter but there were several updates on the actions.

11.3. With regard to Risk 1 - systemic failures in the quality of care - on page 5 in the 'additional assurance required' column, VD queried whether 'development of ward quality accreditation tool and real time quality dashboard (December 2020)' was the replacement of the Quality Care Accreditation Tool (QCAT) and asked whether assessments at ward level were still being conducted. SR explained the Quality Ward Rounds had been suspended due to COVID and the Pandemic Reflections meetings had replaced them. SR confirmed audits were still being conducted at ward level so quality and safety were being monitored.

11.4. With regard to Risk 2 – failure to develop long-term financial sustainability plans for the Trust and with system partners – VD was aware the Trust was fostering a positive working relationship with the Cheshire & Merseyside Health and Care Partnership (HCP) and asked how the relationship was progressing. She observed there appeared to be more joint working across the economy. NK confirmed the Trust had been working with St Helens CCG pre-COVID to build a long-term financial recovery plan and adopt a multi-year approach to bring costs down. Recent examples of collaborative working included the transfer of the St Helens Urgent Treatment Centre (UTC) and the system support for Willowbrook Hospice. There was still an active agenda around St Helens Cares but probably less so currently, with the need to focus on the pandemic.

11.5. Discussions were in an early stage with both the Independent sector and across Cheshire & Merseyside HCP to see how it could operate more effectively as a system to maximise the £2.6b annual health funding. AM added that, as lead for the Hospital Cell, she had responsibility for ensuring Cheshire & Merseyside Trusts worked together collaboratively to respond to the challenges of COVID-19. The response of all the Trusts had surpassed her expectations; there was fantastic mutual support, with everyone pulling together in the crisis to do the best for patients.

11.6. GB queried whether there was anything which could be taken from the pandemic review to add in as other sources of assurance. NB agreed to review the action plan and include any new sources of assurance. **ACTION: NB**

11.7. Board members noted the report.

12. Complaints, Claims & Incidents – NHST(20)068

12.1. SR presented the complaints, claims and incidents report covering for Quarter 1 and Quarter 2 of 2020/21.

12.2. The total number of incidents reported in Q1 was 3177 and in Q2 3761.

12.3. There had been 21 incidents that needed to be reported to StEIS during Q1, and 39 categorised as moderate harm, severe harm, or death. Q2 had 21 incidents reported to StEIS and 37 categorised as moderate harm, severe harm, or death. Board members asked to note that a thematic review of pressure ulcers was being undertaken because of the increase in incidents both hospital and community acquired.

12.4. There were 48 new first stage formal complaints in Q1 and 67 in Q2. Clinical treatment, admissions and discharges remained the highest reasons for complaint.

12.5. There were 1204 PALS queries in Q1 and 1215 in Q2. In Q1, 98.5% of PALS queries were resolved by the service, and in Q2 98.3%.

12.6. There had been 3 new clinical negligence claims in Q1 and 9 in Q2. Of the 9 claims received in Q2, one had previously been investigated as a complaint, one was previously investigated as an incident and one was previously investigated as an incident under the Early Notification Scheme for maternity. In the period 24 claims had been settled with damages, 15 defended and 6 closed following file review, with lessons learned shared across the organisation.

12.7. VD asked if there had been any increase in claims relating to delayed diagnosis from patients whose appointments had been deferred because of COVID-19. SR stated that this was not the case yet as there was usually a time lag between the outcome of treatment and claims being made, but acknowledged that the Trust could potentially see an increase for these reasons in the future

12.8. 28 inquests were opened in the period and 35 inquests closed with no actions against the Trust.

12.9. LK felt this was a positive report and asked for SRs observations on whether the pandemic had impacted on complaints and PALs increasing. SR confirmed that the pressures on the service, the changes to visiting and other restrictions, in addition to the difficulties experienced with assessment and discharge had added to the numbers.

12.10. VD queried whether the figures reported in the 3rd paragraph under the 'Incidents' subtitle related entirely to pressure ulcers in community services, i.e. 17 in Q4 2019/20, 157 in Q1 2020/21 and 177 in Q2 2020/21 as she calculated

this was more than a 17% increase. She asked what assurance could be expected from the community that mitigation was in place and lessons were being learned. SR commented that the Community Services had grown from April 2020 when the St Helens Community Nurses had transferred to the Trust, however it was also important to distinguish between pressure ulcers detected and reported by the community services, i.e. for patients being cared for by family and in care homes and those acquired whilst the patients were in the care of community services. However, a review was also being undertaken in both community services and St Helens UTC to understand if risk assessments for pressures ulcers grades 1 to 4 were being completed appropriately.

Post meeting it was clarified that: there had been a 17% increase in the total number of pressure ulcers reported across the Trust – Q4(560) to Q1(656).

Community nursing services were included in the Trust figures for the first time from Q1 when the services transferred to Trust management.

In Q4 the Community Services Care Group reported 17 pressure ulcers (mostly from Newton/Duffy and Seddon Wards), whilst in Q1 of 2020/21 there were 157 reported, which now included those reported by the Community and District nursing services (which included pressure ulcers reported by these services but not attributable to the care given by them). The situation would be clearer from Q2 reporting.

12.11. RF was pleased to note the Trust acknowledged letters of appreciation as well as complaints, claims and incidents and thanked all staff who delivered those services. There would always be instances where not everything was perfect, however once an issue was identified the most important thing was that it was reported and addressed so improvements could be made.

12.12. Board members noted the report and actions taken as a result of recent complaints, claims and incidents.

13. Safeguarding Annual Report 2019/20 – NHST(20)069

13.1. SR presented the report which provided information and assurance for all aspects of safeguarding children and adults during the financial year 2019/20 and highlighted the increased performance and activity in safeguarding and highlighted that Deprivation of Liberty Safeguards (DoLS) referrals were increasing. The report had been scrutinised by the Quality Committee and was recommended to the Board for approval.

13.2. The Trust had received positive feedback from stakeholders regarding the report and was actively engaged with the Local Safeguarding Board. Trust performance against the safeguarding standards had been rated as green (significant assurance) in all areas except PREVENT Level 3 training compliance, which was rated amber, but in Quarter 4 of the year the trust had achieved the target compliance of 85%.

13.3. The Safeguarding team had been expanded in 2020 with 3.8 FTE additional posts.

13.4. VD asked if there were any ongoing issues with Knowsley Local Safeguarding Board that needed to be escalated. SR confirmed that the issues had been

resolved this financial year and the Trust was now a member of the Knowsley Safeguarding Board.

13.5. GB congratulated the Safeguarding team on the progress made. It was interesting to see the investment to offer training for care homes and private hospitals and suggested the Trust should also consider housing associations.

13.6. LK echoed GB's comment. She was aware DoLS were increasing year on year and wondered whether the team was managing or whether more support was required. SR confirmed the team had sufficient capacity at the current time, with the additional investment that had been made, but this would be kept under review, especially when the impact of the Deprivation of Liberty Safeguards process was known. VD commented that when the business case for extra resource had been written, the impact of community services would not have been known. SR confirmed the situation was being reviewed monthly and the team was currently managing the workload.

13.7. Board members approved the annual report.

14. EPRR (Emergency Planning Response & Resilience) Assurance Framework – NHST(20)070

14.1. SR presented the Trust's EPRR Statement of Compliance with the NHS core standards.

14.2. As part of the NHSE/I EPRR Framework, providers and commissioners of NHS-funded services had to demonstrate they could meet the statutory duty to effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients.

14.3. In 2019, the Trust was 'fully compliant' with 60 of the 64 core standards and 'partially compliant' with the remaining 4. This year, the assessment process was more 'light touch' as a result of the pandemic and the Trust was required to provide progress and assurance on the 4 'partially compliant' standards, to provide lessons learnt from the 1st wave of COVID-19, and provide a brief summary of the Trust's winter plan.

14.4. As a result of this review the report stated the Trust was now 'fully compliant' with 3 of the 4 2019/20 standards and 'partially compliant' with the remaining standard, which related to face-to-face hazardous materials and decontamination training for Emergency Department (ED) staff. A 5-point refresher card had been issued to each member of ED staff to ensure they knew how to deal with such an occurrence and SR confirmed a training programme was in place to achieve 'full compliance', however this was unlikely to be able to be completed for all staff during the 2nd wave of the pandemic.

14.5. GB asked if there were staff with expertise in the ED department. SR confirmed that this was the case, and the training was aimed as a refresher and for new staff. The Trust had all the necessary equipment on site, and this was checked regularly and externally audited.

14.6. Board members approved the compliance statement.

15. Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Report & Action Plan – NHST(20)071 & NHST(20)072

15.1. AMS presented the annual reports of trust compliance with the 9 WRES and WDES indicators and the proposed actions. AMS stated that she would address both papers together because of the importance of the Board approving the Trust's strategic approach to inclusion.

15.2. All the actions were RAG rated as green.

15.3. AMS explained that any organisation could review its performance against other organisations, both regionally and nationally. Page 3 of both WRES and WDES reports provided progress, however she felt that a broader approach was needed to achieve real change.

15.4. The Trust Staff networks were now established and making good progress; they had some fabulous members of staff who were keen and interested to help with this agenda. The Trust therefore had a good Equality, Diversity, and Inclusion (EDI) infrastructure and had now established a strategic advisory group, to guide the development of an EDI strategy.

15.5. The recent 'everyone matters' campaign that had been run across the Trust had been well received and it was hoped would encourage staff to use their voice.

15.6. AMS confirmed the EDI strategy would encompass the WRES/WDES indicators reporting, which were required to be approved by the Board and published each year.

15.7. LK confirmed she was a member of the EDI Steering Group and asked whether it was appropriate to report more frequently, than waiting for next year's WRES and WDES reports. AMS explained the report needed to come to Board as a statutory requirement and was populated with data from external sources, however to this did not preclude more frequent discussion by the Board. AMS suggested the steering group be asked for their suggestions on reporting and celebrating success.

15.8. NK commented on the power of language and how it was used and cited the wonderful feedback received from staff during the pandemic reviews.

15.9. RF commented that at the regional chars meeting he had attended there had been a discussion about the impact of COVID-19 on BAME staff and in particular on staff from the Philippines. SR assured Board members that the Trust undertook a very active risk assessment process of all staff to identify anyone who was a higher risk and mitigations were put in place to protect them.

15.10. In response to a query from VD asking whether it was appropriate for the Trust to look into the impact of health inequalities, AM acknowledged the Trust operated in communities with high levels of high deprivation, whereas the local ethnic minority population was relatively low at 2.6% for St Helens and 2.8% for Knowsley. The public health experts in the Local Authorities were closely monitoring the impact of COVID-19 on different groups in the local population

closely.

15.11. Board members approved the WRES and WDES reports and action plans and endorsed the proposed approach to the development of a Trust inclusion strategy.

16. Q1 2020/21 Learning from Deaths Update – NHST(20)073

16.1. RPJ presented the quarterly update which described mortality reviews that had taken place in both specified and non-specified groups, to provide assurance that deaths were being reviewed and key learning had been disseminated throughout the Trust.

16.2. In Quarter 1 a total of 143 Structured Judgement Reviews (SJRs) had been completed, 32 of which were due to COVID-19 (29%).

16.3. Of the 143 reviews, 119 (83.21%) were rated green (no concerns). A further 4 reviews (2.7%) were rated Amber (significant doubt about whether or not problems in care delivery/service provision contributed to death), and 2 reviews (1.39%) were rated Red (probable that death may have resulted from problems in care delivery/service provision) and 18 (12.58%) were awaiting discussion at the Mortality Surveillance Group.

16.4. Key learning points from Quarter 1 were:

16.4.1. The application and review of DNACPR for patients with COVID-19; and
16.4.2. The need for more training and support for staff caring for end of life patients and bereaved families.

16.5. Development of the Medical Examiner (ME) team was in progress and on target to review 50% of the Trust's deaths by end-October, and 100% by 1st April 2021. It was anticipated that the introduction of MEs would reduce the number of Amber and Red reviews, as most of these concerns should be identified by MEs in their initial case note review. A governance plan had been established to manage the new process.

16.6. VD asked about the support available to staff who had to give bad news to patients' families. RPJ confirmed that the decision that aggressive intervention was not clinically appropriate was made by a Mult-Disciplinary Team (MDT) of senior clinicians who met each day. These decisions were then communicated to the wards and Medical Emergency Team (MET) to ensure the right care was provided for the patient, to ensure a comfortable and dignified death. He acknowledged that this was a difficult situation where the relatives could not be present in the hospital but early conversations with the patient and their families still remained critically important. SR confirmed that the Palliative Care Team operated in the Trust seven days a week and could be contacted 24/7 for advice and support for staff, relatives, and patients.

16.7. GB complimented the approach to sharing the learning from the mortality reviews and asked if this approach was applicable to other areas where learning needed to be cascaded throughout the organisation. RPJ confirmed Dr Elspeth Worthington, Mortality Lead, had shaped the report and would ask

her to review if the approach could be used more widely.

16.8. PG had attended a recent Trust Mortality Surveillance Group meeting and had been impressed with the group's focus on learning.

16.9. Board members noted the report.

17. Effectiveness of Meeting

17.1. RF asked for feedback from Emma Alexander, the HR Graduate Management Trainee and Kenny Lomas, the Local Democracy Reporter.

17.2. Emma stated that she had found the meeting useful and it had been interesting to see how all the information from across the Trust came together. She thanked Board members for allowing her to attend.

17.3. Kenny Lomas acknowledged virtual meetings were not easy but believed the meetings had been run well and to time.

18. Any Other Business

18.1. RF commented on an article that had been published in the previous weekend's 'Sunday Times' implying that the NHS was choosing whether patients received critical care. He understood that medical professionals *had* to make those difficult decisions in the worst of circumstances, and he hoped that none of the Trust clinicians had been negatively affected by the article.

18.2. Board members joined RF in agreeing that the Trust's Staff were doing a fantastic job for their patients.

19. Date of Next Meeting

19.1. The next meeting will be held on Wednesday 25th November 2020 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……………………………………………………………………………………

25th November 2020

Date: ……………………………………………………………………………………

TRUST PUBLIC BOARD ACTION LOG – 25TH NOVEMBER 2020

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.2020 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **Deferred due to COVID-19**	NB/NK	**TBC**
36	26.02.2020 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **Deferred due to COVID-19**	AM	**TBC**
~~41~~	~~24.06.20 (10.5)~~	~~In relation to 7-DS, RPJ to report back to Board regarding "activity re-set" later in the year.~~ ~~**7-Day Services will now not be reinstated until the COVID emergency has ended and service delivery models have returned to a 'business as usual' state.**~~ **ACTION CLOSED**	~~RPJ~~	~~25.11.20~~
45	28.10.20 (11.7)	NB to review pandemic reflections for possible inclusion in the BAF as additional sources of assurance and add key to proposed changes on each page of the summary matrix.	NB	27.01.21

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(20)075
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no Never Events in October 2020. (YTD = 3).

There were no cases of MRSA in October 2020. (YTD = 0).

There were 6 C.Difficile (CDI) positive case reported in October 2020 (6 hospital onset and 0 community onset). YTD there have been 24 cases (14 hospital onset and 10 community onset). The annual tolerance for CDI for 2020-21 has not yet been published (the 2019-2020 limit is being used in the absence of publication of the 2020-21 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2020 was 93.3%. YTD rate is 94.4%.

There were no grade 3 avoidable pressure ulcers in September 2020. (YTD = 1). Reducing the number of Trust-acquired avoidable pressure ulcers, including category 2, is a priority for this year.

During the month of September 2020 there were 2 falls resulting in severe harm. (YTD severe harm fall = 18)

Performance for VTE assessment for February 2020 was 95.70% against a target of 95%. VTE returns for March to October 2020 have been suspended.

YTD HSMR (April to July) for 2020-21 is 106.1

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 20/21 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: 25th November 2020

Operational Performance
Performance against the 62 day cancer standard was above the target of 85.0% in month (September 2020) at 85.8%. YTD 87.6%. Performance in August 2020 was 92.7%. The 31 day target was achieved in September with 96.2% performance in month against a target of 96%, YTD 97.3%. Performance in August 2020 was 98.1%. The 2 week rule target was not achieved in September with 92.4% in month and 93.6% YTD against a target of 93.0%. Performance in August 2020 was 94.5%.
The situation with regard to patients not wanting to attend for appointments is continuing to improve and we are seeing an increase in the numbers of referrals and patients receiving treatment. The impact of a further lockdown in the North West will be closely monitored.

Accident and Emergency Type 1 performance for October 2020 was 72.2% and YTD 81.3%. Type 1 Performance in September 2020 was 80.4%. The all type mapped STHK Trust footprint performance for October was 83.6% and YTD 88.5%**.** The Trust saw attendance levels reduce in October, compared with September, with the average daily attendance being 279, down from 307 in September. Total attendances for October was 8,645. For September it was 9,219 compared with 9,524 in August, 9,374 in July, 8,764 in June, 7,815 in May 2020 and 5,548 in April.

Total ambulance turnaround time in October was 38 mins. (Standard is 30 minutes). Arrival to handover time was 26 minutes which includes on average 6-7 mins time for crews to notify ED of their arrival on site. There were 2,551 ambulance conveyances in October, compared with 2,435 ambulance conveyances in September.

The average daily number of super stranded patients in October 2020 was 69 compared with 119 in October 2019. This remains significantly below the target of 92 @ end of March 2020. (62 was the average in September, 61 in August, 60 in July 2020 and 70 in June 2020).

The 18 week referral to treatment target (RTT) was not achieved in September 2020 with 68.6% compliance and YTD 68.6% (Target 92%). Performance in August 2020 was 60.5%. There were (175) 52+ week waiters. The 6 week diagnostic target was not achieved in September with 70.8% compliance. (Target 99%). Performance in August 2020 was 71.0%. **NB Elective programme closed down with only urgent and 2ww patients being managed during March, April and May.**

The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. We have now restarted activity in all areas, albeit at reduced capacity compared with pre-covid due to social distancing and infection control measures. All patients have been and continue to be clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

The overall community nursing caseload size has come back down to pre-covid levels. There has been an increase in patient visits which is linked to the acuity of the caseload currently in District Nursing.

70% of end of life patients (14/20) were discharged to their Preferred Place of Care. The remaining six patients had a history of dementia or were unresponsive at time of first visit, and therefore unable to confirm PPC.

There has been a reduction in the overall number of incidents reported, returning to similar levels as April and May 2020. Of the 12 low harms, eight related to skin damage (five moisture lesions, two Grade 2 pressure ulcers and 1 Deep Tissue Injury). All appropriate actions have been identified and undertaken. Two incidents related to staff injuries - one needle stick injury and one staff fall.

Urgent treatment centre activity has returned to pre-COVID levels with an average of 120 patients attending a day, 3690 for the month.

Financial Performance
At the March 2020 Board the Trust agreed to a plan of £0.3m deficit excluding the Financial Recovery Fund (FRF). This allowed the Trust to access £0.3m of FRF assuming the planned deficit is achieved.

Following the COVID-19 crisis the financial regime for 2020/21 was put on hold and a system introduced to ensure all Trusts remained in financial balance for six months from April to September 2020. From October this changed to a system-wide funding envelope with a block payment allocated to the Trust by Cheshire and Merseyside Health Care Partnership. A revised forecast was submitted on 22nd October to NHSI and C&M HCP and is reflected in the I&E statement.

Surplus/Deficit - At the end of month 7 the Trust has reported a deficit YTD position of £0.2m and deficit outturn position of £15.9m of in line with the revised forecast which has been shared and approved by the Trust Board.

The Trusts deficit is being driven by the reduced resources allocated in the second half of the year by the Health & Care Partnership (HCP) and NHSE/I.

The agency ceiling issued by regulators for 2020/21 is £7.8m which was a £0.2m increase on 2019/20. The year to date spend is £4.9m which is £0.2m above the agency cap and slightly above the previous years spend.
The requirement for CIP is currently on hold under the block payment arrangement.

At the end of month 7, the cash balance was £41.8m. This high closing balance continues to be high due to changes in funding arrangements related to COVID-19 where the Trust receives block payments one month in advance.

Human Resources
In October overall sickness was 6.9% which is a 0.8% increase from September. Front line Nursing, Midwifery and HCA's is 8.4% which is an increase of 0.6%. Front line Nursing and Midwifery s 6.5% which is a 1.0% increase from September. These figures do not include covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension, or special leave due to e.g. childcare. Appraisal compliance in October is 60.4% which is below the target of 85% by 24.6%. Mandatory training compliance remains below the target of 85% by 6.9%. Appraisal and Mandatory training compliance continues to be impacted by covid, sickness and isolation and operational pressures on staffing levels.

The following key applies to the Integrated Performance Report:

▲ = 2020-21 Contract Indicator
▲£ = 2020-21 Contract Indicator with financial penalty
● = 2020-21 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Oct-20

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Oct-20	3.3%	2.8%	No Target	2.4%		The spike in April reflects the initial height of the COVID pandemic. The overal trend up to August show this spike returned to normal in the crude figures. HSMR Weekend Mortality can be a volatile metric due to the smaller numbers involved meaning that small variations may lead to large changes in monthly figures.	Patient Safety and Clinical Effectiveness	The high HSMR covers the early period of COVID admissions. Of note, the National HSMR for this period is reported as 130. These data are being interrogated to review. Independent consideration of our COVID mortality is currently showing it to be in line with expected rates. This has returned to expected levels as COVID inpatient numbers dropped in the time frame reported.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Jun-20	1.09		1.00						
Mortality: HSMR (HED)	Q	▲	Jul-20	91.5	106.1	100.0	101.6					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jul-20	59.8	109.2	100.0	101.2					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jun-20	106.0	102.5	100.0	97.4		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	Low readmission was likely a reflection of the upswing in COVID cases with low overall numbers of patients.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jul-20	77.0	78.5	100.0	91.9		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. Increased discharges in recent months with improved integrations with system partners. Superstranded patients reduced considerably.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jul-20	65.2	61.6	100.0	100.3					
% Medical Outliers	F&P	T	Oct-20	3.0%	0.5%	1.0%	1.0%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Oct-20	47.2%	54.4%	52.5%	39.3%		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	▲	Sep-20	75.2%	73.6%	90.0%	72.3%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. Specific wards have been identified and new processes developed to support improvement. OP attendance letters - As a result of COVID many appointments had to be moved or replaced with telephone appointments. Not all appointments were conducted at the expected time and a brief disconnect in generating letters occurred. This has been addressed and we continue to support clinicians with our novel processes.		Specific wards have been identified with poor performance and staff are being supported to complete discharge in a timely manner. All CDs and ward managers receive weekly updates of performance. Specific areas in surgery and medicine have been targeted and performance improved.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Sep-20	92.0%	85.6%	95.0%	84.9%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Sep-20	96.4%	96.5%	95.0%	94.9%					

Oct-20

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	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	▲	Oct-20	80.0%	89.2%	83.0%	89.3%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement of required 80% of patients have spent 90% of their stay in the stroke unit	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲ £	Oct-20	0	3	0	1			Quality and patient safety	RCA is being undertaken. Immediate actions in place to mitigate chances of recurrence. Local actions and checks in place to minimise the likelihood of re-occurrence .	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20	98.5%		98.9%	98.7%		Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Oct-20	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Consistent good performance is supported by the EPMA platform.	RPJ
Number of hospital acquired MRSA	Q F&P	▲ £	Oct-20	0	0	0	1		There were no cases of MRSA in October 2020. There were 6 positive C Diff sample in October 2020. Internal RCAs on-going with more recent cases of C. Diff.	Quality and patient safety	The annual tolerance for CDI for 2020-21 has not yet been published. The 2019-2020 trajectory is being used in the absence of publication of the 2020-21 objectives.	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Oct-20	6	24	48	42					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Oct-20	2	17	No Target	25					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Sep-20	0	1	No Contract target	1		No category 3 or 4 pressure ulcers in September 2020.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April.	SR
Number of falls resulting in severe harm or death	Q	▲	Sep-20	2	18	No Contract target	13		2 falls resulting in severe harm in September 2020. The incidents were reported from Ward 1D and 2D.	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Feb-20	95.70%		95.0%	95.54%		**March to October 2020 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA. Performance remained above target.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. A spike of thrombotic events during the height of COVID reflects the nature of the disease and performance has now improved.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Sep-20	3	29	No Target	26					
To achieve and maintain CQC registration	Q		Oct-20	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-20	93.3%	94.4%	No Target	95.6%		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-20	2	20	No Target	8					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	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	▲ £	Sep-20	92.4%	93.6%	93.0%	91.0%		Cancer performance improving as services get back on track. 31 and 62 day performance achieved.	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity 2. Capacity/demand review on going at speciality level 3. Trust is secured additional Imaging capacity via temp CT facility and C&M funding for additional USS approved 4. Trust commenced Rapid Diagnostic Service early 2020 5.Cancer surgical Hub at St Helens to recommence 6. ESCH plans reignited	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Sep-20	96.2%	97.3%	96.0%	97.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Sep-20	85.8%	87.6%	85.0%	86.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Sep-20	68.6%	68.6%	92.0%	90.3%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled.	COVID restrictions had stopped elective programme and therefore the ability to achieve RTT is not possible.	RTT continues to be monitored and patients tracked. Long waiters tracked and discussed in depth at weekly PTL meetings. activity recommenced but at reduced rate due to social distancing requirements, PPE, patient willingness to attend and this has begun to be impacted upon as Covid activity increases again. urgents, cancers and long waiters remain the priority patients for surgery at Whiston	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Sep-20	70.8%	63.8%	99.0%	99.7%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Sep-20	175	175	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Oct-20	0.7%	0.4%	0.8%	0.7%		All routine elective work was cancelled until COVID restrictions lifted and this impacted adversely on the 28 day re-list target	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Sep-20	100.0%	92.7%	100.0%	98.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20	0		0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Oct-20	72.2%	81.3%	95.0%	69.8%		Accident and Emergency Type 1 performance for October 2020 was 72.2% and YTD 81.3%. Type 1 Performance in September 2020 was 80.4%. The all type mapped STHK Trust footprint performance for October was 83.6% and YTD 88.5%. The Trust is saw attendance levels reduce in October, compared with November, with the average daily attendance being 279, down from 307 in September. Total attendances for October was 8,645. For September it was 9,219 compared with 9,524 in August, 9,374 in July, 8,764 in June, 7,815 in May 2020 and 5,548 in April. Total ambulance turnaround time in October was 38 mins. (Standard is 30 minutes). Arrival to handover time was 26 minutes which includes on average 6-7 mins time for crews to notify ED of their arrival on site. There were 2,551 ambulance conveyances in October, compared with 2,435 ambulance conveyances in September.	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 COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Oct-20	83.6%	88.5%	95.0%	83.9%					
A&E: 12 hour trolley waits	F&P	▲	Oct-20	0	0	0	0					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Feb-20	0		0	2		**March to October 2020 submissions suspended.** MSA breach occurred on ICU due to delay in stepping level 1 patients down for 24 hours (involved 2 patients only) as Trust was at full capacity and patients in ED waiting beds. All actions taken to try prevent this.	Patient Experience	All patients waiting step down are highlighted at bed meeting x 3 daily and an escalation plan is in place to prevent this reoccurring where possible.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Oct-20	28	140	No Target	319		% new (Stage 1) complaints resolved within agreed timescales continues to remain above the 90% target year to date, although there was a slight decrease in month.	Patient experience	The Complaints Team continue to focus on increasing response times with active monitoring of any delays and provision of support as necessary. Complainants made aware in April of the significant delays that will be experienced in receiving responses going forward due to current operational pressures, with continued focus on achieving the target of 90%. The impact of the second wave of pandemic in being able to meet the 90% target was evident in October and performance will continue to be closely monitored and addressed to prevent a further decline.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Oct-20	17	134	No Target	310					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Oct-20	82.4%	93.3%	No Target	92.9%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20	24		No Target	21		**March to October 2020 submissions suspended.** In February 2020, the average number of DTOCS (patients delayed over 72 hours) was 24.		COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity/reduce delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Oct-20	267	234		333					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Oct-20	69	64		126					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-20	86.7%		90.0%	86.5%		**March to October 2020 submissions suspended.**	Patient experience & reputation	Despite the suspension of national submissions, the profile of FFT continues to be raised by members of the Patient Experience Team as a valuable mechanism for receiving up-to-date patient feedback. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. There has been an increase in posters being displayed during August 2020 (latest month). 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 are available for each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-20	96.1%		90.0%	95.6%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-20	100.0%		98.1%	98.8%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-20	100.0%		98.1%	97.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-20	100.0%		95.1%	96.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-20	100.0%		98.6%	99.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-20	95.0%		95.0%	94.6%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2020-21 YTD	2020-21 Target	2019-20	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Oct-20	6.9%	6.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.3%		In October overall sickness was 6.9% which is a 0.8% increase from September. Front line Nursing, Midwifery and HCA's is 8.4% which is an increase of 0.6%. Increases are as a result of sickness due to testing following track and trace N.B This includes normal sickness and COVID19 sickness reasons only. These figures do not include, covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension, or special leave.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team review COVID and non COVID absences daily to ensure staff eligible for swabbing are referred to HWWB. Additional health and well being support is provided to help staff with stress, anxiety and depression caused by the impact of COVID19. This includes ongoing support to shielding returners and other staff anxious about working in a covid environment. Daily on site mental health support staff in ICU and ED and additional resilience support has been provided to Matrons in September. Staff have also required support in dealing with childcare issues resulting from being sent home from school to isolate or testing positive.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Oct-20	8.4%	7.8%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Oct-20	60.4%	60.4%	85.0%	79.4%		Appraisal compliance in October is below target by 24.6%. Mandatory training compliance remains below the target by 6.9%.These continue to be below target as a consequence of being paused for 4 months due to COVID19 and subsequently due to high sickness absence, isolation, special leave and other service demands.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance continues to be impacted by COVID 19 with both Appraisal and Mandatory training compliance has decreasing in month and below target. The requirement to complete Appraisals and Mandatory training was resumed in July. Appraisals can be completed through the e-forms and remotely to enable improved compliance. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Oct-20	78.1%	78.1%	85.0%	84.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2			No Contract Target			**Further submissions suspended by NHSE/NHSI until further notice.**	Staff engagement, recruitment and retention.	The Q3 survey in the form of the Annual Staff Survey opened on 1st October and will close on the 30th November.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Oct-20	0.8%		No Target	10.1%		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 62-67)												
UORR - Overall Rating	F&P UOR	T	Oct-20	suspended	suspended	3.0	3.0			Delivery of Control Total	The 2021 financial plan has been put on hold and a system introduced where Trusts will breakeven for the first six months of 2020/21.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Oct-20	suspended	suspended	-	16,152					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Oct-20	(231)	(231)	-	3,900					
Cash balances - Number of days to cover operating expenses	F&P	T	Oct-20	13	13	2	7					
Capital spend £ YTD (000's)	F&P	T	Oct-20	9,900	9,900	26,700	10,293					
Financial forecast outturn & performance against plan	F&P	T	Oct-20	(15,857)	(15,857)	-	3,900					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Oct-20	93.9%	93.9%	95.0%	87.9%					

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020-21 YTD	2020-21 Target	FOT	2019-20	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	89.5%	100.0%	100.0%	100.0%	100.0%	94.6%	100.0%	86.7%	76.5%	100.0%	100.0%	45.5%	86.7%	85.0%		92.7%		RC
	Total > 62 days		0.0	2.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	2.0	0.0	0.0	3.0	6.0			6.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0		
Lower GI	% Within 62 days	▲ £	85.7%	100.0%	78.9%	100.0%	50.0%	100.0%	82.6%	76.0%	85.7%	76.5%	100.0%	75.0%	83.3%	80.5%	85.0%		83.2%		
	Total > 62 days		1.0	0.0	2.0	0.0	2.0	0.0	2.0	3.0	1.0	2.0	0.0	1.0	1.0	8.0			14.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	1.0	0.0	1.0	0.0	3.0			4.0		
Upper GI	% Within 62 days	▲ £	85.7%	100.0%	87.5%	88.9%	100.0%	100.0%	80.0%	60.0%	80.0%	60.0%	100.0%	100.0%	100.0%	83.3%	85.0%		90.5%		
	Total > 62 days		1.0	0.0	1.0	0.5	0.0	0.0	1.0	2.0	0.5	2.0	0.0	0.0	0.0	4.5			8.0		
	Total > 104 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	2.0			2.5		
Urological	% Within 62 days	▲ £	92.3%	84.6%	92.0%	86.4%	86.4%	69.2%	79.3%	74.2%	66.7%	100.0%	100.0%	90.0%	95.7%	87.5%	85.0%		85.5%		
	Total > 62 days		1.0	2.0	1.0	1.5	1.5	6.0	3.0	4.0	2.0	0.0	0.0	1.0	0.5	7.5			23.0		
	Total > 104 days		0.0	0.0	0.5	0.5	1.0	1.0	0.0	1.0	2.0	0.0	0.0	1.0	0.5	4.5			7.0		
Head & Neck	% Within 62 days	▲ £	28.6%	28.6%	20.0%	66.7%		25.0%	20.0%	100.0%	0.0%	100.0%	100.0%	66.7%	0.0%	63.6%	85.0%		29.3%		
	Total > 62 days		2.5	2.5	2.0	1.0		1.5	2.0	0.0	0.0	0.0	0.0	0.5	1.5	2.0			12.0		
	Total > 104 days		1.5	1.0	0.0	0.0		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			3.5		
Sarcoma	% Within 62 days	▲ £	50.0%	100.0%	0.0%	100.0%					100.0%				100.0%	100.0%	85.0%		66.7%		
	Total > 62 days		1.0	0.0	1.0	0.0					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		
Gynaecological	% Within 62 days	▲ £	50.0%	0.0%	75.0%	54.5%	80.0%	66.7%	100.0%	100.0%	40.0%	100.0%	100.0%	100.0%	66.7%	75.0%	85.0%		69.1%		
	Total > 62 days		1.0	0.5	1.0	2.5	1.0	2.0	0.0	0.0	3.0	0.0	0.0	0.0	1.0	4.0			11.0		
	Total > 104 days		1.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			1.5		
Lung	% Within 62 days	▲ £	57.1%	90.0%	100.0%	58.3%	100.0%	71.4%	75.0%	69.2%	86.1%	100.0%	88.9%	60.0%	100.0%	84.0%	85.0%		85.0%		
	Total > 62 days		3.0	1.0	0.0	2.5	0.0	1.0	1.0	2.0	5.0	0.0	1.0	2.0	0.0	10.0			18.5		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	1.0	0.0	1.0			2.5		
Haematological	% Within 62 days	▲ £	100.0%	78.9%	100.0%	86.7%	80.0%	100.0%	100.0%	50.0%	66.7%	100.0%	66.7%	80.0%	100.0%	80.6%	85.0%		86.7%		
	Total > 62 days		0.0	2.0	0.0	1.0	1.0	0.0	0.0	1.0	0.5	0.0	1.0	1.0	0.0	3.5			7.5		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0			2.0		
Skin	% Within 62 days	▲ £	98.2%	80.2%	94.4%	95.8%	78.4%	93.9%	95.2%	91.2%	100.0%	92.5%	97.4%	100.0%	89.5%	94.3%	85.0%		92.0%		
	Total > 62 days		0.5	8.0	1.5	1.0	5.5	1.5	1.5	2.5	0.0	1.5	1.0	0.0	4.0	9.0			24.5		
	Total > 104 days		0.0	1.5	0.5	0.5	1.5	1.5	1.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5			7.0		
Unknown	% Within 62 days	▲ £				100.0%	0.0%						100.0%	100.0%	100.0%	100.0%	85.0%		69.2%		
	Total > 62 days					0.0	0.5						0.0	0.0	0.0	0.0			0.5		
	Total > 104 days					0.0	0.0						0.0	0.0	0.0	0.0			0.0		
All Tumour Sites	% Within 62 days	▲ £	86.2%	83.1%	88.9%	86.2%	85.2%	83.4%	88.0%	82.0%	81.6%	87.5%	96.0%	92.7%	85.8%	87.6%	85.0%		86.2%		
	Total > 62 days		11.0	18.0	9.5	10.0	11.5	12.0	11.5	14.5	13.0	7.5	3.0	5.5	11.0	54.5			127.0		
	Total > 104 days		2.5	5.0	1.0	1.5	2.5	2.5	3.5	2.0	2.0	3.5	0.0	4.0	0.5	12.0			30.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £															85.0%		80.0%		
	Total > 31 days																		0.0		
	Total > 104 days																		0.0		
Acute Leukaemia	% Within 31 days	▲ £		100.0%													85.0%		100.0%		
	Total > 31 days			0.0															0.0		
	Total > 104 days			0.0															0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				

TRUST BOARD

Paper No: NHST(20)076
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 October 2020. There were 5 Executive Committee meetings held during this period. The Executive Committee approved: • Urgent COVID expenditure requests • Emergency Department staffing business case • Trust website business case • General Practitioner remuneration proposals The Committee also considered regular assurance reports covering; Risk Management Council and Corporate Risk Register, Board Assurance Framework, mandatory training and appraisal performance, and the integrated performance report.
Trust objectives met or risks addressed: All 2020/21 Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 25th November 2020

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were 5 Executive Committee meetings in October 2020.

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

All meetings included a standard agenda item to consider the COVID pandemic or restoration and recovery, COVID specific expenditure requests and issues escalated from the operational gold command meetings.

2. 1st October 2020

2.1 Unconscious Bias Training

The Executive Committee participated in a remote training session exploring the impact of unconscious bias and indirect discrimination. The training supported the Trust's response to the NHS People Plan and the development of the inclusion strategy. It was agreed that this training should be made available across the organisation.

2.2 Emergency Department (ED) Staffing Business Case

The Director of Operations and Performance presented a business case detailing the staffing requirements for the new larger stretcher triage area, the overflow waiting area that is needed to maintain social distance between patients during COVID and the increase in Same Day Emergency Care (SDEC) bed capacity. The increased staffing to manage 8 stretcher triage bays was approved. The waiting room staffing was approved until March 2021, and the SDEC staffing decision was deferred pending the benefits realisation from opening Bevan Court, which was designed to remove congestion from ED for patients requiring a frailty assessment. The committee also asked for a review of alternative ED department layouts and staffing models.

2.3 Trust Joint Local Negotiating Committee (TJLNC)

The Deputy CEO/Director of Human Resources presented a paper detailing the arrangements to support the TJLNC at other Trusts across Cheshire and Merseyside. The committee agreed that as the Chair and Vice Chair benefited from Supporting Professional Activities (SPA) sessions which include this commitment, the positions should not be separately remunerated. There was also the facility to agree ad hoc time off for TJLNC duties, which was the same for all staff representatives.

2.4 Pension Tax Flexibilities

The Deputy CEO/Director of Human Resources summarised the temporary flexibilities that had been introduced the previous year to assist senior clinicians to manage tax liabilities if they performed additional duties for the NHS over the winter period. These flexibilities had ended on 31st March and changes to the threshold income had been announced in the spring budget. Given these developments and the small uptake of

the flexibilities the previous year it was agreed that at the current time there was not a need to reintroduce them, even though this had been confirmed as an option for NHS Trusts by NHS Employers.

2.5 COVID Issues

The Committee approved COVID expenditure requests for; additional support on key wards to facilitate communication with relatives whilst visiting remained restricted, and additional cleaning hours to increase the frequency of cleaning on COVID cohort wards in line with national guidance.

The 2nd Wave Executive Action Plan was reviewed and it was noted that 5 of the priority actions had been completed and the remaining three were on track to deliver by the target completion date.

The committee discussed the Trust's response to staff absence relating to school closures and pupils being sent home due to COVID.

Shielding for vulnerable people had not been reintroduced nationally but there was increasing anxiety amongst staff who had been instructed to shield during the first wave of COVID. Arrangements were agreed to review the risk assessments for these staff with Health, Work and Wellbeing and senior clinical support, to ensure the proposed mitigations were sufficient to the escalating situation.

The Director of Operations and Performance detailed the issues escalated from Gold Command, including the increase in COVID positive cases being admitted to the Trust and the pressure on both medical and ICU beds. It was agreed that the plans to increase ICU capacity by re-deploying staff should be triggered, although it was noted that the national imperative to continue the elective and outpatient activity restoration and recovery programme meant that there were fewer staff to redeploy into this area. It was agreed to continue to monitor the situation closely but not cancel elective activity or any business as usual plans at this stage.

The public health information for local boroughs showed that the infection rate in the population continued to increase rapidly and this was likely to be followed by a corresponding increase in hospital admissions.

3. 8th October 2020

3.1 Trust Website Business Case

The Deputy CEO/Director of Human Resources and Director of Informatics presented a joint business case proposing that the development and maintenance of the Trust website and intranet be subcontracted to an external agency, to improve responsiveness and resilience. The proposal was approved subject to some matters of clarification on whether improvements in the search engine function could be achieved.

3.2 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly review of the BAF prior to being presented to the Trust Board. Members considered how the COVID impact had been reflected in the previous BAF review in July and if the risk scores should be increased again for the impacts on quality of care and performance. It was agreed that the current scores reflected the level of risk and the mitigations that were being implemented.

3.3 Pandemic Reflections Meetings Report

The Director of Nursing, Midwifery and Governance presented the report which summarised the staff feedback from the pandemic reflection meetings that had been held with each ward and department between July and the end of September. The report detailed the main themes from the feedback and the actions that had already been taken in response. Members of the Executive Committee had found it informative and at times emotional to hear the reflections of staff on the first wave COVID experiences. The overriding message from the reflections was that the whole Trust had come together to face the challenges presented by the virus and although there were many lessons to be learnt most staff felt that the Trust had coped well.

It was agreed that the reflections should be shared with the Trust Board.

3.4 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agenda for October and the September action log.

3.4 COVID Issues

A number of COVID expenditure requests were approved to re-instate additional staffing to key areas, such as medical cover for the acute medical wards and staffing for the re-deployment hub, in light of the increasing number of positive patients being admitted.

The local population incidence of COVID continued to increase rapidly, and the Trust had reinstated COVID cohort wards. Elective activity was continuing although this was becoming increasing more challenging as the number and acuity of COVID patients increased.

Internally the daily command and control structure had been re-established, although it was disappointing that the situation in Merseyside had not yet been acknowledged regionally or nationally. The Cheshire and Merseyside Hospital Cell escalation plans had been agreed but not yet enacted.

Discharge to care homes and step down beds was once again becoming challenging and the Director of Operations and Performance was working closely with local authority partners to ensure that effective patient flow could safely be maintained.

4. 15th October 2020

4.1 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) - 2020

The Deputy CEO/Director of Human Resources presented the reports setting out the Trust's performance against each of the standards in 2020. The report also included an action plan to improve performance in key areas. These reports were to be presented to the Trust Board and there is a statutory requirement to publish them by the end of October. A Strategic Advisory Group had now been developed with members of the staff networks to develop a Trust Inclusion Strategy, this was being led by the Deputy CEO/Director of Human Resources and the Director of Finance and Information.

4.2 Acute Kidney Injury (AKI) Steering Group

The Medical Director provided an update on the work being undertaken by the AKI Steering Group to reduce hospital acquired AKI. Best practice pathways and early detection tools had now been adopted across the Trust and early indications were that the incidence of AKI was decreasing. However it was noted that there was still more to do to ensure that these practices were embedded. The committee will continue to monitor progress every three months.

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

The Director of Corporate Services presented the Chair's assurance report from the October RMC meeting. The process for escalating high risks to the CRR was being reviewed to ensure Directors were made aware of the risks as soon as possible. Assurance reports were received from the Claims Governance Group, Information Governance Steering Group and the Major Incident Planning Group.

4.4 Emergency Planning, Response and Resilience (EPRR) Annual Assurance Statement

The Director of Nursing, Midwifery and Governance presented the EPRR annual assurance statement. This was to be presented to the Trust Board for approval in October. There is only one area where the Trust was not fully compliant. This was in relation to bio hazard refresher training for staff in the Emergency Department, which had not been able to go ahead due to COVID. Plans were in place to hold the training as soon as it was safe to do so.

4.5 Mandatory Training and Appraisal Performance - September

The Deputy CEO/Director of Human Resources presented the figures for September. Although both mandatory training and appraisals were behind target performance, work had been undertaken to develop recovery plans. It was however acknowledged that the success of these recovery plans would be jeopardised if the number of COVID positive patients being admitted to the Trust continued to increase.

4.6 Integrated Performance Report (IPR) - September

The Director of Finance and Information presented the IPR for September and the narrative for the lead indicators was reviewed.

The continued fluctuation of the HSMR figures was noted as the national model responded to the impact of COVID.

4.7 COVID Issues

The committee reviewed and approved a series of expenditure requests to reinstate the pandemic staffing rotas across medicine for both medical and nursing cover. The continuation of routine elective activity meant that staff could not be re-deployed to support the COVID escalation.

Revised national guidance had been issued to relax the restriction on visiting, however this was considered to be out of step with the situation locally and based on the increasing COVID community infection rates and hospital admissions, the committee felt that the safest course was to retain visiting restrictions. The impact on patients and their families was recognised but it was felt that the priority must be to protect patients and staff from infection.

Nosocomial infections emerging themes and recommendations had been issued nationally. The recommendations included increased wearing of face masks in COVID secure areas and asymptomatic staff testing.

The latest population data showed increasing cases and hospital admissions across the North West, which reflected the pressures being experienced at the Trust. It was anticipated that the Intensive Care Unit (ICU) would need to expand into the surge capacity beds if activity continued to increase.

The situation locally had not yet been reflected in the national escalation levels, which meant that business as usual activities and recovery and restoration plan trajectories continued to be performance managed.

5. 22nd October 2020

5.1 General Practitioner Remuneration Proposals

The Deputy CEO/Director of Human Resources presented proposals in relation to the pay structure for general practitioners employed by the Trust, to achieve greater comparability with hospital consultants. The proposal was supported and would be recommended to the Remuneration Committee.

5.2 Digital Aspirant Programme (DAP)

The Director of Informatics provided an update on the DAP. Changes to the delivery timescales and priorities had been agreed with NHS Digital to reflect the impact of COVID. A formal programme structure had now been established to manage the delivery of all the projects in the DAP over the next three years. The DAP Programme Board will report to the Trust Executive Committee and release of further phases of funding from NHS Digital will be dependent on achieving the agreed milestones.

5.3 Switchboard – post go live

The Director of Informatics provided a progress report on the implementation of the new switchboard and reported that the use of the virtual operator for internal calls had been successful. Approval was sought to extend the virtual operator functionality to external calls and this was agreed. The committee asked for more performance information to be reported on a regular basis to track the benefits of the new switchboard and ensure that calls were connected to the right extension. The importance of supporting relatives to be able to contact wards directly was acknowledged, especially as visiting arrangements are currently restricted.

5.4 COVID Issues

COVID expenditure requests were approved in relation to ward staffing, expansion of the pre-procedure patient swabbing team, extension of the Social Distancing Warden roles, and the temporary move of Haematology Oncology services to St Helens Hospital.

The IT infrastructure to support the roll out of NHS111 first was also approved by the committee.

Committee reviewed the Cheshire and Merseyside latest public health incidence data, which indicated that the growth in the incidence rate was starting to slow, although it was recognised that there would be a time lag for hospital admissions.

The NHSE/I guidance on non-clinical staff wearing face masks at work was reviewed, and the Trust's approach to this was agreed for all office-based staff working in COVID secure environments to wear facemasks when not at their desks.

It was also agreed that hospital based clinical staff should be required to change into their uniform/scrubs on site, using the additional staff changing rooms that had been set up for this purpose.

6. 29th October 2020

6.1 Executive Learning Suite – Supporting leaders in health and care

The Deputy CEO/Director of Human Resources presented the new suite of on-line and digital learning and development resources that had been launched by NHSE/I and the Leadership Academy. These were available to all health and care leaders and

committee discussed how they could be utilised by senior leaders in the organisation. Several directors had already applied for the reciprocal mentoring scheme.

6.2 2020 Local Clinical Excellence Awards (LCEA)

The Deputy CEO/Director of Human Resources presented a paper reporting on the national ratio for determining the value of the LCEA "pot" for 2020. The previously agreed position was that the Trust would follow the NHS Employers/BMA recommendation to distribute the available pot equally between all eligible consultants for 2020, was reaffirmed.

6.3 Care of the deteriorating patient

The Medical Director presented initial findings from a review of services for deteriorating patients and the opportunities to optimise the use of the new Trust IT systems for earlier detection and intervention. It was agreed that more analysis was required to understand the issues before new processes were introduced and a further report will be brought back to the committee once this work had been completed.

6.4 COVID Issues

COVID expenditure requests were approved for additional weekend and evening endoscopy sessions to reduce the waiting list backlog, additional weekend consultant ICU cover and cover for the medical registrar rota gaps.

The infection rates in Merseyside were reported to have reduced again, however the incidence was still increasing in Cheshire, and Warrington was experiencing a very steep increase in cases. Infection rates in the over 60-year-old age group and hospital admissions were continuing to rise, across Cheshire and Merseyside. It was noted that infection rates in other parts of the country were also now reported as increasing sharply.

Staffing concerns had been escalated from Gold Command due to the increase in COVID patients and the on-going pressure of high numbers of non-elective admissions. Staff absence had increased and there were additional pressures due to the half term holidays. There continued to be very few staff to redeploy because the elective activity programme continued. The Chief Executive confirmed that the Hospital Cell had now agreed that the escalation triggers had been met across Cheshire and Merseyside and some elective activity would have to be postponed to free up staff to support the COVID cohort wards and ICU. Escalation also meant that other business as usual activities should be reviewed and cancelled if necessary, to free up capacity to respond to the increase in COVID patients. The Director of Operations and Performance was asked to consider the minimum reduction in elective activity that would free up the capacity needed and to prioritise the patients so that urgent, cancer and patients who had already waited a long time or previously been postponed would be prioritised.

The Committee also discussed the need to boost staff morale, as the experience of the second wave felt very different from the first; there was less support nationally in terms of students and returners supporting the NHS or recognition of the pressures being faced in the North West, the public mood had changed and local business were less able to

support NHS staff. It was agreed to ask the Communications, Media and PR team to present ideas for making staff feel more appreciated and cared for.

ENDS

TRUST BOARD

Paper No: NHST(20)077
Title of paper: Committee Report – Quality Committee
Purpose: To summarise November's Quality Committee and escalate any areas of concern

Agenda items discussed

Matters arising and action log
The action log was updated, noting the continued work to ensure staff undertake their mandatory training whilst facing the challenges of increased staff absence due to the pandemic. The focus remains on the critical skills staff need, including life support, safeguarding and infection prevention. The safety climate questionnaire is being finalised for distribution in Theatres in December. The Trust is providing additional flu vaccinations sessions for staff. The Director of Nursing, Midwifery and Governance is working with relevant teams to further improve safe storage of medicines. A review of information flows and the terms of reference for the Councils will be undertaken and a report presented to the Committee in January.

Safer Staffing – month 6
The latest safer staffing report was noted, with overall RN fill rates above 90% and care staff above 100% due to the number of close observations required, which is in line with previous months and the preceding year. The ongoing challenge in meeting the safer staffing requirement due to the pandemic was noted, with the actions being taken to address this, including block booking a pool of staff to be assigned to areas with staff shortages. A detailed report on Maternity Services will be provided to the next meeting as there had been an increase in the number of incidents reported and a number of indicators have declined. It was noted that there has been an increase in acuity and dependence across Maternity coupled with staffing pressures. Confirmation was provided that additional staff had been recruited for Bevan Court 1&2.

Integrated Performance Report (IPR)
Committee members reviewed the information contained in the IPR, noting in particular that there were no new never events, CDiff figures were lower than this point last year and appraisals and mandatory training were below target, with increased levels of sickness. The Committee were pleased to note that 70% of patients at end of life were discharged to their preferred place of care, but requested confirmation that these were timely discharges.

Patient Safety Council Chair's Report – November 2020
Incident reporting levels have returned to previous levels, from the reduced levels reported last month. The Council noted that there had been a decrease in the number of falls following the spike in fractured neck of femur last month. Updates were received by the Council on infection prevention, safeguarding, medical devices, obstetric and maternity incidents and CAS alerts. Confirmation was provided that Cancer Services are leading a review of the reported cancer incidents.

Clinical Effectiveness Council Chair's Report – November 2020
Presentations were received from Cancer Services, Anaesthetics and Neurophysiology and reports presented included IPR, maternity indicators, mortality surveillance group, drugs

and therapeutics and non-elective laparotomy audit. The Committee discussed the ongoing need to disseminate and embed lessons learned from incidents and never events.

Patient Experience Council Chair's Report November 2020
A summary of the meeting was provided, including reports highlighting changes in the discharge processes to strengthen arrangements and improve patient experience. In addition, the review of systems and structures within the Medical Care Group to ensure actions from patient feedback are completed and recorded and the dissemination of lessons learned from the nationally reported death of Oliver McGowan at another trust were highlighted. It was also noted that there had been an increase in concerns relating to staff attitude, attributed to staffing challenges and the positive impact of 'thank you' week in raising staff morale.

NICE activity and compliance Q4 2019-20 and Q1 2020-21
The Committee noted that there were only three outstanding NICE guidance reports in Q1, which is an improvement from the previous quarter. These related to multispecialty guidance and are being proactively followed up. The improved position was noted.

Telehealth update
An update on telehealth was provided, noting in particular that it works more effectively when used appropriately rather than adopting a blanket approach. Telephone consultations have also been used effectively. Further contextual information will be provided in the next update.

Workforce Council Chair's Report – September 2020
The Council received a number of reports, including updates on the transfer scheme, new starter survey, volunteers, bank pay, HR, equality, diversity and inclusion and the draft Workforce Strategy/People Plan. The work on equality, diversity and inclusion was commended by the Committee. It was noted that the new starter survey results were mainly positive, but the pressures during the pandemic impacted on induction and on-boarding for staff.

Freedom to Speak Up Report
The Committee noted the effective systems in place for responding to issues raised by staff and requested that this is publicised so that staff were aware that concerns are addressed.

Matters for Escalation to the Board
- Ongoing staffing challenges as a result of the pandemic, with negative impact on achieving mandatory training and appraisals
- Review of all Councils terms of reference and information flows

Corporate objectives met or risks addressed: Care, safety, pathways, communication, system

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: Gill Brown, Non-Executive Director and Chair of Committee

Date of meeting: 25th November 2020

TRUST BOARD

Paper No: NHST(20)078
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 19th November 20

Summary:

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
N Khashu – Director of Finance & Information
A Bassi – Divisional Medical Director, MCG
G Lawrence – Deputy Director of Finance & Information
S Clark – Head of Financial Management

Agenda Items

For Assurance

A) Integrated Performance Report

- Performance on RTT and the rise in 52-week waits were discussed, the Trust has had to reduce activity during the second wave but is in a better position than other organisations.
- Cancer performance was highlighted as very impressive especially in comparison to data received for Greater Manchester. The improvements in Cancer staging KPI's were also noted.
- COVID inpatient numbers have been reducing but the impact of the second wave on staff was discussed. NK confirmed staff are fatigued and it's been a difficult period for everyone; AB added the staff 'thank you' week had been very well received and had provided a boost to all staff.
- The Committee discussed Mandatory Training and Appraisal rates and were assured that while full mandatory training is difficult to achieve at the moment, prioritisation has been given to training relating to health and safety.

B) Finance Report Month 7

- Trust has delivered a £0.2m deficit in month, which is in line with the revised forecast submitted in October. The Committee understood the underlying run-rate and how the change in deficit was as a result of a reduction in income rather than an increase in costs.
- The Committee discussed the annual leave accrual and whether this had been done as an average across staffing, NK advised it had been calculated down to individual and the number of days they had outstanding.

For Information

Month 7 2020/21 Financial Performance

- Activity has decreased in A&E which may relate to the local lockdown imposed on the area prior to the national lockdown. Day case and Elective activity has continued to increase along with the average tariff gained for non-elective activity.

CIP Planning 21/22

- The Committee noted the progress made on CIP for 21/22 from the previous month increasing by c.£1.1m.
- The Committee were assured on the number and value of schemes in progress and how this compared to previous years.

Budget Setting

- The Committee noted the proposed process for setting the budget for 2021/22 and understood that the proposed timetable may change as further guidance is received later in the year.
- NK advised the resources allocated to the Trust will be received very late in this financial year so future papers will focus on expenditure. The Trust will plan for CIPs of 3% until further notice

provided.

- Briefing Papers accepted from
- Procurement Steering Council.

Risks noted/Items to be raised at Board
- No items to be raised

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: Jeff Kozer, Non-Executive Director
Date of meeting: 25th November 2020

TRUST BOARD

Paper No: NHST(20)079
Title of paper: Research & Development Operational Capability Statement (RDOCS)
Purpose: As part of the National Institute for Health Research (NIHR) Research Support Services Programme, each NHS organisation is required to publish a Research and Development Operational Capability Statement (RDOCS). This Statement provides a Board level approved operational framework which sets out how the organisation plans to meet its research related responsibilities/requirements as stated in the UK Policy Framework for Health and Social Care Research Clinical Trials Regulations, Operating Framework for the NHS in England, Handbook to the NHS Constitution and other relevant guidance and regulations.
Summary: The statement provides researchers with an operational overview of resources available to support Research & Development in the organisation and an overview of research collaborations and partnerships with other organisations, including areas of special interest. The statement is a tool to improve effectiveness and collaborations in research activities.
Corporate objectives met or risks addressed: • Increased participation in Research and Clinical Trials; • Meet national and local performance standards - including the National Institute for Health Research (NIHR) recruitment targets; • Take forward the clinical, technological and process innovations achieved and lessons learned during the pandemic into our future business as usual.
Financial implications: None, however the RDOCS is viewed by commercial companies who are looking to invest in research and will use the RDOCS to seek out potential sites.
Stakeholders: • St Helens & Knowsley Teaching Hospital's NHS Trust • North West Coast Clinical Research Network (NWC CRN) • Commercial Partners • External Partners
Recommendation(s): This statement should be on STHK website as the Trust has to provide a link to the NWC CRN and they in turn submit to the DOH.
Presenting officer: Rowan Pritchard-Jones, Medical Director
Date of meeting: 25th November 2020

NIHR Guideline B01
RDI Operational Capability Statement

May 2011

Note: This spreadsheet is protected to help avoid inadvertent changes. However there is no password set so that users can unlock the sheet and edit their own content if required.

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
Statement 001					
Statement 002	01/11/2013	01/11/2014	27/11/2013	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 003	18/11/2014	18/11/2015	18/11/2014	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 004	31/12/2015	31/12/2016	27/01/2016	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 005			12/01/2017	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 006	01/12/2017	01/12/2018	29/11/2017	Trust Board	Mrs Jeanette Anders
Statement 007	01/12/2018	01/12/2019	28/11/2018	Trust Board	Mrs Jeanette Anders
Statement 008	01/12/2019	01/12/2020	27/11/2019	Trust Board	Mrs Jeanette Anders
Statement 009	01/12/2020	01/12/2021		Trust Board	Mrs Jeanette Anders

Contents

Organisation RDI management arrangements
Organisation study capabilities
Organisation services
Organisation RDI Interests
Organisation RDI planning and investments
Organisation RDI standard operating procedures register
Planned and actual studies register
Other information

Organisation RDI management arrangements

Information on key contacts.

Organisation details	
Name of organisation	St Helens and Knowsley Teaching Hospitals NHS Trust (STHK)
RDI lead / Director (with responsibility for reporting on RDI to the organisation Board)	Mr Rowan Pritchard Jones
RDI office details:	
Name:	Research Development and Innovation Department
Address:	Whiston Hospital, Ground Floor , Yellow Zone, Warrington Road, Prescot, Merseyside, L35 5DR
Contact number:	0151 430 2334 / 1218
Contact email:	research@sthk.nhs.uk
Other relevant information:	
Key contact details e.g. Feasibility, confirmation of capacity and capability to conduct research at STHK	
Contact 1:	
Role:	Research Development and Innovation Department Manager (RDI)
Name:	Jeanette Anders
Contact number:	0151 430 2334
Contact email:	jeanette.anders@sthk.nhs.uk
Contact 2:	
Role:	Research Development and Innovation Co-ordinator
Name:	Paula Scott
Contact number:	0151 430 1218
Contact email:	paula.scott@sthk.nhs.uk
Contact 3:	
Role:	Research Development and Innovation Administrator
tsp.	Samantha Glover
Contact number:	0151 430 1424
Contact email:	samantha.glover@sthk.nhs.uk

Contact 3:	
Role:	Research Development and Innovation Data Manager
Name:	Amy Millington
Contact number:	0151 430 1274
Contact email:	amy.millington@sthk.nhs.uk

Information on staffing of the RDI office.

RDI team		
RDI office roles (e.g. Governance, contracts, etc.)	Whole time equivalent	Comments indicate if shared/joint/week days in office etc.
Research Development and Innovation Manager	1.0 WTE	
Research Development and Innovation Co-ordinator	1.0 WTE	
Research Development and Innovation Administrator	1.0 WTE	
Research Development and Innovation Data Manager	1.0 WTE	

Information on reporting structure in organisation (include information on any relevant committees, for example, a clinical research board / research committee / steering committee).

Reporting structures		
Trust Board		The Medical Director reports to the Trust Board.
RDI Manager report to the Quality Committee.		The Quality Committee advises the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Manager report to the Clinical Effectiveness Council (CEC)		The CEC Council investigates any issue that sits within it terms of reference. Its aim is to seek and receive from any department or service assurance on the maintenance and improvement of clinical effectiveness. The Council is authorised by the Quality Committee to investigate any issue that may pose a risk to Clinical Effectiveness. The Committee shall advise the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Manager report to the Research Development & Innovation Group (RDIG)		The RDI Group reports to the Quality Committee to provide assurance about all aspects of RDIG activity within and involving the Trust. The RDI Committee has representation from Academia, Primary Care and Finance. The Cair of the RDI Group is the Clinical Director for Critical Care The RDI Group is responsible for: Review and approval of the RDI strategy consistent and compliant with contemporary (inter)national guidance Review and approval of the Annual RDI Report (written by the RDI Manager) Review and approval of the Research Capability and Capacity Statement Review and approval of the Research Standard Operating Procedures Oversee operational delivery of the RDI strategy via updates received from the RDI Manager Review of research studies deemed high risk or with identified issues/concerns will be referred to RDIG for consideration (by the RDI Manager). Any risk or safety issues relating to research activity will be reported to the RDI Group for discussion and action plan.
The Research Practitioner Group (RPG)		The Research Practitioner Group (RPG) has delegated responsibility from the Research Development & Innovation Group (RDIG) to ensure that the trust has robust processes and systems in place for Research Development & Innovation (RDI). The RPG is responsible for: Review Research Standard Operating Procedures (SOPs) prior to submission to RDIG for approval. Ensure that the Trust is prepared for a Research MHRA (Medicines and Healthcare Products Regulatory Agency) inspection through the review and discussion of regular action plans Report to the RDIG quarterly (through the RDI Manager who sits on both groups) Support the aim to embed a positive research culture throughout the organisation Ensure that lessons are learned from research audits/issues and that effective improvement is implemented Ensure that on a day to day basis RDI activities are conducted according to RDI Standard Operating Procedures (SOPs) Support the training programme for Research Nurses to ensure that they are fully complaint in accordance with nursing/trust requirements.

Information on research networks supporting/working with the organisation.
Information on how the organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research networks	
Research network (name/location)	Role/relationship of the research network e.g. host organisation
St Helens and Knowlsey Teaching Hospitals NHS Trust	Nursing and Midwifery, Research Nurse, band 7 (Commercial) 0.73WTE

St Helens and Knowlsey Teaching Hospitals NHS Trust	Nursing and Midwifery, Research Nurse, band 6 (Cross Divisional) 0.5 WTE
St Helens and Knowlsey Teaching Hospitals NHS Trust	Research Development and Innovation Manager 0.1WTE
St Helens and Knowlsey Teaching Hospitals NHS Trust	Research Development and Innovation C0- ordinator 0.1WTE
St Helens and Knowlsey Teaching Hospitals NHS Trust	Nursing and Midwifery, Research Nurse, band 6 (Cross Divisional) 1.0 WTE
St Helens and Knowlsey Teaching Hospitals NHS Trust	Research Administrator band 2, 0.6WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Senior Research Nurse, band 7 (Commercial) 0.27 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Senior Research Nurse, band 7 (Cancer) 1.0 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Cross Divisional) 2.5 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Stroke/Cross Divisional) 1.0 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Rheumatology) 1.0 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Paediatric/Cross Divisional) 0.7 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Maternity /Cross Divisional) 0.5 WTE
Clinical Research Network, North West Coast (CRN NWC)	Data Manager, band 4, 1.5WTE
Clinical Research Network, North West Coast (CRN NWC)	Project Support Officer band 3, 0.6WTE
Clinical Research Network, North West Coast (CRN NWC)	Research Administrator band 2, 0.4WTE

Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, other NHS organisations, higher education institutes, industry).

Current collaborations / partnerships

Organisation name	Details of collaboration / partnership (e.g. university/organisation joint office, external provider of pathology services to organisation, etc., effective dates)	Contact name	Email address	Contact number
Southport and Ormskirk NHS Trust	St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) provide Research Management support to Southport and Ormskirk NHS Trust (SOHT). They support the delivery, performance and oversight of research conducted at SOHT.	Dr K Thomas	kevin.thomas@nhs.net	01704 704765
NIHR Research Design Service -North West	The Research Design Service in the North West is part of the NIHR infrastructure and exists to provide support and advice for people preparing NIHR grant applications.	Dr P Dolby, Communications and information Manager	www.rds-nw.nihr.ac.uk	

Clatterbridge Centre for Oncology (CCC)	STHK & CCC have come to an agreement whereby patients will have access to Systemic Anti-Cancer Therapy (SACT) trials through the availability of CCC employed staff working to CCC governance arrangements.	Dr Maria McGuire	Maria.Maguire@clatterbridgecc.nhs.uk	0151 334 1155 x4917
Innovation Agency (Academic Health Science Network, North West Coast)	The Trust is a partner of the AHSN, we work together to embed innovation as a core part of the business within STHK .	Dr Liz Mear	info@innovationagencynwc.nhs.uk	By email only
Clinical Commissioning Groups	The Trust is involved in a small number of primary care research projects.	For further information contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk	0151 430 2334
Liverpool University	The Trust is involved in a number of research projects with Liverpool University.	For further information contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk	0151 430 2334
St Helens Clinical Commissioning Groups	The Trust has links to Primary Care through the CCG. These links are vital and offer us the potential to collaborate on joint research projects as well as recruiting from the primary care sector.	Professor Sarah O'Brien Accountable Officer and Strategic Director for Peoples Services St Helens CCG	saraho'brien@sthelens.gov.uk	01744 627596
Manchester Metropolitan University	The Trust is involved in a number of research projects with Manchester Metropolitan University	Kayvan Shokrollahi Consultant Burns, Plastic & Laser Surgeon	Kayvan.Shokrollahi@sthk.nhs.uk	Secretary Whiston Hospital: 01514301623
Liverpool University	Mr Rowan Pritchard Jones, Consultant Plastic Surgeon at STHK is involved in a number of research projects with Liverpool University	Mr Rowan Pritchard Jones	rowan.pritchardjones@sthk.nhs.uk	Secretary Whiston Hospital: 01514301175
Liverpool School of Tropical Medicine	The Trust has established links with the Liverpool School of Tropical Medicine and is working on a number of COVID Urgent Public Health studies	Dr Helen Hill PhD Senior Clinical Research Associate Respiratory Research Liverpool School of Tropical Medicine	Helen.Hill@lstmed.ac.uk	By email only

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)

Go to top of document

Organisation study capabilities

Information on the types of studies that can be supported by the organisation to the relevant regulatory standards.

Types of studies organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate phases)	Clinical trial of a medical device	Other clinical studies	Human tissue: Tissue samples studies	Study administering questionnaires	Qualitative study	OTHER
As sponsoring organisation			√	√	√	√	
As participating organisation	√ (Phase, II, III, IV,)	√	√	√	√	√	
As participant identification centre	√ (Phase, II, III, IV,)	√	√	√	√	√	

Information on any licences held by the organisation which may be relevant to research.

Organisation licences			
Licence name Example: Human Tissue Authority licence	Licence details	Licence start date (if applicable)	Licence end date (if applicable)
Human Tissue Act 2004	Licence number 12043		On-going

For organisations with responsibilities for GPs: Information on the practices which are able to conduct research.

Number/notes on General Practitioner (GP) practices

Organisation services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting RDI governance decisions across the organisation.

Clinical service departments					
Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Pathology	Minus 20, 30 and 80 freezers	Kevin McLachlan	Kevin.McLachlan@sthk.nhs.uk	0151 290 4122	
Pharmacy	Designated Research Pharmacist	Jodie Kirk	jodie.kirk@sthk.nhs.uk	0151 430 1537 Bleep 7435	
Pharmacy	Back up Research Pharmacist	Sophie Helsby	Sophie.Helsby@sthk.nhs.uk	0151 290 4291	
Pharmacy	Pharmacy Technician	Philip Buchanan	Philip.Buchanan@sthk.nhs.uk	Bleep 7566	
Radiology	Clinical Radiation Expert	Nabile Mohsin	Nabile.Mohsin@sthk.nhs.uk	0151 426 1600	Clinical Director for Radiology
Radiology	Medical Physics Expert	Paul Connolly	paulconnolly@irs-limited.com	0151 709 6296	Paul Connolly from IRS Ltd is one of the Medical Physics experts for the Trust his MPE number is 128
Radiology	2x 1.5 GE MRI 1 x 3.0T MRI 4 X GE 64 slice CT scanners	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Digital Mammography including tomosynthesis	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Digital dental including cephalometry Cone Beam CT	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Fluoroscopy /1 x interventional	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	20X Ultrasound including Cardiac	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	10x Digital radiography including tomosynthesis	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Cardio-Respiratory Department	24 hour ambulatory electrocardiography Extended ambulatory electrocardiography Cardiomemo Event Recording Carotid sinus massage test Ambulatory blood pressure monitoring Electrocardiograms: 12 lead ECGs Transthoracic echocardiography Transoesophageal echocardiography Stress echocardiography Exercise electrocardiography Spirometry Measurement of maximum expiratory and inspiratory flow volume loop Oximetry assessment Carbon monoxide transfer factor test Simple lung function exercise test Measurement of static lung volume Measurement of respiratory muscle strength Measurement of maximum expiratory and inspiratory flow volume loop Bronchial Reactivity Overnight oximetry (Includes: Measurement of oxygen desaturation index FENO testing	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	

Cardio-Respiratory Department	Assessment for fitness to fly (hypoxic challenge) - flight assessment Pacemaker Implantation - single / dual [plus Box Changes] Implant/Removal of electrocardiography loop recorders ILRs Remote Follow-up inc. Pacemakers /ICDs Coronary Angiography	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	

Information on key management contacts for supporting RDI governance decisions across the organisation.

Management Support e.g. Finance, legal services, archiving					
Department	Specialist services that may be provided	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Archiving	Archiving arrangements are part of the Trust approval process and are detailed in the Clinical Trial Agreement for each study. The Trust holds a corporate archiving contract with Cintas.	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	
Contracts (study related)	Advice and support - See comments	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Contracts (study related)	Sign off of clinical trial agreements	Mr Rowan Pritchard Jones	rowan.pritchardjones@sthk.nhs.uk		The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Contracts (study related)	Review and completion of the Organisational Information Document (OID)	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	The Organisation Information Document is to be used as the Agreement between the Sponsor and participating NHS organisation, this document forms a formal legal contract between the Parties.
Finance	Corporate Accountant	Mary Jockins	Mary.Jockins@sthk.nhs.uk	0151 426 1600	The RDI Department has links with finance and are fully supported in all areas relating to research.
Information Technology	Director of Informatics	Christine Walters	christine.walters@sthk.nhs.uk	0151 430 1134	RDI Department is fully supported by the Director of ICT. IT training, IT system set up, hardware and software configuration set up, firewall configuration and connection to external servers.
Legal	Head of Complaints & Legal Services	Modupe.Oyedeji	Modupe.Oyedeji@sthk.nhs.uk	0151 426 1600	Support and advice with the legal aspects of research is provided when necessary.

HR	Research Passports, Honorary Contracts, Letters of Access	Employment Services	Employment.Services@sthk.nhs.uk	0151 290 4185	
Training	Essential In house Standard Operating Procedure Training	Jeanette Anders, Amanda McCairn, Sandra Greer	research@sthk.nhs.uk	0151 430 2334/ 2315	In house training on essential Standard Operating Procedures is provided for new starters or as updates if required.
Training	Good Clinical Practice (GCP) training. The RDI Manager is a GCP Facilitator.	Jeanette Anders	research@sthk.nhs.uk	0151 430 2334/ 2315	The GCP facilitators are required to facilitate 4 courses per year.
Performance Management of studies	Audit and on-going review of studies.	Contact via RDI Department	research@sthk.nhs.uk	0151 430 2334/ 2315	During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department remain a point of contact, reviewing the progress of each study. A yearly audit is conducted and when a need is identified ad hoc audits will be completed.

Organisation RDI interests

Information on the research areas of interest to the organisation (provide detailed or summary information as appropriate).

Organisation RDI areas of interest				
Area of interest	Details	Contact name		Contact number
Anaesthetics	Anaesthetist for Obs & Gynae	Dr P Yoxall	peter.yoxall@sthk.nhs.uk	0151 430 1267
Anaesthetics		Dr K Mukhtar	karim.mukhtar@sthk.nhs.uk	0151 430 1268
Anaesthetics		Dr S Miller	Scott.Miller@sthk.nhs.uk	
Anaesthetics		Dr Goel	Vandana.Goel@sthk.nhs.uk	
Burns and Plastics		Mr R Pritchard-Jones	rowan.pritchardjones@sthk.nhs.uk	
Burns and Plastics		Mr P Brackley	philip.brackley@sthk.nhs.uk	0151 430 1664
Burns and Plastics		Mr K Shokrollahi	kayvan.shokrollahi@sthk.nhs.uk	
Lung Cancer (Radiology)		Dr Meenal Abhyankar	Meenal.Abhyankar@sthk.nhs.uk	
Cancer		Dr Puneet Malhotra	Puneet.Malhotra@sthk.nhs.uk	
Cancer		Ms Leena Chagla	leena.chagla@sthk.nhs.uk	
Cancer		Dr T Nicholson	toby.nicholson@sthk.nhs.uk	
Cancer		Dr E Hindle	elaine.hindle@sthk.nhs.uk	
Cancer		Dr Z Khan	zahed.khan@nhs.net	
Cancer		Dr R Lord	rosemary.lord@nhs.net	
Cancer		Dr H Innes	helen.innes@nhs.net	
Cancer		Dr E Marshall	ernie.marshall@sthk.nhs.uk	
Cancer		Miss T Kiernan	Tamara.Kiernan@sthk.nhs.uk	
Cancer		Mr A Khattak	Altaf.Khattak@sthk.nhs.uk	
Cancer		Dr Taylor	David.Taylor4@sthk.nhs.uk	
Cancer		Mr R Pritchard-Jones	rowan.pritchardjones@sthk.nhs.uk	
Cancer		Mr P Brackley	philip.brackley@sthk.nhs.uk	
Cancer		Mr Samad	Ajai.Samad@sthk.nhs.uk	
Cancer		Mr J McCabe	John.mccabe@sthk.nhs.uk	
Cancer		Dr Eleana Loizou	Eleana.Loizou@sthk.nhs.uk	
Cancer		Miss Sonia Bathla	Sonia.Bathla@sthk.nhs.uk	
Cancer		Dr Shien Chow	Shien.chow@nhs.net	
Care of the Elderly		Dr Gandecha	Dipen.Gandecha@sthk.nhs.uk	
Cardiology		Dr R Katira	Ravish. Katira@sthk.nhs.uk	0151 430 1041
Palliative Care		Dr A Thompson	Anthony.Thompson2@sthk.nhs.uk	0151 290 4266
Palliative Care		Dr S Coyle	SeamusC@willowbrookhospice.org.uk	0151 430 8736
Critical Care		Dr J Wood	julie.wood@sthk.nhs.uk	0151 430 2394
Critical Care		Dr A Cochrane	Anthony.Cochrane@sthk.nhs.uk	
Critical Care		Ascanio Tridente	Ascanio.Tridente@sthk.nhs.uk	0151 430 1421
Dermatology		Dr J Ellison	judith.ellison@sthk.nhs.uk	01744 646584
Dermatology		Dr E Pang	evelyn.pang@sthk.nhs.uk	01744 646614
Dermatology		Dr M Walsh	Maeve.Walsh@sthk.nhs.uk	
Dermatology		Dr K Eustace	Karen.Eustace@sthk.nhs.uk	
Dermatology		Dr A Alkali	Abba.Alkali@sthk.nhs.uk	
Dermatology		Dr Ngan	Kok.Ngan@sthk.nhs.uk	
Dermatology		Dr Layla Hanna-Bashara	Layla.HannaBashara@sthk.nhs.uk	
Diabetes		Professor K Hardy	kevin.hardy@sthk.nhs.uk	01744 646490
Diabetes		Dr N Furlong	naill.furlong@sthk.nhs.uk	01744 646496
Diabetes		Dr P Narayanan	Prakash.Narayanan@sthk.nhs.uk	
Emergency Medicine		D Frazer	David.Frazer@sthk.nhs.uk	0151 430 2373
Emergency Medicine		Dr J Matthews	john.matthews@sthk.nhs.uk	
Emergency Medicine		Dr M Hedley	Mike.Hedley@sthk.nhs.uk	
Emergency Medicine		Dr C O'Leary	Clare.OLeary@sthk.nhs.uk	
Emergency Medicine		Dr G Inkster	Graeme.Inkster@sthk.nhs.uk	
Musculoskeletal		Dr R Abernethy	rikki.abernethy@sthk.nhs.uk	01744 646586
Musculoskeletal		Dr J Dawson	Julie.Dawson@sthk.nhs.uk	
Musculoskeletal		Mrs Y Hough	Yvonne.Hough@sthk.nhs.uk	
Gastro		Dr A Bassi	ash.bassi@sthk.nhs.uk	
Gastro		Dr R Chandy	rajiv.chandy@sthk.nhs.uk	
Gastro		Dr J McLindon	john.mclindon@sthk.nhs.uk	
Gastro		Dr D McClements	dave.mcclements@sthk.nhs.uk	
Gastro		Dr S Priestley	Sue.Priestley@sthk.nhs.uk	
Gastro		Dr V Theis	Vanessa.Theis@sthk.nhs.uk	0151 290 4274
Gastro		Dr R Jagdish	Reema.Jagdish@sthk.nhs.uk	
Gastro		Dr K Clarke	Katie.Clark2@sthk.nhs.u	

Orthopaedics		Mr Ballester	Jordi.Ballester@sthk.nhs.uk	0151 290 4234
Orthopaedics		Dr Wharton	Danielle.Wharton@sthk.nhs.uk	
Orthopaedics		Mr Lipscombe	Stephen.Lipscombe@sthk.nhs.uk	
Parkinson's		Dr D Gandecha	Dipen.Gandecha@sthk.nhs.uk	
Parkinson's		Dr S Williams	Sarah.Williams2@sthk.nhs.uk	
Paediatrics		Dr R Garr	Rosaline.Garr@sthk.nhs.uk	
Paediatrics		Dr M Aziz	maysara.aziz@sthk.nhs.uk	
Paediatrics		Dr L Chilukuri	lakshmi.chilukuri@sthk.nhs.uk	
Paediatrics		Dr H Bentur	Hemalata.Bentur@sthk.nhs.uk	
Paediatrics		Dr Basavaraju	Jasavanth.Basavaraju@sthk.nhs.uk	
Paediatrics		Dr Ijaz Ahmad	ijaz.ahmad@sthk.nhs.uk	0151 430 1636
Paediatrics		Dr Archana Prasad	archana.prasad@sthk.nhs.uk	
Pharmacy		Mr Greg Barton	greg.barton@sthk.nhs.u	
Reproductive and Child Health		Mrs Sandhya Rao	Sandhya Rao@sthk.nhs.uk	0151 430 2289
Reproductive and Child Health		Miss Vicky Cording	vicky.cording@sthk.nhs.uk	0151 430 1495
Reproductive and Child Health		Mrs Tabassum Safdar	tabassum.safdar@sthk.nhs.uk	
Reproductive and Child Health		Mrs Nidhi Srivastava	nidhi.srivastava@sthk.nhs.uk	
Reproductive and Child Health		Mrs Susmita Pankaja	susmita.pankaja@sthk.nhs.uk	
Reproductive and Child Health		Mr T Idama	Tennyson.Idama@sthk.nhs.uk	
Reproductive and Child Health		Miss Zoe Boyes	Zoe.Boyes@sthk.nhs.uk	
Reproductive and Child Health		Ms Saru Palaniappan	Saru.Palaniappan@sthk.nhs.uk	
Sexual Health		Dr E Acha	Estibaliz.Acha@sthk.nhs.uk	
Sexual Health		Dr Rebecca Thompson Glover	Rebecca.ThomsonGlover@sthk.nhs.uk	
Stroke		Dr Lalitha Ranga	Lalitha.ranga@sthk.nhs.uk	0151 430 2441
Stroke		Dr S Mavinamane	sunandra.mavinamane@sthk.nhs.uk	0151 430 1224
Stroke		Dr S Meenakshisundaram	sanjeevikumar.meeakshisundaram@sthk.nhs.uk	
Stroke		Dr A Hill	andrew.hill@sthk.nhs.uk	
Stroke		Dr A L Kalathil	Latheef.Kalathil@sthk.nhs.uk	
Stroke		Dr H Cooper	Helen.cooper@sthk.nhs.uk	
Stroke		Dr T Smith	tom.smith@sthk.nhs.uk	0151 430 1245
Surgery		Mr R Rajaganeshan	raj.rajaganwshan@sthk.nhs.uk	
Surgery		Mr S Kanwar	Sunjay.Kanwar@sthk.nhs.uk	
Surgery		Mr A Samad	Ajai.Samad@sthk.nhs.uk	
Urology		Mr J McCabe	john.mccabe@sthk.nhs.uk	

Information on local / national specialty group membership within the organisation which has been shared with the CLRN.

Specialty group membership (local and national)					
National / local	Specialty group	Specialty area (if only specific areas within group)	Contact name	Contact email	Contact number
North West	Managers meeting	Research and Development	*Jeanette Anders*	jeanette.anders@sthk.nhs.uk	*0151 430 2334*
Clinical Research Network,North West Coast	Managers meeting	Research and Development	*Jeanette Anders*	jeanette.anders@sthk.nhs.uk	*0151 430 2334*

Organisation RDI planning and investments

Planned investment			
Area of investment (e.g. Facilities, training, recruitment, equipment etc.)	Description of planned investment	Value of investment	Indicative dates
Grant Development	Advice and support in the development of new STHK led grant applications		

Organisation RDI standard operating procedures register

Standard operating procedures				
SOP ref number	SOP title	SOP details	Valid from	Valid to
A suite of SOPs are available upon request				

Information on the processes used for managing research passports.

Indicate what processes are used for managing research passports
Research Passports are accepted at STHK and a letter of access issued via the RDI Department. At present Research Passports are not produced at STHK.

Information on the agreed escalation process to be used when RDI governance issues cannot be resolved through normal processes.

Escalation process
In accordance with RDI management structure: The Research Practitioner Group reports to the Research Development and Innovation Group who reports to the Clinical Effectiveness Council who report to the Quality Committee then to the Trust Board.

Planned and actual studies register

The organisation should maintain or have access to a current list of planned and actual studies which its staff lead or in which they are involved.

Comments
STHK records every research project on the local ReDA database and the NIHR CRN NWC Edge system. These systems are used to register and manage all research projects.

Other information

For example, where information can be found about the publications and other outcomes of research which key staff have led or have otherwise contributed.

Other information (relevant to the capability of the organisation)
In June 2020 the Trust released a new 3 year Research Development and Innovation Strategy. Over the next three years we will continue to transform our approach to managing research at The Trust, ensuring that our systems and processes operate in an efficient manner to increase opportunities for patients to participate in high quality clinical research. Information about publications and other outcomes of research can be found the Research Development and Innovation Annual Report.

TRUST BOARD

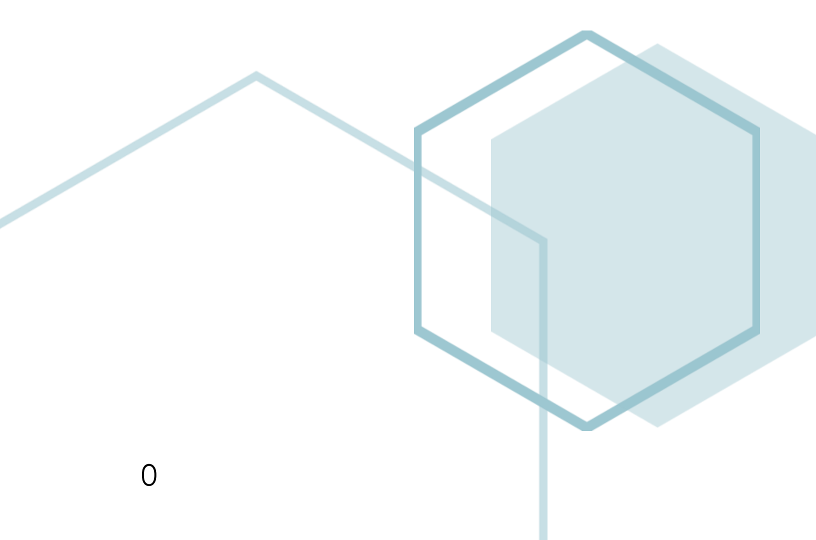
Paper No: NHST(20)079b
Title of paper: Research, Development & Innovation (RDI) Annual Report 2019/20
Purpose: To provide an overview of the RDI activity undertaken across the Trust during the financial year 2019-20 (Apr 19–Mar 20)
Summary: The following report provides an overview of reported RDI activity in the Trust: 2019-20. • During 2019- 2020 STHK were involved in 131 studies, and the National Institute of Health Research (NIHR) supported 95% (n64) of these. Of the 124 NIHR portfolio studies, 90 studies were open to recruitment and 34 were in follow up. • NIHR recruitment figures have exceeded those forecasted during 2019-20. STHK successfully recruited 1151 participants against the proposed target of 1026. • In response to the COVID-19 pandemic STHK has put in place measures to help our expert clinical research teams find the most effective drugs, vaccines and treatments. STHK have worked with the NIHR, CRN NWC by hosting a number of Urgent Public Health COVID 19 research studies. • We were extremely proud to be successful in the North West Coast Research and Innovation awards. The success of the Gastroenterology Research team was reinforced when they won the prestigious Excellence in the Delivery of Commercial Life Science Research at the North West Coast Research and Innovation awards in January 2020. This is second year running that STHK have won in this category and is the only organisation to have achieved this in succession; this is a testament to the dedication of our Research Team, Clinicians and Supporting Services and to the Trust, who value the importance of research and benefits it brings our patients and staff. The report also provides an update on the key aspects of progress and performance of Research and Innovation within the Trust during 2019-20.
Corporate objectives met or risks addressed: • Contributes towards good governance arrangements; providing assurance on the quality of research conducted at STHK to the Board.
Financial implications: The Trust receives funding from the NIHR Clinical Research Network, North West Coast, based on our performance. A total of £88,818.00 additional income was secured from the CRN NWC which included 3 successful applications for contingency funding (£76,490.00). This was utilised to increase both nurse and administrative capacity.
Stakeholders: • St Helens & Knowsley Teaching Hospital's NHS Trust • North West Coast Clinical Research Network (NWC CRN) • Commercial Partners • External Partners
Recommendation(s): Members are asked to approve the annual report.
Presenting officer: Mr Rowan Pritchard Jones
Date of meeting: 25th November 2020

Research Development & Innovation Department

Annual Report 2019/2020

Lead Author – Mrs. Jeanette Anders

Produced – May 2020
Published June 2020



FOREWORDS

In September 2019 the Medical Director, Professor Kevin Hardy, who successfully led the Research Development and Innovation Department for a number of years, left the Trust. We were extremely pleased to welcome Mr Rowan Pritchard-Jones as his successor. Mr Pritchard-Jones, Consultant Plastic Reconstructive Surgeon and Honorary Senior Clinical Lecturer at Liverpool University, has an excellent track record in the delivery of Research, Education and Innovation. We are looking forward to working with him, and to a period that will further enhance the profile and increase the visibility of the RDI department at STHK.

The purpose of this Research, Development and Innovation (RDI) Annual Report is to present information to the Trust Board on the full year RDI activity for 2019-20. The report provides the evidence that St Helens and Knowsley Teaching Hospitals (STHK) maintains and develops their statutory duty to "Promote Research, Innovation and the use of research evidence (Health and Social Care Act, 2012)". It provides an update on the key aspects of progress, performance and financial management.

It includes the current position and progress against National Institute for Health Research (NIHR) and Clinical Research Network North West Coast (CRN NWC) High Level Objectives (HLOs) as well as the on-going areas of work and future developments for 2012-2021.

This year's annual report comes at a time of unprecedented upheaval for our health service. The impact of COVID 19 on research has been immense and the Trust has responded in the most positive way. The Research Team, supported by Consultants, Medics, Nurses, and support services such as Pharmacy and the Laboratories, have opened a number of new NIHR Urgent Public Health Research studies at short notice. Therefore activity on COVID 19 studies opened in March/ April 2020 will be included in this annual report.

Building our research strength is an important part of the Trust's strategy, which clearly states our vision for the continued advancement of Research Development and Innovation at STHK. We have set clear goals and objectives that will enable us to promote a culture where RDI drives better patient care, to improve the Trust's capacity, capability and delivery of clinical research.

May I take this opportunity to express appreciation for the work of all those who have contributed to the Trust's research agenda, our Principal Investigators, Research Practitioners, Data Managers and other support staff, without whose commitment this report would not have been possible. Most of all we would like to thank the patients and carers for giving up their time for the greater good.

Mrs. J Anders
RDI Manager

I am extremely pleased to report another year of strong patient recruitment to an expanding portfolio of organisation wide research. This achievement has only been made possible by the continued support from the committed Consultants who take the role of Chief and Principal Investigators, the research teams, support services and most importantly the patients who give up their time to take part in clinical trials.

Mr. Rowan Pritchard-Jones
Medical Director

CONTENTS:

Sections		Page
	Forewords	1
1.	Background	3
2.	Overview/ Summary of Research Activity	6
3.	Research Conduct, Governance and Finance	11
4.	Key Achievements	14
5.	Education & Training	19
6.	Links with other Groups	20
7.	Innovation	21
8	Conclusions	21
9.	Recommendations	23
10.	References	25

List of Tables

Table 1	Research Delivery Staff	4
Table 2	Studies sponsored by STHK	8
Table 3	Studies assessed for capacity and capability	9
Table 4	Performance against NIHR High Level Objectives	10
Table 5	COVID 19 Studies	14

List of Charts

Chart 1	HLO1 - Recruitment to NIHR Portfolio studies comparison to other trusts in the NWC CRN	6
Chart 2	Study Categories	7
Chart 3	Active Commercial Studies	8

Appendices

Appendix 1	List of Studies (with recruitment)	26
Appendix 2	Terms of Reference of the Research Development & Innovation Group	29
Appendix 3	Publications	30

SECTION ONE: BACKGROUND

1.1 High quality research generates the evidence for tomorrow's best practice: it underpins high quality care and innovation. Doing things better and doing better things helps ensure we get best value for money from our health service – St Helens and Knowsley Teaching Hospitals NHS Trust is committed to a service built on Research, Development and Innovation.

1.2 The NHS recognises that staff, from any discipline or activity, can generate new Research, Development and Innovation, and that it is integral to transforming the delivery of evidence-based, safe, efficient, cost-effective care and improving health outcomes. There are a number of key external policies that recognise the importance of research in the NHS and drive the research agenda nationally.

1.3 The Department of Health (DOH) views Research, Development and Innovation as part of the core mission of all NHS Trusts. NHS England has a statutory responsibility to promote research (NHS Constitution 2013, Health and Social Care Act 2012)[1.]

1.4 Research is a core function of health and social care. It is essential for our health and well-being, and for the care we receive. Research should improve the evidence base, reduce uncertainties, and lead to improvements in future care, while the quality of current care may be higher in organisations that take part in research and adopt research findings. Research develops the skills of staff and involves patients, service users and the public in the pursuit of knowledge that may benefit them and others (UK Policy Framework for Health and Social Care Research 2017)[2].

1.5 Patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recoveries…. We will work to increase the number of people registering to participate in health research to one million by 2023/24….We will invest in spreading innovation between organisations. (NHS Long Term Plan, Jan 2019)[3]

1.6 Research became specific in CQC Well Led inspections for Trusts in Oct 2018, the first time research activity has been formally recognised as a key component of best patient care. The CQC now focuses on how well a Trust as a whole supports research activity via strategic and divisional leadership, and patient opportunity and access around research.

1.7 The National Institute for Health Research (NIHR) funds 15 Clinical Research Networks with the purpose of delivering research of direct benefit to NHS patients. The funding aims to underpin the practical support researchers require delivering high quality clinical research in the NHS environment. Its vision is to improve the health and wealth of the nation through research. In order to achieve this vision the NIHR has set high level objectives (HLOs), and it is against these that NHS Trusts are assessed on the delivery of clinical research for both commercially-sponsored and non-commercial (academic) trials. STHK is a partner organisation to the Clinical Research Network North West Coast (CRN NWC).

1.8 The Innovation, Health and Wealth paper[4] (Department of Health, 2011) recommended the creation of "a more systematic delivery mechanism for diffusion and collaboration within the NHS by building strong cross boundary networks". The aim of Academic Health Science Networks (AHSN) is to "align education, clinical research, informatics, training and education and healthcare delivery" and "to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems".

The Innovation Agency, North West Coast Academic Health Science Network (AHSNs) is one of 15 AHSNs working together in the AHSN Network, and is the innovation arm of the NHS. The AHSNs work collaboratively, identifying and supporting the successful development of innovations in our local regional healthcare communities, and helping to spread these across our national Network. They are the only organisations that connect all partners across sectors: NHS and academia, local authorities, the third sector, industry and citizens.

1.9 To accelerate the translation of research into patient benefit and population health, and increase the appeal of the UK as a global hub for life sciences, all sectors of the ecosystem – patients, industry, regulators, research funders, public health organisations, academia and the NHS – must work closely together. (Transforming Health Through Innovation: Integrating NHS and Academia)[5]

1.10 National funding to the Clinical Research Networks (CRNs) is allocated from the National Institute for Health Research (NIHR) via the Department of Health annually across all CRNs based on a number of parameters, including performance. Each local network has a number of High Level Objectives (HLOs) they must achieve annually. Performance is monitored across the CRNs and funding is in part allocated dependant on performance across the region. Each organisation that is a member of the CRN NWC is responsible for working with the network to support delivery of the HLOs. Funding is received from the CRN NWC to cover the costs of working on NIHR adopted studies, e.g. research nurses, research administrative staff and research-related activities in key service support departments.

The following table displays the research delivery staff funding arrangements for 2019/2020.

Table 1 – Research Delivery Staff

Research Delivery Staff funded by Clinical Research Network North West Coast		
Job Title	**Area**	**WTE**
Senior Research Nurse	Cancers	0.80
Senior Research Nurse	Generic	0.27
Research Midwife	Generic /Midwifery	0.50
Research Nurse	Generic	2.50
Research Nurse	Generic/Stroke	1.00
Research Nurse	Generic / Rheumatology	1.00
Research Nurse	Generic/Paediatric	0.50
Research Nurse	Cancers	1.00
Data Manager	Cancers	1.50
Research Support Officer	Generic	0.60
RDI Administrator	Generic	0.40
Research Delivery Staff funded by STHK		
RDI Manager	RDI	1.00
Senior Research Nurse	Generic	0.73
Research Nurse	Generic	0.50
RDI Coordinator	RDI	1.00
RDI Data Manager	RDI	1.00
RDI Administrator	RDI	0.60

1.11 The national funding model, which is employed to define Local CRN budgets, has changed this year, and a new funding model will be introduced for 2020/21. A percentage of the funding allocated from the CRN NWC will be based on High Level Objective performance for HLO 1 (Recruitment), HLO2 (Recruitment to Time and Target) and HLO 9 (Study Set-up times). This rewards and incentivises organisations that perform well across a range of performance metrics. For the 2020/21 financial year, a cap and collar of 5% on overall allocations has also been introduced to provide organisations some stability.

1.12 The Trust also receives income from industry-sponsored research, the majority of which goes directly to the speciality undertaking the research, though the RDI Department does retain a proportion to cover Trust overhead costs and for capacity building. All research income is managed centrally within RDI, with support from the Finance Department, to ensure consistency, accountability and transparency of research income and expenditure.

1.13 In order for clinical research to be meaningful, researchers need to be able to complete their study within an acceptable timescale. They also need to be able to meet recruitment targets with the number of patients or other participants required to make the study feasible. The Trust is performance managed by the CRN NWC against a set of NIHR High Level Objectives (HLO). The HLO model changed in 2019/20 with emphasis on recruitment, recruiting to time and target, and study set up times:

- HLO 1 Number of participants recruited to NIHR CRN portfolio studies
- HLO 2a Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period at confirmed CRN sites
- HLO 2b Proportion of non-commercial contract studies achieving or surpassing their recruitment target
- HLO 9a Median set up time for commercial contract studies, at confirmed CRN sites (days). Site selected to first patient recruited - ambition target of 80day.
- HLO 9b Median set up time for non- commercial contract studies, at confirmed CRN sites (days). Site selected to first patient recruited - ambition target of 62days.

1.14 The Health Research Authority (HRA) was established as an executive non-departmental public body (NDPB) sponsored by the Department of Health on 1 January 2015. Their aim is to make sure the UK is the best place in the world to do research. Many members of the public want the opportunity to participate in research. The HRA make sure that health and social care research involving them is ethically reviewed and approved, that people are provided with the information they need to help them decide whether they wish to take part, and that their opportunity to do so is maximised by simplifying the processes by which high quality research is assessed. In doing this, they help to build both public confidence and participation in health research, and so improve the nation's health[6].

To achieve this, the HRA are constantly streamlining the process of applying for research approval, and making their procedures as simple and straightforward as possible for applicants.

They have already introduced a range of measures to make life easier for those applying for research approval, including proportionate consent guidance, helping to improve consistency within UK-wide research and HRA Approval .

All research conducted at STHK must have HRA approval, Confirmation of Capacity and Capability (CCC) issued by the Research Management Office and where necessary Research Ethics approval.

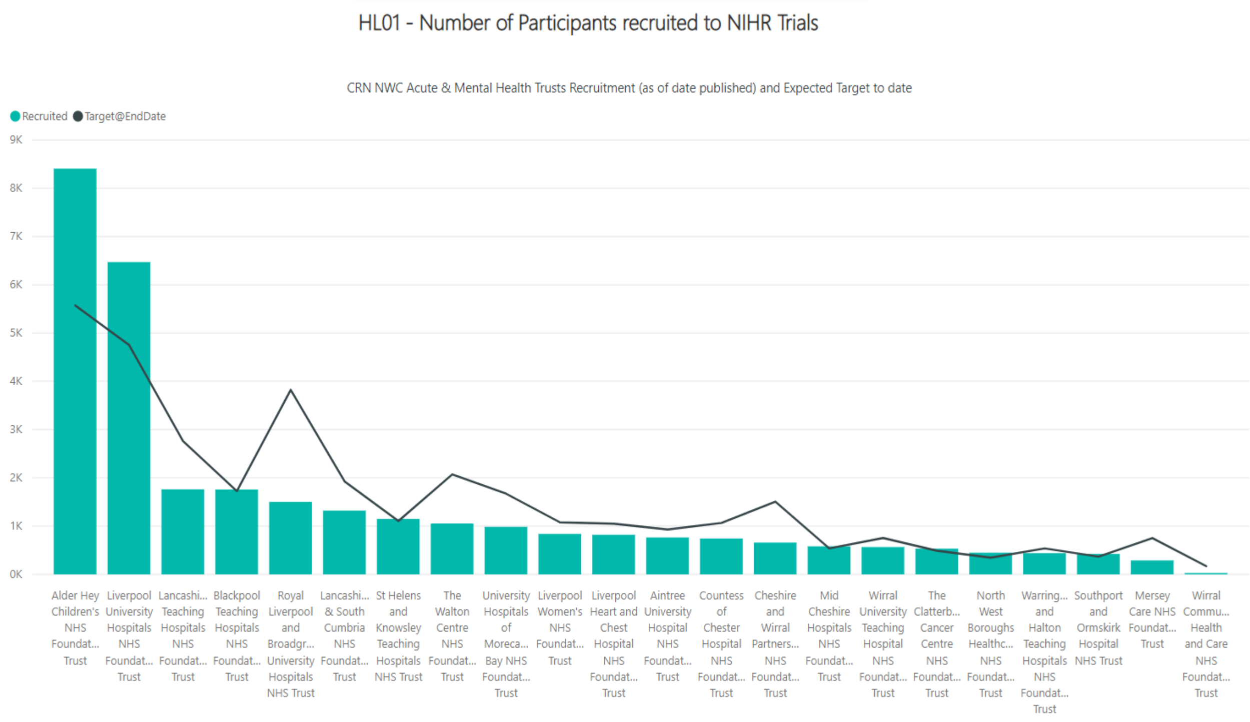
1.15 The RDI Strategy outlines our vision as a fully research active organisation. The 3 year strategy reflects the change in policies and the direction of travel with regard to Research and Innovation at STHK.

1.16 STHK continues to provide a research management service for Southport & Ormskirk Hospital NHS Trust. This includes support from the Research Manager, Senior Research Nurse and RDI Co-ordinator. This was agreed in a formal Service Level Agreement which is due for review on 31st March 2021.

SECTION TWO: OVERVIEW / SUMMARY OF RESEARCH ACTIVITY

2.1 We were pleased that NIHR recruitment figures surpassed the target during 2019/20. STHK successfully recruited 1151 participants against a target of 1026, and enabled us to attain the ranking of 7th out of 21* Trusts across the CRN NWC. This is a great achievement and the result of a huge effort from all the Research Team; it also demonstrates our commitment to offering patients and public the opportunity to take part in research.

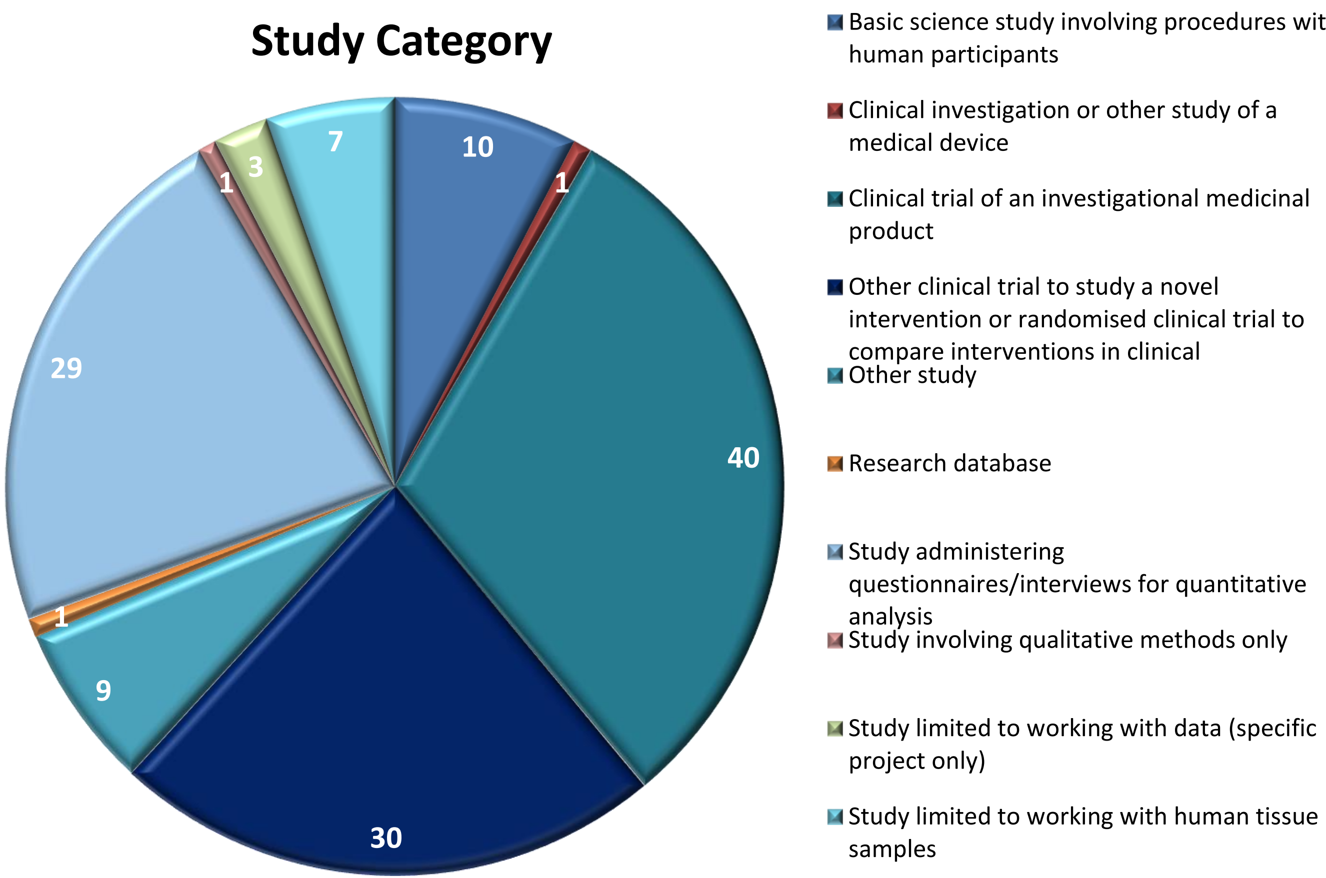
Chart 1 – Number of Participants Recruited to NIHR studies (Comparison to other Trusts in the NWC CRN) * Excludes Wirral Community



2.2 During 2019-2020 STHK was involved in 131 studies, National Institute for Health Research (NIHR) Portfolio Studies (n124) and non-portfolio (n7) studies. Of the 124 portfolio studies, 90 studies were open to recruitment and 34 were in follow up.

2.3 We have a balanced portfolio of studies ranging from observational to complex interventional studies; the following table demonstrates the types of studies conducted at STHK during 2019/2020.

Chart 2 - Study Categories



2.4 In some cases the Trust takes on the role as Sponsor. The Sponsor is the individual, company, institution or organisation which takes on the ultimate responsibility for the initiation, management (or arranging the initiation and management) and/or financing (or arranging the financing) for that research. The sponsor takes primary responsibility for ensuring that the design of the study meets appropriate standards, and that arrangements are in place to ensure appropriate conduct and reporting.

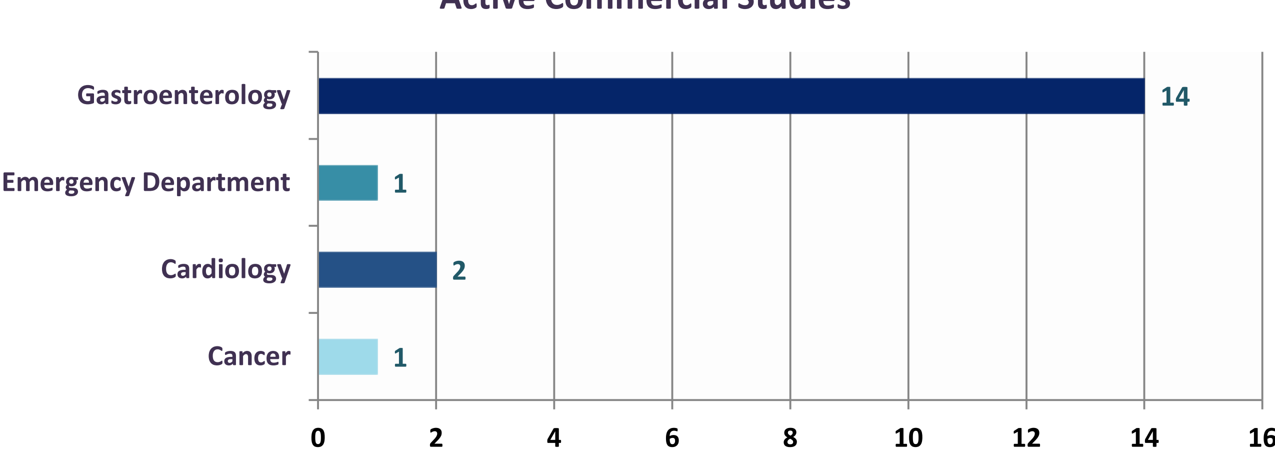
STHK sponsored 6 studies during 2019/2020 compared to 2 studies in 2018/19; none of these were CTIMPs (Clinical Trial of an Investigational Medicinal Product). It is encouraging to note that 2 of these studies were multicentre studies and 3 were NIHR portfolio studies; by increasing the number and type of studies that STHK sponsor it demonstrates our commitment to expanding and raising the profile of our Trust to one that can support the set up and delivery of studies in the NHS. STHK sponsored the following studies:

Table 2 – Studies Sponsored by STHK

Name	Type	Speciality
Clyz Cancertain - An observational study to assess the potential of the Clyz CanCertainTM Assay to predict patients' drug response from stage III/IV Lung Carcinoma biopsy samples in vitro	Single centre, Observational study, NIHR Portfolio adopted.	Cancer
VOCs - Investigation of biological changes in urine in lung cancer - a pilot study	Multi- Centre, NIHR Portfolio adopted.	Cancer – Palliative care
Ketones - Changes in fat content (Ketones) towards the end of life – a feasibility study	Multi- Centre, NIHR Portfolio adopted.	Palliative care
Exploring the impact of pharmacist-led feedback on insulin prescribing	Single Centre Staff only	Pharmacy
Exploring the experiences, perceptions and opinions of hospital pharmacists to participate in simulation based training.	Single Centre Staff only	Pharmacy
Patient Engagement with Advanced Nurse Practitioners: A Phenomenological Investigation into the Advanced Nurse Practitioner's Lived Experience	Single Centre Staff only	Trust Wide

2.5 A key priority for the Department of Health is for the Trust and Research Networks to engage with Industry. During 2019/20 we had 18 active commercial studies open to recruitment, compared to 15 during 2018/19, this is a 20 % increase in activity since 2018/2019. The Gastroenterology team at STHK continues to expand their research portfolio, and have an excellent national reputation for delivering clinical research. Inflammatory Bowel Disease (IBD) research has been a big area for the department with the Trust developing and supporting a number of important trials looking at improving the treatment for this common condition.

Chart 3 – Active Commercial Studies 2019/2020



2.6 The Trust also leads or collaborates on a range of studies across the health care priorities for research identified by the Department of Health. There was a 27 % increase in the number of NIHR studies where capacity and capability was assessed between the 1st April 2019 and the 31st March 2020. A total of 33 new studies were assessed in 2019/20 compared to 26 in 2018/19.

Table 3 - Studies assessed for Capacity and Capability during 2019/2020 at STHK (n33):

Speciality	No. of Studies	CTIMP	Commercial
Cancer	2		
Care of the Elderly	1		
Critical Care /Emergency	4		
Gastroenterology	6	2	2
General Surgery	4	1	
Obstetrics & Gynaecology	2		
Paediatrics	4	1	
Pharmacy	2		
Rheumatology	2		
Sexual Health	1		
Stroke	3		
Trust Wide	2		
Totals	**33**	**4**	**2**

2.7 The follow up of patients recruited to research studies can be very time consuming for Research Nurses and Administrative Staff. This can impact on the resources allocated by the CRN for recruitment to active studies. Follow up of patients includes scheduling research visits according to trial protocols, collecting data for the Case Report Forms (CRFs) and answering data queries. Follow up can range from weeks to years and in some cases it can be for life. Responding to data queries can be time consuming and in some cases the Research Nurse may receive requests from Sponsors of studies that are closed to recruitment.

2.8 The NIHR Clinical Research Network (NIHR CRN) provides funding for service infrastructure, including pharmacy, pathology and radiology services, to support clinical research in the NHS in England. We have a dedicated research pharmacist who supports the delivery of Clinical Trials of Investigational Medicinal Products (CTIMPs).

The Medicines and Healthcare Products Regulatory Agency (MHRA) is required under European law to inspect Clinical Trials of Investigational Medicinal Products (CTIMPs) conducted by both commercial and non-commercial organisations. GCP Inspectors assess compliance with all relevant legislation and guidance. In particular, the MHRA assesses whether organisations sponsoring and/or conducting CTIMPs have systems in place to meet the requirements of the Clinical Trials Regulations (this includes The Medicines for Human Use (Clinical Trials) (Amendment) (EU Exit) Regulations 2019). In order to address the pharmacy requirements of the MHRA a full suite of pharmacy Standard Operating Procedures are in place.

2.9 The CRN NWC measures its effectiveness against a set of HLOs. They produce monthly reports which are distributed to individual Trusts across the Network indicating performance. The Research Team at STHK have had a successful year and have worked extremely hard to meet the NIHR CRN NWC High level

Objectives; this is due to team work, including setting recruitment strategies/goals and clarifying responsibilities for each member of the team. The following chart demonstrates the excellent performance of STHK, compared to the overall performance of the CRN NWC (this includes all 21 partner organisations). STHK were 1 of 8 Trusts that met the recruitment target during 2019/2020.

Table 4 – Performance against the NIHR High Level Objectives (HLOs)

HLO	Definition	STHK Performance	CRN NWC Coast (all Trusts n=21)
HLO1	Number of participants recruited to NIHR trials	Target = 1026 Achieved =1151	8 of the 21 Trusts including STHK met the recruitment target
HLO 2a	Number of commercial studies achieving or surpassing their recruitment target during their planned recruitment period.	100%	53%
HLO 2b	Number of non- commercial studies achieving or surpassing their recruitment target during their planned recruitment period.	90%	63%
HLO 9b	Non-commercial studies - Date site selected to first recruit (Ambition of 60 days)	87.5%	46%

2.10 The Trauma Audit and Research Network (TARN) is a national organisation that collects and processes data on moderately and severely injured patients in England and Wales. In doing so, it allows networks, major trauma centres, trauma units, ambulance services and individual clinicians to benchmark their trauma service with other providers across the country. STHK is a Trauma Receiving Unit (TU) within the Cheshire & Mersey Major Trauma Network (CMMTN) and submits data on all TARN-reportable patients, with injuries ranging from minor (ISS 0-8) (Injury Severity Score) to major (ISS >15) trauma. STHK have a local audit programme with the Accident & Emergency department which addresses areas highlighted by the national TARN data. The TARN database provides an excellent platform for trauma research locally, nationally and internationally.

2.11 ICNARC (Intensive Care National Research & Audit Centre) was set up in 1994 to provide a national resource for the monitoring and evaluation of intensive care (ICNARC, 1994). STHK joined ICNARC in May 1996.

Alongside being involved in national and government research projects, ICNARC collects data on patient outcomes from adult critical care units in England, Wales and Northern Ireland known as the Case Mix Programme (CMP). 100% of all adult general critical care units participate.

The information that produces this data is obtained from every single patient admitted to the Critical Care unit. The CMP is included as a National Clinical Audit for Department of Health Quality Accounts & results displayed on the National Critical Care dashboard – NHS England.

ICNARC compares the data from our patients with that of outcomes from other similar patients, other similar units and all the units in the CMP. It also shows trends over time.

SECTION THREE: RESEARCH CONDUCT, GOVERNANCE AND FINANCE

3.1 Anyone connected with research which involves NHS patients, samples, information, facilities, staff or services is expected to conduct research to the appropriate standards. This includes staff with letters of access, students and part-time staff, or those on short term attachments.

The health and safety of research staff and participants should be given priority at all times and be actively incorporated into the research process. We are committed to ensuring research is conducted to the appropriate standards and legislative requirements (e.g. UK Policy Framework for Health and Social Care Research 2017, the Medicines for Human Use (Clinical Trials) 2004 and others).

3.2 Good Clinical Practice (GCP) is the international ethical, scientific and practical standard to which all clinical research is conducted. It is important that everyone involved in research is trained or appropriately experienced to perform the specific tasks they are being asked to undertake. GCP training is a requirement set out in the UK Policy Framework for Health and Social Care Research developed by the Health Research Authority for researchers conducting clinical trials of investigational medicinal products (CTIMPs).

Different types of research may require different training, and some researchers are already well trained and competent in their area of expertise. Some researchers doing other types of clinical trials may also benefit from undertaking GCP training, but other training may be more relevant.

The NIHR offers range of Good Clinical Practice (GCP) courses and training aids for the clinical research delivery workforce. Their GCP courses are designed for individuals involved in the delivery of studies at research sites.

The RDI department ensures that information and support is available to researchers, and that GCP training is made available to all staff involved in research. The RDI department has a set of instructions which acts as a guide to researchers and assists them in accessing and setting up NIHR online GCP training.

3.3 The 19 principals in the UK Policy Framework for Health and Social Care Research (2017) serve as a benchmark for the conduct of research. Adhering to these standards is a must and ensures the health and safety of research staff and participants.

3.4 STHK Hospitals Trust has a responsibility to ensure that all research within the Trust is conducted in accordance with the relevant legislation and guidelines. In order to assist research teams in fulfilling their obligations, the Research Development and Innovation Department have developed a suite of Standard Operating Procedures (SOPs). All research activity at STHK is conducted in accordance with the Trust approved SOPs. These cover all aspects of the set up and conduct of a research project. These SOPs are reviewed and amended to reflect changes in the regulations.

3.5 In order to maintain the highest standards of rigour and integrity at all times, Principal Investigators are expected to sign an Investigator Declaration form prior to commencing any new research study. The declaration form very clearly outlines the Investigators responsibilities when undertaking research at STHK.

3.6 It is good practice for the PI to be involved with, or be aware of, all aspects of the research study, particularly with regard to Clinical Trials of an Investigational Medicinal Product (CTIMP). The research Nurses meet regularly with the PI to complete a review form, which demonstrates PI oversight of the study.

3.7 Anyone connected with research which involves NHS patients, samples, information, facilities, staff or services is expected to conduct research to the appropriate standards. This includes staff with letters of access, students and part-time staff, or those on short term attachments. The RDI office works with the Human Resources department to ensure that the correct employment checks are in place prior to issuing research approval.

3.8 The RDI Manager has regular reviews with the research workforce; this is to ensure that all staff are given the opportunity to discuss the workload, CRN recruitment targets and training opportunities, and it also enables any issues to be highlighted at an early stage. This is formally documented and fits in with the Trust's PDR process.

3.9 The RDI department is accountable through its Medical Director to the Trust Board sequentially through the Research Development and Innovation Group (RDIG), Clinical Effectiveness Committee and the Quality & Safety Committee. The RDIG meet quarterly; membership includes key local research stakeholders to ensure the Trust works collaboratively with partner organisations, as well as key internal and external personnel, who enable the RDIG to meet strategic objectives in relation to Research Development & Innovation. Members are selected for their specific role or because they are a representative of a professional group/speciality/directorate or division.

3.10 The Research Development and Innovation Group promotes, oversees and fosters clinical Research Development and Innovation within St Helens & Knowsley Teaching Hospitals NHS Trust. On the 1st May 2019 the Terms of Reference were reviewed and updated, the Chair, Dr Ascanio Tridente, Consultant in Intensive Care, continues to lead this group after being appointed in August 2018.

3.11 The Research Practitioner Group (RPG) at STHK also meets quarterly and plays an important role in the delivery of good quality research at STHK. NIHR recruitment is a standing item on the agenda, and updates on performance are discussed, and plans put in place to achieve compliance.

3.12 The NIHR Clinical Research Network is responsible for the provision of the NHS Support resources to enable studies to be conducted in the local NHS regions they are responsible for. Within many Trusts this funding covers a number of different areas as follows:

- Research Nurses - feasibility support, and to recruit and manage patients in research studies
- Non clinical research support staff – administrative staff who assist with study feasibility along with record keeping and data collection as part of research studies
- Service Support departments – Pharmacy, Radiology and Pathology (where this service is provided by organisations as an NHS support activity in the delivery of clinical research).

The purpose of the CRN funding model is to best apportion the national CRN funding allocation from the Department of Health and Social Care (DHSC) to the 15 Local Clinical Research Network. For the 2019/2020 financial year, the CRN funding model has been radically simplified and the basis will remain unchanged for a minimum three-year period.

3.13 Core funding is allocated from the CRN NWC to support the RDI team and Support Services. The total amount of funding allocated to STHK for 2018/19 was £456,298.00, however after allowing for contingency funding and adjustments the final figure was £486,236.00. In 2019/20 STHK were allocated £471,295.00, after adding contingency and final adjustments the total came to £560,113.00, an overall increase of £88,818.00. Contingency funding is non-recurrent funding provided by the CRN NWC, Trusts bid throughout the year for this funding and it can be used to support the delivery of NIHR portfolio studies. STHK submitted 3 applications during 2019/20 and all were successful, these accounted for £76,490.00, this was used to support areas such as ICU, Obstetrics & Gynaecology and Gastroenterology.

3.14 All Trusts were instructed by the CRN to produce an Income Distribution Plan. This provides a transparent and consistent approach to the distribution of income from commercial research studies. Commercial research is defined as research that is sponsored and funded by commercial companies, usually pharmaceutical or device manufacturers, and is directed towards product licensing and commercial development. It is a key strategic goal within the Trust RDI Strategy to increase commercial research contracts. This will only be achieved if clinicians are supported to do this research, and are incentivised to do so in the form of income generation for their teams and departments. The money generated from commercially-sponsored studies is a valuable source of income for NHS Trusts. This income can be used to encourage key stakeholders to develop capacity for new research within the Trust and increase the volume, and therefore future income generation.

The principles of commercial income distribution are:

- Departments and individuals are recognised for their contribution to commercial research within the Trust and are incentivised fairly
- All costs incurred by the Trust are fully recovered
- Commercial research continues to afford both investigators and the Trust the opportunity to fund additional research related activities.

3.15 The RDI Department also supports smaller studies, including individual research undertaken as part of higher qualifications, such as MSc or PhD. This involves guidance through the RDI approval process and ethics review, and the provision of advice and training. As part of their continuing professional development, many staff aim to progress through higher qualifications and/or research work.

SECTION FOUR: KEY ACHIEVEMENTS

In response to the COVID-19 pandemic STHK has put in place measures to help our expert clinical research teams find the most effective drugs, vaccines and treatments. STHK have worked with the NIHR, CRN NWC by hosting a number of Urgent Public Health COVID 19 research studies, including:

Table 5 – COVID 19 Studies

Short Title:	Description:
ISARIC	A study aiming to discover the background of the virus so attempts can be made to find better ways to manage and treat the infection in the future
RECOVERY	A new clinical trial to test the effects of potential drug treatments for patients admitted to hospital with both suspected and confirmed COVID-19.
GenOMICC	A study aiming to find the genes that cause some people to be more vulnerable to COVID-19.
REMAP CAP	An international platform trial that has been specifically designed for a pandemic period. The platform will test multiple treatments at the same time (antivirals, immune modulation drugs and corticosteroids), and more treatments will be added as new evidence emerges. The aim is to reduce mortality, reduce intensive care use, and reduce morbidity in severely ill patients with COVID-19 infection
UKOSS	A maternal and perinatal outcomes of pandemic influenza or novel coronavirus in pregnancy study
PAN COVID	A global registry of women with suspected COVID-19 or confirmed SARS-CoV-2 infection in pregnancy and their neonates; understanding natural history to guide treatment and prevention
Neonatal Complications of Coronavirus Disease (COVID-19) Study	A study collecting data about babies who have Coronavirus infection and babies whose mothers have Coronavirus infection
COVID-19 – Vaccine Group Recruiting Frontline Health Care Workers	The Covid - 19 Vaccine Randomised Controlled Trial Oxford Vaccine Group are recruiting Front Line Health Workers at Liverpool School of Tropical Medicine (LSTM). STHK will be involved in the follow up of any STHK health care workers who take part in this study
SIREN	The impact of detectable anti SARS-COV2 antibody on the incidence of COVID-19 in healthcare workers

Although some of the above studies opened during April 2020, and are outside the timeframe for this annual report, it was deemed important to include them to highlight the response that the Trust has made in terms of COVID 19 research. A COVID-19 research delivery team was rapidly assembled with research nurses, providing a 7-day service to help clinical teams identify and recruit patients. They also worked closely with the administrative staff to ensure the smooth set-up and running of these studies. The input from other services across the Trust, including pharmacy and pathology, was also exceptional.

In addition to the fantastic achievement of meeting the CRN NWC HLO objectives, the following are examples of how STHK continuously drive to improve the quality of service provided through research:

4.1 In January 2020, the Gastroenterology Research Team at STHK, led by Dr Rajiv Chandy, won the Excellence in the Delivery of Commercial Life Science Research in the North West Coast Research and Innovation awards. This is an outstanding achievement for the team and demonstrates their commitment to offering patients and public the opportunity to take part in research. The awards were hosted by the Innovation Agency, NIHR Clinical Research Network North West Coast (CRN NWC), and Applied Research Collaboration North West Coast (ARC NWC) (formerly CLAHRC NWC). Completion was competitive with nominations from a wide variety of stakeholders, including NHS organisations, industry and academic partners, third sector organisations, local authorities and other collaborations in health innovation. This is the second time that the Trust has won this prestigious award, and are the only Trust to win 2 years in succession; in 2018/2019 the Trust won this for Sponsoring and recruiting to the Clyz Cancertain study (An observational study to assess the potential of the Clyz CanCertainTM Assay to predict patients' drug response from stage III/IV Lung Carcinoma biopsy samples in vitro).

4.2 Dr Chandy also delivered an excellent presentation at the CRN NWC Gastroenterology and Hepatology Research event in September 2019. He was invited to share his experiences of taking part in gastroenterology research and describe how the team had been become so successful.

4.3 In August 2019 STHK were the first Trust to recruit the first patient, to the SCIENCE study (Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows).

4.4 Two studies recruited their first patients within one day of the site being given the green light to begin recruitment. This included the Pre BRA study (Pre-pectoral Breast Reconstruction Evaluation) and the BSR-PSA study (The British Society for Rheumatology Psoriatic Arthritis Register).

4.5 Also in September 2019, our Research Team helped recruit the 600th patient to the BLING III trial (a phase III randomised controlled trial of continuous beta-lactam infusion compared with intermittent beta-lactam dosing in critically ill patients). The Trust has made a significant contribution to this multi-centre trial and has so far recruited 44 patients to this study, the most in the CRN NWC.

4.6 During 2019/2020 STHK were a top recruiting site in a number of research specialties across the CRN NWC including:

- Cancer
- Critical Care
- Diabetes
- Gastroenterology
- General Surgery
- Palliative Care
- Stroke
- Rheumatology

This is a fantastic example of how recruitment can increase when you have an enthusiastic Research team supported by Clinical Teams and Support Services.

4.7 NIHR want to understand more about patient experience of clinical research taking place in the NHS, therefore the Trust has increased and promoted research to both staff and patients. In particular, we have made a significant contribution to the NWC CRN Patient Research Experience Survey (PRES). Since April 2019 the PRES has been recognised as one the NIHR HLOs and we have sent out over 200 questionnaires to patients who have participated in research.

4.8 In July 2019 the Chief Executive received a letter of gratitude from a patient who was on taking part in the Mini tub trial (prospective registry of Sentinel Node (SN) positive melanoma patients with minimal SN tumour burden who undergo Completion Lymph Node Dissection (CLND) or Nodal Observation). The patient expressed how fortunate they felt to be part of this important research trial.

4.9 One of our success stories of 2019-20 is the opening of 4 new NIHR portfolio research studies in General Surgery, which historically has been a speciality naïve to research. This is thanks to the enthusiasm of Mr Raj Rajaganeshan and Mr Ahsan Javed, who have encouraged the team to become actively involved in research. Due to their input the General Surgery department has now embedded research as business as usual, with support from the Research and Clinical Nurse Specialists. They encourage junior members of staff to get involved in research and is extremely supportive of their career progression.

4.10 This year more than 100 patients diagnosed with cancer have participated in a cancer research study. The Cancer Research team are committed to providing patients with the opportunity to take part in high quality cancer research studies. Life science lung cancer research has developed and grown in 2019 and is the tumour group that has the most patients recruited to research. These sustained efforts have ensured that patients are involved in their cancer care pathway, and by being involved in research they are contributing to the development of cancer treatments for the future.

4.11 In April 2019 the Diabetes department appointed a 3-year fixed-term Clinical Research Fellow to evaluate the impact of the Department's Diabetes Transformation Programme on delivering improved health care for people with Diabetes Mellitus within the local population. This PhD project, entitled 'Evaluating National Diabetes Performance Measures – What Does Good Look Like?' was registered with Edge Hill University. Focusing on supported self-management of diabetes in the primary and community care settings, this project utilises a mixed-methods approach to evaluate the individualisation of national metrics used to monitor and performance-manage diabetes service provision in the borough of St Helens. Within the first year this work has generated 6 pieces of work accepted for presentation at a national conference.

4.12 Congratulations to our Paediatric Research Nurse, Shelley Mayor, who was recognised as an Inspirational Nurse on International Nurses Day 2019.

4.13 The Paediatric department are a research active department; they were involved in a number of paediatric neurology, respiratory medicine and diabetes studies. The team took part in a neonatal research study with Cambridge University and partners, the Study of Preterm Infants and Neurodevelopment Genes (SPRING) study, the results of which were presented at the 2019 summer neonatal society meeting and published online[7].

4.14 Dr Constanta Amoasii (Rheumatology Registrar) was successful in winning the poster prize (at the Royal College of Physicians annual conference in Manchester) for her systematic literature review investigating whether methotrexate causes chronic pulmonary fibrosis.

4.15 STHK have continued to promote Research and Innovation to staff and patients via:

- Social media, and regularly posting good new stories on the STHK Facebook and Twitter
- TV screens in the Diabetes outpatient clinic
- Library Services
- Training and education
- Volunteer induction day

4.16 International Clinical Trials Day (iCTD) is an annual event that takes place on 20th May, where we raise awareness of clinical trials to encourage patients, carers and the public to get involved in research. We also celebrate our achievements and take time to be grateful for the improvements made to public health. In May 2019, the research team celebrated with a stall promoting the campaign.

4.17 Staff publications (research and academic) have been recorded by the library and knowledge services at STHK which shows our commitment to transparency, and our desire to improve patient outcomes and experience across the NHS.

These achievements have only been made possible by the continued support from the committed Consultants, who take the role of Chief and Principal Investigators, the research teams, support services and, most importantly, the patients, who give up their time to take part in clinical trials.

SECTION FIVE: EDUCATION AND TRAINING

5.1 It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff, either by providing an onsite trainer, enabling access to off-site courses at other Trusts, or by signposting staff to do an individual online course. Three members of staff are qualified as GCP trainers, and run courses both in house and outside of the Trust on behalf of the CRN. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials.

5.2 The RDI Manager is a GCP Facilitator, and has successfully delivered both Introductory and Refresher NIHR GCP courses last year to research staff across the North West Coast.

5.3 The NIHR offer career development opportunities, including training programmes and fellowships based in the NIHR research infrastructure. Training and career development awards are available at different levels and accessible by different professional backgrounds. These awards are all managed by the NIHR Trainees Coordinating Centre and comprise both personal awards, which can be applied for directly, and institutional awards, which should be applied for through the host institution. They also develop and support the people who conduct and contribute to the NIHR CRN Portfolio of studies. This is done by providing training opportunities via the NIHR Learning Management System, which includes a variety of online and taught courses. The Research Department signpost staff to these recourses and encourage participation.

5.4 Research Design Service - The NIHR Research Design Service provides a very good service in supporting staff in Research for Patient Benefit (RfPB) grant applications on a one-to-one basis. Interested staff are signposted to this service when required.

5.5 We encourage our Research Nurses and data staff to actively seek new opportunities to develop their careers. During 2019/20:

- Three Research Nurses either enrolled or are currently working towards a Master's degree.
- One Research Nurse enrolled on to the NIHR Leadership Programme
- One Data Manager completed a Level 3 Business Administration Course and another one enrolled onto the course.

5.6 There was evidence that all staff had annual PDRs and appraisals, and also evidence that staff had the opportunity to set objectives.

5.7 All of the Research Nurses at STHK were issued with the research SOPS. They were asked to sign the training and reading log declaring that they had read and understood all of the SOPs.

5.8 RDI office staff also attended various training sessions, seminars, and R&D Forums to maintain knowledge and expertise in order to provide a good service, with appropriate advice and signposting to researchers, as well as ensuring quality data management and timely returns of performance data to the CRN, DOH and Trust Board as required.

SECTION SIX: LINKS WITH OTHER GROUPS / PARTNERS

6.1 The collaboration between Southport and Ormskirk NHS Trust and STHK launched in April 2016 has gone from strength to strength. STHK provide a research management service under a formal Service Level Agreement. Since 2016, SOHT have increased their Research Portfolio year on year and during 2019/2020 they met all of the CRN NWC High Level Objectives. This is a testament to both research teams who have shared knowledge and good practice.

6.2 We have developed partnerships with other local academic organisations including Manchester Metropolitan University. During 2019/2020 we started to develop plans for Clinical Academic roles, and aim to have at least 2 of these posts in place by the end of 2020.

6.3 In January 2019 STHK a process was developed with the Clatterbridge Cancer Centre (CCC) to enhance recruitment to cancer research studies. This allows CCC staff to attend CCC clinics taking place at STHK to recruit patients under CCC governance arrangements.

6.4 The Trust has links with key external stakeholders such as the CRN, who provide funding from the National Institute of Health Research (NIHR), the research arm of the Department of Health. Regular business planning meetings with the Delivery Managers enable us to scope the NIHR portfolio and identify any potential new studies.

6.5 The Trust is a partner in the Innovation Agency North West Coast Academic Health Science Network (NWC AHSN) which aims to:

- Transform and improve patient outcomes
- Improve quality and productivity
- Drive economic growth and wealth creation

6.6 During 2019/2020 negations were started with the CRN NWC Stroke Speciality Lead regarding STHK applying for Hyper Acute Stroke Research Status. This status will make STHK a specialist centre for research in the 'hyper-acute' time period following a stroke (within a few hours), when treatment is most likely to be effective. It will also enable STHK to be at the cutting edge of acute stroke research and mean we can enrol more of our patients into the very latest clinical trials.

6.7 Within the organisation, RDI is linked with the Quality Improvement and Clinical Audit Department, as part of the Trust governance requirements.

6.8 The RDI Manager is a member of the North West Research and Development Managers' Group. The purposes of the meetings are to share best practice, provide peer to peer support and to keep up to date with current development in the R&D community.

6.9 The RDI department now has links with Library and Knowledge Service and has a specific section on their website where staff can now access information about research services and resources. The Research Twitter account is now well established.

6.10 The Trust has continued to build upon new and existing relationships commercial companies. In particular, with the Gastroenterology commercial companies it is in this area that we have seen the most growth.

SECTION SEVEN: INNOVATION AT STHK

7.1 All staff are encouraged to solve clinical and service problems and to develop new ways of working which benefit patients and improve their care. Many innovations will not be patentable or copyrightable, but nevertheless have enormous potential benefits if successfully implemented. At STHK we are keen to provide staff with opportunities to pursue their ideas. Therefore the Trust's RDI Department has responsibility for disseminating information on Intellectual Property (IP) rights, promoting awareness of those rights across the Trust, and offering advice as required to ensure activities are managed appropriately. The Intellectual Property Policy was updated in 2020 and contains an IP Pathway for staff to follow should they have an idea or invention that they wish to pursue.

7.2 At the core of the Department of Health mandate is Innovation, and the gold standard for any Trust is to develop their own innovations in care. However, all Trusts are not equal in terms of academic infrastructure and resource and the funding required developing such innovations. The Trust have made a commitment to carry out an extensive review of the Innovation function at STHK in order to shape it to meet the needs of both academic and commercial partners.

SECTION EIGHT: CONCLUSIONS

8.1 In conclusion, there have been changes to the RDI Leadership structure, and we welcomed Mr Rowan Pritchard-Jones, Medical Director, as our Research Development and Innovation Lead for the Trust, and Dr Ascanio Tridente continues as the Chair of the RDI Group.

8.2 We are extremely proud of how STHK have taken on the challenge of COVID 19. They are at the forefront of research into new treatments for COVID-19. The Research team have worked hard to open up as many NIHR Urgent Public Health research studies as possible in a short period of time. The support that the Research Team received from Clinicians, Pharmacy and Pathology staff has been exceptional and very much appreciated during this challenging time.

8.3 STHK has made excellent progress in growing its National Portfolio research activity and prioritising CRN NWC targets. We are pleased to report that STHK recruited a total of 1151 participants into NIHR CRN portfolio research studies against the proposed NIHR target of 1026. In particular only 8 out 21 organisations across the NWC CRN achieved their recruitment target and STHK we were 1 of these Trusts; this is an exceptional achievement and something that we are extremely proud of.

8.4 Having a varied portfolio of studies is of vital importance to the development of better health and care for our patients at STHK. During 2019/2020 STHK were top recruiters in a number of specialties across the NWC CRN.

8.5 It is reassuring to know that 95% (124) of research studies taking place at STHK are high quality NIHR portfolio studies. These studies have been adopted onto the NIHR portfolio, have a clear value to the NHS and have undergone the rigorous protocol peer review required before they can be considered for NIHR CRN support.

8.6 The number of new studies registered and assessed for capacity and capability has increased by 27%, from n26 in 2018/19 to n33 in 2019/2020. This is a direction of travel that we wish to continue and has been made possible by the hard work of all the Research and Support Staff at STHK.

8.7 During 2019/2020 STHK increased the number of studies that it sponsored (n6), with 2 of these being multicentre studies. Taking on the role of Sponsor means that we have responsibility for the initiation, management and financing (or arranging the financing) of a research study. Our RDI Co-ordinator and Data Manager and Research Support Team have put systems in place to ensure the smooth running of these studies.

8.8 Commercial activity has increased by 27% with 18 studies open to recruitment, compared to 15 during 2018/19. The majority of these were Gastroenterology studies (n14), which demonstrates that the team have built up an excellent reputation, and are recognised as a site that exceeds in this speciality.

8.9 The success of the Gastroenterology Research team was reinforced when they won the prestigious Excellence in the Delivery of Commercial Life Science Research at the North West Coast Research and Innovation awards in January 2020. This is second year running that STHK have won in this category and is the only organisation to have achieved this in succession; this is a testament to the dedication of our Research Team, Clinicians and Supporting Services and to the Trust, who value the importance of research and benefits it brings our patients and staff.

8.10 A total of £88,818.00 additional income was secured from the CRN NWC which included 3 successful applications for contingency funding (£76,490.00). This was utilised to increase both nurse and administrative capacity. It was recognised that the Research Nurses can get weighed down with data and administrative duties, which can be burdensome, and this support allowed the nurses to focus on recruitment

8.11 Partnerships with neighbouring Universities were instigated during 2019/2020 with the aim of increasing Clinical Academic posts and working together on NIHR funding calls/bids in the future.

8.12 The Research Team were encouraged to further develop their skills and were supported to enrol onto various university and local educational courses.

SECTION NINE: RECOMMENDATIONS FOR 2020/2021

It is imperative that the Trust builds on its success in the future and develops our reputation as a Research and Innovation active Trust.

In these uncertain times of COVID 19 it is also important that we maintain a balanced research pipeline, therefore we will continue to scope the NIHR portfolio for suitable studies whilst ensuring research into COVID 19 remains a priority.

Our aims for 2020-2021 are to:

9.1 Work hard to ensure that the objectives of the 3 year Research, Development and Innovation strategy are met. This clearly states our vision for the continued advancement of Research, Development and Innovation and will enable STHK to promote a culture where RDI drives better patient care, and improve the Trust's capacity, capability and delivery of clinical research.

9.2 Increase our Research Nurse Workforce. Research at the Trust has grown exponentially over recent years; therefore more support is required for the delivery of important research. We intend to increase the research workforce, by submitting business cases to the CRN NWC for additional income when opportunities arise.

9.3 Negotiate the funding allocation from the CRN NWC. Further clarity is required to justify the new funding allocation methodology and how it is allocated proportionally to partner organisations across the patch. The Medical Director and Chair of the RDI Group will meet with CRN NWC to take this forward.

9.4 Strive to qualify for the minimum £20k DOH Research Capability Funding (recruiting 500 or more participants to non-commercial research).

9.5 As stated in the RDI Strategy we recognise there is a need to empower staff to become innovators, therefore we will promote and raise awareness via as many routes as possible. We will develop and implement an innovation awareness session that will give staff the confidence to come forward with their ideas and review them for potential. It is important that staff have at least:

- A brief introduction to innovation
- Definition of what innovation is
- Explanation of what the innovation process involves
- Provision of some examples of innovation projects

We will also identify Innovation Champions from a range of professions. Individuals will need to spend some time (approx 6-10 days/year) on their Innovation Champion role alongside their normal duties. This will be someone with an interest in, and passion for, innovation related to all aspects of improving health care. We expect them to access national networks, to share learning and experiences, and make new connections. This is vital to expanding and growing innovation at STHK.

9.6 Explore opportunities for dedicated research appointments, including clinical academic posts, in order to address clinically relevant research questions for the benefit of our patients.

9.7 Deliver more NIHR studies. We will involve Doctors in training as Associate Principal Investigators and encourage Research Nurses to take on the role of Principal Investigators for low risk, non- interventional studies.

9.8 Develop partnerships with other local academic organisations, including John Moore's University, Manchester Metropolitan University and in particular Edge Hill University. Edge Hill have recently opened a new Medical School that is one of only three new free-standing medical schools in the country, and the only one in the North West, the undergraduate programme complementing the University's well-established postgraduate medical degrees. These partnerships will allow us to seek out the best academic expertise to work with our staff and patients wherever possible to ensure that our patients benefit from world-class research.

9.9 Ensure that we build on existing strengths and key areas of current research, as well as supporting developments in other health priority areas.

9.10 Continue to work in partnership with the CRN NWC to ensure that the NIHR high level objectives are met.

9.11 Maintain the quality of research undertaken at STHK by introducing and adapting to new systems and processes.

9.12 Promote and increase engagement in Trust research by raising awareness of research activities amongst all staff and patients.

9.13 A key priority for the Department of Health, Trust and Research Networks is to engage with industry. In 2019/2020 we aim to generate increased research funding by increasing the number of commercially sponsored studies on our portfolio.

9.14 We will invest in training our research staff, as it is imperative that they possess an understanding of the important issues that underpin research practices.

9.15 In 2020 the Library and Knowledge Services will be updating their website; we will use this opportunity to revamp the RDI section. Staff will be signposted and have access to up to date RDI developments, changes to legislation and relevant documents.

SECTION TEN: REFERENCES

1. NHS Constitution
   https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#staff-your-rights-and-nhs-pledges-to youhttp://www.legislation.gov.uk/ukpga/2012/7/section/23

2. UK Policy Framework for Health and Social Care Research 2017
   https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

3. Long Term NHS Plan
   https://www.longtermplan.nhs.uk/

4. Innovation, Health and Wealth
   https://www.nwppn.nhs.uk/attachments/article/28/InnovationHealthandWealthDec2011.pdf

5. Transforming Health Through Innovation: Integrating NHS and Academia
   https://acmedsci.ac.uk/file-download/23932583

6. The Health Research Authority
   https://www.hra.nhs.uk/

7. Results of the SPRING study
   https://www.neonatalsociety.ac.uk/?s=spring

SECTION ELEVEN: APPENDIX 1

Short Title	Managing Speciality	Recruitment 2019/20
IBD Bioresource	Gastroenterology	185
Pregnancy and Eating Behaviour (P-EAT) (Version 1)	Woman & Child	117
IBD-BOOST: SURVEY	Gastroenterology	93
VOCs in Lung ca	Cancer	69
ORION-4	Diabetes	61
The TIRED-UK Study	Emergencies	52
Clyz CanCertain Assay version 1.3	Cancer	49
BLING III	Critical Care	45
Ketone changes at end of life	Cancer	38
ISCOMAT	Cardiovascular Disease	33
PITSTOP	Surgery	31
Molecular Genetics of Adverse Drug Reactions (MOLGEN)	Cancer/Burns & Plastics	31
Toxicity from biologic therapy (BSRBR)	Rheumatology	30
UKIVAS	Rheumatology	29
Clinical Characterisation Protocol for Severe Emerging Infection	Critical Care	26
Minitub (EORTC 1208)	Cancer	21
PrEP Impact Trial	Sexual Health	20
BRAGGSS Study	Rheumatology	19
The 'Big Baby Trial'	Woman & Child	15
BSR-PsA	Rheumatology	14
WORKWELL: Testing work advice for people with arthritis	Rheumatology	13
STARRT-AKI	Critical Care	13
The CIPHER study	Surgery	12
UK Genetic Prostate Cancer Study	Cancer	11
RETAKE - Return to Work After Stroke	Stroke	10
PRIMETIME	Cancer	10
TTTS Registry	Woman & Child	9
AIR - Ankle Injury Rehabilitation	Orthopaedics	9
The Pre-Bra Feasibility Study	Surgery	6
Inflammatory signalling pathways	Rheumatology	6
Reduction Of Surgical Site Infection using several Novel Interventions	Surgery	6
POETICS 2	Critical Care	6
GenOMICC	Critical Care	6
The RE-ENERGIZE Study	Burns & Plastics	5
Record-keeping in Inflammatory Bowel Disease	Gastroenterology	4

Short Title	Managing Speciality	Recruitment 2019/20
Investigating genes in patients with polymyositis and dermatomyositis	Rheumatology	4
Development and Validation of the GCA PRO questionnaire	Rheumatology	3
The People Living with HIV Stigma Survey UK	Sexual Health	3
Patient Emollizoo study	Paediatrics	3
Parkinson's Families Project (PFP)	Care of the Elderly	3
DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	Paediatrics	3
Critical illness related cardiac arrest (CIRCA)	Critical Care	2
Open label long-term trial of BI 655130 in ulcerative colitis patients	Gastroenterology	2
CALDOSE - 1	Gastroenterology	2
The FUTURE Study	Woman & Child	2
Patient Concerns Inventory in head and neck cancer clinics	Cancer	2
EAGLE FM	Cancer	2
OUTPASS	Rheumatology	2
UKALL 14	Cancer	2
NSCCG	Cancer	2
Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows	Orthopaedics	1
Upadacitinib CD Ph 3 Conventional Therapy IR	Gastroenterology	1
1368-0005 BI 655130 in patients with active ulcerative colitis	Gastroenterology	1
BI655130 ad-on therapy in Ulcerative Colitis (UC)	Gastroenterology	1
Long Term Safety of Filgotinib in Active Crohn's Disease	Gastroenterology	1
Long Term Safety of Filgotinib in Active Ulcerative Colitis	Gastroenterology	1
ALPHA.	Dermatology	1
LORIS	Cancer	1
LI-1	Cancer	1
BADBIR	Dermatology	1

Managing Speciality	Number of Studies	Number of Recruits
Burns & Plastics	1	5
Cancer	12	208
Cancer/Burns & Plastics	1	31
Cardiovascular Disease	1	33
Care of the Elderly	1	3
Critical Care	6	98
Dermatology	2	2
Diabetes	1	61
Emergencies	1	52
Gastroenterology	10	291
Orthopaedics	2	10
Paediatrics	2	6
Rheumatology	9	120
Sexual Health	2	23
Stroke	1	10
Surgery	4	55
Woman & Child	4	143
Grand Total	**60**	**1151**

SECTION ELEVEN: APPENDIX 2

Terms of reference of the Research Development and Innovation Group

No	Title Core Members	Named Deputy (if app)
1	Consultant Critical Care, Consultant Physician	Chair
2	RDI Manager (Vice Chair)	Vice Chair

3.	RDI Co-ordinator	13.	Diabetes Consultant
4.	Research Pharmacist	14.	Emergency Medicine Consultant
5.	Senior Research Nurse	15.	General Surgery Consultant
6.	Cancer Services Manager	16.	Obstetrics & Gynaecology Consultant
7.	Education Facilitator	17.	Paediatrics Consultant
8.	Radiologist	18.	Plastic Surgery Consultant
9.	Management Accountant	19.	Rheumatology Consultant
10.	Lay Member	20.	Palliative Care Consultant
11.	Stroke Consultant	21.	Sexual Health Consultant
12.	Anaesthetics Consultant		

No	Title Non-Core Members
1	R&D Manager – NW Borough's Healthcare NHSFT
2	Clinical Research Network – Northwest Coast

Objectives

- Review and approval of the RDI strategy consistent and compliant with contemporary (inter)national guidance.
- Review and approval of the Annual RDI Report (written by the RDI Manager)
- Review and approval of the Research Capacity and Capability Statement
- Review and approval of the Research Standard Operating Procedures

SECTION ELEVEN: APPENDIX 3

Adams, T; Connor, M; Whittaker, R. (2019). **Protecting our digital medicine infrastructure**. *NPJ Digital Medicine*. epub Oct 2

Adjei, B; George, C; McArthur, P. (2019). **An anomalous accessory flexor digitorum profundus muscle to the ring finger originating from the flexor pollicis longus tendon**. *Journal of hand surgery (European volume)*. Published ahead of print

Al-Jabir, A; McCabe, JE et al. (2019). **The role of dry-lab and cadaveric simulation for cystoscopy and intravesical Botulinum toxin injections**. *Translational Andrology and Urology*. 8 (6), 673-677

Barton MA. (2019). **Boosting morale: "good job, junior"**. *BMJ*. 365 (24 June), l4344

Benson, R; Abernethy, R et al. (2020). **Biologic monotherapy in the biologic naïve patient with rheumatoid arthritis (RA): results from an observational study**. *Rheumatology International*. epub 21 Feb

Chidozie, E;. (2019). **Suprapubic catheter change, what could go wrong?** . *BMJ Case Reports*. 12 (7)

Chin, G; Allsup, S; Fratalia, L. (2019). **Autoimmune encephalitis presenting with cognitive decline and hyponatraemia.** *British journal of hospital medicine*. 80 (6), p350-351.

Coomarasamy, A; Rao, S et al. (2019). **A randomized trial of progesterone in women with bleeding in early pregnancy**. *New England Journal of Medicine*. 380 (19), 1815-1824

Daskalopoulou, A; Keeling, K; Pritchard-Jones, R. (2019). **Understanding technology mediation and new service provider roles in health care**. *Journal of Services Marketing*. 33 (2), 245-254

Daskalopoulou, A; Palmer, M; Keeling, K; Pritchard-Jones, R. (2019). **Discretionary technology bootlegging tensions in institutional healthcare work**. *New Technology, Work and Employment*. 34 (1), 73-89

Edwards, M and Tridente, A. (2019). **EP229 Initial Measurement of Ideal Body Weight in Ventilated Patients to Guide Tidal Volumes**. *Journal of the Intensive Care Society*. 20 (Suppl 2), 174-5

Eustace, K; Carr, R; West, E; Bakshi, A. (2020). **Multiple Lobulated Swellings: Answer**. *American Journal of Dermatopathology*. 42 (1), 61-62

Eustace, K; Carr, R; West, E; Bakshi, A. (2020). **Multiple Lobulated Swellings: Challenge**. *American Journal of Dermatopathology*. 42 (1), e1-e2

Fenning LA. (2019). **Time for a new approach?**. *Imaging & Therapy Practice*. Aug (0), 18-24

Fenning, LA; Melling, R. (2019). **Posters in imaging & therapy practice: radiographer abnormality detection systems: how accurate are we?**. *Imaging & Therapy Practice*. Nov (-), 20

Floyd, MS Jr. (2019). **Starting a Urethroplasty Service: Initial results from a UK centre**. *European Urology Supplements*. 18 (5), e2528

Floyd, MS Jr. (2020). **Letter to the Editor re: A rare case of renal collision tumour of oncocytoma and sarcomatoid renal cell carcinoma, Chang et al**. *Journal of Clinical Urology*. 13 (1), 70-71

Floyd, MS Jr; Khadr, RN. (2019). **Re: Antibiotic prophylaxis prior to urodynamic study in patients with traumatic spinal cord injury. Is there an indication?**. *International Brazilian Journal of Urology*. 45 (4), 860-1.

Floyd, MS Jr; Omar AM. (2019). **Letter to the editor re: Paratesticular sarcomas: a case series and literature review: Keenan et al**. *Therapeutic advances in urology*. epub May 3

Floyd, MS Jr; Omar AM. (2019). **Re: MR urethrography compared with operative findings for the evaluation of urethral strictures**. *International Urology and Nephrology*. 51 (11), 1985-1986

Floyd, MS Jr; Omar, AM; Baird, AD; Anderson, PCB. (2019). **Re: The effect of urethroplasty surgery on erectile and orgasmic functions: a prospective study**. *International journal of Brazilian Urology. 45 (2)*

Gibson, JAG; Shokrollahi, K et al. (2019). **Identifying patient concerns during consultations in tertiary burns services: development of the Adult Burns Patient Concerns Inventory**. *BMJ Open*. 9 (12).

Gumprecht, J; Domek, M; Hill, AM; Lip, GYH. (2020). **Avoiding Stroke: A Continuous Monitoring Challenge**. *Cerebrovascular Diseases.* epub Mar 20.

Hanley, T; Lavery, M; Thompson, B; Fattah, A; Parslew, R; Al-Sharqi, A. (2019). **PA13 Paediatric 2-week-wait skin cancer audit**. *British Journal of Dermatology*. 181 (S1), 150

Hanson, F; Brown, J. (2019). **Low-carbohydrate diets for children and young people with type 1 diabetes: Unpicking the evidence**. *Journal of Diabetes Nursing*. 23 (5), 95

Howard, J; MacKenzie, B; Nicholson, T; Connolly S; Parmar, R . (2019). **A unique presentation of destructive shoulder arthropathy in the chronic phase of chronic myeloid leukaemia**. *Shoulder & elbow*. 11 (3), p210-214

Hughes, KE; Corbett, HJ. (2019). **Ultrasound evidence of bladder outlet obstruction secondary to lichen sclerosus et atrophicus in boys (balanitis xerotica obliterans)**. *Journal of Pediatric Surgery*. epub Aug 13

Irwin, A; Whitehead, I et al. (2019). **The NeST (neoadjuvant systemic therapy in breast cancer) study – Protocol for a prospective multi-centre cohort study to assess the current utilization and short-term outcomes of neoadjuvant systemic therapies in breast cancer**. *International Journal of Surgery Protocols*. 18, 5-11

John, CM; Mathew, DE; Abdelaziz, M; Mahmoud, AAH; AlOtaibi, AD; Sohal, APS. (2019). **Anti-N-methyl-d-aspartate receptor encephalitis: A case series and review of the literature**. *Journal of Pediatric Neurosciences*. 14 (4), 180-185

Kalaiselvan, R; Liyanage, A; Rajaganeshan, R. (2019). **Short-term outcomes of endoscopic pilonidal sinus treatment.** *Annals of the Royal College of Surgeons of England.* 5, p1-4.

Katira, A; Katira, R. (2019). **Cangrelor**. *Practical Diabetes*. 36 (6), 222-223a

Khan, KA; Mubarik, A; et al. (2020). **Working Collaboratively: Outcomes of Geriatrician Input in Older Patients Undergoing Emergency Laparotomy in a District General Hospital**. *Cureus*. 12 (2), e7069

Kostopoulou, A; Zeljko, HM et al. (2019). **Atrial fibrillation-related stroke in women: Evidence and inequalities in epidemiology, mechanisms, clinical presentation, and management**. *Clinical Cardiology*. epub Nov 6

Lloyd, M. (2020). **Comparison of pharmacy technicians' and doctors' medication transcribing errors at hospital discharge**. *European Journal of Hospital Pharmacy*. 27 (1). 9-13

Lloyd, M; Bennett, N; Hart, A; Michaels, S; Cardwell, J; Furlong, N. (2019). **Exploring the impact of a pharmacist-led feedback intervention on insulin prescribing error frequency**. *Diabetic Medicine*. 36 (S1), 29

Lloyd, M; Hart, A; Bennett, N; Michaels, S; Cardwell, J; Furlong, N. (2019). **Exploring the impact of a feedback intervention on insulin prescribing behaviour: A qualitative study**. *Diabetic Medicine*. 36 (S1), 112

Loizou, E. et al. (2019). **Developing today's trainees to become tomorrow's clinical researchers – an innovative collaboration driving improvements in clinical training and research delivery**. *Future healthcare journal*. 6 (1 suppl)
Matar, HE; Emms, N; Raut, V. (2019). **Effectiveness of Negative-Pressure Wound Therapy following Total Hip and Knee Replacements**. *Journal of Long-Term Effects of Medical Implants*. 29 (1), 51-57

Matar, HE; Stritch, P; Emms, N. (2019). **Failure of Cemented Constrained Acetabular Component at the Bipolar Outer Femoral Head Interface in Revision Hip Arthroplasty**. *Journal of Long-Term Effects of Medical Implants*. 29 (1), 7-9

McAllister, R; Hassan, D; Shokrollahi, K. (2019). **Book Review: Special Types of Finger Replantation**. *Annals of Plastic Surgery*. 83 (5), e1

McIntosh, SA; Whitehead, I et al. (2020). **National utilisation of neoadjuvant systemic therapy and impact on surgical treatment - A prospective multi-centre cohort study**. *Cancer Research*. 80 (4 Suppl), Abstract nr P2-16-04

McMullen, P; Lewis, P; McGugan, O' Mortimer, K. (2019). **Perils of the Pneumatic Tube: How Clean Are Your Pods?**. *Journal of Hospital Infection*. epub Nov 29

Mohan, R; Dhotare, SV; Unnikrishnan, PN; Jakaraddi, C. (2020). **Bilateral hamstring origin calcification: rare presentation of Gitelman syndrome**. *BMJ Case Reports*. 13 (1)

Mohan, R; Unnikrishnan, P.N.; Gudena, R. (2020). **Validity of direct magnetic resonance arthrogram in patients with femoroacetabular impingement and their outcome post hip arthroscopy**. *Journal of Orthopaedics*. 18 (March-April), 204-208

Nagarajan, M; Mohamed, S; Asmar, O; Stubbington, Y; George, S; Shokrollahi, K. (2019). **Data from**

national media reports of ‘Acid attacks’ in England: A new piece in the Jigsaw. *Burns*. epub Nov 26

Nagarajan, M; Shokrollahi, K. (2019). **Book review: Dermatologic Complications With Body Art Tattoos, Piercings and Permanent Make-up**. *Annals of Plastic Surgery*. 83 (5), e2

Nicolson, P; Loizou, E; Garth, L et al. (2019). **A HaemSTAR-led, UK-wide 'flash-mob' audit of -intravenous immunoglobulin use in immune -thrombocytopenia**. *Clinical Medicine*. 19 (Suppl 3), S82

O'Donnell, S; Davies, F; Vardhan, M; Nee, P. (2019). **Could this be measles?** *Emergency Medical Journal*. Published Online First: 03 April 2019

Ogwulu, OCB; Rao, S et al. (2020). **The cost-effectiveness of progesterone in preventing miscarriages in women with early pregnancy bleeding: an economic evaluation based on the PRISM Tria**l. *BJOG An International Journal of Obstetrics and Gynaecology*. epub 30 Jan

Peach, H; Pritchard-Jones, R et al. (2020). **Current role of sentinel lymph node biopsy in the management of cutaneous melanoma: A UK consensus statement**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*. 73 (1), 36-42

Pedder, A; Harrold, R; Cruikshanks, A; Tridente, A; Raithatha, A. (2019). **P256 Impact of frailty on critical care and hospital mortality in critically-ill patients with decompensated alcoholic liver disease**. *Critical Care*. 23 (S2), 110-111

Pina, IM; Hughes, KE, Floyd, MS Jr; Shokrollahi, K; Omar, AM . (2019). **Letter to the editor re: Penile paraffinoma: A rare but important presentation. A Gaukroger et al**. *Journal of clinical urology*. 1-2

Pina, IM; Omar, AH; Floyd, MS Jr. (2019). **Re: “Late Presentation of a 9mm Bullet in the Ureteropelvic Junction Causing Acute Renal Failure in a Solitary Functioning Left Kidney” by Jhaveri and D'Angelo (J Endourol Case Rep. 2018;4:173–175)**. *Journal of Endourology Case Reports*. 5 (1), 28-29

Pina, IM; Omar, AM; Floyd, MS Jr. (2019). **Eccrine hidrocystoma of the external meatus in a hypospadiasis patient: a rare finding**. *Journal of Clinical Urology*. epub Aug 20

Povey, M; Blacker, S et al. (2019). **Awareness of surgical expenditure amongst UK trainees and consultants: A questionnaire study**. *International Journal of Surgery*. 67 (July), 8-12

Power, G. (2019). **Breast School: A Holistic Approach to Optimise Recovery Following Breast Surgery**. *European Journal of Surgical Oncology*. 45 (11), 2227

Pushdary, K; Atherton, J; Ray, A; Jois, R. (2019). **Re-excision After Breast Conservation Surgery – Our Breast Unit experience**. *European Journal of Surgical Oncology*. 45 (11), 2201

Qazi, E; Phillips, D; Low, SE; Khirwadkar, N; Ngan, K. (2019). **DP18 A rare association between interstitial granulomatous dermatitis and myelofibrosis: An interesting case report**. *British Journal of Dermatology*. 181 (S1), 125

Quah, E; Amoasii, C; Mudawi, T; Dawson, J. (2019). **Systematic literature review investigating whether**

methotrexate causes chronic pulmonary fibrosis. *Future Healthcare Journa*l. 6 (Suppl 2), s4

Ramavath, A; Howard, N; Lipscombe, S. (2019). **Biomechanical considerations for strategies to improve outcomes following volar plating of distal radius fractures**. *Journal of Orthopaedics*. 16 (5), 445-450

Reddy, G; Islam, SUI; Chandran, P; Attar, F. (2020). **Can the Surgical Approach to Total Knee Arthroplasty Influence Early Postoperative Outcomes? – A Comparative Study between Trivector and Medial Parapatellar Approaches**. *International journal of applied & basic medical research*. 10 (1), 25-29

Riogi, B; Sripadam, R; Barker, D; Harris, O; Innes, H; Chagla, L. (2020). **Management of the axilla following neoadjuvant chemotherapy for breast cancer- A change in practice**. *The Surgeon*. epub Mar 17

Rousseva, C; Kammath, V; Tancred, T; Smith, H. (2020). **Health workers' views on audit in maternal and newborn healthcare in LMICs: a qualitative evidence synthesis**. *Tropical Medicines & International Health*. epub 29 Jan

Rowson, M; Lloyd, M; Hart, A; Michaels, S; Cardwell, J; Furlong, N. (2019). **Application of multiprofessional simulation-based training to support healthcare staff in the management of hypoglycaemia**. *Diabetic Medicine*. 36 (S1), 30-31

Santini, AJ; Jakaraddi, CA; Polydoros, F; Metikala, S. (2019). **Validity of the International Prostate Symptoms Score in predicting urinary retention after joint replacement**. *Journal of Orthopaedic Surgery*. 27 (3)

Saunders, R; Clark, S; Stubbington Y; Tridente, A. (2019). **EP282 Revising the RCA; Streamlining Root-Cause Analyses for bacteraemias on ITU**. *Journal of the Intensive Care Society*. 20 (Suppl 2), 212

Saunders, R; Clark, S; Tridente, A; Stubbington Y. (2019). **EP265 De- Bugging ITU; What to do with a positive blood culture**. *Journal of the Intensive Care Society*. 20 (Suppl 2), 201

Selinger, CP; Bassi, A et al. (2019). **Assessment of steroid use as a key performance indicator in inflammatory bowel disease—analysis of data from 2385 UK patients**. *Alimentary Pharmacology and Therapeutics*. 50 (9), 1009-1018

Sharkey, K; Marsh, K. (2019). **Posters in imaging & therapy practice**. *Imaging & Therapy Practice*. October (-), 22

Smith, EMD; Lythgoe, H; Hedrich, CM. (2019). **Vasculitis in Juvenile-Onset Systemic Lupus Erythematosus**. Frontiers in pediatrics. 7 (149)

Taghizadeh, R. (2019). **Invited discussion on: Identifying Preoperative Factors Associated with the Volume Discrepancy in Patients Undergoing Breast Reconstruction with the Extended Latissimus Dorsi Musculocutaneous Flap Coverage**. *Aesthetic Plastic Surgery*. 43 (6), 1497–1499

Thornton, H. (2019). **Reflection on 30 years as a PDSN**. *Journal of Diabetes Nursing*. 23 (5), 94

Touil, L; Barnes, J; Howes, A; Harper-Machin, A; Shaaban, H. (2019). **An 11-year analysis of head and neck**

melanomas following Sentinel lymph node biopsy. *Nuclear medicine communications*. 40 (4), p422-423.

Touil, LL; Saggar, AK; Taghizadeh, R. (2019). **Autologous breast reconstruction in patients with achondroplasia: Reconstructive and anaesthetic challenges**. *Journal of plastic, reconstructive & aesthetic surgery: JPRAS*. 72 (7), 1219-1243

Tridente, A; et al. (2019). **Methodological challenges in European ethics approvals for a genetic epidemiology study in critically ill patients: the GenOSept experience.** *BMC Medical Ethics.* 20 (30), epub 7 May

Veal, A; Goel, V. (2019). **Introducing a quick reference guide for emergency uterotonic and uterine relaxant drug use in maternity theatres**. *Anaesthesia*. 74 (s3), 94

Vlajcic; Z; Dewing, D et al. (2019). **The "dermal cage": Inferiorly based dermal flap technique for breast reconstruction after mastectomy**. *JPRAS: Journal of Plastic, Reconstructive & Aesthetic Surgery*. epub Oct 5

Whitehead, IJ; Fernandes, L; Haris, O; Chagla, L. (2019). **Gynaecomastia: a cosmetic concern or a concerning clinical sign?**. *Annals of the Royal College of Surgeons England*. 101 (8), e184-186

Williamson, J; Lloyd M. (2019). **Understanding randomised controlled trials: a guide for prescribers**. *Journal of prescribing practice*. 1 (5)

Wolstenhulme, S; Daulby, M. (2019). **Re: Professional protectionism; a barrier to employing a sonographer graduate?**. *Radiography*. 25 (3), 274-275

Wolstenhulme, S. and Daulby, M.. (2019). **RE: Sevens and Reeves 'Professional protectionism; a barrier to employing a sonographer graduate?' and Mitchell and Nightingale 'Sonography culture: Power and protectionism'**. *Radiography*. 25 (3), p.276

Wong, SWP; Yap, Y; Narayanan, RP; Al-Jubouri, M; Grossman, A; Daousi, C; Mahgoub, Y. (2019). **Etomidate in the management of severe Cushing's disease and MRSA bacteraemia in a district general hospital in the United Kingdom**. *Endocrinology, Diabetes & Metabolism Case Reports*. epub Sep 12

Xu, J; Aslam, A; Biswas, A. (2019). **Asymptomatic Indurated Plaque in a 16-year-Old Girl**. *American Journal of Dermatopathology*. 41 (12), 948-949

Yip, V; Hindle, E; Olsson-Brown, A; Pirmohamed, M. (2019). **P097 Cutaneous toxicity from immune checkpoint inhibitors: Experience from a specialist dermatology unit**. *British Journal of Dermatology*. 181 (S1), 69

TRUST BOARD

Paper No: NHST(20)080
Title of paper: Arrangements for 2021/22 Trust Board Meetings
Purpose: To advise Board members of the proposed dates for Trust Board meetings throughout the next Financial Year; the supporting timetable, and agreed work plan.
Summary: 1. Board meetings have been held on the last Wednesday of each month and it is proposed that this arrangement will continue during 2021/22. 2. The paper confirms the dates for agenda setting, collation and distribution of papers and of actual meetings. 3. The Board also maintains a work plan to schedule agenda items throughout each year to ensure that it meets all statutory requirements and delivers the duties and responsibilities in the Trust's standing orders. 4. This schedule, once approved, is used to inform the work plans of the Board committees 5. The work plan may be amended as a result of the annual board effectiveness review that is conducted between January and April each year, or in light of any new statutory or regulatory requirements.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements which ultimately support the Trust in achieving its Annual Objectives.
Financial implications: None directly from this report.
Stakeholders: Directors, Commissioners, Regulators and other stakeholders and partners.
Recommendation(s): The Trust Board are asked to: 1. Approve the proposed dates and associated administrative timetable for Trust Board meetings. 2. Approve the proposed schedule of planned agenda items for Trust Board meetings.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 25th November 2020.

SCHEDULE OF TRUST BOARD MEETING DATES (2021/22)

1. Meeting Schedule

1.1. Board meetings are held on the last Wednesday of each month with the exception of August and December.

1.2. The Trust believes in being open and transparent and members of the public are able to attend the public section of each Board meetings. Public Trust Board meetings, commence at 9:30a.m. and are scheduled to run for 2 - 3 hours.

1.3. Four meetings a year (April, June, October and February) include discrete sessions for discussion on strategy, which are held in private following public Trust Board meetings.

1.4. In addition, where necessary, meetings include discrete closed sessions for discussion on items of a sensitive or confidential nature, which are held in private following public Trust Board meetings.

2. Administrative Arrangements

2.1. Board agendas are developed by the Executive Committee on behalf of the Chairman at least ten days in advance of meetings.

2.2. Both hard copies and electronic versions of the Board papers are distributed to members on the Friday preceding each Board meeting.

2.3. Papers for Public Board Meetings are uploaded onto the Trust internet site on the Tuesday before each meeting.

2.4. The following table captures the schedule for the 2021/22 Financial Year. Meetings that include a strategy session are shaded grey.

Financial Year 2021/22	Agenda set	Board papers to be received	Electronic & hard copies circulated	Electronic copies on internet	Board date
April	Thurs 08 Apr	Tue 20 Apr	Fri 23 Apr	Tue 27 Apr	Wed 28 Apr
May	Thurs 06 May	Tue 18 May	Fri 21 May	Tue 25 May	Wed 26 May
June	Thurs 10 Jun	Tue 22 Jun	Fri 25 Jun	Tue 29 Jun	Wed 30 Jun
July	Thurs 08 Jul	Tue 20 Jul	Fri 23 Jul	Tue 27 Jul	Wed 28 Jul
August					
September	Thurs 09 Sep	Tue 21 Sep	Fri 24 Sep	Tue 28 Sep	Wed 29 Sep
October	Thurs 07 Oct	Tue 19 Oct	Fri 22 Oct	Tue 26 Oct	Wed 27 Oct
November	Thurs 04 Nov	Tue 16 Nov	Fri 19 Nov	Tue 23 Nov	Wed 24 Nov
December					
January	Thurs 06 Jan	Tue 18 Jan	Fri 21 Jan	Tue 25 Jan	Wed 26 Jan
February	Thurs 04 Feb	Tue 15 Feb	Fri 18 Feb	Tue 22 Feb	Wed 23 Feb
March	Thurs 10 Mar	Tue 22 Mar	Fri 25 Mar	Tue 29 Mar	Wed 30 Mar

3. PROPOSED TRUST BOARD WORK PLAN (2021/22)

ANNUAL TRUST BOARD CALENDAR 2021/22 (Proposed)

Month			ToR	A	M	J	J	A	S	O	N	D	J	F	M	Report	Presenter
Scheduled agenda items	General	Employee of the month		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Anne-Marie	Richard
		Patient story			✔		✔		✔		✔		✔		✔	Sue	Various
		Apologies		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Declaration of interests	8	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Minutes of the previous meeting		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Action list / matters arising		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Meeting Effectiveness Review		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Any other business		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
	Committee Reports	Audit (inc approval of Corp Governance Manual and Standing Financial Instructions)	2,6,7,10,11,14,15,32,33,34	✔	✔				✔	✔				✔		Nik	Ian
		Executive	3,11,16,18	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nicola	Ann
		Finance and Performance	11	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	Jeff
		Quality (inc Safer Staffing and infection control)	11, 25	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Sue	Gill
		Charitable Funds	11			✔				✔				✔		Nik	Paul
	Operational performance reports	Strategic and regulatory report	3	✔		✔				✔				✔		Nicola	
		Integrated performance report	3,4	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	
		Corporate Risk Register	3	✔			✔			✔			✔			Nicola	
		Board Assurance Framework	3	✔			✔			✔			✔			Nicola	
		Aggregated Incidents, Complaints and Claims report	3,9		✔					✔			✔			Sue	
		Informatics Report and Strategy update	3			✔										Christine	
		Learning from Deaths Quarterly Report	3	✔			✔			✔			✔			Rowan	
		Workforce Strategy and HR indicators report	3				✔						✔			Anne-Marie	
	Annual reports	Adoption of Annual Accounts	1		✔											Nik	
		Approval of Quality Account	25		✔											Sue	
		NHS Licence Conditions Board declarations	1			✔										Nicola	
		Audit Plan approval	33		✔											Nik	
		Board and Committee Effectiveness Review	5,12,13		✔											Nicola	
		Information Governance Annual Report	1,3		✔											Christine	
		Trust objectives approval & mid year review	3,24,31		✔						✔				✔	Nicola	Ann
		Medical revalidation annual declaration	20						✔							Jacqui Bussin	
		Audit Letter sign-off	1,33						✔							Nik	
		Charitable Funds Accounts & Annual Report	1							✔						Nik	
		Research & Development Annual Report	4								✔					Rowan	
		Research & Development Annual Capability Statement	4								✔					Rowan	
		Biennial Review of NHS Constitution	1								✔					Nicola	
		Trust Board meeting arrangements	1								✔					Nicola	
		EPRR Compliance statement	1						✔							Sue	
		WRES & WDES Reports and Action Plans	1,3				✔									Anne-Marie	
		Clinical and quality strategy update	24,25										✔			Rowan	
		Safeguarding Annual Report (Adult & Children)	1							✔						Sue	
		Operational Plan - Budget and activity approval	1,2,7,29,30										✔		✔	Nik	
		National Quality Board - annual workforce plan approval and 6 month staffing review/Workforce Safeguards Report	1, 3						✔					✔		Sue	Anne-Marie
		Infection Control Annual Report	3						✔							Sue	
		CQC registration	1,25												✔	Sue	
		Mixed sex annual declaration	1												✔	Sue	
		Fit and Proper Persons Chair's Report	8			✔										Nicola	Richard
		Freedom to speak up - Board Self Assessment	20											✔		Anne-Marie	
		7 - Day Services Assurance Reports	3, 20			✔					✔					Rowan	
		Gender Pay Gap Annual Declaration	20												✔	Anne-Marie	
		Staff survey report and action plan	20												✔	Anne-Marie	
	Total scheduled items			16	20	17	17	0	17	20	18	0	19	16	18		
Closed Session	Chair and NED meeting (or as required)			✔		✔				✔				✔		Richard	
	Chief Executives report				✔		✔		✔		✔		✔		✔	Ann	
	Serious untoward incidents		1		✔		✔		✔		✔		✔		✔	Sue	
	Suspensions		17		✔		✔		✔		✔		✔		✔	Anne-Marie	
	Feedback from external meetings and events				✔		✔		✔		✔		✔		✔	All	
	Review of meeting effectivness				✔		✔		✔		✔		✔		✔	Richard	
	Director mandatory training / Corporate Law update		20							✔						External facilitators	

* Bi ennial unless national changes to the NHS Constitution

TRUST BOARD

Paper No: NHST(20)081
Title of paper: Quality Account 2019-20
Purpose: To submit to the Board the final draft version of the Quality Account for 2019-20 for review and approval.
Summary: The final draft of this year's Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012. The deadline to publish the Account by 30th June was postponed this year, with a revised date of 15th December agreed. The Director of Nursing, Midwifery and Governance and Deputy Director of Governance presented the draft Account to a number of partners at an external event via Teams on 16th October to St Helens and Knowsley CCG and Healthwatch representatives. The feedback from the presentation was very positive, with no amendments required to the report. Written feedback has been received from both Knowsley and Halton Healthwatch and St Helens and Knowsley Clinical Commissioning Groups. The final Quality Account will be provided to the Communications Team for layout and design purposes. We remain on track to ensure that the final version is uploaded to the NHS website by the deadline of 15th December 2020. There was no requirement for the Account to be reviewed by our External Auditors this year. The Quality Committee reviewed the draft at the meeting held on 22nd September 2020. The final draft is attached as Appendix 1.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch
Recommendation(s): Members are asked to review and approve the Quality Account.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 25th November 2020

Appendix 1

Quality Account 2019-20

What our patients said about us in 2019-20

My husband had a stroke … From a very bleak outlook explained to us with compassion and care he is now home. The staff on 5D and 5C were amazing. They treated him with dignity and care and us with compassion. They were always friendly and professional, ensuring both his physical and emotional needs were met.

The catering and cleaning staff worked relentlessly to ensure he had food he liked and could manage and the room was spotless.

The teamwork has continued with regular visits at home from the stroke team, speech and language and physio. As a family we cannot thank everyone enough. You are all truly outstanding. For a system that is clearly under immense pressure from underfunding and stretched staff we just have incredible gratitude and admiration for everyone who cared for our family.

Stroke services

I attended St Helens Hospital today, three weeks after cataract surgery.

I cannot thank the team enough for their sterling work, from the pre-op where they went through all the steps of the procedure, putting my mind at rest, to the operation itself.

The nurses, anaesthetist and surgeon were absolutely brilliant; this is a gold standard service!

Eye clinic

I was recently admitted to Ward 2D and would like to say what a wonderful ward and staff they are. Nothing was ever too much, my care was exemplary, any test I needed was arranged quickly.

I can't commend the staff highly enough – it's a very busy ward but the team work shown was fabulous. A sign of excellence. Thank you to all the staff for their expert care and time.

Endocrinology/General Medicine

I recently had a hip replacement done at Whiston and would just like to pass on my thanks to every single person involved in my treatment.

The ward staff on Ward 3E are an exceptional group of dedicated and professional people. My treatment by them was exemplary….I even enjoyed the food, every meal was hot, well presented and very tasty. All in all I had the best experience I could have had whilst undergoing a medical procedure. I hope you will pass on my praise and thanks to all of the staff on Ward 3E.

Trauma and Orthopaedics

Best hospital in the North West. Best staff; been here about 5 times in 10 years. Never had a single fault. Wish they were all like this. Thank you to the CT scan team who treated me today. All three very polite and professional.

Radiology and Trust-wide

Drafting note – text in green font is mandated text

Contents

1. Section 1 7

1.1. Statement on quality from the Chief Executive of the Trust 7
1.2. Summary of quality achievements in 2019-20....... 10
1.3. Celebrating success....... 12

2. Section 2 13

2.1. About us....... 13
2.1.1. Our services 13
2.1.2. Our staff and resources 16
2.1.3. Our communities 19
2.1.4. Our partners 19
2.1.5. Technology and information 22
2.2. Summary of how we did against our 2019-20 Quality Account priorities....... 27
2.2.1. Progress in achieving 2019-20 quality goals 27
2.3. Quality priorities for improvement for 2020-21 30
2.4. Statements relating to the quality of the NHS services provided by the Trust in 2019-20 34
2.4.1. Review of services....... 34
2.4.2. Participation in clinical audit....... 34
2.4.3. Participation in clinical research 43
2.4.4. Performance in initiation and delivery of research (PID data)....... 44
2.4.5. Commercially sponsored studies....... 44
2.4.6. Key achievements 44
2.4.7. Research aims for 2020-21 47
2.4.8. Clinical Goals agreed with commissioners 47
2.4.9. Statements from the Care Quality Commission (CQC)....... 48
2.4.10. Learning from deaths 50
2.4.11. Priority clinical standards for seven day hospital services....... 55
2.4.12. Information governance and toolkit attainment levels....... 56
2.4.13. Clinical coding error rate 57
2.4.14. Data quality 57
2.4.15. Benchmarking information....... 58
2.4.16. Performance against national targets and regulatory requirements 70

3. Section 3 71

3.1. Summary of how we did in achieving our strategies 71

 Drafting note – text in green font is mandated text

3.1.1. Clinical and Quality Strategy 2019-22 71
3.1.2. Nursing and Midwifery Strategy 2020...71
3.1.3. Workforce Strategy 2019-20..72
3.1.4. Equality, Diversity and Inclusion Strategy..74
3.1.5. Freedom to speak up...76
3.1.6. Staff survey key questions...77
3.1.7. Health, Work and Wellbeing 79
3.2. Patient safety 81
3.2.1. Pressure ulcers...81
3.2.2. Falls 83
3.2.3. Venous thromboembolism (VTE)..83
3.2.4. Medicine safety...84
3.2.5. Theatre safety...84
3.2.6. Being open – duty of candour..85
3.2.7. Never Events 86
3.2.8. Safety Thermometer 86
3.2.9. Infection control 87
3.2.10. Safeguarding..90
3.3. Clinical effectiveness..93
3.3.1. National Institute for Health and Care Excellence Guidance 93
3.3.2. Clinical audit 94
3.3.3. Intensive Care National Audit & Research Centre (ICNARC).......................94
3.3.4. Mortality 94
3.3.5. Copeland risk adjusted barometer (CRAB)..94
3.3.6. Promoting health 95
3.4. Patient experience 96
3.4.1. Friends and Family Test 98
3.4.2. Complaints...100
3.5. Service developments during 2019-20...101
3.5.1. Surgical Care Group..101
3.5.2. Medical Care Group 103
3.5.3. Primary and Community Services Care Group...106
3.5.4. Clinical Support Services Care Group 107
3.6. Summary of national patient surveys 109
3.6.1. National Inpatient Survey...109
3.6.2. National Urgent and Emergency Care Survey...110

3.6.3. National Children and Young People Survey 2018 110
3.6.4. National Maternity Survey 111
3.6.5. National cancer patient experience survey (NCPES) 112
4. Annex 114
4.1. Statement of Directors' responsibilities in respect of the Quality Account 114
4.2. Written statements by other bodies 115
4.2.1. Knowsley Clinical Commissioning Group and St Helens Clinical Commissioning Group 115
4.2.2. Healthwatch Halton 117
4.2.3. Healthwatch Knowsley 119
4.3. Amendments made to the Quality Account following feedback and written statements from other bodies 120
5. Abbreviations 121

 Drafting note – text in green font is mandated text

1. Section 1

1.1. Statement on quality from the Chief Executive of the Trust

We are pleased to present the Trust's eleventh annual Quality Account, which reviews our performance and achievements over the past year, as well as outlining the priorities for improving quality in the coming year. It has been an extremely busy and challenging year, during which the Trust has continued to expand and grow, taking on additional services, including St Helens Urgent Treatment Centre and a wider range of community services. The end of the financial year brought with it unprecedented challenges as the Trust responded to the international COVID-19 pandemic, which required the Trust to work in new ways, to care for patients with the virus, as well as maintaining other essential services.

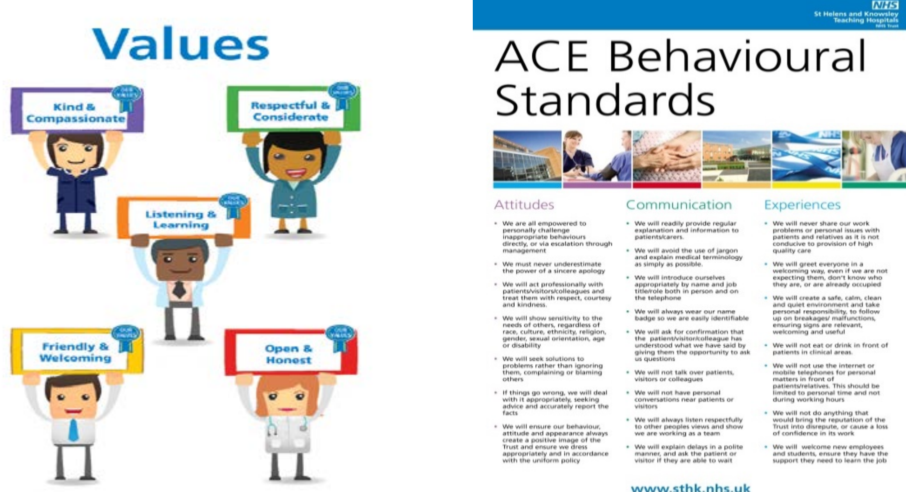
The Trust has continued to focus on its mission to provide high quality health services and an excellent patient experience. I am immensely proud of the key achievements the Trust attained, including the prestigious Acute/Specialist Trust of the Year at the Health Service Journal (HSJ) awards 2019. We have maintained our outstanding CQC rating and were the best in the country for the Patient Led Assessments of the Care Environment (PLACE). We continued to receive exceptional staff survey results, including retaining the top score nationally for quality of care and staff engagement. I was, however, extremely disappointed that during the year there was one never event relating to a retained swab in theatre and we have seen an increase in category 2 pressure ulcers. As a Trust we are committed to learning from these incidents and putting measures in place to improving the care we provide, which are outlined in more detail in section 3 below.

Our vision to provide 5-star patient care remains the Trust's primary objective so that patients and their carers receive services that are safe, person-centred and responsive, aiming for positive outcomes every time. The mission and vision continue to be embedded in the everyday working practices of staff throughout the Trust, where delivering 5-star patient care is recognised as everyone's responsibility.

The vision is underpinned by the Trust's values, five key action areas and the ACE behavioural standards of **A**ttitudes, **C**ommunication and the **E**xperiences we create. These are shown in the diagrams below:

St Helens and Knowsley Teaching Hospitals NHS Trust's Vision

St Helens and Knowsley Teaching Hospitals NHS Trust's Values and ACE Behavioural Standards



The Trust's vision is the driving force for our focus on continuous improvement, supported by the Clinical Strategy. The Strategy outlines the Trust's commitment to improving both quality and efficiency with the specific aim of promoting a culture of continuous value improvement, underpinned by robust systems and processes and individual and collective accountability. It focusses on a small number of improvements that are key local health economy priorities. The Strategy was refreshed in 2019 and is supported by an implementation plan.

The Trust has delivered a comprehensive programme of quality improvement clinical audits throughout the year, with a number of actions taken as a result of the audit findings (detailed in section 2.4.2 below). Delivery of the quality improvement and clinical audit programme is reported to the Quality Committee via the Clinical Effectiveness Council.

In addition, the Trust has a quality care accreditation programme which measures leadership, patient care, safety and experience on all wards. The Quality Care Accreditation Tool (QCAT) programme ensures that individual ward areas are clear on the quality standards required and any shortfalls requiring an improvement plan. The QCAT incorporates a range of quality indicators into the final score, including CQC fundamental standards, nursing care indicators and harm-free care scores. It also incorporates the Friends and Family Test results, patient care and safety standards, including nutrition and hydration, falls, pressure ulcers and infections, and staff training and appraisal rates. Both the nursing care indicators and the QCAT use peer review to provide assurance on the quality of care being provided to patients. The outcomes of the QCAT programme are reported to the Quality Committee via the Patient Experience Council. In 2019-20, the QCAT was reviewed, strengthened and updated and will continue to be rolled out in 2020-21.

Members of the Trust Board and Executive Team continue to visit the wards and departments across the Trust regularly, completing formal quality ward rounds to review quality and performance, noting areas of good practice and any actions taken at a local

level to address areas of concern. This provides the opportunity for the Trust Board to see first-hand the care provided to patients and for the clinical areas to provide both quantitative and qualitative information to demonstrate that the services are safe, effective, responsive, caring and well-led in line with the CQC's domains. Representatives from our local Clinical Commissioning Groups (CCGs) are invited to attend the quality ward rounds.

We have continued to work with patients and carers during the year to ensure that they are able to influence changes made to our services. Patients are able to present their experiences of the care received, in their own words, as a patient story at the start of our public Trust Board meetings.

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils, both of which report to the Trust Board's Quality Committee and the Equality and Diversity Steering Group. This ensures effective external representation in the oversight and governance structure of the Trust. Patients, carers, patient representatives and members of the public are invited to attend the open Patient Engagement Group events and to contribute to discussions about the services provided and future plans.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting any challenges and the initiatives undertaken to work towards realising our vision of 5-star patient care. It also includes a summary of the Clinical and Quality Strategy. It outlines our quality improvement priorities for 2020-21, which were subject to consultation with staff, patient representatives and our commissioners.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2019-20 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the progress we have made.

Our greatest asset is our staff and our achievements are gained through their continued hard work, their unfailing professionalism, commitment and dedication to the provision of outstanding care for our patients and their carers, as well as to each other and to the Trust. This was recognised by the Trust being awarded the highest accolade, the HSJ's Trust of the Year. I am extremely proud of all our staff and never more than now, when I have seen them respond to the needs of patients during the pandemic, tirelessly working to care for patients and each other; therefore, on behalf of the Trust Board, I would like to offer my heartfelt thanks, admiration and gratitude to all of our staff who have contributed to our many exceptional achievements, during the most challenging times we have faced.

Ann Marr
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust

1.2. Summary of quality achievements in 2019-20

Quality of services overall

- **Outstanding** rating awarded by the Care Quality Commission (CQC), the best possible rating, in the latest report received in March 2019

Well-led

- Awarded the prestigious Acute/Specialist Trust of the Year at the Health Service Journal (HSJ) awards 2019, following the outstanding CQC rating and being the best in the country for both the NHS Staff Survey and Patient Led Assessments of the Care Environment (PLACE) in 2018
- Ann Marr, Chief Executive awarded an Order of the British Empire (OBE) in the Queen's New Year Honours

National staff survey

- Most recommended acute Trust for care and treatment for second year running
- Top acute Trust for staff engagement for fourth consecutive year
- Top acute Trust for safety culture for third consecutive year
- Best national scores for 5 of the 11 themes and second best for another 5
- Highest marks in the following areas:
    - Staff morale (2018 & 2019)
    - Quality of care (2015, 2016, 2017, 2018 & 2019)
    - Bullying and harassment (2018 & 2019)
    - Positive organisational culture of safety (2017, 2018 & 2019)
    - Staff engagement (2016, 2017, 2018 & 2019)
    - Fairness for career progression (2017, 2018 & 2019)

Staff

- Disability Confident Employer accreditation in place until 2020
- Navajo Charter Mark accreditation, an equality mark signifying good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ) individuals
- Gold award for participation in the Ministry of Defence's Employer Recognition Scheme
- Shortlisted in the Reservist Support Initiative HSJ award category for the work supporting veterans' careers following service with the Armed Forces
- Nicola Walsh, Senior Pharmacy Assistant, won 'Apprentice of the Year' at the St Helens Chamber Annual Dinner & Business Awards for excelling in her apprenticeship in warehousing and distribution within Pharmacy
- Jessica Crolla, Senior Buyer, Purchasing and Supplies Department, was shortlisted for the NHS Procurement Rising Star Award at the North Excellence in Supply Awards, which celebrate inspirational examples of businesses, third sector organisations and the NHS working together to provide great patient care
- Victoria Reynolds (Equality, Diversity and Inclusion Lead) won the NHS Advocate for Step into Health award and Carl Walsh (HR Governance and Quality Lead) was highly commended for the Outstanding Impact since joining the NHS award

Patient safety

- Patients received 98.7% new harm-free care during 2019-20. New harm is the harm occurring whilst an inpatient in the Trust and reported via the NHS Safety Thermometer
- For the second year running, there were no methicillin resistant staphylococcus aureus (MRSA) bacteraemia, with one contaminant
- No patients experienced a hospital acquired category 4 pressure ulcer
- Reductions in incidents resulting in harm in 2019-20 compared with 2018-19:
    - 50% reduction in theatre-related episodes of moderate and above harms
    - 29.4% decrease in falls incidents resulting in severe harm or above from 17 in 2018-19 to 12 in 2019-20
    - 0 prescribing incidents of severe harm
    - 27.4% decrease in medicines administration omitted doses, down from 281 in 2018-19 to 204 in 2019-20
- VTE risk assessments were completed in 95.57% of patients from April 2019 to February 2020, when submissions were suspended due to the pandemic (compared to 95.92% of patients in 2018-19, exceeding the national target of 95%
- 93.9% of frontline staff received their flu vaccination, significantly above the target of 80%
- The average safer staffing fill rate for the year was 95.6%
- Completed the Trust-wide roll out of Electronic Prescribing and Medicine Administration (ePMA), enhancing safe prescribing and administration processes
- The Cellular Pathology, Microbiology, Clinical Biochemistry and Haematology & Blood Transfusion departments based at Whiston, St Helens, Southport and Ormskirk hospitals achieved United Kingdom Accreditation Services (UKAS) ISO15189 accreditation for the first time and at the first attempt since the new standards replaced the previous ones. This means that pathology is performing to high international standards with regard to quality and competency
- Trust's Radiology Service has achieved the Quality Standard for Imaging (QSI), the first trust in Cheshire and Merseyside to receive this award

Patient experience

- Best NHS trust for Patient Led Assessments of the Care Environment (PLACE) results for the third consecutive year, scoring 100% for cleanliness and condition, appearance and maintenance of the hospital buildings
- Runner up in the National Dementia Awards for the most dementia friendly hospital
- 95.6% of inpatients would recommend our services, as recorded by the Friends and Family Test (April 2019 to February 2020 as submissions were suspended in March 2020)
- Maternity Bereavement Team nominated for a Butterfly award
- Maternity service nominated for the Royal College of Midwives Caring for You award 2020
- Jenny Baxter (RM) was shortlisted for RCM Midwife of the Year award 2020

Clinical effectiveness

- Maternity Service were the top performer for the PReCePT project 2020, for significant improvements in administering magnesium sulphate to reduce the risk of cerebral palsy in pre-term babies

- Urology Specialist Nurses won the 'Team of the Year' award at the British Association of Urology Nurses (BAUN) meeting in November 2019 for their innovative and transformational service
- Research poster presented by the cancer nurses at BAUN meeting describing the outstanding work they have done in transforming the prostate cancer pathway at the Trust
- Gastroenterology Research Team won the Excellence in Commercial Life Science Research Award at the North West Coast Research and Innovation Awards, which is an outstanding achievement and demonstrates the commitment to offering patients and public the opportunity to take part in research
- Diabetes Team were the runners up for the annual Rowan Hillson Inpatient Safety Award for the Best Inpatient Educational Diabetes Programme for Health Care Professionals, reflecting the excellent diabetes education initiatives delivered at the Trust
- Consistently maintained high rating overall in the Sentinel Stroke National Audit Programme (SSNAP), delivering sustained excellent performance despite 30% increase in activity since becoming the regional centre for Mid-Mersey from April 2019
- 89.3% of stroke patients spent at least 90% of their hospital stay on a stroke unit, above the national target of 83% and better than last year's performance of 85.7%
- 94.9% of electronic E-attendance summaries sent for patients attending the Emergency Department (ED) within 24 hours
- Gastroenterology Service successfully secured Joint Advisory Group (JAG) accreditation for a further year
- Sustained achievement of the cancer performance targets against the national cancer waiting times standards prior to the impact of COVID-19 pandemic in March 2020
- St Helens and Knowsley Library and Knowledge Services won a British Burn Association award for a poster presentation in conjunction with the clinical service leads

Technology

- Telehealth solution won many accolades during 2019, including:
  - Highly commended at the inaugural Digit@ll awards at the iLinks Event in Liverpool
  - Shortlisted for the HSJ Value award
  - Highly commended in the Leading Healthcare Awards 2020 in the Most Promising Pilot category announced on 2nd April 2020
- St Helens Shared Care Record was shortlisted for the HSJ Partnership award for system and data integration

1.3. Celebrating success

The Trust continues to celebrate success internally, hosting our 15th Annual Staff Awards presentation evening in June 2019. The awards celebrate the outstanding contribution of staff and the difference they make to the lives of many patients every day of the year. The readers of the St Helens Star newspaper awarded the Dermatology Department the prestigious People's Choice Award, highlighting the appreciation that patients and their families have for the excellent care they receive.

The Trust held its third annual awards ceremony to celebrate the invaluable contribution our many volunteers make across the organisation.

These ceremonies, along with the Employee of the Month, are important ways of recognising and rewarding the ongoing dedication and commitment of staff throughout the year. In addition, positive comments received from patients continued to be shared via a weekly 'Thank You Thursday' email sent to all members of staff.

2. Section 2

2.1. About us

2.1.1. Our services

St Helens and Knowsley Teaching Hospitals NHS Trust provides a range of acute and specialist healthcare services including, inpatient, outpatient, community, primary care, maternity and emergency services. In addition, the Trust hosts the mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital. The Trust provides the Mid-Mersey Hyper Acuity Stroke Unit (HASU) and the Mersey Regional Burns and Plastic Surgery Unit, providing services for around five million people living in the North West of England, North Wales and the Isle of Man.

The Trust has over 700 inpatient beds, with circa up to 40 additional escalation beds and provides the majority of its services from two main sites at Whiston and St Helens hospitals, both of which are state-of-the-art, purpose built modern facilities that are well-maintained. Whiston Hospital houses the Emergency Department, the Maternity Unit, children and young people's service, and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, rehabilitation beds, the Lilac Centre (a dedicated cancer unit, linked to Clatterbridge Centre for Oncology) and Marshalls Cross Medical Centre (primary care services). The Trust provides outpatient and diagnostic services in a small number of other settings.

The Trust also provides an Urgent Treatment Centre at the Millennium Centre in St Helens and intermediate care services at Newton Hospital, which has 30 inpatient beds. In addition, the Trust delivers a range of community services, including Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy.

The Trust provides community adult nursing services in St Helens, which were delivered by North West Boroughs Healthcare NHS Foundation Trust under contract. These services were rated as good by the CQC at their last inspection in 2018-19. The Trust is now directly providing these services since April 2020.

The Intermediate Care Service has multidisciplinary input including GP, therapy, nursing and geriatrician to ensure patients receive the right level of care, in a less acute setting, admitting patients either from their own homes or from an acute hospital.

The Community Frailty Service provides Comprehensive Geriatric Assessments (CGA) for frail older people in St Helens, to enable a plan to be put in place to support them to continue to live at home. The service provides a 2 hour response for those patients who

are at risk of hospital admission and a 72 hour response time for assessment of complex patients to help prevent crisis and promote wellbeing.

The Healthy Heart Team provides the cardiac rehabilitation service for patients who have had a heart attack on an 8 week programme and is based at Fingerpost Medical Centre, in St Helens town centre. The Healthy Heart Team also provide a Community Heart Failure service to the patients of St Helens, which is a Consultant-led service, delivered with nurse specialists. It offers community clinics and home visits by the nursing team. The COPD service is a community service based in Lowe House in the centre of St Helens town. This is a nurse specialist led/consultant supported service that provides home visits to avoid hospital admissions and early supported discharge from the Trust.

The CaSH Service operates clinics across St Helens and Halton. Community based clinics offer predominantly contraception services and asymptomatic screening for sexually transmitted infections (STIs). This includes provision of long acting reversible contraception (LARC). St Helens Hospital provides predominantly STI and HIV based services with an on-site laboratory offering microscopy. The service also has a dedicated health improvement team and TAZ young person's clinic (19 and under) open six days per week at The Millennium Centre in St Helens.

The Trust Board is committed to continuing to deliver safe and high quality care, set within the on-going demand and financial challenges facing the NHS. There has been a continued increase in demand for the majority of services, as the Trust continues to be one of the busiest acute hospital trusts in the North West of England. It has an excellent track record of providing high standards of care to its population of over 350,000 people across St Helens, Knowsley, Halton and South Liverpool, as well as further afield, including Warrington, West Lancashire, Wigan and the Isle of Man.

The Trust has continued to see an increase in activity in both elective admissions and Emergency Department attendances during 2019-20, as shown in the table below. The average length of stay for non-elective admissions is 6.5 days.

	2017-18	2018-19	% change 2017-18 to 2018-19	2019-20	% change 2019-20 to 2018-19
Outpatient attendances (seen)	453,343	451,040	-0.51%	467,633	3.68%
Non-elective admissions	54,423	57,456	5.57%	56,458	-1.74%
Elective admissions	49,873	50,443	1.14%	52,141	3.37%
Births	4,094	4,051	-1.05%	3,983	-1.68%
Emergency Department attendances (as reported)	111,340	115,734	3.95%	119,158	2.96%
Emergency Department attendances (excluding GP Assessment Unit)	106,319	109,605	3.09%	112,720	2.84%

2.1.1.1. Primary and Community Services Care Group

Primary and Community Services as a Care Group was formally established in 2019 following an increase in the delivery of different community services. It was recognised that focussed energy was required to develop these further and to take advantage of future opportunities to deliver more care outside of hospital. Provision of a wider range of community services enables the effective development of pathways and joining together of resources in a consistent fashion, with a focus primarily on keeping people well in their own homes. It also allows the development and improvement of discharge pathways from the hospital.

2.1.1.1.1. Care Group Vision

The Care Group's aim is to develop consistent pathways and models of care delivery which centre around and firmly engage with the local Primary Care Networks. This helps professionals to support patients, both children and adults, to be cared for in their own home.

The focus is on ensuring consistency and consolidation of delivery and clinical pathways to ensure equitable cover for all of our population. The sharing of learning and expertise across different sectors and the strengthening of resilience in what are often underfunded and/or isolated services will also be a key benefit. This will include adult community services by strengthening the relationship and pathways between key services such as Community Matrons, Frailty, Intermediate Care, Specialist Nursing and Urgent Treatment Centres, recognising that these are key components of complex and same day emergency care provisions which patients may need support in accessing in the most effective way.

District Nursing services, based directly in localities, engage with local GPs from the Primary Care Network to manage and coordinate care for patients. They can understand what is available locally and work as part of the multidisciplinary team (MDT) to improve the health of the localities' population.

The Trust has strengthened its role within Primary Care over the last 12 months through education and engagement, set within the context of changes arising from the new GP long term plan (NHS England 2019) and subsequent contract.

2.1.1.1.2. Developing relationships

A key role for the Trust is the proactive engagement with the developing Primary Care Networks. This interaction opens up the potential for practical discussions between services and primary care to resolve local issues and support the system to deliver care differently across historical boundaries. It also presents opportunities to pilot and trial changes using the collective resources of the network, community services and secondary care.

2.1.1.1.3. Primary Care delivery

In 2018 the Trust started to directly deliver a primary care practice in Marshalls Cross Medical Centre, on the site of St Helens Hospital. The focus has been on meeting the challenges of raising the quality of care and recruitment, to meet CQC standards and efficiently deliver a GP contract and its associated funding streams. A key driver for the Trust is to support the delivery of robust Primary Care and to look at how resources could start to be shared across multiple practices to increase resilience and standardise pathways.

2.1.1.1.4. Horizon scanning and bringing the vision to life

There are a number of development opportunities spanning the three main boroughs we serve, St Helens, Halton and Knowsley. These are outlined in more detail below:

Within St Helens, the Trust is identified as a key provider of physical health services as a successful acute trust and, more recently, as a provider of community services. This has included the direct delivery of some speciality nursing services such as a new frailty team, healthy heart (Cardiac Rehab and Heart Failure functions) and continence services. Alongside these we also deliver two Intermediate Care Units; Duffy and Newton and sub-contract the delivery of all community nursing services including district nursing, community matrons, treatment rooms, as well as, phlebotomy services to North West Boroughs NHS Foundation Trust.

There has been a planned transition of services from Bridgewater Community Healthcare NHS Foundation Trust to both this Trust and North West Boroughs Healthcare NHS Foundation Trust, which was completed by April 2020. This saw the Urgent Treatment Centre (UTC) and IV Therapy service join the Trust in December 2019 and a range of community children services and GP with special interests (GPSI) outpatients on 1st April 2020. These services include community paediatrics serving St Helens residents and children's continence and children's complex needs community nurses which are pan-borough with Halton.

As the Care Group has formed and the leadership capacity has strengthened, the ability to effectively deliver and support the next phase of community service transformation has begun to grow. There is a growing appetite within the system and particularly the Trust to see how we can further enhance and develop community nursing services alongside end-to-end clinical pathways within the Trust.

2.1.2. Our staff and resources

- The Trust's annual total income for 2019-20 was £447 million.

We employ more than 6,100 members of staff and we are the lead employer for Health Education North West, Health Education Midlands, Health Education East of England and Palliative Care London and are responsible for nearly 10,000 trainee specialty doctors based in hospitals and general practice (GP) placements throughout England.

The Trust recognises the importance of maintaining high quality patient care in the context of year-on-year increases in demand and on-going recruitment challenges facing the NHS. There are a number of measures in place, which are outlined below, to ensure the right staffing is in place across the Trust, including a continued year-on-year focus on recruitment and retention and the creation of new roles.

There are a number of staff networks in existence as part of the Trust's Everyone Matters programme to ensure that staff are able to share experiences and access the right support; these are:

- LGBT+ Network
- Building a Multicultural Environment (BAME) Staff Network
- Carers Staff Network
- Armed Forces Network
- Disability Network

The Trust strives to meet the best standards of professional care whilst being sensitive and responsive to the needs of individual patients. Clinical services are organised within four care groups; clinical support services, surgery, medicine and community and primary care, working together to provide integrated care. A range of corporate services contribute to the efficient and effective running of all our services, including human resources, education and training, informatics, research and development, finance, governance, facilities, estates and hotel services.

The Trust acknowledges the challenges that it faces in maintaining high quality care when delivering the increased activity levels highlighted above and is working to ensure appropriate staffing levels across all areas, within the financial pressures facing the NHS. During the pandemic, a redeployment hub was established to support the effective movement of staff to those wards and departments requiring additional staff, including Critical Care, and to provide additional training to enhance staff skills when working in different areas. In addition, the Trust saw over 250 students join the workforce supported by the Practice Education Facilitators in various roles. These new employees made a valuable contribution to patient care across the Trust.

The average staff turnover rate in the Trust for 2019-20 was 11.74%, which is 3.90% better than the national rate of 15.60% for the national acute teaching sector (latest data available is March 2020).

Significant recruitment challenges remain within specific specialties and for specific roles, in particular: medical, nursing and scientific staff. The Trust is proactive in addressing these challenges and has established the Trust 'brand' via social media as an employer of choice, using online and other media advertisement with open days and nursing campaigns. There have been on average 25 medical gaps since April 2019 and a number of actions have been taken to address these, including developing new roles such as physician associates, physician assistants and advanced clinical practitioners. The full rollout of e-rostering for the junior doctors has been completed and will support improved demand and capacity modelling to ensure the most effective use of the Trust's medical workforce.

In addition, the Trust hosts regular recruitment events and uses international recruitment to ensure vacancies are filled. The Trust has collaborated with Masaryk University, Brno, Czech Republic in the recruitment of newly qualified doctors who trained in Brno using the English syllabus since 2014. These new recruits join the Trust for two years as Clinical Fellows at foundation year one and two, to support our wards and fill the gaps and vacancies resulting from reduced numbers of allocated posts from the North West Deanery. The scheme returned to Brno in March 2020 to recruit more newly qualified doctors for the August 2020 intake, to maintain a constant stream of medical support for the Trust. To ensure these Doctors are prepared for working in the UK and at the Trust we also support their undergraduate placements with up to 14 weeks placement within Medicine, Surgery and Paediatrics before they qualify. The Brno Project provides the opportunity to reduce agency spend and maintain continuity of care. The doctors have the same opportunities to access further training in the North West, which keeps the talent pool local. They are a valuable asset to the Trust and our delivery of patient care.

The Trust is also exploring all possible opportunities to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals (AHPs), including:

- On-boarding and retention of new and existing staff including flexible working, self-rostering, itchy feet discussions, career clinics, assigning a buddy, welcome packs/information, retire and return initiatives
- An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally
- Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and ODP apprenticeships
- Implementation of the new nursing associate role with 15 trainees due to complete their training in March 2021 and a further 24 to commence training in September 2020
- Implementing the St Helens and Knowsley Teaching Hospitals NHS Trust Preceptorship Plus and Foundations in Clinical Leadership, alongside a nursing leadership development programme which will be further developed across other professions
- Implementation of e-rostering, e-job planning and activity manager for allied health professionals to ensure the most effective rostering and planning of work

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours of registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with the guidance. The acceptable monthly fill rate is 90% and over, which the Trust consistently exceeds overall. There is Executive Committee scrutiny of the individual areas that fall below 90% each month to review the actions in place to reduce the risk of any recurrence. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can have an impact on the quality of care provided. The Trust has an embedded daily process for reviewing nurse staffing levels across the Trust, with a daily matron huddle, that ensures

all areas have appropriate nursing staff and skill mix to support the delivery of high quality care and to maximise patient safety. The introduction of SafeCare Allocate in 2018-19 has enabled more effective review of staffing levels and patient acuity by ward.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total of the midnight count of inpatients in the ward. The Trust's position is reported monthly as part of the mandated safer staffing report. The wards facing ongoing challenges with recruitment are generally the wards that are unable to meet the safer staffing 90% fill rate consistently.

2.1.3. Our communities

The communities served by the Trust are characterised by their industrial past, with the local population being generally less healthy than the rest of England, with a higher proportion having at least one long-term health condition. Many areas suffer high levels of deprivation, which contributes to significant health inequalities among residents, leading to poorer health and a greater demand for health and social care services. Rates of obesity, smoking, cancer and heart disease, related to poor general health and nutrition, are significantly higher than the national average. In addition, it is anticipated that the elderly population will continue to grow significantly over the next ten years, which is likely to increase the incidence of diseases linked to older age and potentially increase demands on health and social care services in our local area. The local population is growing faster than the national average, with an increasing proportion of people aged over 65 as noted above.

2.1.4. Our partners

The Trust continues to be fully engaged in the work of the health and care partnership in Cheshire and Merseyside, leading on a number of the priority work programmes on behalf of the health system. In line with the requirements of the NHS Long Term Plan, published in January 2019, the Trust contributed to the development of the Cheshire and Merseyside system five year transformation plan and is planning on a system basis for future years.

The Trust continues to work with other providers across Cheshire and Merseyside to develop the detailed plans for a Pathology Services Network. Work is also progressing to establish Rapid Diagnostic Centres for cancer diagnosis and create an Eastern Sector Cancer Hub that will improve access to chemotherapy for patients with cancer who live in St Helens, Knowsley, Halton or Warrington.

The Trust is a partner in three "Place" systems, working with the Local Authority and Clinical Commissioning Groups (CCGs) and other agencies to create local care systems for St Helens, Knowsley and Halton. Each Borough has a different approach and is proposing different solutions based on their geography and populations, with a common purpose to facilitate greater collaborative and integrated working across organisational boundaries to improve the health of residents.

Examples of how the Trust has worked with its partners to deliver more integrated care during 2019-20 include;

- Working with Halton, Knowsley and St Helens boroughs to reduce the number of delayed discharges and long stay patients, who can be cared for in community settings and do not need to stay in an acute hospital bed
- Employing reablement staff to support rota gaps in community teams and delivering the discharge to assess model of care to support a reduction in long-term social care needs
- Expanding Community Frailty Services, which provides early assessment and intervention in the Emergency Department or in the individual's home to prevent a hospital admission
- Direct delivery of the entire Frailty Team in St Helens and providing clinical leadership and oversight for Knowsley and Halton Frailty Teams
- Participating in the Primary Care Networks (PCNs) that have been created in each CCG to improve access to primary care
- Hosting of PCN pharmacists
- Creation of an integrated discharge team and common assessor roles
- Working with Halton CCG to improve the utilisation and performance of the Widnes Urgent Treatment Centre (UTC)
- Direct management of the UTC in St Helens with a view to transforming urgent care pathways, supporting better patient experience and reducing the number of patients deflected to the Emergency Department (ED)
- Working collaboratively with St Helens CCG to improve diabetes care in primary and community care with specialist support, which will be expanded to other CCG areas
- Working with care homes to provide education and training on pressure ulcer prevention
- Expansion of the shared care record to other agencies, which allows all parts of the health and care system to view a patient's information
- Working together to maximise both community and hospital bed capacity to cope with the increased demands of winter
- Leadership of the Mid-Mersey Accident and Emergency Delivery Board, which coordinates and standardises the approach to urgent and emergency care across primary, community and secondary care services. This includes the inputs from Social Care services that enable a whole system response, to seeing and treating people in the most appropriate setting in a timely manner
- The Trust became the Hyper Acute Stroke Unit for Mid-Mersey from 1st April 2019, with all patients receiving their initial specialist care and treatment for a stroke at Whiston Hospital
- Clinically leading the Cheshire and Merseyside endoscopy optimum pathway work stream
- Developed the vague symptom and site specific Rapid Diagnostic Services (RDS)
- Led on the implementation for faecal immunochemical test (FIT) for Cheshire Merseyside Cancer Alliance, which went live in February 2020
- Working in partnership as part of the collaborative commissioning forum to support development of sustainable services for the local population

Attendance at the Health and Wellbeing Boards (or equivalent) in our catchment boroughs helps the Trust to respond to the local health improvement priorities and develop strategies with commissioners to target specific population groups.

The Trust actively participates in the mid-Mersey patient safety and healthcare associated infection collaborative. This includes working in partnership with primary care, Local Authorities and commissioners to ensure the services we provide meet the needs of our local population and to share lessons learned as widely as possible.

Staff attend and contribute to a wide range of expert clinical groups both locally and nationally to ensure that the Trust continues to provide services based on best practice evidence. This includes;

- Hosting the North West Hospitals Falls Forum which allows falls nurses from across the region to share best practice and to learn from each other.
- North West Infection Prevention Society meetings to share new guidance, innovations and best practice
- North West intravenous/aseptic non-touch technique (ANTT) forum meetings
- Antimicrobial resistance collaborative which is, for example, standardising the guidance and pathways for urinary tract infection management
- Work on the identification and timely thrombo-prophylactic management of atrial fibrillation to prevent stroke
- Well-established collaboration with Edge Hill University on the development of their new undergraduate medicine curriculum to widen access to medical training
- Collaboration with University of Liverpool to widen access to medical training (the Anfield Project)
- Working with Liverpool John Moores University to develop extended roles (including non-medical prescribing) for nurses, physiotherapists and other health professionals

On 21st November 2019 the Sepsis Team held its first conference with the event introduced by Ann Marr, Chief Executive. Dr Ron Daniels, one of the founders of the UK Sepsis Trust gave an overview of sepsis and a 27 year old sepsis survivor shared their difficult journey. Key speakers came from Urgent Care 24, North West Ambulance Service, Alder Hey Children's NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust and the UK Sepsis Trust.

The Trust continues to maintain close working relationships with Healthwatch, NHS England/Improvement (NHSE/I) and the Care Quality Commission, as well as local voluntary organisations that work with people in their own communities and homes to prevent hospital admissions.

There is excellent partnership working with the construction and facilities services providers at the Trust which ensures that we continue to offer an excellent environment and facilities for patients, visitors and staff. The Estates and Facilities Team provided an incredible service in making adaptations in a number of areas in response to the pandemic, including structural changes to support infection prevention.

At the end of 2019-20 the first effects of the COVID-19 pandemic were felt with a major incident being declared nationally by the UK government at the end of January and for the health service in March. This resulted in the suspension of much of the routine business for the whole of health and social care, as the main focus turned to preparing for and managing the expected surge in coronavirus cases.

A command and control structure was put in place by NHSE/I for the North West region and within each of the localities there were hospital and out of hospital "cells" which directed and coordinated the service response. The Trust's Chief Executive was the hospital cell commander for Cheshire and Merseyside, ensuring that the 12 acute hospital trusts in the region worked closely together to optimise the capacity to care for acutely ill patients with coronavirus symptoms.

2.1.5. Technology and information

St Helens & Knowsley Health Informatics Service (HIS) continues to deliver organisational and integration projects across the health and social care organisations within the St Helens and Knowsley footprint. Making the right choice when it comes to optimising existing or new technology, whilst ensuring a strategic fit to the wider integrated programme of change, has been the key to the successes that have been achieved to date. All developments are in full alignment with the Trust's objectives as well as the NHS Long Term Plan, Sustainability and Transformation Plan (STP) Digit@ll strategy, Place Based and Shared Care support.

The Trust has already achieved the largest digital change it has undertaken to date, with the replacement of the previous Patient Administration System with the new Medway in 2018. The implementation included Order Communications for Pathology and Radiology tests and results and the Emergency Department IT system. The Trust is now well on the way towards having a comprehensive, fully digitised patient record. Since the initial implementation, the Trust's digital journey has continued with the deployment of eVitals *(*to collect and record patients' observations*)* across ward areas and the Emergency Department in a fast paced eleven week deployment. The replacement of the wireless network in February 2019 was a key enabler to this allowing the collection of electronic observations using mobile devices at the patient bedside.

As a result of these improvements, the Trust is now demonstrating more than 99% compliance with NHS England's Commissioning for Quality and Innovation (CQuIN) framework for patient observation recording and, more importantly, improving the quality and timeliness of care for patients who are deteriorating.

2.1.5.1. Clinical Systems

An upgrade to Medway in autumn 2019 saw the inclusion of past history data to assist clinicians with their planned care of patients. In addition, child protection information is now available to appropriate users across the Medway user base.

Again, supporting our clinicians and patient journeys through the hospital, an electronic handover (eHandover) system was deployed, enabling clinicians to collaborate with each other to refer patients for surgery, paediatrics and other types of care using mobile technology and safe, secure communications.

The implementation of two-way text messaging now allows patients to cancel or rearrange outpatient appointments on their mobile devices, opening up yet more channels of communication and helping to avoid unforeseen non-attendance at hospital appointments which is costly and inefficient.

The Trust has also implemented a Telehealth solution, initially within the Stroke and Burns and Plastics services, through partnerships with other technology software suppliers. Telehealth offers a wider choice for some patients who are now able to have appointments with clinicians from the comfort of their home. Within these specialties, this option of appointment is unanimously supported as the patients preferred method of contact, which in turn, results in greater and more efficient utilisation of clinical resources and provision in outreach areas. This award-winning Telehealth project is already a huge success amongst patients and clinicians alike, improving access for patients and reducing did not attend (DNA) rates. A follow-up project is in progress to extend the solution across other specialties using the tried and tested processes across the wider health economy.

In June 2019, e-Prescribing (the electronic generation, transmission, and completion of a medical prescription) was launched across Surgical Wards in the hospital, after a successful deployment in 2018 across Medicine. This means appropriate medication is given to patients, reducing unnecessary life-threatening exposure to adverse drug related accidents and reducing delayed and missed doses. It also means, for clinicians, the provision of decision support at the point of prescription, improved legibility, a reduction in transcription errors and improved and effective communication between pharmacists and medical and nursing staff. The number of missed doses has decreased significantly and throughout 2019 there was a steady decrease in reportable incidents.

2.1.5.2. Safe and Secure Systems

Cyber-attacks to the NHS have increased and, as the Trust moves forward in its digital maturity, the safety and security of the IT systems and infrastructure are of utmost importance. The Informatics Team has moved forward, significantly, in its cyber technology programme with the implementation of state of the art systems to protect its partner organisations' systems and data from cyber threats. With the implementation of a dedicated cyber security and management team and the investment in an Intrusion Detection System, Informatics will ensure adequate protections for the Trust and partner organisations.

2.1.5.3. Back to Basics Technology

The safety of the infrastructure is an ongoing priority for St Helens and Knowsley Health Informatics Service and any clinical system deployments can only be successful if the underlying technical infrastructure is robust. The Informatics team has continued to

strengthen the infrastructure and IT platforms on which all the Trust's critical systems reside. A 'back to basics' approach has included significant replacement of the fundamental IT infrastructure including core network equipment, server equipment and the replacement of several hundred computers as part of the NHS mandate to migrate to the Microsoft Windows 10 operating system. This project will ensure that all computers across the Trust and its partner organisations are fit for purpose, faster and therefore allow increased productivity for staff and services.

The deployment of Windows 10 allows for improved security of both staff and patient data using enhanced security features, delivered in real time, to protect against cyber threats. This includes the detection of viruses, phishing and malware before they are able to spread. These enhanced security features allow the protection of devices and users 24 hours a day, 7 days a week and with the new hardware users will experience a reduction in downtime, which will in turn reduce the impact of such events on patients. The new hardware, with all its benefits, enhances the staff experience, thereby developing confidence in the Digital Systems which are so intrinsic to patient care.

The Windows 10 project is a cross-organisational initiative, led by St Helens and Knowsley Health Informatics Service, meaning that partner organisations will reap the same benefits in terms of safe, secure and reliable hardware. This is critical because the needs of the local population can only be achieved through the collaboration between the hospital and the other key health and social care services in this area.

2.1.5.4. St Helens Shared Care Record

Aside from the hardware, the Informatics Team has been a key enabler for the digital innovations that are required for the system-wide collaboration and this can be seen particularly through the St Helens Shared Care Record (SHSCR). A year following implementation, the SHSCR is a key enabler to those clinicians whose role relies on access to complete and accurate patient data.

The shared care record has developed over the last year so that:-

- Health and social care workers have the most up-to-date and accurate information about each patient's health, medications, treatment and care plan
- Patients get the right treatment and care in the most appropriate place
- There is a reduction in duplicate appointments and tests
- There is a reduced need for patients to repeat their medical or social care history to different care providers

The SHSCR is now accessed by staff at the Trust, Social Care Teams, North West Boroughs Healthcare NHS Foundation Trust clinicians, GPs and community workers. The SHSCR presents information digitally and directly to care professionals, removing the need for staff to send emails or make phone calls for information about a patient. This important initiative has brought significant time savings, efficiency and care benefits.

Clinicians working in the hospital's ED now have access to primary care information, including current medications and medical history, at the touch of a button. This has become especially relevant in the evenings or at weekends where previously the staff

would have had to phone the GP out of hours' services to try and locate the relevant GP record, wasting valuable time in an area of healthcare where time is often of the essence.

Clinician
"The shared care record is a life-saver! Having all the GP information easily accessible has absolutely been a Godsend. It cuts down time spent trying to access a patient's record and is invaluable out of hours".

Pharmacist, Whiston Hospital
"SHSCR has saved us time when completing medicines reconciliation as we do not have to ring a GP surgery and request a fax of patients' medications. I would say it can save a minimum of 10 minutes per patient."

2.1.5.5. Health and Social Care Network (HSCN)

Again helping to improve the sharing of appropriate data across care providers, the HSCN is a new data network for health and care organisations which replaced N3. It provides the underlying network arrangements to help integrate and transform health and social care services by enabling them to access and share information more reliably, flexibly and efficiently.

The Trust migrated to HSCN from N3 in August 2019. The introduction of GovRoam, a national system which promotes agile working means that clinicians and staff can now access systems from any NHS location in the Health and Social Care Network footprint.

We continue to support the formation of Primary Care Networks, providing shared infrastructure, as well as shared projects across the health and social care partnership footprint.

2.1.5.6. Significant Assurance

Locally and nationally the IT services within the Trust are recognised as leading edge.

Mersey Internal Audit Agency (MIAA) completed an audit of the Trust's Informatics Governance Toolkit submission (as required of larger NHS organisations) and the Trust maintained their rating of 'Significant Assurance'.

The operational and technical teams continue to be committed to delivering the technology that will culminate in every healthcare professional being able to access real time, comprehensive and secure patient information, wherever they are delivering care. The Trust will continue along its Digital Maturity journey, working with our strategic supplier, System C, to deliver the new functional components of the CareFlow solution.

We will continue to harness our Chief Clinical Information Officer (CCIO) expertise and their clinical networks to engage and collaborate widely across the clinical user base,

promoting clinical champions and ultimately delivering the Trust vision of 5-star patient care.

The journey for Clinical Digital Maturity is well underway and it is evident that clinicians are benefitting from digital systems, which are supporting the delivery of care. The drive to deliver digital transformation of our hospitals and financial constraints remain and despite this, the Trust moved from being the 178th ranked Trust on the Clinical Digital Maturity Index (CDMI), to 19th is less than a year which is a significant achievement.

2.2. Summary of how we did against our 2019-20 Quality Account priorities

Every year, the Trust identifies its priorities for delivering high quality care to patients, which are set out in the Quality Account. The section below provides a review of how well the Trust did in achieving the targets set last year.

2.2.1. Progress in achieving 2019-20 quality goals

Quality Improvement Goal	Outcome delivered	Progress
Ensure timely and effective assessment and delivery of care within the Emergency Department	Achieved	**First Clinical Assessment < 2hours** The average time to first clinical assessment for 2019-20 was 100 minutes, which is under the 120 minute target.
	Achieved	**Compliance with national early warning score (NEWS) policy** All patients have observations completed on arrival in line with the NEWS2 protocol. Any patients who require repeat observations, or who trigger are escalated accordingly, so that acutely unwell patients are reviewed by a middle grade or senior medic in a timely manner. To improve compliance with the escalation protocol, daily audits have been implemented, undertaken by senior nursing staff. This has improved compliance as planned; from August 2020, all NEWS scores will be visible on the Emergency Department Tracker screen on Medway, clearly highlighting acutely unwell and deteriorating patients at a glance.
	Achieved	**Sepsis screening** The Trust achieved over 93% compliance with sepsis screening and treatment for Q4 against the previous CQuIN targets in ED.
	Improvement	**Triaged within 15 minutes** The average time to triage remained above 15 minutes due to the increased activity, however this reduced over the year from 28.3 minutes in quarter 1 to 24.8 minutes by quarter 4. Further improvements were made in quarter 1 of this year to 17.1 minutes.

Maximise the effectiveness and utilisation of new electronic systems to improve the timeliness and effectiveness of patient care	Achieved	• Following further rapid deployments in June across a number of wards, electronic prescribing and medicines administration (**ePMA)** is now live across all of Medicine and Surgery at St Helens and Whiston sites with the exception of Critical Care step down/Endoscopy and Radiology. Implementation into these 3 areas is currently in scope for phase 4 of the ePMA project, which will be completed in Q1 2020-21. Work is underway in conjunction with the Information Team to review the process of transfer/discharge to Newton to ensure the maximum benefits of ePMA are achieved. o Early indications demonstrated a significant reduction in the number of recorded medication incidents on Datix. • **Electronic recording of patient observations** is now live across all of the Trust inpatient areas via NEWS2, paediatric early warning score (PEWS) and modified early obstetric warning score (MEOWS) and supporting staff in the early detection of deteriorating patients. Additional work is underway with our suppliers to develop observation models that will support paediatric patients who attend ED. This will be live by the end of 2020. o NEWS2 is a sensitive tool, altering the Medical Emergency Team (MET) to deteriorating patients. There has been an increase of patients who have alerted and have consequently been reviewed prior to requiring a full MET call (newly identified as Tier 1 calls), particularly out of hours when the patients' own clinical team are not on site. There has been a reduction in the number of cardiac arrests from April 2019 to January 2020 from 0.87 per 1000 admissions to 0.66 and a reduction in transfers to critical care (following an emergency call). This indicates that the detection and initial treatment of deteriorating patients are being made in a more timely fashion. • **eHandover (Careflow Connect)** is live in Paediatrics, General Surgery, Urology and ED. Plans to progress eHandover to medicine are underway along with Burns and Plastics and Trauma and Orthopaedics. Functionality to include photography is also being explored. Specialist Nursing Teams are being engaged with to continue with expansion of the system. • **Child Protection Information Sharing (CP-IS)** went live in May 2019 and is now being used across urgent care settings and maternity departments. This alerts the relevant authorities when a child or expectant mother with a child protection plan in place presents to these settings. o Within the first 5 weeks 81 children from across the UK passed through the care of the Trust creating alerts on CP-IS. These notifications ensure that the relevant authorities in the different areas were alerted so that the right action could be taken by safeguarding teams. • **Patient Communications** – 2-way text messaging went live in July 2019. This enhanced the appointment reminder texts already in place, by giving the patient the option to reply with a confirmation/ cancel/re-book. o This showed a reduction in "do not attend" incidents by around 2% across the Trust. • **Major Medway Upgrade** completed in September 2019 providing a foundation on which future digital solutions will be built, maximising the investment in the Patient Administration System in 2018. • **Windows 10** – deployment commenced across the Trust to move all personal computers (PCs) and laptops to the Windows 10 platform, removing Windows 7 from the Trust's infrastructure, as this will no longer be supported by Microsoft in January 2021. • **TeleHealth** – following successful pilots in 2 areas, (6 months Stroke Review and Drains Outreach Service), the Refero platform was upgraded to enable integration with Medway. This means that appointments can be booked via the Trust standard business process for booking patients into Telehealth clinics and sending out instruction emails. Appointment reminders can be pushed direct to patients' devices. o Early implementation saw non-attendance rates for the six-month Stroke Review service drop from around 25% to 10% • **Maternity Upgrade –** In February 2020, the first of three upgrades to the Maternity Medway System was successfully completed. These upgrades will allow the Trust to comply with Maternity Service Data Set (MSDS) requirements. Clinicians will now be able to input the required data, and together with a Business Intelligence upgrade, the Trust can report on these in accordance with Clinical Negligence Scheme for Trusts (CNST) national requirements.

Increase the proportion of patients who report that they have received an appropriate amount of information to meet their needs in a way they can understand	Improved	• Detailed analysis of the information questions in the latest patient survey report highlights some initial improvement in the questions relating to receiving appropriate information following surgery and receiving understandable answers to questions from doctors. • Further work is required to improve the information provided on discharge and embedding the recently re-launched discharge leaflet, which includes space for personalised information.

2.3. Quality priorities for improvement for 2020-21

The Trust's quality priorities for 2020-21 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff, commissioners and patient representatives, as well as placed on the Trust's website for public participation. In addition, Healthwatch members of the Trust's councils were asked for their views on what should be included in the list of priorities.

The consultation was undertaken using SurveyMonkey with 77 responses received in total. This was a significant reduction on the 163 received last year, potentially due to the impact of the pandemic as the survey was undertaken in March. Analysis of the responses has shown overwhelming support, in particular for improving the effectiveness of discharge. All priorities received over 93% agreement.

No.	Quality domain	Objective	Rationale	Lead Director	Measurement	Governance Route
	Patient safety	Continue to ensure the timely and effective assessment and care of patients in the emergency department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety, whilst also responding to increased demand for services	Director of Operations and Performance	Patients triaged within 15 minutes of arrival First clinical assessment median time of <2 hours over each 24 hour period Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits	Quality Committee

No.	Quality domain	Objective	Rationale	Lead Director	Measurement	Governance Route
	Patient safety	Reduce incidents of pressure ulcers due to possible lapses in care	A key Trust priority is patient safety and embedding a culture of safety improvement that reduces harm. In 2019-20 there has been an increase in the number of category 2 pressure ulcers (denoting an open wound), although the Trust has maintained its performance in reducing/preventing category 3 (a wound reaching the deeper layers of the skin) and category 4 pressure ulcers (very deep wounds reaching muscle or bone).	Director of Nursing, Midwifery and Governance	Quarterly audit to confirm compliance with Trust policy in the identification of patients at risk of developing pressure ulcers 10% reduction in category 2 pressure ulcers due to possible lapses in care from 2019-20 baseline	Quality Committee

No.	Quality domain	Objective	Rationale	Lead Director	Measurement	Governance Route
	Clinical effectiveness	Ensure patients in hospital remain hydrated	Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls.	Director of Nursing, Midwifery and Governance	Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately Reduced rates of acute kidney injury (AKI) and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee
	Patient experience	Increase the proportion of patients who report that they have received an appropriate amount of information about their care	Findings from the national inpatient survey indicate that a significant proportion of patients do not receive the right level of information at the right time to meet their needs	Director of Nursing, Midwifery and Governance	Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	Quality Committee
	Patient experience	Improve the effectiveness of the discharge process for patients and carers	A key theme from patient feedback and engagement events during 2019-20 has been a need to improve the discharge experience for patients and their carers	Director of Operations and Performance	Ensure sufficient and appropriate information is provided to all patients on discharge Improve Inpatient Survey satisfaction rates for receiving discharge information Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet	Quality Committee

No.	Quality domain	Objective	Rationale	Lead Director	Measurement	Governance Route
					Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards Implementation of standardised patient equipment ordering process for aides required at home	

2.4. Statements relating to the quality of the NHS services provided by the Trust in 2019-20

The following statements are required by the regulations and enable comparisons to be made between organisations, as well as providing assurance that the Trust Board has considered a broad range of drivers for quality improvement.

2.4.1. Review of services

During 2019-20, the Trust provided and/or sub-contracted £357m NHS services.

St Helens and Knowsley Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2019-20 represents 97% of the total income generated from the provision of NHS services by St Helens and Knowsley Teaching Hospitals NHS Trust for 2019-20.

The above figures relate to income from patient care activities. The remaining 18% of total operating income mainly arose from NHS North West Deanery for the education and training of junior doctors, services provided to other organisations, such as IT, HR and pathology services, and Private Finance Initiative (PFI) support funding.

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2019-20

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items.

It should be noted that some audits are listed as one entity on the published list, however will involve a number of individual projects being undertaken under this single heading, e.g. NCEPOD; as detailed below:

Therefore the total number of individual audits undertaken equates to 49 during 2019-20.

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - 3 individual audits
- Chronic Obstructive Pulmonary Disease (COPD) audit programme - 3
- National Gastro-Intestinal Cancer Programme - 2

During 2019-20, 40 national clinical audits and 3 national confidential enquiries covered relevant health services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

During that period, St Helens and Knowsley Teaching Hospitals NHS Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust was eligible to participate in during 2019-20
- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in during 2019-20
- The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2019-20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

	National clinical audits and clinical outcome review programmes	**Eligible**	**Participated**	**Rate of case ascertainment % submitted**
1.	National Cardiac Audit Programme (NCAP) (includes the Myocardial Infarction National Audit Programme- MINAP)	Yes	Yes	Continuous monitoring
2.	National Heart Failure Audit	Yes	Yes	Continuous monitoring
3.	British Association of Urological Surgeons (BAUS): Female Stress Urinary Incontinence	Yes	Yes	100%
4.	BAUS: Urology Audits: Nephrectomy	Yes	Yes	100%
5.	BAUS: Percutaneous Nephrolithotomy	Yes	Yes	100%
6.	Rheumatoid/Early Inflammatory Arthritis Ncareia	Yes	Yes	Continuous monitoring
7.	British Thoracic Society (BTS) Smoking Cessation	Yes	Yes	100%
8.	UK Cystic Fibrosis Registry	Yes	Yes	Continuous monitoring
9.	National Joint Registry (NJR)	Yes	Yes	Continuous monitoring
10.	Inflammatory bowel disease (IBD) programme (registry)	Yes	Yes	Continuous monitoring
11.	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous monitoring
12.	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Yes	Yes	100%
13.	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100%
14.	NCEPOD (surgery and medical) • Acute bowel obstruction • Dysphagia • Out of hospital cardiac arrests (OHCA)	Yes	Yes	85% 100% 100%

	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
15.	National audit of care at the end of life (NACEL) - round 2	Yes	Yes	100%
16.	Elective Surgery National Patient Reported Outcome Measures (PROMs) Programme	Yes	Yes	Continuous monitoring
17.	National Diabetes Audit (NDA) (18-19 Data Set)	Yes	Yes	Active
18.	National gastro-intestinal cancer programme • Oesophago-gastric cancer (NAOGC) • Bowel Cancer (NBOCA)	Yes	Yes	Continuous monitoring
19.	UK Parkinson's Audit 2019	Yes	Yes	100%
20.	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	Active
21.	Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	Active
22.	Surgical Site Infection Surveillance Service	Yes	Yes	Active
23.	Perioperative QI programme	Yes	Yes	Active
24.	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring
25.	College of Emergency Medicine (CEM) ED Cognitive Impairment Older People	Yes	Yes	Active
26.	CEM ED Care of Children	Yes	Yes	Active
27.	CEM ED Mental Health Care	Yes	Yes	Active
28.	National Ophthalmology Audit	Yes	Yes	Continuous monitoring
29.	Epilepsy 12-(round 3)-paediatrics	Yes	Yes	Active
30.	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Continuous monitoring
31.	National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous monitoring
32.	(Paediatric) NPDA 19-20	Yes	Yes	100%
33.	National Hip Fracture Data Base	Yes	Yes	Continuous monitoring
34.	National Asthma and COPD Audit Programme (NACAP) • COPD audit • National NACAP Asthma (adults) • NACAP asthma (children)	Yes	Yes	Continuous monitoring
35.	National Lung Cancer Audit (NLCA)	Yes	Yes	Continuous monitoring
36.	National Audit of Dementia (NAD)	Yes	Yes	Active
37.	National Audit-Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Active
38.	National Prostate Cancer	Yes	Yes	Active
39.	Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Yes	Continuous monitoring
40.	Society for Acute Medicine's Benchmarking Audit - Acute Medical Unit (SAMBA –	Yes	Yes	100%

	National clinical audits and clinical outcome review programmes	Eligible	Participated	Rate of case ascertainment % submitted
	AMU)			
41.	Trauma Audit & Research Network (TARN): Major Trauma Audit-ED	Yes	Yes	Continuous monitoring
42.	National Audit of Seizure Management (NASH3)	Yes	Yes	100%
43.	National Audit of Cardiac Rehabilitation: NACR	Yes	Yes	Continuous monitoring

2.4.2.2. Other National Audits n29 (Not on Quality Account list 2019-20)

National audits
Fitness for older patients
Magseed and wire/roll localisation
Rapid access chest pain clinic (RACPC) audit programme
Flash glucose monitoring audit – paediatrics (freestyle libre)
Flash glucose monitoring audit - adults (freestyle libre)
National diabetes foot care audit (NDFA)
Tranexamic acid in hip fracture surgery: the paths study
Seven-day hospital services
National audit of neo-adjuvant systemic therapy
Diverticular abscess management: an international snapshot audit
Management of major haemorrhage
National diabetes inpatient audit 2019
National audit of intermediate care (NAIC)
Each baby counts – national quality improvement project (QIP)
Perinatal mortality review tool (PMRT) programme
Gap score audit (standardised case outcome review and evaluation) missed cases
National children and young people diabetes and quality programme
Breast and cosmetic implant surgery
National 3rd corrective jaw treatment audit
Learning disability mortality review programme (LeDeR)
National comparative re-audit of the medical use of red cells 2019
National audit of non-melanoma skin cancer excisions by plastic surgery
Haem-star “flash-mob” thrombotic thrombocytopenic purpura (TTP) audit: -
Diverticular abscess management: an international snapshot audit (DAMASCUS)
Compass: Management of complicated intra-abdominal collections after colorectal surgery
Mastitis and mammary abscess management: mamma- multicentre/ national
BAD 2020: national clinical audit on management of hidradenitis suppurativaa
Sepsis review Health & Care Partnership for Cheshire & Merseyside through AQuA

The reports of 60 national clinical audits were reviewed by the provider in 2019-20 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Emergency Department	
National RCEM: 2017-18 procedural sedation audit: 733 17/18	A new pro forma has been designed and education delivered to staff New advice leaflets have been written.
National RCEM 17/18: management of pain in children: 732 17/18	Looking at developing triage prompts/stickers and how we can incorporate this into nurse training in Paediatrics Emergency Department (ED). Pain charts and posters have been displayed. A quality improvement project (QIP) is being undertaken to look at the best ways to empower parents to re-evaluate pain and request more analgesia as/ when required.
National RCEM audit 2017-18 : fractured neck of femur audit (#NoF) 734 17/18	ED consultant link with Orthopaedics established. Amendments have been made to the Trust's NoF pathway. This is to include guidance on the use of computerised tomography (CT) and magnetic resonance (MR) scans for patients with normal X-rays, who are still felt clinically to have a query (?) fracture NoF. Also to include guidance on pain relief, including the use of fascia iliac blocks. Amending the pathway to incorporate prompts for pain scores at 30 minutes, after analgesia, and then hourly thereafter.
RCEM Feverish Child	The audit showed some positive results, appropriate screening and management as per NICE guidance and good use of sepsis screening tool. Further review of the pathway and tool will be undertaken to assist with decision making
RCEM Vital Signs	The audit showed some areas of 100% compliance To ensure that the 15 minute target for triage is met, staffing was reviewed and a second triage nurse will be trialled. In order to ensure repeat abnormal observations are taken and acted upon, ER Doctors are to review NEWS >5 patients in the zones or waiting room
RCEM VTE Risk Assessment in Lower Limb Immobilisation	Improvements in VTE prophylaxis assessment shown throughout the audit period. A new patient advice leaflet for VTE risk in patients in lower limb immobilisation to be developed. To improve documentation further a sticky label is to be designed to go on the notes to show decision making following assessment
Severe Trauma: Trauma Audit & Research Network (TARN)	Reports and TARN Dashboard are continuously reviewed locally and by the Cheshire & Mersey Major Trauma Network / Operational Delivery Network - no further clinical actions
Paediatrics	
National Paedaitric Diabetes Audit Results 2017/18 data	Improvements have been shown compared to the previous audit data (2016/17) Monthly MDT meetings to discuss and monitor patients with high HbA1c Further work has been undertaken to improve the did not attend (DNA) rates so annual health reviews can be undertaken: • Review undertaken during a hospital admission • Telephone reminders and appointment cards handed out / posted for each clinic
Critical Care	
ICNARC Intensive Care National Audit Research Centre	Whiston Hospital participates in ICNARC – Case mix programme – collecting information on all patients admitted to Critical Care – this information produces quarterly quality reports measuring quality indicators with other Critical Care

	Units – 100% General Critical Care Units participate within England, Wales & Northern Ireland. This information is shared with all relevant members of staff highlighting areas of excellence & any areas that require review – robust systems in place to ensure information is reviewed and relevant action plans are implemented.
Cardiology	
MINAP Myocardial Ischaemia National Audit Programme	This ongoing project is now part of the National Cardiology Audit Programme. After the implementation of the new NICOR Portal last year, all initial teething problems appear to have been overcome and the portal runs smoothly. Data are submitted on a daily basis and, validated monthly, by the MINAP co-ordinator. A new system for exporting data has been introduced which makes validation and reporting easier. While this data is used nationally to improve patient pathways, it is also used by our own clinicians for local audit purposes. As part of this Trust's continuous monitoring, compliance with the provision of Secondary Prevention Medication on discharge is reported, our Trust consistently achieves a high standard with compliance and systems are in place to ensure that any deviation from this is addressed without delay.

National Confidential Enquiry into Patient Outcome and Death(NCEPOD)/Child Heath Programme	
The Trust has participated in all eligible studies during 2019-20. Completed study reports have been disseminated and reviewed with report recommendations implemented or planned.	
Current Active Studies: • Dysphagia In Parkinson's Disease	Completed Studies 2019/20: • Out of Hospital Cardiac Arrest • Mental Health Conditions in Young People • Pulmonary Embolism • Acute Bowel Obstruction
Audit Title	**Outcome/actions**
Child health chronic neuro-disability 252 15 16	Actions include the creation of a joint policy for cerebral palsy with Community Paediatricians

Local clinical audit information

The reports of 172 local clinical audits were reviewed by the provider in 2019-20 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/Actions
Emergency Dept. (ED)	
Management of cervical-spine fractures	Implementation of c-spine pathway to aid management of this injury
Flu swabs in the ED: quality improvement project (QIP)	Results found that generally flu swabs are being taken on appropriate patients Posters to highlight indications for the flu swabs have been put up around the ED leading up to and during the Flu season 2019-20. Re-audit planned
General Surgery: Breast Surgery	
Breast referrals To Burney Breast Unit–(NICE)	The audit found inappropriate referrals related to breast pain were in the majority. To target the most common issue of breast pain, a new pro forma has been introduced.
General Medicine :	
Acute Medical Unit (AMU) /Haematology	
Ambulatory anaemia management pathway audit	General Anaemia Clinic to be set up in order to follow up ambulatory patients to help expedite investigations and ensure referrals are made in a timely manner
Cardiology	
Audit on stress Echocardiography Service	100% compliance was noted in several aspects audited Some referrals were not always appropriate and within 6 weeks. Implementation of a new protocol for requesting a stress echo test Implement specific meetings for double reading/double review of stress echo test: (April 2022)
Care of the Elderly:	
Promotion of patient centered care	The results of the audit demonstrated an aggregate percentage increase of 27% of individual needs captured. This finding was supported by themes in the interviews with the nurses highlighting improvements in their interpersonal skills, self-awareness and practice relating to person-centred assessment.
Dermatology	
Audit of introduction of a phototherapy referral/consent form	Following the Introduction and use of specific Phototherapy Referral Form the results of the audit found significant improvements
Diabetes	
Patients presenting with a random plasma glucose >11.0MMOLS/L (NICE)	The audit showed that patients were not always being managed as per guidelines. This has prompted the diabetes team to consider the implementation of 1 page tick-list pathway for hyperglycaemia in Acute Coronary Syndrome to ensure the appropriate actions are taken. An easily accessible referral system to Diabetic Specialist Nurses (DSNs) has been implemented and posters displayed on all wards to show how to refer to DSNs. Diabetes Teaching sessions for junior doctors undertaken.
Respiratory Medicine	
Venous thromboembolism (VTE) champion review: improving VTE risk assessment completion within 24 hours	Significant improvement in patients having VTE risk assessment documented and carried out within 24 hours following the introduction of the VTE Champion.
Oxygen prescription re-audit	Prescription of oxygen target saturations improved to achieve

Audit Title	Outcome/Actions
	100% and improved accuracy of prescriptions overall: – 7% accuracy pre-intervention, 12% accuracy post-intervention. Electronic Prescribing (EPMA) is being rolled out across the Trust and has been adopted on medical wards with plan to re-audit once the system is embedded. Further education with medical and nursing staff planned.
Palliative Care	
Preventable admissions from care homes	The audit helped to identify local care homes that need extra education/guidance on the use of Advance Care Planning (ACP). The use of ACP will be monitored going forward; need to raise awareness across the Trust in particular in ED in relation to ACP. Support cross boundary work streams to support education and staff development. Education will be delivered to staff across these units
Paediatrics	
Prolonged jaundice care audit	Implementation of an integral pathway which will include prompts for action. Implementation of a new prolonged jaundice service.
Management of prolonged and recurrent febrile seizures in children	Integrate first aid information into the febrile seizures leaflet. Re-education given to staff.
Paediatric sepsis screening tool and pathway audit	Continuous audits are undertaken to review documentation and practice. Improvements have been noted throughout the year; however more needs to be done to reach all the required targets. Further staff education and actions are planned
Diagnosis and management of children with coeliac disease	Good adherence to guideline was found with annual review and patients being seen by specialist dietician. Referral pro forma for coeliac clinic in place.
Obstetrics & Gynaecology	
Audit of Management of women with antenatal & postnatal mental illness	The audit showed good compliance against the guideline standards and information sharing. Actions to be taken include: To introduce the “Continuity of Carer” with perinatal mental health To liaise more effectively with other trusts outside of StHK to enable women, to receive secondary care mental health input during their perinatal period. More education for multidisciplinary professionals who care for women during the perinatal period who are diagnosed with mental health disorders.
Substance misuse in pregnancy	Good information sharing via use of information, cause for concerns/email and phone updates. Success in contacting those women who need to be seen Very good relationship with Care Grow Live (CGL) – sharing information. Good liaison with keyworkers and work well in seeing the women together. Yearly training for Gap and Grow is in place to improve documentation
Intrauterine deaths: management of delivery	The audit found that 100% of all auditable standards were met, and there were no causes for concern or improvement needed.
Stillbirth audit	Continue with the ‘Saving Babies Lives’ programme New Care bundle introduced Staff training has been completed and continues going forward The Trust’s ‘Baby Garden’ is now ready Implementation of Butterfly team underway.

Audit Title	Outcome/Actions
Orthopaedics/Therapies	
Attendance at the foot/ankle school pre-surgery	The audit was initially difficult to progress due to issues identifying all the patients who should have been invited to foot school. Lack of documentation made it impossible to know if an invitation had been sent. However; there is good evidence that indicates attendance improves the outcome following surgery. **Actions take to resolve this issue going forward:** List of appropriate procedures sent to the appointments staff so they can identify who should be invited to foot and ankle school. All patients who are invited to attend the foot/ankle school will have this recorded on Medway going forward. This will facilitate re-audits going forward. **Results:** Evidence suggests a drastic improvement in levels of Foot School attendance since the implementation of the actions. A further review is planned to evidence a sustained improvement.
Pharmacy	
Review of neonatal prescriptions for parenteral nutrition (PN)	Neonatal parenteral nutrition prescription form has been updated to include a space and prompts for staff to ensure accurate prescribing and safe administration is undertaken.
Quality Improvement-Clinical Audit Dept. (QICA): Quality and Risk (Q&R)	
Action plan documentation and submission review	Although action plans (AP) are produced following review of project results, the audit found that they varied in quality and completeness. Actions to address this short falling have now been taken with the implementation of the new monitoring and escalation process for action plans. A new post has been developed in QICA to monitor action plans as part of the role. Stage 2 of the project: trialling the new monitoring system to be completed when the new post starts
Safeguarding /Maternity Services	
Audit of safeguarding compliance for young parents within the maternity service	The specialist midwife for young parents will receive safeguarding supervision as additional support Safeguarding plans and paediatric liaison forms are to be generated for all young parents and communicated to the Community Midwives/General Practitioner/Health Visitor for all young parents with safeguarding concerns Specialist Midwives to receive additional training The child sexual exploitation (CSE) tool to be used for every young parent booking.
Sexual Health	
Did Not Attend (DNA) rates at HIV clinics	Text to be sent out for all upcoming appointments Overall the 2 audit cycles found a 54.5% decrease in DNAs over the 12 month period since the introduction of text reminders.
Trust-wide Programme	
Record Keeping Audit Programme	The annual record keeping (RK) audit programme has continued during 2019-20 Most specialities have seen consistent improvements in the areas audited. Some specialities have met all targets on occasions, with most specialties scoring highly in several areas. Some improvements are still needed, which are being worked towards and drill-down audits recommended to target the areas of poor compliance, where errors are consistently found.

2.4.3. Participation in clinical research

Research is built into the NHS Constitution which states that the NHS is committed "to innovation and to the promotion and conduct of research to improve the current and future health and care of the population".

Clinical research is about improving the clinical treatments available to patients and discovering new ways of managing conditions. The Trust is passionate about the contribution that clinical research can make to patient care. Our engagement with clinical research demonstrates that our patients are able to gain access to the best available treatments and services, which have been rigorously tested, as well as innovative and leading edge treatments that can significantly improve health outcomes.

The Trust is a partner organisation in the Clinical Research Network, North West Coast, (CRN NWC) and works collaboratively with them to increase the opportunities for patients to take part in clinical research. We ensure that studies are carried out efficiently and meet the National Institute for Health Research (NIHR) high level objectives, which include increasing the number of patients recruited to NIHR portfolio studies.

The Trust employs a team of specialist research staff to support clinical research across the organisation and to increase recruitment to high quality clinical trials and other robust research studies.

The number of patients receiving relevant health services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2019-20 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 1151

During 2019-20 the Trust was involved in 131active studies, and the NIHR supported 124 of these, with the remaining 7 studies being local or student studies.

The Trust is pleased that NIHR recruitment figures have exceeded those forecasted during 2019-20 and that the Trust successfully recruited 1151 participants against the proposed target of 1026.

The Trust has impressive research activity across a wide range of clinical specialities. Since 1st April 2019 the RDI department produced RDI permission (confirmation of capacity & capability) for 33 new studies of which 28 were NIHR portfolio adopted studies. The following table displays the specialties of the new studies:

Speciality	Number of Studies – NIHR Portfolio	Non – Portfolio
Cancer	2	
Care of the Elderly	1	
Critical Care	4	
Gastroenterology	6	
General Surgery	4	
Obstetrics & Gynaecology	2	

Paediatrics	4	
Pharmacy		2
Rheumatology	2	
Sexual Health	1	
Stroke	2	1
Trust Wide		2

2.4.4. Performance in initiation and delivery of research (PID data)

Performance benchmarks have been introduced by the National Institute of Health Research (NIHR) for the time taken to initiate and deliver clinical trials within the NHS. The Trust's performance against these benchmarks is published quarterly and the reports are available at: www.Trust PID data

2.4.5. Commercially sponsored studies

We have continued to increase our participation in commercially sponsored studies, with 18 commercial studies active within the Trust.

2.4.6. Key achievements

The Trust has been recognised for the following during the year:

- Being a top recruiting site in a number of research specialties across the CRN NWC including:
    - Cancer
    - Critical Care
    - Diabetes
    - Gastroenterology
    - General Surgery
    - Palliative Care
    - Stroke
    - Rheumatology

The success of this is due to team work, including setting recruitment strategies/goals and clarifying responsibilities for each member of the team.

- In August 2019, the Trust was the first trust to recruit a patient to the SCIENCE study (Surgery or Cast for Injuries of the Epicondyle in Children's Elbows) over a weekend
- Two studies recruited the first patient within one day of the site being given the green light to begin recruitment. This included the Pre BAR study (Pre-pectoral Breast Reconstruction Evaluation) and the BSR-PSA study (The British Society for Rheumatology Psoriatic Arthritis Register)
- Also in September 2019, our Research Team helped recruit the 600th patient to the BLING III trial (a phase III randomised controlled trial of continuous beta-lactam infusion compared with intermittent beta-lactam dosing in critically ill

patients). The Trust has made a significant contribution to this multi-centre trial and has so far recruited 45 patients to this study, the most in the CRN NWC

Other achievements include:

- Performing well against the NIHR High Level Objectives (HLOs). In particular, delivering a vast improvement with HLO9b; in 2019-20 86.67% of non-commercial studies recruited their first participant, within the NIHR 60 day ambition target, (date site selected to first recruit).

High Level Objective	Definition	Performance
HLO1	Number of participants recruited to NIHR trials	Number - 993 Target = 1026 Achieved = 1151
HLO 2a	Number of commercial studies achieving or surpassing their recruitment target during their planned recruitment period.	100%
HLO 2b	Number of non- commercial studies achieving or surpassing their recruitment target during their planned recruitment period.	90%
HLO 9b	Non-commercial studies - Date site selected to first recruit (Ambition of 60 days)	87.5%

- NIHR want to understand more about patient experience of clinical research taking placing in the NHS, therefore the Trust has increased and promoted research to both staff and patients. In particular, we have made a significant contribution to the NWC CRN Patient Research Experience Survey (PRES). Since April 2019 the PRES has been recognised as one of the NIHR HLOs and we have sent out over 200 questionnaires to patients who have participated in research
- In January 2020, the Gastroenterology Team won the Excellence in the Delivery of Commercial Life Science Research in the North West Coast Research and Innovation awards. This is an outstanding achievement for the team and demonstrates their commitment to offering patients and public the opportunity to take part in research
- The Gastroenterology team has a well-established commercial portfolio and has continued to open more new studies in 2019-20 (n2). They have also been extremely successful in recruiting to a non-commercial study, IBD Bio Recourse study (The Inflammatory Bowel Disease Bio-Resource: Progressing from Genetics to Function and Clinical Translation in Crohn's Disease & Ulcerative Colitis) and during 2019-20 they recruited 185 participants to this important study
- One of our success stories of 2019-20 is the opening of 4 new NIHR portfolio research studies in General Surgery, which historically has been a specialty naïve to research. This is thanks to the enthusiasm of Mr Raj Rajaganeshan and Mr Ahsan Javed, who have encouraged the team to become actively involved in research. Due to this input the General Surgery Department has now embedded

research as business as usual, with support from the Research and Clinical Nurse Specialists. They encourage junior members of staff to get involved in research and are extremely supportive of their career progression

- This year 135 patients diagnosed with cancer have participated in a cancer research with an additional 87 patients taking part in a Care of the Dying studies. The Cancer Research team are committed to providing patients with the opportunity to take part in high quality cancer research studies. Life science lung cancer research has developed and grown in 2019 and is the tumour group that has the most patients recruited to research. These sustained efforts have ensured that patients are involved in their cancer care pathway, and by being involved in research they are contributing to the development of cancer treatments for the future
- Congratulations to our Paediatric Research Nurse, Shelley Mayor, who was recognised as an Inspirational Nurse on International Nurses Day 2019
- Dr Constanta Amoasii (Rheumatology Registrar) was successful in winning the poster prize (at the Royal College of Physicians annual conference in Manchester) for her systematic literature review investigating whether methotrexate causes chronic pulmonary fibrosis
- In July 2019 the Chief Executive received a letter of gratitude from a patient who was taking part in the Mini tub trial (prospective registry of Sentinel Node (SN) positive melanoma patients with minimal SN tumour burden who undergo Completion Lymph Node Dissection (CLND) or Nodal Observation). The patient expressed how fortunate they felt to be part of this important research trial
- The Trust has continued to promote research and innovation to staff and patients via:
  - Social media, regularly posting good new stories on Facebook and Twitter
  - TV screens in the Diabetes outpatient clinic
  - Library Services
  - Training and education
  - Volunteer induction day

- International Clinical Trials Day (iCTD) is an annual event that takes place on 20th May, to raise awareness of clinical trials to encourage patients, carers and the public to get involved in research. We also celebrate our achievements and take time to be grateful for the improvements made to public health. In May 2019, the research team celebrated with a stall promoting the campaign

These achievements are only possible because of the continued support from the committed consultants, who take the roles of Chief and Principal Investigators, the Research Nurses, Research Administrative teams, support services and, most importantly, the patients, who give up their time to take part in clinical trials.

82 publications (research and academic) have resulted from our involvement in both NIHR and Non-NIHR research, which shows our commitment to transparency and our desire to improve patient outcomes and experience across the NHS.

2.4.7. Research aims for 2020-21

Our aims for 2020-21 are to:

- Update the Trust Research Strategy and Vision to ensure that over the next three years the Trust fulfils its clinical research obligations to its patients, staff, the NHS and the wider economy
- Increase participation in research and clinical trials
- Ensure that we build on existing strengths and key areas of current research, as well as supporting developments in other health priority areas
- Continue to work in partnership with the CRN NWC to ensure that the NIHR high level objectives are met
- Increase our Research Nurse Workforce. Research at the Trust has grown exponentially over recent years; therefore more support is required for the delivery of important research
- Maintain the quality of research undertaken at the Trust by introducing and adapting to new systems and processes
- Promote and increase engagement in Trust research by raising awareness of research activities amongst all staff and patients

2.4.8. Clinical Goals agreed with commissioners

A proportion of St Helens and Knowsley Teaching Hospitals NHS Trust income in 2019-20 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2020-2021 and for the following 12-month period are shown below.

As a consequence of the COVID-19 pandemic, guidance was released by NHS England/NHS Improvement (NHSE/I) on the 27th March 2020, which confirmed suspension of CQuIN data submissions for the Quarter 4 2019-20 period. Commissioners took the pragmatic approach of awarding full payment for this period to the Trust. Prior to March the Trust had been working towards the targets in place at the beginning of the year as shown in the table below.

2.4.8.1. CQuIN targets 2019-20

Details of the agreed goals for 2019-20 are shown in the table below:

Commissioner	Indicator Brief Description
CCG1	AMR - Lower Urinary Tract Infections in Older People
CCG1	AMR - Antibiotic Prophylaxis in Colorectal Surgery
CCG2	Staff Flu Vaccinations
CCG3	Alcohol and Tobacco – Screening
CCG3	Alcohol and Tobacco – Tobacco Brief Advice
CCG3	Alcohol and Tobacco – Alcohol Brief Advice
CCG7	Three high impact actions to prevent Hospital Falls
CCG11	SDEC – Pulmonary Embolus
CCG11	SDEC – Tachycardia with Atrial Fibrillation
CCG11	SDEC – Community Acquired Pneumonia
CCG Total	
Spec Comm PSS1	Pss1 : Medicines Optimisation and Stewardship
Specialised Commissioning TOTAL	
PHE	No CQUIN Scheme Allocated To The Trust
PHE Total	
Community 1	Staff Flu Vaccinations
Community 3	Alcohol and Tobacco – Screening
Community 3	Alcohol and Tobacco – Tobacco Brief Advice
Community 3	Alcohol and Tobacco – Alcohol Brief Advice
Community 7	Three high impact actions to prevent Hospital Falls
Community 8	Community Sepsis
Community 9	UTC appointments
Community Total	
Cardiac & Heart	Alcohol and Tobacco – Screening
Cardiac & Heart	Alcohol and Tobacco – Tobacco Brief Advice
Cardiac & Heart	Alcohol and Tobacco – Alcohol Brief Advice
Community Cardiac & Heart	
GRAND TOTAL	

2.4.8.2. CQuIN Proposals 2020-21

Continuation of the COVID-19 pandemic into the 2020-21 financial year has resulted in NHSE/I suspending the operational delivery of 2020-21 CQuIN schemes for all providers during 2020-21. Providers are to be awarded full payment of their CQuIN allowance during the COVID-19 period as part of the COVID-19 central top up allocation arrangement.

2.4.9. Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where these fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information and assesses services against five key questions to determine the quality of care a Trust provides, asking if services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

The latest comprehensive CQC inspection, using the new approach, took place in July and August 2018. The Use of Resources review was undertaken on 5th July, the unannounced inspection took place during the week commencing 16th July, the inspection of Marshalls Cross Medical Centre was completed on 14th August and the planned well-led review was completed during the week commencing 20th August.

Teams of inspectors visited Whiston, St Helens and Newton hospitals and the Trust's directly provided community and primary care services during the inspection period to talk to patients, carers and staff about the quality and safety of the care provided. They reviewed care records and observed the care provided. The Trust was able to demonstrate to the inspection team the high standard of work that is undertaken on a daily basis to ensure patients receive excellent care.

St Helens and Knowsley Teaching Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2019-20.

St Helens and Knowsley Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2019-20.

St Helens and Knowsley Teaching Hospitals NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in July/August 2018. The CQC's assessment of the Trust following that review was outstanding.

CQC ratings table for St Helens and Knowsley Teaching Hospitals NHS Trust March 2019

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Outstanding	Good	Outstanding	Outstanding

The Trust's Emergency Department was rated as requires improvement for the responsive and safety domains, with action plans in place to address the recommendations.

As part of the 2018 inspection, the CQC inspected Marshalls Cross Medical Centre, which was a new service that the Trust was contracted to provide from March 2018. The inspection identified three areas where the Trust has not yet met the requirements of the CQC regulations. The Trust took action to address the issues identified at the time of the inspection in August 2018. Mersey Internal Audit Agency subsequently reviewed these actions and confirmed that they had been implemented.

The Trust is taking the following action to address the points made in the CQC's assessment:

- Delivery of comprehensive action plans in continuing attempts to achieve key national targets to enable timely care of patients in ED, including arrival to initial assessment times and the DH decision to admit, transfer or discharge target

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2020 in taking such action:

- Delivery of action plans to address the areas of non-compliance in Marshalls Cross Medical Centre and all the should do recommendations, including those areas where the Trust requires improvement in the ED, including ensuring all applicable staff receive level three children's safeguarding training and clarifying and monitoring the quality and completion of ligature and clinical risk assessments to ensure they are completed as appropriate for all patients requiring them in ED

Processes for the following have been strengthened in relation to Marshalls Cross Medical Centre:

- Follow up of uncollected prescriptions
- Monitoring of NICE guidelines
- Managing patients on high risk medicines
- Undertaking risk assessments
- Audit programme to monitor quality and identify areas for improvement
- Ensuring sufficient numbers of skilled and experienced staff to provide formal clinical leadership

2.4.10. Learning from deaths

2.4.10.1. Number of deaths

During Quarters 1-4 2019-20, 1,757 of St Helens and Knowsley Teaching Hospitals NHS Trust's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:
408 in the first quarter;
415 in the second quarter;
456 in the third quarter;
478 in the fourth quarter.

By end of Q4, 522 case record reviews and 12 investigations (reds and ambers) have been carried out in relation to 1,757 of the deaths included in item 2.4.10.1 (above).

In 12 cases (reds and ambers), a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
151 in the first quarter;
123 in the second quarter;
127 in the third quarter;
121 in the fourth quarter.

4 representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient (red rated).

In relation to each quarter, this consisted of:
0 representing 0.0% for the first quarter;
0 representing 0.0% for the second quarter;
1 representing 0.2% for the third quarter;
3 representing 0.7% for the fourth quarter.

These numbers have been estimated using the St Helens and Knowsley Teaching Hospitals NHS Trust Royal College of Physicians Structured Judgement Review (SJR).

167 (reviews) case record reviews and 3 (reds and ambers) investigations completed after 31-12-2018 which related to deaths which took place before the start of the reporting period.

0 representing 0.0% (reds) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the St Helens and Knowsley Teaching Hospitals NHS Trust Structured Judgement Review (SJR) (which uses NCEPOD Quality Score and RAG rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance. This represents the final position for Quarter 4 of 2018-19.

5 representing 0.3% of the patient deaths during 2018-19 are judged to be more likely than not to have been due to problems in the care provided to the patient. This represents all four quarters of 2018-19.

2.4.10.2. Summary of learning from case record reviews and investigations

The Trust has focussed on two key learning priorities for each quarterly report to the Trust Board and is establishing a database that collates all learning from deaths, incidents, complaints, PALS and litigation into a single repository for quarterly thematic analysis and sharing. The key lessons shared in 2019-20 are:

- Ensuring staff, patients and carers understand what is meant by the term ‘fast track discharge’. This relates to fast-track assurance of funding and does not a guarantee that discharges from hospital will be achieved before death. A number of reasons such as complexity of needs, family/patient preferences and availability of care in the community may impact on the ability to facilitate this
- Improving the shared information platform between community and hospital care to ensure that advance care plans (DNACPR, preferred place of death) can be met as often as possible
- 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

- 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
- Learning from Deaths Mission Statement
  To put the patient at the forefront of what we do by being empowered to question our peers, without fear of reprisal, judgement or blame, in order to learn so that learning can lead to change and accepting that, in questioning, we may raise more questions with the ultimate aim of improving care
- Our challenge is:
  By building and nurturing an improved culture new ways of thinking and working can be introduced, but these new ways will only become embedded within the team if they enable people to work more effectively than before. Effective culture change, therefore, is about building and nurturing an environment that allows culture change to occur naturally. When trying to encourage the adoption of a new way of doing things, we must make sure that our expectations are realistic. Culture change cannot be delivered overnight so we must try not to drive change too rapidly. Ref: NHSI Improvement Leaders Guide 2017
- Accurate Record Keeping
  During investigations it has become apparent that not all staff adhere to the instructions in the Record Keeping Policy when it comes to identifying themselves in patient's notes. You must ensure that all records are accurately dated, timed, signed and the signature printed to certify that each entry can be attributed to an individual, also adding your role
- Key Senior Decision Making
  Care groups must ensure that they drive forward practice to ensure that delays in assessment by doctors are addressed. Timely senior decisions have a crucial bearing on the outcome of the patient's care. We must ensure standards are maintained, despite times of pressure or when the patient may not be in the ideal environment

2.4.10.3. Actions taken resulting from learning

The Trust's Learning from Deaths Policy was refreshed in December 2019 and incorporates the principles laid down in the National Quality Board document "Learning from Death: Guidance for NHS trusts on working with bereaved families and carers".

Lessons identified from the structured judgement reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, Intranet Home Page, global email, Medical Care Group (Governance), Surgical Care Group (Governance), Medical Care Group Directorate Meetings, Surgical Care Group Directorate Meetings and Clinical Support Directorate meetings.

In addition to sharing the learning identified above the following actions are being taken:

- A working group, including the Trust's Solicitors, are developing a learning package for clinicians to support patients at the end of their lives and those with a do not attempt cardiopulmonary resuscitation (DNACPR). This will guide the

timely identification of a dying patient and the moral and legal position when making decisions
- Seminar to share with the Trust staff the learning so far from end of life cases, the changes achieved so far and ongoing work to be held on 25th November 2020: Dying Matters – the Next Steps (Insight to Learning from Deaths)
- Aggregated, comprehensive review of patients who have required multiple calls to the Medical Emergency Team (MET) to determine learning or gain assurance that the MET policy is followed and that an appropriate senior decision maker is involved in the patient's ongoing care
- Review of death certificates with learning shared with junior doctors, via case review teaching. This will be superseded by the forthcoming appointment of senior clinicians into the Medical Examiner role
- Recognition of exceptionally good care, which is acknowledged by the Mortality Surveillance Group in writing and used by individual clinicians to support appraisal and revalidation

2.4.10.4. Impact of actions taken

The effectiveness of learning is assessed by audit of Datix, serious incidents, complaints, PALS, Litigation and Mortality Reviews for evidence of failure to deliver these priorities. Systematic assessment of effectiveness is necessarily two quarters behind priorities, allowing time for sharing and then time to establish that learning has become embedded.

2.4.10.5. Trust approach to learning from deaths

A summary of the Trust's approach to learning from deaths is outlined below:

Total Deaths in Scope[1]

Check	Review
Check against NWB downloaded LD List **'Learning Difficulties Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yr, but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[5]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
25% Sample, include all low risk deaths[4] **'Sample Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool (see Appendix A)
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths, include any CQC alerts or 12-month internal monitoring alerts from the previous financial year

2.4.11. Priority clinical standards for seven day hospital services

The Seven Day Hospital Services Programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. Ten clinical standards for seven day services (7DS) have been developed, against which each trust's performance is measured. Audits are routinely carried out 6-monthly to monitor performance against standards 2 and 8, the priority standards, however only one audit was completed this year due to COVID-19.

Clinical Standard 2 (CS2) - All emergency admissions must be seen and have a clinical assessment by a Consultant as soon as possible, but at the latest within 14 hours of admission to hospital. The target set by NHS England (NHSE) is that 90% of patients meet CS2 by 2020.

Clinical Standard 8 (CS8) - Patients should be reviewed by a consultant (or their delegate) at least once every day, seven days a week. The target set by NHSE is that 90% of patients meet CS8 by 2020.

A sample of patients admitted to the Trust during the period of September 7th-14th 2019 was audited by the Deputy Medical Director, with the following results:

CS2 - The audit showed that 78% of the Consultant reviews on weekdays and 90% of the Consultant reviews at weekends occurred within 14 hours of admission to hospital, showing an improvement in performance from the Spring 2019 audit (73% on weekdays and 78% at weekends).

CS8 - The audit demonstrated that CS8 was met on both weekends and weekdays for the first time, showing an improvement in weekend performance from 80% in April 2019 to 91% in September 2019.

The Trust continues to meet standards 5 and 6, which are described below:
CS5 – Access to diagnostic tests
Hospital inpatients must have scheduled 7 day access to specialist diagnostic services including magnetic resonance imaging (MRI), echocardiography and endoscopy.

CS6 – Access to consultant-directed interventions
Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions, either on-site or through formally agreed networked arrangements. These interventions include: interventional radiology, interventional endoscopy, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention and cardiac pacing.

While improvements have been made in Trust performance against the 7DS standards, further work must be undertaken to meet and maintain CS2 and CS8, 7 days a week. The individual specialities' performance will be discussed with the relevant Divisional and Clinical Directors to allow them to continue to improve delivery of timely, consistent Consultant review. This will sit alongside work which

continues to be carried out by the Trust Urgent and Emergency Care Council to improve the efficiency of non-elective patient care.

Actions for 2020-2021 to improve 7DS

- The most common reason for patients failing to meet CS2 is delay in transfer to the relevant clinical assessment area. The planned increases in capacity for inpatients are anticipated to relieve pressure on the assessment areas, allowing patients to be moved from ED to see the appropriate Consultant sooner
- Extension of the Acute Medical Unit outreach pilot to provide Consultant presence in the ED to review medical patients who remain in the ED for a longer period of time
- A Trust-wide review will be carried out to identify the number of clinicians required across each clinical area and to identify ways to deliver safe and sustainable medical staffing

2.4.12. Information governance and toolkit attainment levels

Information Governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws and regulations regarding handling and dealing with personal information. Within our organisation, we have clear policies and processes in place to ensure that information, including patient information, is handled in a confidential and secure manner.

The Trust benchmarks itself against the Data Security and Protection Toolkit DSPT), which provides a mechanism for organisations to assess themselves against the National Data Guardian (NDG) 10 data security standards, through confirming assertions and providing supporting evidence. The assertions and evidence items within the DSP Toolkit are designed to be concise and unambiguous. Documentary evidence is only requested where this adds value.

St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall submission position for 2019-20 was rated as meeting the required standards. This submission was audited by Mersey Internal Audit Agency who provided a “Substantial” level of Assurance for the DSPT 2019-20 which demonstrates the Trust’s commitment to protecting the information it holds and uses.

The Trust will continue to enhance its robust Information Governance Framework which is led by Joanne Fitzpatrick, Head of Information Governance and Data Protection Officer. Dr Alex Benson, Clinical Director for Burns and Plastic Surgery, is the Trust’s Caldicott Guardian and is the dedicated designated individual with responsibility for ensuring confidentiality of personal information. The Trust also has a Senior Information Risk Owner (SIRO), Christine Walters, Director of Informatics, who is responsible for reviewing and reporting on the management of information risk to the Trust Board. The SIRO is supported by a network of Information Asset Owners (IAOs), who ensure that any identified information risks are appropriately managed in line with the Trust’s Risk Management Policy.

The Data Protection Officer, SIRO and Caldicott Guardian are appropriately qualified, trained, registered and accredited.

The Trust has a duty to report any incidents regarding breaches of the Data Protection Act to the Information Commissioner's Office (ICO) and for the financial year 2019-20 there was one such reportable incident. As a result of the incident steps have been taken to improve processes to prevent this reoccurring. A procedure has been introduced with further training for the team concerned. The ICO has reviewed the incident and the actions taken by the Trust and has confirmed that no further action is required

2.4.13. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2019-20 by the Audit Commission. The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security & Protection Toolkit 2019-2020. The error rates reported in the latest published audit for that period of diagnoses and treatment coding (clinical coding) were:-

2019-20 data reported in January 2020				
Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
Data Security & Protection Toolkit	3.5%	7.44%	3.82%	4.97%

2.4.14. Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of this process. Audit outcomes are monitored to ensure that the Trust continues to maintain performance in line with national standards. The data quality work plan is reviewed on an annual basis ensuring any new requirements are reflected in the plan.

The standard national data quality items that are routinely monitored are as follows:-

- Blank/invalid NHS number
- Unknown or dummy practice codes
- Blank or invalid registered GP practice
- Patient postcode

The Trust implemented a new Patient Administration System (Medway) in 2018 which has the functionality to allow for National Spine integration, giving users the

ability to update patient details from national records using the NHS number as a unique identifier.

The Medway configuration restricts the options available to users. Validation of this work is on-going and forms part of the annual data quality work plan.

2.4.14.1. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during 2019-20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which:

Included the patient's valid NHS number was:

Care Setting	StHK result	National Average
Admitted patient care	99.6%	99.5%
Outpatient care	99.9%	99.7%
Accident and Emergency care	99.2%	97.8%

Included the patient's valid General Medical Practice Code was:

Care Setting	StHK result	National Average
Admitted patient care	100%	99.8%
Outpatient care	100%	99.8%
Accident and Emergency care	99.8%	98.2%

(Source: SUS Data Quality Dashboard)

In all cases, the Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

The Trust will be taking the following actions to improve data quality:

- Data Quality Team will continue to monitor data quality throughout the Trust via the regular suite of reports
- Awareness raising sessions in order to focus on addressing any specific issues
- Providing data quality awareness sessions about the importance of good quality patient data and the impact of inaccurate data recording

2.4.15. Benchmarking information

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS trusts. The Trust has more up-to-date information for some measures; however, only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

2.4.15.1. Benchmarking Information

Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data sources. Any internal figures included are displayed in purple font.

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
SHMI	NHS Digital	Jan-19 to Dec-19	1.088	1.000	0.689	1.200	
SHMI	NHS Digital	Oct-18 to Sep-19	1.076	1.000	0.698	1.188	Next SHMI data (for Apr-19 to Mar-20) due to be published Aug 2020
SHMI	NHS Digital	Jul-18 to Jun-19	1.053	1.000	0.697	1.192	
SHMI	NHS Digital	Apr-18 to Mar-19	1.036	1.000	0.707	1.206	
SHMI Banding	NHS Digital	Jan-19 to Dec-19	2	2	3	1	
SHMI Banding	NHS Digital	Oct-18 to Sep-19	2	2	3	1	
SHMI Banding	NHS Digital	Jul-18 to Jun-19	2	2	3	1	
SHMI Banding	NHS Digital	Apr-18 to Mar-19	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Jan-19 to Dec-19	37.5%	36.4%	9.9%	59.8%	
% of patient deaths having palliative care coded	NHS Digital	Oct-18 to Sep-19	36.9%	36.2%	12.0%	58.7%	
% of patient deaths having palliative care coded	NHS Digital	Jul-18 to Jun-19	36.0%	35.8%	14.6%	59.6%	
% of patient deaths having palliative care coded	NHS Digital	Apr-18 to Mar-19	36.9%	35.3%	12.3%	60.0%	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
Information relating to mortality is monitored monthly and used to drive improvements.
The mortality data is provided by an external source (Dr Foster).
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by:
Monthly monitoring of available measures of mortality.

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned.							
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-19 to Sep-19 (provisional)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	Next PROMs data due to be published Aug 20 The mandatory varicose vein surgery and groin-hernia surgery national PROMS collections have now ended * data suppressed due to small numbers
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-17 to Mar-18 (final)	0.076	0.089	0.029	0.137	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-19 to Sep-19 (provisional)	*	0.475	0.406	0.562	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.428	0.465	0.348	0.557	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-17 to Mar-18 (final)	0.411	0.468	0.376	0.566	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-19 to Sep-19 (provisional)	*	0.349	0.262	0.435	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-18 to Mar-19 (final)	0.309	0.338	0.266	0.405	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-17 to Mar-18 (final)	0.280	0.338	0.234	0.417	

Drafting note – text in green font is mandated text

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-19 to Sep-19 (provisional)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-18 to Mar-19 (final)	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-17 to Mar-18 (final)	*	0.096	0.035	0.134	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: Delivering a number of actions to improve patient experiences following surgery. Monitoring the PROMs data at the Trauma and Orthopaedic bi-monthly clinical effectiveness meeting.							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-11 to Mar-12	12.73	11.45	0.00	17.15	2011-12 still latest data available. Date of next version to be confirmed. Lowest and best national performance based on acute providers
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	12.60	11.43	0.00	17.10	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to	NHS Digital	Apr-11 to Mar-12	11.39	10.01	0.00	14.94	

Drafting note – text in green font is mandated text

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
the Trust within 28 days of discharge							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	10.66	10.01	0.00	14.11	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The data is consistent with Dr Foster's standardised ratios for re-admissions. The data is monitored monthly by the Trust Board. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by: Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2018-19	69.5	67.2	58.9	85.0	Next version expected Aug-20
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2017-18	70.5	68.6	60.5	85.0	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does. The Trust was rated outstanding overall for caring by the CQC following their latest inspection in 2018. The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website.							

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by: Promoting a culture of patient-centred care. Responding to patient feedback received through national and local surveys, Friends and Family Test results, complaints and Patient Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning.							
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2019	87.4%	70.5%	39.7%	87.4%	All data is for Acute Providers only
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2018	87.3%	71.2%	39.7%	87.3%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2019	12.9%	20.3%	26.5%	12.9%	Low scores are better performing trusts
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2018	11.8%	20.4%	28.4%	11.8%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2019	91.9%	84.4%	70.7%	91.9%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2018	94.3%	84.0%	69.3%	94.3%	

Drafting note – text in green font is mandated text

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons; The Trust provides a positive working environment for staff with a proactive Health, Work and Wellbeing Service. An independent provider, Quality Health, provides the data. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Engagement of staff at all levels in the development of the vision and values of the Trust. Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.							
Friends & Family Test – A&E – Response Rate	NHS England	Feb-20	17.8%	12.1%	0.0%	44.4%	
Friends & Family Test – A&E – Response Rate	NHS England	Jan-20	18.8%	11.7%	0.0%	43.7%	
Friends & Family Test - A&E - Response Rate	NHS England	Dec-19	13.4%	11.6%	0.0%	40.0%	National average includes Independent Sector Providers
Friends & Family Test - A&E - Response Rate	NHS England	Nov-19	17.8%	12.0%	0.0%	33.2%	
Friends & Family Test - A&E - Response Rate	NHS England	Oct-19	18.2%	12.6%	0.0%	43.8%	
Friends & Family Test – A&E - % recommended	NHS England	Feb-20	86.7%	85.0%	40.0%	98.5%	
Friends & Family test – A&E - % recommended	NHS England	Jan-20	88.8%	85.5%	34.4%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Dec-19	85.3%	84.2%	50.0%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Nov-19	84.0%	84.0%	13.3%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Oct-19	88.3%	84.6%	59.1%	100.0%	
Friends & Family – Inpatients – Response Rate	NHS England	Feb-20	28.7%	24.4%	1.1%	100.0%	
Friends & Family – Inpatients – Response	NHS England	Jan-20	33.0%	24.0%	1.6%	100.0%	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Rate							
Friends & Family Test – Inpatients – Response Rate	NHS England	Dec-19	24.2%	22.6%	0.5%	100.0%	
Friends & Family – Inpatients – Response rate	NHS England	Nov-19	33.4%	24.8%	1.1%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Oct-19	30.2%	25.0%	1.6%	100.0%	
Friends & Family Test – Inpatients - % recommended	NHS England	Feb-20	96.1%	95.9%	73.1%	100.0%	
Friends & Family – Inpatients - % recommended	NHS England	Jan-20	95.3%	95.8%	80.0%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Dec-19	95.2%	95.8%	82.0%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Nov-19	96.4%	95.8%	77.2%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Oct-19	95.5%	95.8%	78.1%	100.0%	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust actively promotes the Friends and Family Test across all areas.
The data is submitted monthly to NHS England.
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by:
Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology.
Actively working with ward staff and the Trust's Patient Experience and Dignity Champions to improve levels of engagement with the system, to ensure the

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
latest results are shared at local level.							
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2019-20	96.24%	95.25%	71.59%	100.00%	All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2019-20	95.23%	95.40%	71.72%	100.0%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2019-20	95.23%	95.56%	69.76%	100.0%	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Sustained delivery of the 95% target for patients having a VTE risk assessment within 24 hours of admission to ensure that they receive the most appropriate treatment, having achieved 95.4% for April 2019 to February 2020. Submissions were suspended from March 2020 due to the pandemic. Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed. During 2019-20, 26 patients developed a hospital acquired thrombosis, of which 21 RCAs have been completed to date and 100% were found to have received appropriate care. Data on VTE risk assessments are submitted to NHS England each month. St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Maintaining focus on, and closely monitoring, the rate of risk assessments undertaken by the Quality Committee. Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed. Sharing any learning from these reviews and providing ongoing training for clinical staff.							
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	Internal	April-19 to Mar-20	16.9* *Trust acquired				2019-20 figures include community onset
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned	GOV.UK	Apr-18 to Mar-19	10.2	12.2	0	79.7	Data for Apr-19 to Mar-20 not yet published

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
cases)							
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-17 to Mar-18	11.4	13.6	0	90.4	
St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Infection prevention and control remains a priority for the Trust. All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory reporting to Health Protection England. The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea. Cases are thoroughly investigated using RCA, which is reported back to a multidisciplinary panel chaired by an Executive Director to ensure appropriate care was provided and lessons learned are disseminated across the Trust. St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: Focussing on ensuring staff compliance with mandatory training for infection prevention and control. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.							
Incidents per 1,000 bed days	Internal	Oct-19 to Mar-20	36.70	/	/	/	
Incidents per 1,000 bed days	NHS Improvement	Apr-19 to Sep-19	35.70	48.80	26.29	103.84	Next data to be published in September 2020 Based on acute (non-specialist) trusts with complete data (6 months data)
Incidents per 1,000 bed days	NHS Improvement	Oct-18 to Mar-19	35.77	45.07	16.90	95.57	
Incidents per 1,000 bed days	NHS Improvement	Apr-18 to Sep-18	34.95	44.10	22.08	107.37	
Number of incidents	Internal	Oct-19 to Mar-20	4715	/	/	/	
Number of incidents	NHS Improvement	Apr-19 to Sep-19	4429	6314	1392	21685	

Drafting note – text in green font is mandated text

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Number of incidents	NHS Improvement	Oct-18 to Mar-19	4401	5881	1580	22048	
Number of incidents	nrls.npsa.co.uk	Apr-18 to Sep-18	4228	5714	1285	23692	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Oct-19 to Mar-20	0.16	/	/	/	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-19 to Sep-19	0.01	0.15	0.00	0.67	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-18 to Mar-19	0.08	0.14	0.01	0.49	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Apr-18 to Sep-18	0.09	0.15	0.00	0.54	
Number of incidents resulting in severe harm or death	Internal	Oct-19 to Mar-20	21	/	/	/	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-19 to Sep-19	1	19	0	95	
Number of incidents resulting in severe harm or death	NHS Improvement	Oct-18 to Mar-19	10	19	1	72	
Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Apr-18 to Sep-18	11	19	0	87	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Oct-19 to Mar-20	0.4	/	/	/	

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-19 to Sep-19	0.02%	0.3%	0.0%	1.6%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-18 to Mar-19	0.2%	0.3%	0.0%	1.8%	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Apr-18 to Sep-18	0.3%	0.3%	0.0%	1.2%	

St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust actively promotes a culture of open and honest reporting within a just culture framework.
The data has been validated against National Reporting and Learning System (NRLS) and HSCIC figures. The latest data to be published is up to September 2019. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.02%.
St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by:
Undertaking comprehensive investigations of incidents resulting in moderate or severe harm.
Delivering simulation training to enhance team working in clinical areas.
Providing staff training in incident reporting and risk management.
Monitoring key performance indicators at the Patient Safety Council.
Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.

Due to reasons of confidentiality, NHS digital has supressed figures for those areas highlighted with an * (an asterisk). This is because the underlying data has small numbers (between 1 and 5)

2.4.16. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2019-20 is shown in the table below:

Performance Indicator	2018-19 Performance	2019-20 Target	2019-20 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Not Achieved	100.0%	98.3%	Apr19-Mar20
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Achieved	92%	90.3%	Apr19-Mar20
Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	97.1%	Apr19-Mar20
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	96.5%	Apr19-Mar20
- anti-cancer drug treatments	Achieved	98%	96.6%	Apr19-Mar20
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	86.2%	Apr19-Mar20
- from consultant upgrade	Achieved	85%	87.4%	Apr19-Mar20
- from urgent screening referral	Achieved	90%	92.5%	Apr19-Mar20
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Not Achieved	93%	91.0%	Apr19-Mar20
Emergency Department waiting times within 4 hours – all types	Not achieved	95%	83.9%	Apr19-Mar20
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	89.3%	Apr19-Mar20
Clostridium Difficile	Achieved	48	42 avoidable	Apr19-Mar20
MRSA bacteraemia	Not achieved	0	1 contaminant	Apr19-Mar20
Maximum 6-week wait for diagnostic procedures: % of diagnostic waits waited <6 weeks	Achieved	99%	99.7%	Apr19-Mar20

Drafting note – text in green font is mandated text

3. Section 3

This section of the Quality Account reviews the Trust's performance for quality and quality improvement indicators not covered in the report so far. It includes an update on progress in delivering the Trust's own strategies.

3.1. Summary of how we did in achieving our strategies

3.1.1. Clinical and Quality Strategy 2019-22

The Trust's vision to provide 5 star patient care encapsulates the Trust's approach to quality in striving to achieve the best possible care for patients. The Trust performs very strongly against national, regional and local targets, therefore, when the Clinical Quality Strategy was revised in 2019 its aim was to promote a culture of continuous value improvement, underpinned by robust systems and processes and individual and collective accountability.

Safety has been improved with the Mortality Surveillance Group that has trained doctors to appraise care with Structured Judgement Reviews and to identify learning in individual cases. This is supported by the deployment of Copeland Risk Adjusted Barometer (CRAB) into the Trust's medical groups, which provides detailed interrogation of the themes that sit behind outcomes and the creation of robust plans to improve care wherever possible.

Timely care has been enhanced with a rapid and successful deployment of NEWS-2 in the electronic Careflow Vitals system. Sepsis mortality has improved since deployment and in-hospital cardiac arrest is almost half the national average.

Healthy Care has included improving the adoption of NICE guidance and importantly evidencing its implementation across all parts of the organisation. Monthly data is gathered to ensure staff always use the best evidence to support care.

Kind care has seen the St Helens Cares Record deploy in record time to strengthen the data shared with GPs and other agencies to allow clinical staff to have the best information possible and avoid duplicating the questions staff ask at a time of heightened distress for patients coming into hospital acutely unwell.

3.1.2. Nursing and Midwifery Strategy 2020

The previous Nursing and Midwifery Strategy's aim was to embed the Chief Nursing Officer's '6Cs' through strong clinical leadership. Significant progress has been made in all areas and a new strategy has now been developed to build on our current successes.

The new strategy is built around the Chief Nursing Officer for England's key priorities shown below:
- Workforce fit for the future including Workforce Race Equality Standards (WRES)
- Pride in the profession
- Collective voice

This is underpinned by the aspiration for a national Shared Governance Collective Leadership Programme, of which the 3 central components are:
- Local accreditation

- Nursing & midwifery excellence
- Shared decision-making

The core elements of the previous Nursing & Midwifery Strategy are still being delivered and significant work in delivering the aims of the new strategy have begun. Examples that were delivered in 2019-20 include:

- Strengthening the reviews of the staffing ratios based on the needs of our patients to ensure the consistent provision of safe effective patient centred care. This has been achieved by the introduction of an electronic tool which measures the dependency of each patient. Staff with the right skills are then able to be deployed to areas of greatest need in a timely manner.
- The introduction of telemedicine for the 6 month reviews for stroke patients, which has been a great success so far in improving patient experience and increasing the effectiveness of the service, by reducing inconvenience and travel times for patients.
- Delivery of a project to improve the experiences of cancer patients when they have worries or fears

Our senior nursing, midwifery and allied health professionals' leadership team is focussed on supporting teams to deliver the best possible care for patients by investing in bespoke development programmes and opportunities for the creation of advanced roles. This is in addition to ensuring that teams are led with compassion as this directly affects the outcomes and experience of our patients.

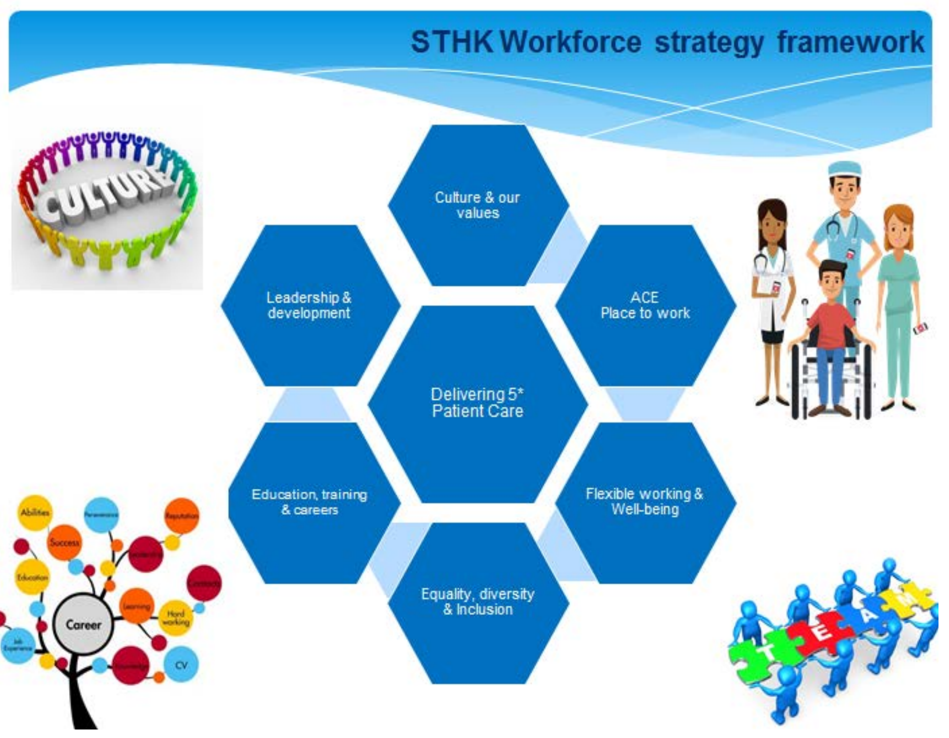
The newly developed strategy includes a focus on communities working together to prevent unnecessary ill-health through an improved focus on health and well-being and a continuous drive to deliver person-centred care in collaboration with families and other valued partners.

3.1.3. Workforce Strategy 2019-20

The Trust is committed to developing the organisational culture and supporting our workforce. The Workforce Strategy 2019-20 outlined the six key workforce priorities and detailed how each objective and outcome would be measured through the delivery of an action plan during the year. The priorities were:

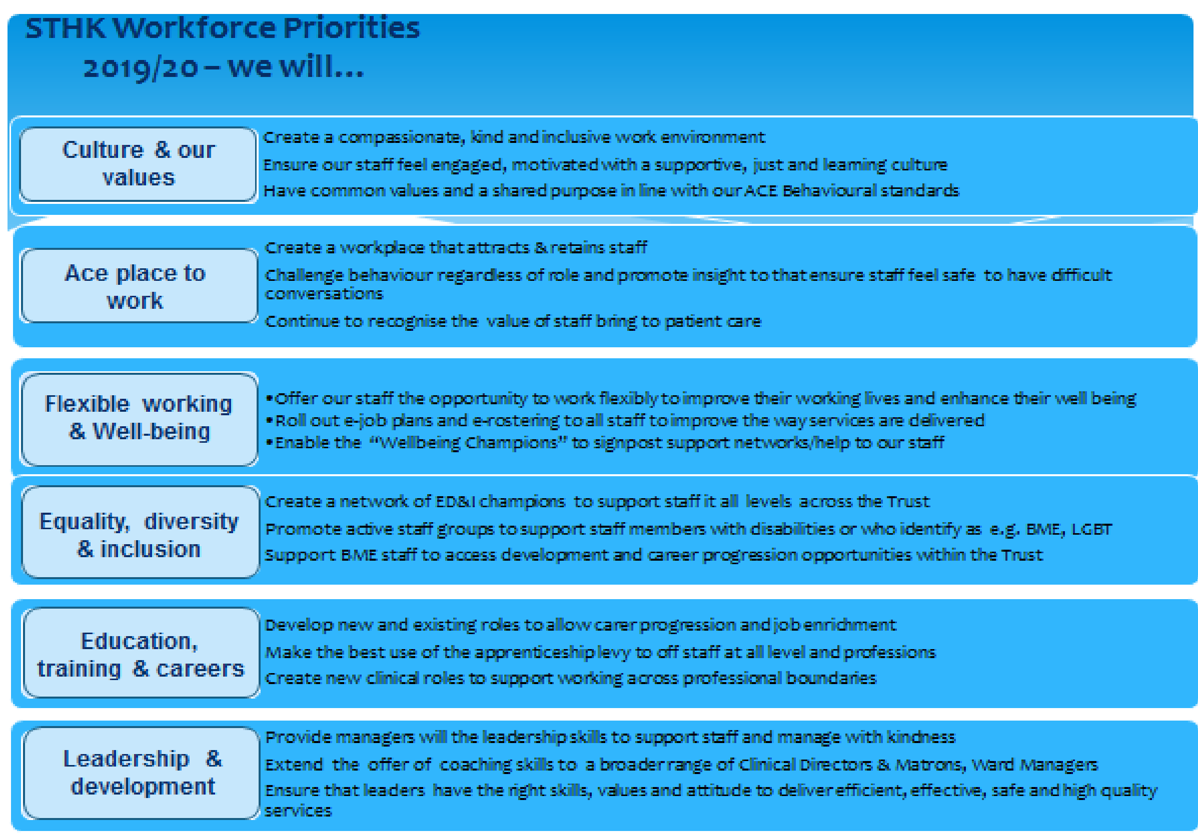
- Culture and our values
- ACE place to work
- Flexible working and well-being
- Equality, diversity and inclusion
- Education, training and careers
- Leadership and development

The Trust's Workforce Strategy was developed to support the Trust's vision to deliver five star patient care and to align with our Trust values. The following diagram shows the elements of the strategy which will to support the successful delivery of the Trust's Workforce Strategy.



STHK Strategic Workforce Priorities 2019/20

The following 6 workforce priorities were developed following engagement across the Trust with staff from all departments, professional groups and staff side colleagues:



STHK Workforce Priorities 2019/20 – we will…

Priority	Actions
Culture & our values	Create a compassionate, kind and inclusive work environment Ensure our staff feel engaged, motivated with a supportive, just and learning culture Have common values and a shared purpose in line with our ACE Behavioural standards
Ace place to work	Create a workplace that attracts & retains staff Challenge behaviour regardless of role and promote insight to that ensure staff feel safe to have difficult conversations Continue to recognise the value of staff bring to patient care
Flexible working & Well-being	•Offer our staff the opportunity to work flexibly to improve their working lives and enhance their well being •Roll out e-job plans and e-rostering to all staff to improve the way services are delivered •Enable the "Wellbeing Champions" to signpost support networks/help to our staff
Equality, diversity & inclusion	Create a network of ED&I champions to support staff it all levels across the Trust Promote active staff groups to support staff members with disabilities or who identify as e.g. BME, LGBT Support BME staff to access development and career progression opportunities within the Trust
Education, training & careers	Develop new and existing roles to allow carer progression and job enrichment Make the best use of the apprenticeship levy to off staff at all level and professions Create new clinical roles to support working across professional boundaries
Leadership & development	Provide managers will the leadership skills to support staff and manage with kindness Extend the offer of coaching skills to a broader range of Clinical Directors & Matrons, Ward Managers Ensure that leaders have the right skills, values and attitude to deliver efficient, effective, safe and high quality services

The delivery of the Workforce Strategy and the six 2019-20 priorities was executed through the following strategies and their associated action plans which were presented to the Workforce Council as part of the annual reporting schedule:

- Recruitment & Retention Strategy
- Volunteer Strategy
- Workforce Development Strategy
- Leadership & Talent Management Strategy
- Staff Engagement Strategy
- Workforce Equality, Diversity & Inclusion Strategy
- Health, Work & Well Being Strategy

3.1.4. Equality, Diversity and Inclusion Strategy

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally hard to reach groups are not disadvantaged when accessing the services the Trust provides.

The Trust's Diversity and Inclusion Steering Group meets quarterly to ensure full compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the steering group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and independent service users.

A new toolkit for carrying out equality analyses (equality impact assessments) was rolled out across the Trust early in 2019, to guide and support staff when carrying out these assessments. It has been well received by staff and is enabling robust assessments to be carried out. The toolkit is especially useful when assessing proposed changes to services or cost improvement programmes as it allows staff to clearly demonstrate that due regard has been given to decisions made. These analyses enable the Trust to meet both the general and specific equality duties by carrying out a comprehensive and systematic assessment of all the Trust's activities in order to eliminate actual or potential discrimination at the earliest stage and before there is an adverse impact on patients, employees or visitors to the Trust. These assessments also provide an opportunity to identify any positive impacts on people from all protected groups, carers and hard to reach groups. The toolkit includes a section to evidence where consultation has taken place, in line with the Gunning Principles, and a section to provide assurance that the Public Sector Equality Duty (PSED s149) has been met.

Equality Objectives 2019-23

Early in 2019 the Trust held its Equality Delivery System (EDS2) panel assessment, which was attended by senior leaders in the Trust, representatives from all local Healthwatch

groups and CCGs. The following equality objectives and a robust action plan were developed following the panel discussion. We aim to:

- Improve access and outcomes for patients and communities who experience disadvantage
- Improve our equality performance by collaboration and partnership working
- Engage and consult with all our local communities and to raise awareness of health inequalities both within our workforce and in our local communities
- Take steps to ensure that our workforce is broadly representative of the communities we serve at all levels
- Improve the wellbeing of staff employed in the Trust
- Improve the experiences of Black and Minority Ethnic staff employed in the Trust

Actions relating to the Equality Objectives are being steadily progressed and those already completed are highlighted in the sections below.

Improving access to services and information for patients whose first language is not English:

- During 2019 the Trust jointly led on the development of quality standards for interpreting services, following consultation with community groups and local CCGs. These standards have now been approved and should be included in any contracts that trusts across Cheshire and Merseyside enter into with providers of interpreting services
- STHK contracted with a new provider of foreign language interpreting services and the quality standards form part of the contract, including the standard of qualifications and experience that interpreters provided to the Trust must meet
- Established regular engagement events with refugees and asylum seekers from Halton to understand any barriers they may face when accessing the services we provide, with plans to extend this engagement to St Helens and Knowsley during 2020

Improving access to services for patients who are D/deaf:

- Ensured the quality standards for interpreting services also set the minimum qualifications required for interpreters of British Sign Language, which were developed in collaboration with St Helens Deafness Resource Centre
- Introduced two way text messages for appointments, allowing patients to accept/decline or reschedule appointments using a two-way text messaging service, thereby allowing patients to take control of their own appointments
- Staff and clients from St Helens Deafness Resource Centre are now invited to carry out access audits around the Trust to ensure that any new building works are accessible to patients who are D/deaf
- Provided awareness training for trainee doctors and other clinical staff in collaboration with St Helens Deafness Resource Centre
- Actively engaged with D/deaf service users to update our patient access system with details of any additional communication needs in line with the Accessible Information Standard

Improving the experiences of LGBTQ patients accessing services:

- Currently engaged in Merseyside and Cheshire Task and Finish group to address some of the issues trans patients face when accessing services in the Trust
- Review of patient literature in progress to ensure it provides relevant information on services/procedures to people who identify as LGBTQ.
- Steadily progressing actions in the Navajo Chartermark Action Plan

- Continuing to provide quarterly patient engagement events, ensuring that the LGBTQ community is represented at all meetings
- Continuing to work with Merseyside Trans Community Action Group to identify any health inequalities and to provide the group with information about our services
- The Trust's LGBT Health Promotion Specialist delivered HIV training to the Trans Community Action Group and provided details of the Trust's Sexual Health Services to the group

Improving the experience of disabled members of staff in the Trust by:
- Implemented the Workforce Equality Disability Standard (WDES) in line with timescales provided by NHS England, with a Board approved report and action plan
- Established a Disability and Wellbeing Staff Network, with attendees including staff with disabilities and line managers representing staff with disabilities

Hate Crime Reporting
- Following the launch of the Trust's Hate Crime Reporting System in February 2019 in collaboration with Merseyside Police there have been successful prosecutions for hate crime related incidents reported by members of our local communities and staff during 2019

Improving the experience of BAME staff in the Trust:
- Establishment of a staff network for BAME staff

3.1.5. Freedom to speak up

The Trust is committed to providing and developing a culture where all staff feel empowered to speak up or raise concerns. The Trust values include being open and honest and listening and learning. There a number of supportive facilities for staff to raise concerns, including:

- Freedom to Speak Up

The Trust has appointed four Freedom to Speak Up Guardians, who provide support to staff across the organisation. The guardians are representative of various staff groups and backgrounds. They provide an alternative way for staff to discuss and raise concerns and act as an independent and impartial source of advice to staff at any stage of raising a concern.

The work of the Guardians has a direct impact on continuously improving safety and quality for our patients, carers and families, as well as enhancing the experience of our staff, by acting on the concerns raised. The Guardians provide feedback to the staff who have raised a concern, in a manner that is supportive, whilst ensuring that there are no repercussions for the person raising a concern.

The Trust works in partnership with the National Guardian's Office and North West Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns. The Trust achieved 81% in the Freedom to Speak Up Index published by the National Guardian's Office in 2019, demonstrating improvements in the speaking up process measured from staff survey feedback.

The Guardians have offered support and advice to staff members and have received very positive feedback on the help offered.

- Speak in Confidence system

The Trust has in place an anonymous reporting system, Speak in Confidence, which enables all staff, irrespective of their role, to feel confident that they can raise concerns without disclosing their identity. The system uses a browser-based interface to ensure anonymity so that the concern raiser remains anonymous at all times. However, the manager receiving the concern is able to provide a response to the concern, to request further information and/or to provide assurances of actions taken to mitigate the risks associated with the concern raised via the on-line system.

- Raising concerns hotline

The Trust also has a telephone hotline, which provides access to report any concerns, which are reviewed and actioned by the Deputy Medical Director.

- Health, work and wellbeing hotline

Staff members have access to a dedicated helpline, to provide advice and support regarding health and well-being aspects relating to work or impacting on the individual. Individualised support can be offered dependent on the needs and circumstances. Concerns about workplace can be raised through the hotline.

- Hate crime reporting

A hate crime is when someone commits a crime against a person because of their disability, gender identity, race, sexual orientation, religion, or any other perceived difference. The Trust, in partnership with the Merseyside Police, launched and continues to support staff members with the first ever Hate Crime Reporting Scheme based at an NHS Trust. This is a confidential on-line reporting service that enables anyone from across our organisation and local communities to report, in complete confidence, any incidents or concerns around hate crime to Merseyside Police.

- Policies and procedures

There are a number of Trust policies and procedures that facilitate the raising of staff concerns as follows: Grievance Policy and Procedure, Respect and Dignity at Work Policy and Being Open Policy. Staff are also encouraged to informally raise any concerns to their manager, nominated HR lead or their staff side representative, as well as considering the routes listed above.

3.1.6. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. The Trust's response rate for the 2019 survey was 46%, a decrease from last year's 51%.

A new theme has been introduced, which measures team working, so there are now 11 themes, positively scored on a 0 to 10 point scale, with a higher score indicating a better result.

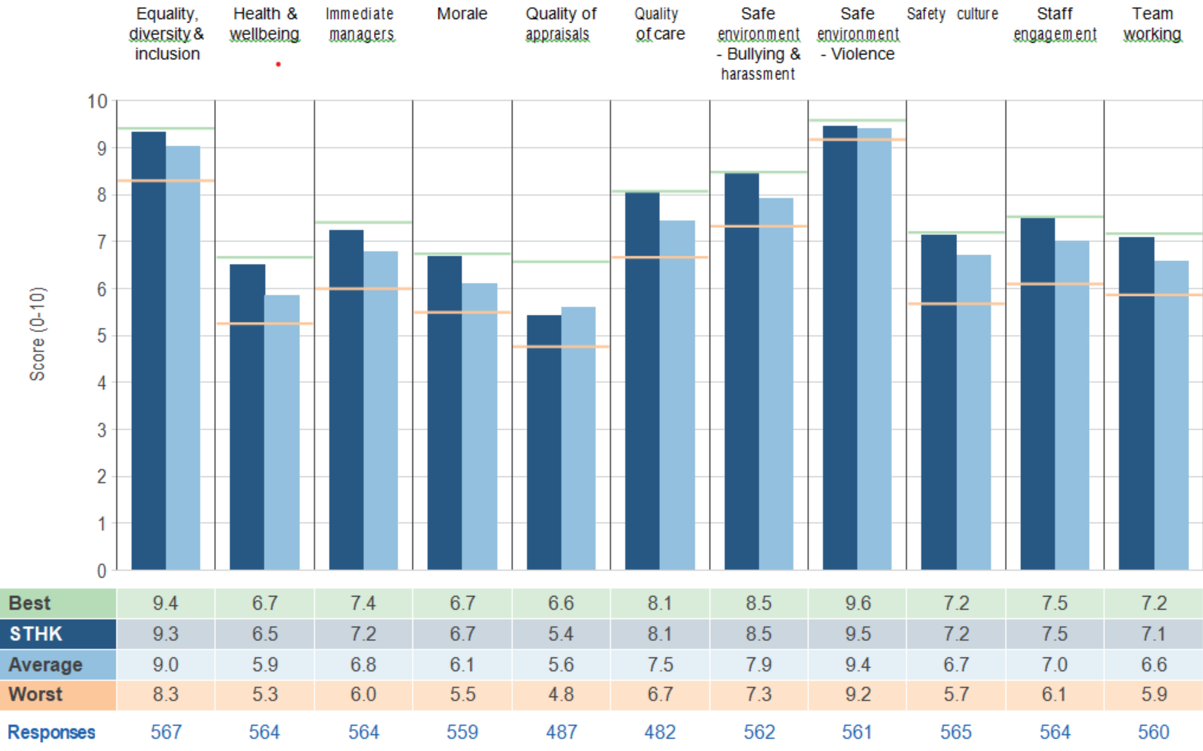
Overall, the Trust has the highest national score for the following five themes:

- Quality of care

- Safety culture
- Staff engagement
- Morale
- Safe environment – bully and harassment

The Trust has the second best national score for the following 5 themes:
- Equality, diversity & inclusion
- Health & wellbeing
- Immediate managers
- Safe environment – violence
- Team working

These are shown in the chart below:



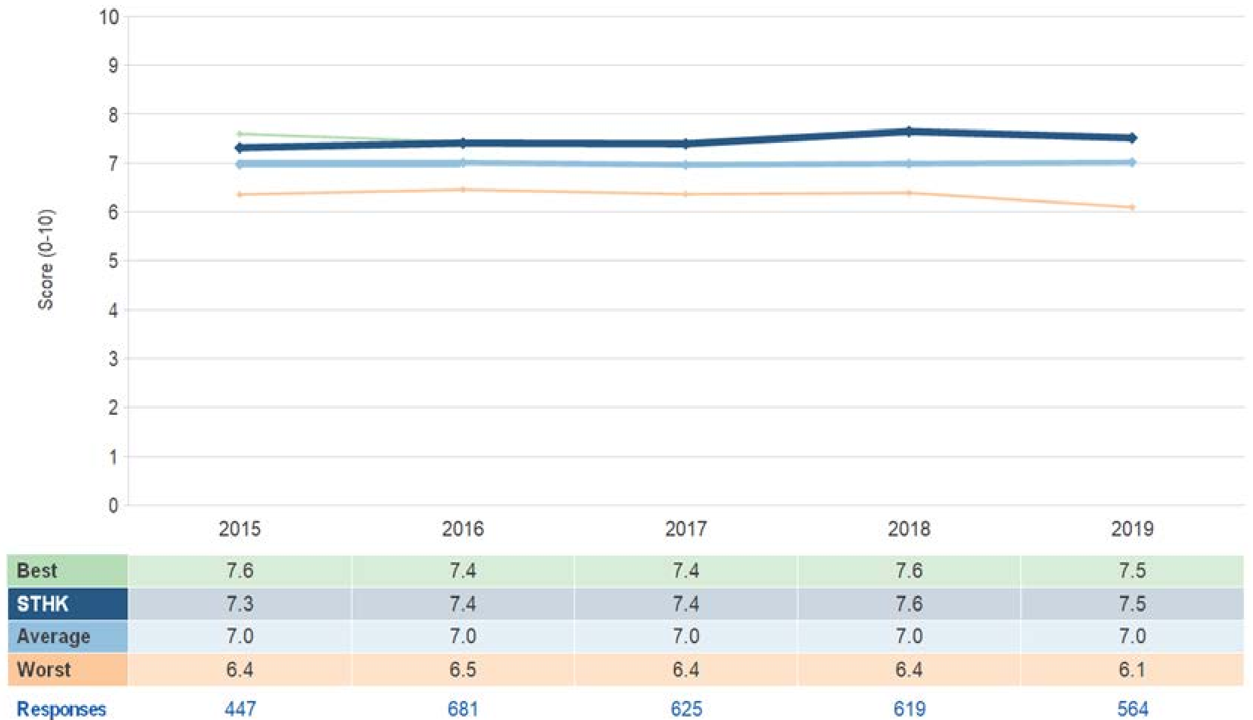
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
STHK	9.3	6.5	7.2	6.7	5.4	8.1	8.5	9.5	7.2	7.5	7.1
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	567	564	564	559	487	482	562	561	565	564	560

The Trust has been rated as the best place to receive care or treatment in the NHS for the third consecutive year. In addition, 87.2% of staff agreed that care of patients/service users is the organisation's top priority.

Also, for the third consecutive year, the Trust has recorded the highest national score for staff's belief that it acts fairly with regards to career progression.

Overall Staff Engagement is measured as an average across three themes: advocacy, motivation and involvement. Staff engagement scores fall between 0 and 10, where the higher the score, the more engaged the staff. The graph below shows that the Trust has the best score nationally for the fourth consecutive year, with a significant improvement since 2015.

Graph showing the Trust's staff engagement scores from 2015 to 2019



	2015	2016	2017	2018	2019
Best	7.6	7.4	7.4	7.6	7.5
STHK	7.3	7.4	7.4	7.6	7.5
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.5	6.4	6.4	6.1
Responses	447	681	625	619	564

The most notable contributory responses to this overall indicator of staff engagement is the staff friends and family test question, which measures staff members' willingness to recommend the Trust as a place to receive care or treatment (87.4%), for which the Trust has had the best scores nationally, since 2017.

Whilst the overwhelming majority of responses are positive, the quality of appraisals has been identified as an area for improvement. This area has the potential to impact on both staff morale and development; therefore, it is imperative that the Trust takes steps to address these. A deep dive has identified the specific areas and staff groups where focussed action will be taken and an action plan is being developed to support this work.

3.1.7. Health, Work and Wellbeing

The Trust has a Health, Work and Wellbeing Strategy 2016-2021 in place, which is delivered by the Health, Work and Wellbeing Service. The service is nurse-led and includes many different specialists who work together collaboratively. The team includes Occupational Health Physicians, Occupational Health Nurse Advisors, Screening Nurses, Counsellors (telephone and face-to-face), Psychology, and a physiotherapy service (online and face-to-face) which is supported by an administrative team. In addition, the Trust offers staff a 24/7 employment assistance service which provide telephone and online staff support.

The main aim of the service is to ensure that employees are both physically and mentally healthy whilst in work, as a healthy motivated workforce is integral to achieving better care for patients. Research shows that supporting the wellbeing of the workforce is paramount to achieving higher levels of performance (Boorman Review, 2009).

The Health, Work and Wellbeing service is SEQOHS accredited, which means that the service continues to meet the national minimum standard when delivering a Safe Effective Quality Occupational Health Services (SEQOHS). The assessment looks at the following aspects of Occupational Health; business probity, information governance, people, facilities and equipment, relationships with purchasers and workers.

2018 saw the recruitment of the wellbeing champions and throughout 2019 the number of wellbeing champions increased. There are plans to recruit more to ensure that all areas within the Trust are represented. Wellbeing champions assist the Health, Work and Wellbeing team to implement the Health, Work and Wellbeing calendar, ensuring key health messages and Public Health England campaigns are accessible to all employees.

2019 also saw the beginning of the training for Mental Health First Aiders in the work place, two groups of employees from clinical and non-clinical sites have already had training and there are plans to offer more staff this opportunity.

The annual Health, Work and Wellbeing Open Day was held in September 2019, which attracted over 400 staff from all over the Trust. The session provided information on a range of health and wellbeing topics, for example, mental health support (mindfulness, employee assistance programme and counselling), increasing physical activity and healthy eating. Other wellbeing events are being planned for the other Trust sites throughout 2020.

Following on from the success of the Menopause awareness sessions the 'Menopause café' was launched. This is a drop-in support session where staff can talk and support each other and educate others on the Menopause.

The successful flu vaccination programme was launched at the Health, Work and Wellbeing open day. The 2019-20 campaign saw an increase in the number of peer vaccinators and an increase in the number of areas achieving 100% staff vaccinations. The first 'jabathon' (mass flu immunisation at work) took place and feedback from staff indicated this was very popular as staff found it difficult to leave their work area. 93.9% of frontline healthcare workers were vaccinated, which far exceeds the 80% national CQuIN target.

2020 saw the launch of the Health, Work and Wellbeing calendar, and to date has seen two national public health campaigns implemented within the Trust.

3.1.7.1. Clinical education and training

Providing excellent education remained a priority in 2019-20 for the Clinical Education Team. Both postgraduate and undergraduate education portfolios have grown and seen significant change. To comply with the GMC's quality framework, new educational governance systems have been established within postgraduate medical education for medical trainees, ensuring there are clear systems in place to support their educational experiences and opportunities. Undergraduate medical education has undergone a review and the curriculum aligned to the General Medical Council's 2018 document, Outcomes for Graduates.

The use of simulation as an educational modality has continued to grow following the procurement of speciality paediatric equipment and the appointment of a second

simulation tutor. We now provide regular in-situ simulation programmes, across multiple directorates within the Trust, with a vision to cross pollinate education to multi-speciality teams, which will improve team work, communication and patient safety. The Simulation Team have continued to support teams across the Trust, such as, sepsis, intensive care and stroke.

The team have again increased the dentistry simulation portfolio, following positive feedback. In addition, the appointment of a clinical skills and simulation lead for foundation trainees further increased the delivery of simulation training in the foundation training programme.

In April 2019, a new Preceptorship Programme was launched. This 10 day programme follows a patient's journey from admission to discharge using both simulation and theory and feedback from participants has been excellent. Newly qualified nurses are also invited to attend ongoing development sessions and professional discussion meetings at 3, 6, 9, 12 and 18 months facilitated by the Clinical Education Support Tutor and other healthcare professionals. The professional discussion meetings explore progress and their thoughts on the Trust's Preceptorship Programme, with early evidence suggesting this can support retention. The development sessions provide newly qualified nurses with more advanced skills such as dealing with difficult conversations and resilience training. In addition, the Care Certificate Programme for Health Care Assistants has been further developed, since appointing the Clinical Education Support Tutor.

International recruitment continues to be successful. In 2019-2020 the Clinical Education Team supported 52 nurses to pass their OSCE exams and progress to practice at the Trust. The Nursing Midwifery Council planned to amend the OSCE criteria for international recruited nurses in June 2020, however, this has been delayed due to the pandemic, with no date confirmed at the time of writing.

3.2. Patient safety

One of the Trust's key priorities in 2019-20 was to continue to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience.

3.2.1. Pressure ulcers

The Trust remains focussed on delivering five star patient care and is committed to patient safety. The Trust has continued to prevent any hospital acquired category 4 pressure ulcers, as a result of lapses in care since 2015.

During 2019-20, there was one incidence of hospital acquired category 3 pressure ulcer reported due to the deterioration of a category 2 pressure ulcer which was present on admission. A thorough and in-depth investigation was commissioned to identify the root cause of this incident with the following improvement actions taken:

- Education for staff members to improve early risk identification and appropriate action planning to prevent the development of a pressure ulcer or deterioration of an existing pressure ulcer
- Development of new documentation to improve information about care of pressure ulcers and wounds

- Development of refined electronic risk assessment in the electronic patient administration system, Medway

The Trust was very disappointed to have an increase in the number of Trust-acquired category 2 pressure ulcers, increasing from 23 in 2018-19 to 59 in 2019-20. This was partially attributable to long waits in the Emergency Department and to strengthening the criteria for ascertaining lapses in care to ensure robust identification of lessons learned. The Trust has set its priority for the reduction in the number of hospital acquired pressure ulcer by 10% in 2020-21.

A number of interventions and actions were implemented last year to reduce the risk that a patient will develop pressure ulcers, listed below:

Improving access to prevention equipment/devices

- Improving access and availability of devices to support prevention of pressure ulcers for e.g. prevention devices designed for heels
- Implementation of early to bed initiative in the Emergency Department resulting in all patients being risk assessed and placed directly on appropriate pressure relieving mattresses or air mattresses to prevent tissue damage. This includes establishing contracts with specialist mattress providers to provide access to specialist pressure prevention mattress round the clock.
- Introduction and ensuring availability of specialist mattresses like TurnCair pressure relieving mattress for patients with complex conditions and to enhance patient comfort

Development of new processes and pathways

- Development of new pathway documentation, enabling better recording of risk and interventions implemented. New care plan and charts have already been developed and implemented across the Trust inpatient areas to support improved care and treatment planning
- Development and implementation of Plaster of Paris Passport for improving and recording of care for patients requiring casts.

The following further actions are currently being implemented:

Education and resource development

- Focussed education to high risk areas and increased availability of specialist input to support ward clinical professionals
- Development of a Trust App acting as a resource for staff, readily available on Trust devices
- Development of tissue viability ward champions to provide additional expertise and support for staff at a local level

Development of new processes and pathways

- IT based solution for risk assessment and identification of prevention interventions, by innovative use of Datix and Medway Vital module, is in progress for implementation in 2020/21

3.2.2. Falls

The Trust has sustained improvements in falls prevention for patients admitted to the hospital. The Falls Team continue to develop strategies to minimise the occurrence of inpatient falls and as a result have been able to reduce the number of harm incidents compared to last year.

In 2019-20, the Trust reported:
- 0.88% decrease in all inpatient falls; a further improvement from the 2.7% decrease seen in 2018-19 compared to 2017-18
- 13.89% decrease in falls incidents resulting in moderate harm or above
- 29.4% decrease in falls resulting in severe harm or above category, with 12 in 2019-20 compared to 17 in 2018-19

The Trust has developed and implemented a new falls strategy covering 2018 to 2021. The strategy focuses on seven key areas for improvement:
- Using data to drive improvement
- Lesson learning and information sharing
- Procurement of equipment/services
- Changing culture
- Education and awareness
- Planning and implementation of falls prevention care
- Planning and implementation of post falls care

3.2.3. Venous thromboembolism (VTE)

VTE covers both deep vein thrombosis (DVT) and its possible consequence and pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. However, if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE) that could lead to death.

Preventing VTE is a national and Trust priority. The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action. This might include prescribing and administration of appropriate medication to prevent blood clots and application of specialised stockings.

VTE risk assessments were completed in 95.57% of patients from April 2019 to February 2020, when national reporting was suspended due to the pandemic, compared to 95.92% of patients in 2018-19, exceeding the national target of 95%.

The Trust has increased the number of risk assessments completed and the appropriate prevention interventions by:
- Implementing an electronic VTE risk assessment tool, integrated to the new patient administration system (Medway), enabling real time performance reviews
- Introducing and sharing of compliance dashboards twice daily
- Undertaking a root cause analysis investigation of all cases of Hospital Acquired Thrombosis in order to prevent it happening again
- Providing immediate feedback/education to ward staff, disseminating learning points and implementing any actions for improvement
- On-going VTE training for all clinical staff

3.2.4. Medicine safety

The inpatient electronic prescribing and medicines administration (ePMA) system is live in most inpatient locations in the Trust (with the exception of Paediatrics, Intensive Care and Maternity). The implementation of ePMA has delivered the following benefits:

- Removed the need for drug charts to be re-written thus reducing transcription errors
- Drug charts no longer have to leave the ward and can be accessed anywhere across the Trust, removing the need for them to be sent to pharmacy for example
- Information is available for ward rounds
- Previous admissions are retained on the system which can be accessed to provide information regarding previous medication
- Quality of the information is improved as it is legible and the prescriber can be identified and contacted as required
- Audit log allows the prescriptions to be reviewed to see why a drug has been stopped or suspended or why a drug has been modified
- Course lengths, for example, of antibiotics can be added to the system and the prescription will stop automatically rather than requiring a doctor to stop it

The system also has a number of reports that can be run, including reports of any outstanding medicines reconciliations and any drugs not available to prescribe on the system. A report has also been built to identify patients prescribed a specific drug and a report which lists medicines by prescriber and date should this be needed for a drug recall, for example, or if a prescription needed to be queried.

A missed and omitted doses report has also been generated which is sent to ward staff each day. This has subsequently been added to the ward dashboard. Work will be undertaken to roll this out across the Trust. Omitted and missed doses are now more obvious on the system. If a dose has not been signed for then this will be flagged to the nurses during their administration rounds and they will be made aware that the dose has not been given. If a dose is missed then the reason for the omission has to be recorded.

The Trust has continued to reduce the number of medication incidents in 2019-20 compared to 2018-19, supported through proactive work streams led by pharmacy, including:

- No severe harm incidents relating to medication administration or prescription
- 27.4% decrease in omitted doses

3.2.5. Theatre safety

The Trust operating theatre department have a number of initiatives to improve safety of patients, which are highlighted below:

- Development and implementation of National Safety Standards for Invasive Procedures (NatSSIPs) to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur
- Development and implementation of Local Safety Standards for Invasive Procedures (LocSSIPs), as per the national guidance. These documents provide a framework for ensuring safety checks are carried out using a nationally approved methodology

- Further work to improve the structure and content of the communication tool used in theatre, enabling all team members to contribute to ensuring safety and minimising errors
- Commitment to 'being open' and enabling staff to speak up in case of any concerns. The Operating Department continues to use the hierarchy challenge tool (HALT), which offers a series of prompts for any team member to tell the team they have a concern. The development and adoption of this tool by the Trust has been recognised as a national pioneer in CQC publication 'Opening the door report' published in December 2018 https://www.cqc.org.uk/sites/default/files/20181224_openingthedoor_report.pdf
- Introduction of crisis trolleys in the operating department, providing a multipurpose equipment base to replace multiple trolleys and equipment used in challenging emergency situations in theatre. This ensures the right equipment is available for clinical teams in the event of a clinical emergency, enabling the right care and treatment to be given to the patient as soon as possible
- Introduction of clinical practice leads, to support the safe development of newly qualified Operating Department Practitioners (ODPs) and registered nurses newly employed to theatre settings. Clinical practice leads provide training and clinical supervision enabling the development of a safe and effective clinical workforce
- Support for the workforce and safe staffing levels through active recruitment process, with higher retention rates. The department has very low turnover rates and has improved retention rates compared with previous years, demonstrating recognition of the support offered to all levels of staff members and higher levels of staff satisfaction
- Operating theatres have also reengineered the patient journey to theatre, by developing forward wait areas. The new processes help improve the overall patient experience with reduced delays before surgery. The innovative process also offers enhancement in patient safety, by facilitating streamlined checking processes to be carried out before surgery
- The Department has also invested in innovative approaches in obstetric care with the introduction of a second midwife or midwife assistant in theatre. Additional resources available allows the midwife to attend to and support new mum and baby, as well as the family member present, allowing the clinical teams to focus on the surgical procedure, enhancing both the safety and the experience for the mother
- Continued to invest heavily in training of clinical and non-clinical skills, in recognition of the value of highly skilled staff to delivering safe care. Simulation exercises are regularly carried out involving multi-disciplinary team members. These exercises are undertaken to familiarise staff members with unfamiliar situations and rare clinical emergencies. The training is underpinned with the principles of human factors and just culture. Incremental challenging scenarios are used to develop skills and confidence amongst staff members

The Operating Department has been able to achieve:

- 50% reduction in theatre-related episodes of moderate harm and above
- 17% reduction in all theatre related incidents

3.2.6. Being open – duty of candour

The Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there

have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

- The Trust's incident reporting system has a mandatory section to record duty of candour
- Weekly incident review meetings are held, where duty of candour requirements are agreed on a case-by-case basis allowing timely action and monitoring. This allows the Trust to ensure that it meets its legal obligations
- The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings
- Duty of candour training is also included as part of mandatory training and root cause analysis training for staff

3.2.7. Never Events

Never Events are described by NHS England as serious incidents that are wholly preventable. Guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers.

Each Never Event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a Never Event. Never Events include incidents such as: wrong site surgery, retained foreign object post-surgical procedure and chest or neck entrapment in bedrails.

The Trust had one never event in 2019-20, relating to retained foreign body during surgery. The Trust remains committed to using Root Cause Analysis (RCA) to investigate adverse events. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and encourage feedback in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented. Improvement actions include strengthening theatre checking processes and enabling a safer theatre working environment to provide assurance that lessons have been learned.

3.2.8. Safety Thermometer

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care during hospital stays. This measures four key harms: pressure ulcers, falls, catheter acquired urinary tract infection and VTE (blood clots). The Trust has continued to achieve over 98% new harm free care, that is harm that has occurred whilst an inpatient and is one of the best performing trusts in the region.

Data for all inpatients is collected on one day every month. This identifies patients who are admitted from home with harms and harms which occurred whilst in hospital. Specialist nursing staff validate the results from this audit. Once validated, the information is then submitted to the NHS Information Centre.

The Trust maintains good practice in relation to the prevention of pressure ulcers, falls with harm and VTE by:

- Ensuring education and training is available for all ward staff to enable them to complete and submit the NHS Safety Thermometer as required
- Weekly harm review meeting reviews all incidents across the Trust, including falls
- Bi-monthly Falls Improvement Group oversees the implementation of the revised falls strategy and performance manages the associated action plans
- The implementation of a new Supplementary Care Policy, helping to ensure appropriate levels of additional supervision are in place when required
- Providing non-slip anti-embolic stockings
- Continuing to provide education for all clinical staff on VTE, resulting in increased compliance with the prescribing and administration of anticoagulants to prevent these occurring
- Nursing staff attending one hour tissue viability training every three years
- Access to a full day wound management training session
- Providing each ward with a comprehensive tissue viability folder as a staff resource
- Working towards meeting the Falls CQuIN
- Development and implementation of risk assessment tools and care intervention pathways (Bristol Royal Infirmary Checklist) in Emergency Department
- Introduction of ‘Heels RED - think BED’ initiative aimed at reducing the chances of developing heel pressure risks associated with electric profiling beds
- Development of new pathway documentation for Tissue Viability, enabling better recording of tissue status

3.2.9. Infection control

The Health and Social Care Act 2008 requires all trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). The Trust’s Director of Infection Prevention and Control (DIPC) is the Director of Nursing, Midwifery and Governance. She has Board level responsibility for infection control and chairs the Hospital Infection Prevention Group.

The infection prevention team undertakes a rolling programme of infection prevention audits of each ward and department, with individual reports discussed with ward managers and teams for action. Infection prevention indicators are included within the Quality Care Accreditation tool (QCAT).

The Trust’s infection prevention priorities are to:

- Promote and sustain infection prevention policy and practice in the pursuit of patient, service user and staff safety within the Trust
- Adopt and promote evidence-based infection prevention practice across the Trust
- Identify, monitor and prevent the spread of pathogenic organisms, including multi-resistant organisms throughout the Trust
- Reduce the incidence of HCAI by working collaboratively across the whole health economy

During the reporting period April 2019 to March 2020, the Trust reported the following:

- MRSA bacteraemia (MRSAb): one positive blood sample, which was a contaminant, against a threshold of zero
- Clostridium Difficile infections (CDI): The threshold for cases of CDI set for our Trust in 2019- 2020 by NHS Improvement (NHSI) was no more than 48 cases. NHSI issued new definitions detailing which cases would be assigned towards the Trust's threshold. Prior to April 2019, this only included cases that were detected in the hospital 4 or more days after admission (if day of admission is day 1). From April 2019 onwards, the Trust's threshold included the two following categories of cases:
  a) **Hospital onset healthcare associated:** cases that are detected in the hospital 3 or more days after admission (if day of admission is day 1)
  b) **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

These changes contributed to an increase in the number of cases assigned towards the Trust's threshold, with 61 cases recorded, of which 19 were successfully appealed as there were no lapses in care.

Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb): The Trust has 25 cases of (MSSAb), To date, seven cases were deemed avoidable following post infection review (PIR).

Lessons learned from PIRs of MRSAb and CDI cases are shared Trust-wide via a monthly infection prevention report. Lessons learned include good practice identified, as well as areas for improvement. This information is also shared monthly with the CCGs.

The latest surgical site infection (SSI) rates related to elective hip and knee procedures from April to March 2020 are shown below:

- Hips 0.6% against a national average of 0.9%
- Knees 0.3% against a national average of 1.2%

In May 2016, the Government announced its ambition to halve Gram-negative bloodstream HCAI by 2021. As approximately three-quarters of E. coli bloodstream infections (BSIs) occur before people are admitted to hospital and, therefore, reduction requires a whole health economy approach. The Trust, in collaboration with CCGs and partners, has developed a health economy action plan particularly focusing on a 10% in-year reduction in urinary tract infections and to learn and share lessons. The Trust continues to work closely with the infection prevention, patient safety and quality teams in the wider health economy, attending collaborative meetings across the region in order to improve infection prevention and control practices and monitoring.

The Trust vaccinated 93.9% of front-line staff, exceeding the national flu CQuIN target of 80%. In addition, the Trust promoted the flu vaccination with pregnant women and patients in long stay rehabilitation wards. This season the Trust introduced flu vaccinators/ champions for every ward and department to make it easier for staff to access vaccination. There were also peripatetic vaccinators throughout the Trust. During the flu season, the Trust had daily flu ward rounds undertaken by the DIPC and respiratory clinician.

The Trust has 21 Consultant infection prevention champions and over 70 link nurses who attend education and training and complete local audits to monitor compliance.

Key achievements for 2019-20 were:

- PLACE assessments achieved 100% for cleanliness for Whiston and St Helens sites
- Continued SSI surveillance within elective hip and knee
- Introduced e-learning for mandatory infection prevention training
- Introduced e-learning for aseptic non-touch technique (ANTT)
- There are 439 Aseptic Non Touch Technique key trainers in the Trust who are responsible for ensuring all staff are compliant with ANTT
- 100% compliance with carbapenemase-producing enterobacteriaceae (CPE) and MRSA screening
- Ensured that there was infection prevention input into environmental monitoring systems and implementation of national standards for cleanliness and validation of standards
- Ensured there was infection prevention input into new builds and building modification
- Continued to use electronic assessments for recording patients' bowel habit, monitoring using the Bristol Stool Chart and also for CPE risk/screening assessment using the Patientrack system.
- Introduced bi-weekly multi-disciplinary ward inspections with estates and facilities, Medirest, Vinci and new buildings to monitor ward cleanliness and estates and facilities provision
- Changes to the RCA processes to improve and prioritise cases that require oversight and input from the executive and clinical teams. Timely RCA reviews for CDI cases has improved the dissemination of lessons learned and targeted the infection prevention team input to ward areas that require support

3.2.9.1. COVID-19

COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. COVID-19 is now a pandemic affecting many countries globally.

The most common symptoms of COVID-19 are fever, dry cough, and tiredness. Other symptoms that are less common and may affect some patients include aches and pains, nasal congestion, headache, conjunctivitis, sore throat, diarrhoea, loss of taste or smell or a rash on skin or discoloration of fingers or toes. These symptoms are usually mild and begin gradually. Some people become infected but only have very mild symptoms.

The disease spreads primarily from person to person through small droplets from the nose or mouth. People can catch COVID-19 if they breathe in these droplets from a person infected with the virus. These droplets can land on objects and surfaces around the person such as tables, doorknobs and handrails. People can become infected by touching these objects or surfaces, then touching their eyes, nose or mouth.

The Trust began to prepare for potential COVID patients in January 2020 and instigated its emergency preparedness response and business continuity plans. The first patient admitted to the organisation was on the 12th March 2020.

The Infection Prevention Team members were responsible for:

- Advising the Trust on the most up-to-date and continually changing guidance from Public Health England (PHE) and NHS England via silver and gold command

- Education for staff on how to care for COVID patients, providing the highest quality care and protecting themselves while caring for them
- Working closely every day with the procurement department ensuring provision of personal protective equipment (PPE) to wards and departments was available and fit for purpose. Communicated Trust-wide any changes to PPE requirements issued by PHE and NHS England.
- Working with estates and facilities in altering existing services and buildings to create additional non-invasive ventilation (NIV) and critical care unit beds, COVID wards, staff changing and break out rooms etc.
- Provided the fit test service and expertise throughout the pandemic, including training staff on the new quantitative fit testing machines purchased during the pandemic
- Visiting wards and departments providing support and reassurance for staff.
- Provision of learning aids, posters on PPE, hand hygiene and environmental cleaning
- Providing advice to community colleagues and care homes
- Contributed to clinical protocols for COVID patients
- Providing a 7 day week infection prevention service on site
- Providing advice and support to our Medirest and Vinci colleagues
- Surveillance and reporting throughout the day on new COVID cases
- Providing support to staff self-isolating or at home with suspected/confirmed COVID

3.2.10. Safeguarding

The Trust takes its statutory responsibilities to safeguard vulnerable patients of all ages very seriously and welcomes external scrutiny of its robust policies, procedures and processes. The Trust submits quarterly key performance indicator data to the CCGs, including the Trust's policies, for external scrutiny. The Safeguarding Team submitted weekly then fortnightly position statements during the COVID-19 pandemic and evidence to CCGs and to the Safeguarding Boards, as requested. The Trust also submits responses to the Commissioning Standards template and reports progress against any required actions. Safeguarding compliance is monitored by St Helens CCG through key performance indicators and St Helens CCG then provide assurance to Halton and Knowsley CCGs.

The Trust has a dedicated Safeguarding Team comprising of:
- Assistant Director of Safeguarding
- Named Nurse, Safeguarding Children
- Named Doctor, Safeguarding Children
- Named Midwife
- 2 x Safeguarding Specialist Nurses
- 1.6 whole time equivalent clerical support

The Named Midwife is supported by a Specialist Midwife and administration staff.

The following additional staff joined the Safeguarding Adults Team from March 2020:
- Named Nurse Safeguarding Adults
- Learning Disability Specialist Nurse
- Mental Capacity Act Specialist Practitioner

The Safeguarding Team provides support and advice to staff and delivers mandatory safeguarding supervision and training to all staff throughout the organisation. The Team ensures that policies and procedures are reviewed regularly in line with current legislation, including all aspects of safeguarding, Prevent, child exploitation, trafficking and modern slavery.

The Trust's safeguarding assurance framework had separate safeguarding children and adults steering groups, which met quarterly to discuss required actions, activity and updates on current practice and drive the safeguarding agenda within the Trust. In September 2019 the children and adults groups were combined to become the Safeguarding Assurance Group due to the crossover of some agendas and to support cross working across family generations. The Safeguarding Assurance Group reports to the Patient Safety Council. Designated Nurses from the CCG and Healthwatch colleagues are invited to the meetings for external scrutiny and to facilitate information sharing.

Annual reports are approved by the Trust Board for both Safeguarding Children and Safeguarding Adults. These reports are subsequently shared with Local Safeguarding Adult and Children's Multi-Agency Boards and inform their annual reports accordingly.

3.2.10.1. Safeguarding Children

The Trust continues to work pro-actively with St Helens, Knowsley and Halton Safeguarding Partnership Boards in line with the new arrangements that came into being in June 2019, following the publication of Working Together to Safeguard Children 2018 as a consequence of the Wood review recommendations.

The Trust is involved in the Partnership Forum and sub-groups across the three local authority areas ensuring that the acute Trust perspective is considered and that safeguarding continues to be a priority, as well as maintaining partnership working across the footprint.

The Safeguarding Team contributes, as required, to multi-agency reviews including serious case reviews, practice learning or management reviews. Any identified learning points are shared across the Trust and any necessary actions implemented to improve practice.

The Trust continues to support and safeguard children at risk of all forms of abuse contributing to the 'early help' agenda and multi-agency safeguarding procedures.

3.2.10.2. Safeguarding Adults

The Trust continues to work pro-actively with St Helens, Halton and the Merseyside Safeguarding Adult Boards as either a board or sub-group member.

The Trust, along with partner agencies, continues to work in line with current statutory guidance. The Safeguarding Team contributes to any multi-agency reviews including safeguarding adult reviews, domestic homicide reviews and management reviews. Any identified learning points are shared across the Trust and any necessary actions implemented to improve practice as required.

The Trust continues to support the patient journey of adults who have additional needs or who are identified as potentially being adults at risk. This cohort of patients includes people

with a learning disability, mental health issues, substance misuse or any other vulnerability factor. The Safeguarding Team works closely with staff to identify and safeguard these individuals, also advising regarding reasonable adjustments.

3.2.10.3. Mental Capacity Act and Deprivation of Liberty Safeguards

The Trust's Mental Capacity Act (MCA) Policy and Procedure is embedded into clinical practice. Applications for Deprivation of Liberty Safeguards (DoLS) continue to increase. An audit into referrals this year generated an information sheet for front line staff to support decision making.

Quarterly information is supplied to the CCG regarding the applications that are made and the outcome of the application. The Trust will review all MCA/DoLS processes in line with the forthcoming Liberty Protection Safeguards (LiPS), to ensure robust arrangements are in place when the Trust becomes the Responsible Body for reviewing applications, signing off authorisations and monitoring any restrictions that are deemed necessary, under the new arrangements. The Trust is included in multi-agency meetings regarding the LiPS and is awaiting the publication of a Code of Practice.

Funding for an additional post within the Safeguarding Team was agreed which will support this agenda in the following year with the new staff in post from March 2020.

3.2.10.4. Domestic Abuse

The Trust actively contributes to the local domestic abuse agenda with completion of MERIT risk assessment tools, signposting to relevant support agencies or Multi-Agency Risk Assessment Conferences (MARAC), active participation at both St Helens and Knowsley MARAC meetings and reports by exception to Halton and Warrington.

The Trust Domestic Abuse Policy ensures support is offered to both patients and staff members who may be affected by domestic violence and/or abuse. Training is embedded in all levels of both safeguarding children and adult sessions to ensure that the workforce is competent in the identification and support of domestic abuse victims and children.

Contribution to Domestic Homicide Reviews is undertaken as required by Community Safety Partnerships. There have been two Independent Management Reviews required this year, both of which had minimal learning for the Trust.

3.2.10.5. Learning Disability

Guidance has been implemented for patients with a learning disability attending any department within the Trust on how to meet their individual needs. This is supported by a toolkit to ensure that staff are able to provide the highest standards of care. The Trust works with partner agencies to support the patient journey and to share best practice. Safeguarding Adult staff support this agenda, highlighting and supporting those patients who attend the Trust requiring reasonable adjustments and support with communication whilst using Trust services.

The Trust is working to implement the NHS England Learning Disability Improvement Standards and has been part of the NHS England and Improvement benchmarking exercise again this year. The Trust has agreed funding for a Learning Disability Specialist Nurse and, following successful recruitment, the successful candidate took up the post in March 2020.

All those with a Learning Disability who die in the Trust have their case reviewed by a member of the safeguarding team looking at any lapses in care or reasonable adjustments. There is also a Structured Judgement Review on each case to look at clinical care and review if there are any lessons to learn. The Trust is part of local LeDeR panels and is supportive of reviewers accessing Trust records to undertake external reviews. Learning Disability work streams are reported through the Patient Experience Council and subsequently the Quality Committee. The Safeguarding team support staff with reasonable adjustments required for patients. Carers are also supported with those who have difficulties accessing the Trust due to a Learning Disability, which may be due to health or behaviour complexities or those requiring adjustments to facilitate a visit or treatment.

The newly appointed Learning Disability Specialist Nurse will support the Trust in ensuring training is fit for purpose and that staff can access specialist advice as required. The Trust has employed a Mental Capacity Act Specialist Practitioner who will also support those with a Learning Disability and staff treating patients under the Mental Capacity Act. The Trust employs 18 whole time equivalent staff with a Learning Disability.

3.3. Clinical effectiveness

The Clinical Effectiveness Council meets monthly and monitors key outcome and effectiveness indicators, such as mortality, nationally bench-marked cardiac arrest data, critical care performance, hip fracture performance, readmissions, clinical audit and application of National Institute for Health and Care Excellence (NICE) guidance.

3.3.1. National Institute for Health and Care Excellence Guidance

St Helens and Knowsley Teaching Hospitals NHS Trust has a responsibility for implementing NICE guidance in order to ensure that:

- Patients receive the best and most appropriate treatment
- NHS resources are not wasted by inappropriate treatment
- There is equity through consistent application of NICE guidance/quality standards

The Trust must demonstrate to stakeholders that NICE guidance/quality standards are being implemented within the Trust and across the health community. This is a regulatory requirement that is subject to scrutiny by the CQC. The Quality Improvement and Clinical Audit (QICA) Team are responsible for supporting the implementation and monitoring NICE guidance compliance activity.

207 pieces of new or updated NICE guidance were released during the year 2019-20. There is a system in place to ensure all relevant guidance is distributed to the appropriate clinical lead to assess its relevance and the Trust's compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance will be rigorously assessed by mandatory departmental compliance audits reportable

through the Trust audit meetings. The Trust is fully compliant with 79 of those guidance papers issued and working towards achieving the remainder.

3.3.2. Clinical audit

The Trust has an active clinical audit programme and is an active participant in required national audits where performance is strong. Details of the work undertaken this year are contained in section 2.4.2 above.

3.3.3. Intensive Care National Audit & Research Centre (ICNARC)

The Trust's Critical Care Unit performs well in the patient centred quality indicators, as externally benchmarked by the Intensive Care National Audit and Research Centre (ICNARC), which collects data from 100% of all Intensive Care Units in the country (https://www.icnarc.org).

3.3.4. Mortality

The government's preferred measure for mortality is the Summary Hospital Level Mortality Indicator (SHMI). The latest published data is for the 12 month period Oct-18 to Sep-19. The Trust's SHMI for this period is 1.08, which is as expected.

The Trust's mortality is also within expected levels for both of the other commonly used measures, with the Standardised Mortality Ratio (SMR) at 104.3 and the Hospital Standardised Mortality Ratio (HSMR) at 104.9.

3.3.5. Copeland risk adjusted barometer (CRAB)

The Trust has established the use of CRAB to review complications and mortality trends across the surgical specialties in the Trust. The CRAB Benchmarking Group is made up of representatives from each of the surgical specialties and as a group reviews these trends on a monthly basis. With this powerful tool, surgical mortality and complications trends can be examined across the whole Trust, within surgical departments and even at the individual surgeon level. CRAB creates an accurate picture of surgical consultants' practice, adjusting for presenting risk, operation complexity and intra-operative complications. It prevents harmful misuse of crude mortality statistics and helps to identify best practice. Until recently CRAB Surgical only reflected the activity of surgical in-patient episodes and did not reflect the management of medical patients within the Trust. However, owing to the success of CRAB Surgical, the Trust has now obtained CRAB Medical, thus broadening the benefits across both surgical and medical patients.

The CRAB methodology is based on the POSSUM system which is the clinical audit system of choice recommended by the Royal College of Surgeons of England and Scotland, NCEPOD, the Vascular Society of Great Britain and Ireland, the Association of Coloproctology of Great Britain and Ireland, and the Association of Upper Gastrointestinal Surgeons.

With the advent of clinical governance CRAB provides high quality clinical process and outcome information. It provides a wide range of reports based on extensive data

captured before or at the time of operation documenting the patient's condition. For each case, the risk of mortality or morbidity is calculated using POSSUM algorithms and the raw data may be reviewed by looking at individual cases in the risk report. Any concerning trends or higher than expected complication or mortality rates are examined for potential causality within the CRAB Benchmarking Group and by each of the core members of the specialty in question.

Outcomes from this group are fed into the Clinical Effectiveness Council (CEC) on a quarterly basis. Monthly reports for the benchmarking group meetings are prepared prior to the meetings taking place and distributed to the members for review. During the meetings, the report is reviewed for performance at the Trust level and subspecialty level and recommendations for review are made. It is the responsibility of each CRAB specialty representative to feed back the review to the CRAB lead and the reports are amended accordingly. Action plans are generated for each of the monthly meetings and reviewed by all members of the CRAB team to ensure that the issues have been addressed.

Issues and concerns identified at the CRAB meetings are reviewed by the group as a whole and reviewed in more depth by specialty CRAB representative. This more detailed review is fed back to the CRAB lead and the reports are adjusted to reflect this. If improvements in performance are not seen then it is the responsibility of the CRAB representative to escalate to the clinical director of that specialty and persistent concerns relayed to the CEC meetings.

3.3.6. Promoting health

The Trust continues to actively promote the health and wellbeing of patients by undertaking a holistic assessment on admission that looks at physical, social, emotional and spiritual needs. Patients are referred or signposted to relevant services, for example; dieticians, stop smoking services and substance misuse. The initial review of patients includes a number of risk assessments that are used to highlight specific concerns that are acted upon, including nutrition and hydration and falls. The Trust has a Smokefree Policy in place that promotes a healthy environment for staff, patients and visitors, with measures in place to support staff and patients to give up smoking. The Trust has been participating in the alcohol and tobacco CQuIN, whereby patients are asked on admission about smoking and alcohol intake and then provided with support and guidance as required. In addition, the Maternity Service actively promotes breast-feeding.

The Trust works in partnership with other agencies to provide holistic services throughout the patient's journey to ensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the work of our Community Falls Team, who work collaboratively with the local council, primary and community care and our Infection Prevention and Control Team who liaise closely with community teams and GP services.

The Trust has an effective volunteering service and has 325 volunteers currently working across the organisation, with recruitment events held every other month. The Trust's Volunteer Department has continued to work with multidisciplinary agencies to support people back into employment, through building confidence, learning new skills and improving both mental and physical wellbeing through becoming a volunteer at the Trust. Volunteers are offered a variety of training opportunities that will be advantageous should they wish to apply for Trust jobs or employment outside of the organisation.

Due to COVID-19 all volunteers over 70 years of age and those with underlying health conditions were required to self-isolate, which impacted on many of our volunteers. In order to minimise the impact of this there has been continued recruitment of new volunteers throughout the pandemic, supported by furlough schemes and the closure of higher education institutions. Ward volunteers were redeployed into new roles that could speed up the discharge process.

New roles included;

- Volunteer Responders were contactable by telephone to run errands and deliver items from relatives to patients
- Volunteer Pharmacy Drivers delivered medication to patients in the local community who were shielding/self-isolating
- Family Liaison volunteers supported the PenPALS by delivering messages from families

Trust staff volunteered their time to support vulnerable volunteers with a Check in and Chat telephone service.

In addition, the Trust has signed the Step into Health Pledge to champion and assist the transition of ex-military staff into NHS employment. NHS Employers and the Royal Foundation support the pledge.

3.4. Patient experience

Patient experience is at the heart of the Trust's vision to deliver 5 star patient care and we are keen to learn from all our patient and carer experiences so we can continuously make improvements and share good practice.

Patient stories remain a pivotal part of the patient experience agenda throughout the Trust. Patient stories are shared in a number of forums including the Trust Board, Patient Experience Council and the Patient Experience and Dignity Champions group. Patients and their families are welcomed and encouraged to present their experiences in their own words and make suggestions to improve the patient journey.

Patient stories have contributed to a number of positive service improvements throughout the Trust, including the introduction of telehealth which enables video consultations for patients requiring outpatient speech and language therapy, providing a more flexible and inclusive service. There are plans to implement this within other services such as Frailty, Liver Surveillance and Breast reconstruction. The community intravenous therapy (IV) team have enhanced the responsiveness of their service by offering additional drug therapies to support patients' preference to stay at home and continue with their normal day to day activities, reducing the need for hospital attendance or admission. The Trust is considering whether this can be further developed to benefit more patients.

A range of mediums have been used to deliver patient stories including patient films, patients and their relatives attending in person and submitting stories for staff to deliver on their behalf.

Prior to the pandemic, the Patient Experience Manager engaged with 5 patients or carers each day in a range of settings, including wards and outpatients clinics. This provided

valuable ‘real time’ feedback from patients and carers about their experience and allowed early identification of any individual problems which could be easily resolved. More complex issues and any emerging themes or trends across the Trust were escalated to senior teams.

A number of actions have taken place this year to enhance patient and carer experience. These include the implementation of a carer’s passport developed in conjunction with local carers groups; the passport recognises the Trust’s commitment to working together with carers as partners, identifying and supporting their needs.

Further developments include the planned introduction of a pager system for patients waiting for prescriptions in the Pharmacy department to enable patients and carers to leave the department and return once the prescription is ready for collection.

The Trust has continued to engage with patients via a number of patient participation groups. Forums take place within the specialities of paediatrics, maternity, diabetes, gastroenterology, the continence service and rheumatology. The Trust-wide patient engagement group continued to meet regularly and was attended by a wide range of participants. This provided the opportunity for staff to share the Trust’s developments with patients, carers and members of the community and gain their feedback in relation to service developments, priorities and progress of the Patient Experience Strategy for 2019-2022.

What our patients said about us in 2019-20

Sanderson Suite

Just returned from having cataract surgery and have to send such a positive review! The staff were amazing and were so kind and professional! Have to mention one of the nurses who put my mind at rest as I was very nervous before hand! Thank you all very much

Dermatology Clinic

I attended the Dermatology clinic in a state of worry and dread as I am a nervous person and I feared the worst! As it was I could not have been treated better. I did not have a long wait and was greeted by a caring nurse. The consultant was very understanding and allayed my fears and assured me of choices. The outcome was much

Urology Department

I've attended hospital for the last 7 Fridays in the urology department. The nursing staff and the consultant were very professional ….so understanding about the traumatic situation my life had taken and the stressful life I am facing. All the staff were amazing. I've visited 3 different hospitals and the quality of service I have received is outstanding. I've got surgery coming up shortly and have every confidence in the team treating me. Thank you all you are all so very special people to me.

3.4.1. Friends and Family Test

The Friends and Family Test (FFT) asks patients if they would recommend the ward or department where they recently received healthcare to their friends or family if they needed similar care or treatment. It is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback in real-time about their experience.

The feedback gathered is used to identify themes or trends, stimulate local improvement and empower staff to carry out changes that make a difference to patients and their care.

The Trust uses a variety of survey options, with inpatient ward areas and maternity services providing patients with a postcard on discharge and Emergency Department and outpatient areas use texting and interactive voice mail service.

The Trust's inpatient response rate at the end of February 2020 was 29.7% compared to the national average of 24.4% based on February 2020 inpatient national data and including independent sector providers). Wards and departments across the Trust monitor the patient feedback and create 'you said, we did' posters for display. These posters reflect our response as a result of patient comments and are invaluable in maintaining staff motivation and influencing change. Some examples include:

Diabetes

You said
The staff treated me as if I was the only patient they had when there were very many. Any questions I had were answered honestly and professionally and I couldn't ask for better treatment.

We did
Our team are always on hand to offer expertise, advice and answer any questions you may have. Our staff are often under a lot of pressure within such a busy department therefore it is heart-warming to hear that they make our patients feel so special and individual

Emergency Department

You said
I was not happy with the time I waited while I was in so much pain and I was not offered any pain killers.

We did
We apologise about the delay to be seen. We will place notices in the waiting room to ask patients to speak with the triage nurse if they require analgesia.

Ward 1B

You said
The care I received whilst on 1B was very professional and the staff were lovely and caring.

We did
Staff are encouraged to be professional at all times and adhere to ACE behavioural standards

Eye Clinic

You said
Professional service as usual but the 2 hour wait is still an annoyance. In the bigger picture I am extremely grateful that my sight is being preserved, and look forward to the prospect of a more permanent fix being made available.

We did
Thank you for your comments we appreciate waiting times can be inconvenient, we do have a buzzer system so you are able to go for a drink and we keep our delay board updated so that you can be informed of any delays.

Postnatal Ward

You said
I was here 4 years ago and again now. Everything has been amazing I can't fault the care and I always recommend friends and family should have their babies here.

We did
Thank you so much fir your kind comments. It is lovely to know you recommend our Maternity Unit to your friends and family.

In April 2020, The Trust will implement the new NHS England Guidance 'Using the Friends and Family test to improve patient experience'. NHS England will no longer publish response rates as there will be no limit on the number of times someone can leave feedback, the focus will be on the quality of feedback received. However, the Trust will

continue to monitor response rates internally to ensure that the feedback is representative of the number of patients using our services.

3.4.2. Complaints

The Trust takes patients' complaints extremely seriously. Staff work hard to ensure that patients and carers concerns are acted on as soon as they are identified and that there is a timely response to rectify any issues that are raised at a local level, through the Trust's PALS team, or through the AskAnn email. Ward and departmental managers and matrons are available for patients and their carers to discuss their care and to provide timely resolution to ensure patients receive the highest standards of care. Each area has a patient experience notice board to highlight how patients and carers can raise a concern and this is also included on the information table placemats available for patients. At times, however, patients and their carers may wish to raise a formal complaint and these are thoroughly investigated so that patients are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust internet.

In 2019-20, the Trust received 325 new complaints that were opened for investigation. This represents an increase of 19% in comparison to 2018-19, when the trust received 273 new complaints. Many of the additional complaints were associated with the very challenging winter period when there was additional pressure on the Trust's capacity.

There were 36 complainants that were dissatisfied with the initial response and raised a stage two complaint, compared to 36 in 2018-19. The total number of PALS contacts increased by 3.84% to 3298 in 2019-20.

Work remains ongoing to improve the timeliness of responses to those who made the effort to highlight concerns about their care. The average time to respond to new complaints within the agreed timescale has increased from 92.1% in 2018-19 to 93.4% in 2019-20.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2019-20, with a copy of the survey sent out with all response letters. There were 22 responses in total received in 2019-20, a 7% response rate. A summary of the findings is below, noting that the % figures provided are based on the number of respondents answering the specific question:

- 81.8% confirmed that our written response included a clear explanation of the options available to them if they weren't satisfied with our findings
- 77.2% found it very or fairly easy to complain, with three finding it fairly difficult and one finding it very difficult
- 69% felt that their complaint had been responded to in a reasonable timescale whilst 31% felt that their complaint had not been responded to in a reasonable timescale
- 63.6% confirmed that the reasons for the Trust's decision was made clear to them
- 59% were very or fairly satisfied with the way the complaint was handled
- 54.4% confirmed that they felt that they had been treated with respect throughout the process whilst 22.7% confirmed that they had been treated with respect some of the time in the process

The Complaints Team are continuing to work hard on reducing the time taken to provide complaints responses, whilst maintaining the quality of the investigation and response.

A number of actions were taken as a result of complaints made in 2019-20 and a sample of these actions is recorded on the Trust's internet in keeping with the Francis Inquiry recommendations.

Actions taken include:

- Additional nurses have been recruited to provide further triage facility in Emergency Department
- A pathway has been implemented in conjunction with North West Ambulance Service to ensure that dialysis patients are admitted directly to the local dialysis provider
- The Emergency and Paediatrics departments have reviewed the referral pathways and a more robust referral process between the two departments is now in place
- Processes and systems have been changed within the cardiology clinic and the booking clerk will cross check to ensure that an appointment has been made when a procedure is marked as urgent
- Spot check audits undertaken of documentation regarding wound care management, risk assessment, rounding tool, catheter monitoring forms and moving & handling assessments and associated equipment
- All staff in the department (ward 5A) to review the pressure ulcer prevention policy

3.5. Service developments during 2019-20

3.5.1. Surgical Care Group

3.5.1.1. General Surgery and Urology

- Increased the numbers of trainee nurse clinicians across General Surgery and Urology, with three new recruits to the training posts, leading to two in urology, two in general surgery and one joint post
- Introduced 7 day cover for the Emergency Surgery Coordinators/'Hot' Gallbladder service, in October 2019, from five days, following a period of training for a second coordinator
- Involved in trial with radiology for ward-based scanning, both for inpatients and GP patients who might not require admission and will return for scan the following day. This happened throughout February 2020 and the benefits were that all inpatients who needed a scan were highlighted and scanned and also patients who were reviewed the previous day in GP triage were asked to return the following morning for their scan. This avoided the patients moving from department to department and also had an impact on length of stay as patients did not wait lengthy periods for scans
- Increase in pharmacy cover across wards 4A and 4B with new pharmacists in post, which improves both the patient journey and allows earlier discharges to be facilitated during each day to improve patient flow
- Clinical space provided to enable the pull up model from ED to ward 4B. This area has been created to "pull" patients from ED who are deemed fit to sit. They are reviewed on the ward and investigations carried out before a decision to admit is made. Often these patients avoid admission and are reassured that a plan of action has been put in place to manage their condition
- A second nutritional nurse has been employed by the Gastroenterology Team, which has improved the service to patients who are artificially fed. Ward 4C have the majority

of the inpatients who require Total Parental Nutrition (TPN) and the wards have close links with the team to ensure feeding is set up in a timely manner

- Increase in hot slots for lithotripsy on ward 4A from January 2020, with an additional session created in the clinic taking the days from two to three. Currently there are four additional slots for this, which includes a slot for inpatients who need the procedure
- The Urology Team, in collaboration with Edge Hill University, is developing a Post Graduate Certificate in Urology Practice starting in September 2020, which will be hosted at the Trust with the majority of the teaching being delivered by clinicians who are experts in their field from throughout the region. Funding has been secured from the Cheshire and Merseyside Cancer Alliance to establish the programme and develop the Urology Unit into a training hub for nurses, based on the recommendations of the Get It Right First Time (GIRFT) report
- Urology hot clinics implemented daily on ward 4A which has very positive feedback. The clinics aim to reduce length of stay as patients can be discharged home, with a follow up review as required in the clinic on the ward. This service has been expanded to long standing urology patients who may require interventions which would previously have been listed as an elective admission
- Expansion and development of the services within Urology Unit continue with the establishment of a laser bladder tumour service, allowing for more appropriate triaging and treatment of patients which in turns frees up theatre capacity. The two trainee Urology Nurse Practitioner posts highlighted above will allow the service to move to 6 day working, once trained, therefore increasing capacity. Existing staff within the Unit have been undertaking Advanced Masters level modules allowing them to advance their practice further to enhance the patient journey. Work is also ongoing to move the transperineal prostate biopsy service from theatre to the Urology Unit
- The Uro-Oncology Clinical Nurse Specialist continues to expand their nurse-led clinics and now sees the vast majority of patients who have undergone nephrectomy regardless of risk in the nurse-led clinic. A nurse-led active surveillance clinic for men with prostate cancer has also been established and both these developments have freed up capacity in Consultant clinics. The Urology Support work now attends board rounds, as well as completing patient information ward rounds, which allows for further assessment of the potential information needs of urological cancer patients
- The Continence Team are developing a complex catheter care service within the community for patients who experience problems with catheters to prevent unplanned attendances at the Emergency Department and the Urology Hot clinic. A member of the Continence Team has been accepted on the Nurse Associate allowing for further development

3.5.1.1. Ophthalmology

The Ophthalmology Service has recently entered into a collaborative arrangement with Warrington and Halton Hospitals NHS Foundation Trust to provide out-of-hours emergency ophthalmology services to the patients of both hospitals. This arrangement provides sustainability to the two providers after the previous collaboration ended with the merger of the Royal Liverpool Hospital and Aintree University Hospital.

The service has expanded its nurse-led services by training and introducing the nurse-led clinics in Botox for the treatment of eyelid disorders and laser surgery for YAG (yttrium aluminium garnet) capsulotomy, a special laser treatment used to improve vision after cataract surgery.

3.5.1.2. Maternity

The Maternity Service has been involved within the National Maternal and Neonatal Health Safety Collaborative and is focussing on the recognition and management of deterioration in babies, including improved processes relating to the neonatal sepsis pathway**.** The aim of phase one of the locally designed Improving Neonatal Sepsis Pathway Outcomes **(**INSPO) Project was to increase the number of eligible babies who receive intravenous (IV) antibiotics within an hour, without separation of mum and baby, by 75% by March 2019. The project has achieved 100% of all babies from the Delivery Suite receiving IV antibiotics, within an hour, from decision to delivery, without separation from mum, since December 2018. Phase two of the project will spread the improvement to the whole of the Maternity Service concentrating on the postnatal ward.

The Maternity Service has developed pathways of care to achieve the national ambition of Continuity of Carer. As a service we achieved the first milestone of 20% of women booked on to a Continuity of Carer pathway in March 2019 and achieved the 35% target by March 2020. This means that we will continue current pathways in place for women who are suitable for midwifery-led care and next birth after caesarean section (NBAC).

The NBAC pathway was successfully launched in August 2019 and is now providing continuity of carer to women who have previously had a caesarean section. The team has a dedicated consultant obstetrician who is working in collaboration with the NBAC midwives to provide continuity of carer for these women regardless of their birth choices.

The third Continuity of Carer pathway has been identified for vulnerable women who use our Service. The Amethyst Team has been formed by the specialist midwives to develop a team that facilitates continuity for our most vulnerable women. This team is combining the specialist services to provide continuity to women with severe perinatal mental health concerns, substance misuse, young parents, high level safeguarding concerns and black, Asian and minority ethnic women. Women often do not have these vulnerabilities in isolation and often have a complex social, psychological and medical background. The team is highly experienced in delivering care for vulnerable groups and by combining as a Continuity Team they will enable women to build a trusting and meaningful relationship with their midwife and her team that will provide choice and personalisation in a supportive and non-judgemental environment. This team have started taking referrals and were fully operational by June 2020.

Plans are being made to incorporate the proposed Community Hub into the enhancing choice and personalisation for women and improving service provision. Women eligible for pathways will be identified at booking with the aim of team continuity in the antenatal, intrapartum and postnatal period from a dedicated birth team.

3.5.2. Medical Care Group

3.5.2.1. Gastroenterology

Endoscopy

- Trust continued to lead the regional Cheshire and Mersey Cancer Alliance Endoscopy Improvement Programme

- Maintained Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation in October 2019
- Expanded bowel scope screening programme to detect cancer earlier improving outcomes
- Introduced 7 day week endoscopy

Nutrition
- Introduction of nutrition nurse led and multidisciplinary clinics
- Continued use of 'Pill Cam' and gastrointestinal (GI) physiology to further aid diagnostics for patients with GI disorders

Inflammatory Bowel Disease (IBD)
- Participated in extensive national IBD research trials
- Introduced virtual biologics clinics and other non face to face clinics avoiding hospital visits for IBD patients

3.5.2.2. Diabetes and Endocrinology
Transformation programme delivered with the following benefits:
- Structured education for St Helens residents (79%)
- Improved specialist nurse input for inpatients (62% increase)
- 7 day service and daily clinics to facilitate discharges
- Reducing length of stay for inpatients with diabetes from 9.3 pre-transformation to 3.91 days currently
- Diabetic foot service increased with reduced waiting times
- Working with 28 GP practices, to improve diabetes related outcome measures and provided education to the primary care teams
- Achieved an outstanding GIRFT report
- 15 posters shortlisted for presentation at national conference

3.5.2.3. Dermatology
- Developed nurse led phototherapy and skin cancer follow up clinics
- Advice and Guidance service in place to improve GP access to consultant advice
- Won People Choice's Awards at the Trust's annual staff awards ceremony in June 2019
- Launch of regional melanoma clinic in St Helens Hospital, one of the first outside London to offer this service

3.5.2.4. Rheumatology
- Commenced AMU rheumatology rapid access clinic to enable timely review and treatment for patients
- Maintained the Customer Service Accreditation award with yearly re-accreditation and patient reference group
- Launched the Early Inflammatory Arthritis and Giant Cell Arteritis clinics in January 2020

3.5.2.5. Department of Medicine for Older People/Frailty
- Development of North West Ambulance Service (NWAS) direct admission pathways to the ambulatory area on the frailty ward resulting in earlier comprehensive geriatric assessment for frail older people

- Further development of Community Frailty Service provided in St Helens, Knowsley and Halton to support review and care of older people at home, reducing hospital admissions
- Ongoing reductions in length of stay for patients with fractured neck of femur (#NoF), achieving targets for older people following surgery
- Continued excellence in dementia care and a finalist for the Best Dementia Friendly Hospital award

3.5.2.6. Stroke

- Remained as one of the top performing stroke units as demonstrated by Sentinel Stroke National Audit Programme (SSNAP) performance across both the Hyper Acute and Acute Stroke Units
- Prevention of Stroke in Atrial Fibrillation (AF) nurse post commenced, resulting in 60 patients whose treatment was optimised by the service leading to an average of 2.5 strokes prevented per year
- Telemedicine used for 6 month reviews and tested for out of hours thrombolysis leading to faster access and treatment

3.5.2.7. Cardio-respiratory

- Established community heart failure clinics and developed Community Entresto (blood pressure medication) clinics, giving a better patient experience and releasing acute capacity
- Collaborated with CCG, GPs and Trust clinicians on the chronic obstructive pulmonary disease (COPD) pathway to improve access to services across both primary and secondary care
- Virtual working in the lung cancer pathway became firmly embedded, reducing time from GP referral to CT scan from 7 days to 4 days and from GP referral to diagnosis from 20 days to 11 days
- Introduced a pilot scheme in the Emergency Department to reduce admissions with approximately 15% of patients seen by COPD nurses avoiding an admission to hospital

3.5.2.8. Haematology

- Undertook trial to implement Point of Care Testing (PoCT) devices at home for eligible anti-coagulated patients that are unable to switch from Warfarin to new oral anticoagulant (NOAC) drugs to reduce the need to attend appointments
- Pilot site for stratified self-management programme to ensure patients receive the most appropriate care to meet their identified needs
- Appointed Haematology Nurse Clinician to provide further capacity to see patients in a timely manner
- Continued to deliver 100% 2 week wait (2WW) cancer performance

3.5.2.9. Paediatrics

- Introduced Tongue Tie Clinic
- Consultant body introduced dedicated GP advice hotline (1 hour/5 days a week initially)
- Accepted referrals directly from ED into weekly Paediatric Ambulatory Clinics
- Pilot neonatal hospital at home continues, with 21 babies discharged under the new criteria, saving 100+ cot days
- Joint Walton Centre and STHK Epilepsy Transition Clinics set up
- Did not attend (DNA) rate reduced from 17% to 13% following ring and remind service

- National Paediatric Diabetes Audit 2018-19 results published, with the Trust ranked as best performer in North West (3rd highest previously) for most children/young people with an HbA1C (average blood glucose (sugar) levels) of less than 58 mmol/mol

3.5.2.10. Critical Care Unit

- Two Research Fellow jobs with Manchester Metropolitan University (MMU) (40% MMU and 60% Trust funded) created for critical care and burns research
- Expansion of the rehabilitation/follow up/counselling for patients with post-traumatic stress and their relatives

3.5.2.11. Emergency Department

- Involved in a national pilot with Health Education England to provide additional clinical educators within ED; this has been a big success and feedback scores from trainees within ED has significantly increased
- GP streaming was embedded; patients who do not need the services of an ED medic are streamed at triage to a co-located GP
- Trainee Advanced Clinical Practitioners commenced in post to strengthen the skill set within the department and to reduce waiting times
- Estate remodelling was completed to increase stretcher triage spaces, enabling smoother ambulance handovers and to provide a new waiting area for majors patients, improving efficiency in managing of non-ambulant and walk-in patients
- Paediatric Emergency Medicine Consultant training undertaken in partnership with Alder Hey Children's NHS Foundation Trust

3.5.3. Primary and Community Services Care Group

3.5.3.1. Community nursing

- Developing locality based multidisciplinary teams with GPs to review complex cases and patients at highest risk of admission to ensure they receive optimal care within the community

3.5.3.2. Community IV

- Staff transferred into the Trust in December 2019
- Pharmacy service level agreements (SLAs) developed with local distributors to ensure fast access to medication
- Joint Service Specification between St Helens and Knowsley CCGs being developed

3.5.3.3. Marshalls Cross Medical Centre

- Achieved a total of 98% for the Quality Outcomes Framework (QOF), with 10.8 out of a possible 11 points in total
- Established a clinical Pharmacist post, whose remit will include clinical reviews of patients' medication, NICE assessment, audits and searches/reviews to assess safety and quality, including prescribing safely. The new post holder is due to start in the summer of 2020

3.5.3.4. Intermediate Care

- In the top 3 intermediate care providers nationally for accessing step up and step down beds (national intermediate care audit), meeting the NICE standard of 48 hours from referral to admission and achieving 80% for the same day referral to admission when audited

- Reduced length of stay to below national intermediate care average, whilst improving the overall patient journey as part of a quality improvement project

3.5.4. Clinical Support Services Care Group

3.5.4.1. Pathology Services

- All pathology departments are accredited to the UKAS ISO:15189 (2012) standard
- Laboratories provide training for Junior Medical Staff, Biomedical Scientists (BMS) and medical students. Medical and Biomedical Science staff actively participate in research and development, both internally and in conjunction with hospital colleagues.

3.5.4.2. Patient Booking Services (PBS)

- Introduced two-way text reminders, which allows patients to respond to text reminders indicating if they will attend, or need to cancel or rebook. This service maximises clinic utilisation and reduces the number of patients who do not attend (DNAs) thus improving patient waiting times and improving the pathways of care for patients.
- Expanded evening and weekend outpatient clinic availability on the St Helens Hospital site, with weekly Saturday clinics and Thursday evenings to improve appointment waiting times and increase patient choice

3.5.4.3. Radiology

- One of only a few departments nationally with Quality Standards for Imaging (QSI) accreditation. The Trust was the first trust in Cheshire and Merseyside to achieve this accreditation and currently only 1 of 2 in the North West
- Developed pathway to achieve the challenging targets required of ensuring the patient is offered a CT scan on the same day or within 24 hours if a radiographer sees an abnormality on their GP requested chest X-ray, in response to the National Optimal Lung Cancer pathway. Future developments with Artificial Intelligence (AI) may improve this pathway further
- Involved at a regional level in the development of standard protocols to facilitate faster diagnosis for all the optimised pathways and to speed up the pathway for the patient, detecting cancer earlier and improving prognosis
- Radiology is proactive in encouraging staff development and skill mix and in 2019 supported:
  - 2 newly qualified plain film reporting radiographers
  - 1 plain film reporting radiographer in training
  - 1 chest reporting radiographer in post
  - 1 MRI knees and spines reporting radiographer in post
  - 1 CT head reporting radiographer in post
  - 1 trainee Assistant Practitioner in post
- Trialled a system of ward-based ultrasound (US) scans on the Surgical Assessment Unit (SAU). Patients are booked into an early morning ward based US list and a sonographer attends SAU every morning to scan the patients booked in and to give results as soon as the scan is finished. This facilitates earlier discharge for patients and supports the 'home for lunch' initiative
- Replaced all CT and MR scanners ensuring the most up-to-date technology is available for outpatients. At the same time, an additional CT and a MR scanner were also installed, increasing capacity and reducing waiting times. The new MR scanners have had mood lighting installed to help patients with claustrophobia and anxiety. This investment in high quality, state of the art equipment provides the highest quality images at the lowest radiation doses

- Trialling artificial intelligence (AI) products to help support the identification of abnormalities for diagnosis. AI can be applied to chest X-rays to speed up a patient's pathway and AI is also being implemented to check the brain perfusions of a suspected stroke speeding up the pathway to thrombectomy if appropriate

3.5.4.4. Therapy Services

- Respiratory work streams developed and strengthened physiotherapy competencies across all multi-disciplinary teams to upskill the workforce
- Integrated analysis of CRAB mortality data between therapy services and surgical directorate to identify ways to reduce respiratory complications post operatively
- Reablement Therapy team successfully integrated into Therapy Services to strengthen links with community provision and aid patient flow
- Telehealth developments during the pandemic allowed a platform to be used to provide telephone and virtual appointments for patients minimising delays to outpatient care
- Rheumatology Therapy continue to participate in the WORKWELL research
- Critical Care and Surgery therapy team successfully piloted an outreach model during the pandemic to follow up critical care step down patients on the wards

3.5.4.4.1. Speech and Language Therapy Team (SALT)

- Implemented an International Dysphagia Descriptor Standardisation Initiative (IDDSI) to improve the safety of patients with eating, drinking and swallowing disorders
- Introduced e-referral pathway for inpatients, which has improved the governance of patient data and reduced delays in assessment
- Introduced e-triage for outpatient referrals to allow quicker triaging and reducing delays in appointments being offered
- Speech and Language Therapists, in collaboration with the University of Manchester, delivered simulation based learning for under graduate students

3.5.4.4.2. Trauma & Orthopaedics Therapy Team

- Trialled early supported discharge for patients with fractured neck of femur, who can be supported at home, reducing their length of stay and promoting independence at home
- Multidisciplinary team working on an enhanced recovery pathway for total hip replacement and total knee replacement patients
- Implemented an amputee pathway with resource pack to ensure best practice

3.5.4.4.3. Medicine for Older People (MOP) Therapy Team

- Parkinson's Disease Group has moved from an 8 week to a 12 week programme, incorporating a more graded programme of exercises and more structured external speakers, following feedback in a patient survey

3.5.4.4.4. Dietetics Team

- Completed project ratifying the prescribing choice for cow's milk protein allergy (CMPA) and implemented a training programme to support
- Provided education programme to staff on paediatric wards to optimise support of young people with Type 1 Diabetes
- Carbohydrate (carb) counted new ward menus (in a format that allows families to learn how to carb count i.e. carbs per 100g) for use with patients and their families
- Dietitians were awarded the Trust's Audit Heroes in 2019

- Developed a therapy communication board that will go behind the patients' beds on Critical Care to document therapy input with the patient, for example, how they transfer/mobilise, what diet they are having and speech and language recommendations
- Breast school education developed with the first cohort commenced January 2020
- One year Macmillan funded Upper Gastrointestinal Cancer Virtual Optimisation Hub scoping project was completed and identified that dietetic intervention stabilised or improved nutrition impact symptoms in 70% of patients

3.5.4.4.5. Seddon Team

- Developed and implemented dysphagia e-learning to use with ward nursing staff
- Developed and implemented traffic light menu, colour co-ordinated breakdown for patients to increase knowledge of food content and to allow them to make more informed, healthier food choices
- Reviewed and re-developed the spasticity service to include more specific assessment, use of goal attainment scaling and patient information leaflets

3.6. Summary of national patient surveys

The full results for all the Care Quality Commission's national patient surveys can be found on their website at http://www.cqc.org.uk/

3.6.1. National Inpatient Survey

The Trust participated in the annual National Inpatient Survey 2018 coordinated by the Care Quality Commission. The results were published in June 2019 and the Trust's response rate was 39% compared to the national response rate of 45%.

The Trust was included in the best performing trusts nationally for the following indicators:

- Cleanliness of rooms or wards – (9.5/10)
- For feeling well looked after by non-clinical staff (9.6/10)
- For being given enough privacy when discussing their condition or treatment (9.0/10)
- For being given enough privacy when being examined or treated (9.7/10)
- For hospital staff discussing if any further health or social care services were needed when leaving hospital (8.7/10)

The Trust was rated about the same as other trusts for the remaining indicators, other than for being told how the operation or procedure had gone in a way they could understand, which was rated in the lowest 20%.

The Trust is taking a number of actions to improve patient care including:

- Enhancing the discharge process
- Improving the quality of written information provided to patients
- Reiterating the importance of staff introducing themselves

3.6.2. National Urgent and Emergency Care Survey

The Care Quality Commission published the results of the 2018 Urgent and Emergency Care Survey in October 2019. The national response rate was 30% and the Trust's response rate was 25%.

The Trust was rated better than other trusts in the following area:
- Being given the right amount of information about their condition or treatment

The Trust was rated as about the same as other trusts for all other areas, with no scores rated lower.

The following actions were taken following the previous survey to improve the services we provide:
- Ongoing provision of information about waiting times for patients, including installation of TV screens in the new extension opened in February 2019
- Increased availability of cubicles within the main department, with a new reception area and triage room
- Provision of a water fountain in the waiting room, accessible for both patients and relatives
- Introduced new ways of working to allow an earlier first point of contact to reduce the time waiting to be examined and assessed. A doctor is identified every shift to be available to assess patients in various clinical areas (triage/stretcher triage/paediatric unit)
- A doctor is identified per shift to be the "Emergency Response" doctor to attend to any patient within the department who triggers an alert via the national early warning score (NEWS), thus reducing any delays for reviews and treatments
- Increased training and development for nursing staff and implementation of patient group directives to allow nursing staff to provide simple pain relief prior to patients being seen by medical staff remains ongoing

The staff continue to work on delivering five-star patient care and have focussed on reducing waiting times by introducing allocated GP slots for out-of-hours patients whose presenting complaints would be suitable for a GP, but one was not on duty at that time. In addition, volunteers are positioned in the waiting area to be a visual point of contact for patients. The volunteers are also able to identify any patients that may require assistance. Nursing staff in major waits area will reassess pain in patients who are waiting and assess the efficacy of any pain relief given when observations are repeated.

3.6.3. National Children and Young People Survey 2018

The survey rated the experiences of patients (and their families/carers) who were admitted to hospital as an inpatient or day case during November and December 2018 and the results were published in November 2019. There were tailored questions that were levelled at three specific age groups:
- Parents/carers of 0-7 year olds
- Patients aged 8-11 years and their parents/carers
- Children and young people aged between 12-15 years

The overall response rate for the Trust was 13% (126 out of 969 questionnaires sent) against an average for all trusts of 25% (total 33,179 respondents).

Scores were received for the 0-7 year old category only (with 73 responses) as there were insufficient amounts of responses for those in the other two age brackets, with 13 responses for ages 8-11 years and 14 responses for the 12-15 years.

There were over 40 questions specifically related to the 0-7 year old category, but not all were answered.

The Trust scored amongst the best performing trusts for:

- Cleanliness of ward (9.6/10)
- Appropriateness of ward (10/10)
- Facilities for parents and carers staying overnight (8.1/10)
- Understandable explanations given prior to procedures (e.g. 'what to expect') (9.8/10)

All other scores were the about the same as other trusts, with better than average scores for:

- Friendliness of staff
- Respondents feeling well looked after
- Being treated with dignity and respect
- Ward facilities being excellent
- Good level of patient privacy
- Good communication
- Confidence and trust in staff
- Respondents feeling involved in decision making
- Good pain management
- Staff working well together
- Families feeling comfortable when raising concerns with staff
- Having a good overall experience

There were no questions where the Trust scored within the lowest performing trusts.

The Paediatric team have developed an action plan to address three specific areas where responses were on the lower end of the scale within the 'about the same bracket'; which will be closely monitored by the team and progress will be reported on a quarterly basis to the Patient Experience Council. These relate to:

- Having enough things for your child to do in hospital
- Staff playing with your child whilst in hospital
- Your child liking the hospital food provided

3.6.4. National Maternity Survey

The Women's Experience of Maternity Care Survey was undertaken between April and August 2019 and involved 126 NHS acute trusts in England. The Care Quality Commission published the full results at the end of January 2020. The national response rate was 36.5% and St Helens and Knowsley Teaching Hospitals NHS Trust's response rate was 23.23%, compared to 27% the previous year.

The survey provides information on women's experiences during all aspects of their maternity care, including antenatal care, postnatal care, the care received during labour and birth. The Trust was rated better for the following indicators and about the same as other trusts for the remaining indicators:

- Having skin to skin contact with the baby shortly after birth
- Having confidence and trust in the staff caring for them during labour and birth
- Thinking the hospital room or ward was clean

The women surveyed all had their babies at the Trust; however a percentage of the women surveyed may have received their antenatal and postnatal care from other maternity care providers. Women were surveyed using a total of 72 questions across five areas of care. Overall, the 2019 survey demonstrated a sustained improvement in the majority of areas and an action plan has been developed to address areas where further improvements can be made.

The Continuity of Carer pathway for Midwife-Led Care has commenced across the Community Teams. A woman will receive joined up care between a small community midwifery team and the midwives on the Midwife-Led Unit (MLU) throughout her pregnancy, birth and post-natal period. Community midwives will be able to attend the MLU and provide some aspect of care for their own women when they are in labour. The Maternity Services will be able to provide wider choice of place of birth for women who are eligible for Midwifery Led Care with the launch of the Community Hub in St Helens. This will have two state of the art birthing suites for women with a low risk pregnancy. The Community hub will have a dedicated community birth team that will care for women who are low risk and have chosen to birth at home of the Community Hub.

3.6.5. National cancer patient experience survey (NCPES)

Patient comment

From seeing my GP to my OPD with the consultant and ongoing surgery and treatment, all staff (from consultant to ancillary staff) were excellent. All were knowledgeable and caring in their roles and had a caring manner. I was treated with care and speed. My disabled husband needs a wheelchair and was allowed to visit outside of visiting hours, which made parking easier.

The NHS England National Cancer Patient Experience Survey (NCPES) is designed to monitor national progress on cancer care, to drive forward quality improvement and to inform the work of groups supporting patients. The survey was developed and has been run by Quality Health for the Department of Health since 2010 until 2018. It is the largest and most comprehensive survey of cancer patients in the world and is now run by Picker.

Patients treated for cancer within the Trust rated the overall level of care they received as 8.8 out of 10.

In the 2018 NCPES results, published in September 2019, the Trust's score for patients being able to talk to staff about worries and fears when an inpatient, whilst above the national average, was 59%, lower than the 75% reported in 2014. Evidence from

Macmillan suggests that patients report that they do not want to disturb staff and, therefore, do not talk about worries and fears.

The Trust's Cancer Services, in collaboration with the Service Improvement Team and Wards 4C and 3A participated in a NHS England (NHSE) programme to improve patient experience. The programme aim was to increase the number of inpatients who found someone to talk to about their worries and fears by 10% by 2020. The programme was considered a success by NHSE and initial findings suggest an increase of 9% of patients are able to have these conversations, within three months of the project starting.

The programme has resulted in the implementation of Information and Support Ward Rounds. Trained staff, who are known as Cancer Support Workers, arrange to meet with cancer patients during their hospital admission and discuss any worries and fears. They are able to signpost patients to local support groups, benefits advisors and much more to help them with non-clinical worries and fears. The initial results are really positive and the project has been rolled out to all the cancer teams.

A number of other developments are in place to address areas highlighted by the survey, including:

- Breast School which provides support and education for breast cancer patients pre-operatively
- Supported self-management in haematology and colorectal cancer pathways
- Facilitation of three patient focus groups to inform the teams' work programmes and improve patient experience
- Worked in collaboration with patients to develop a new multidisciplinary leaflet
- Introduced a bell on the Lilac Centre to enable patients to celebrate an important stage in their cancer pathway
- Breast team are reviewing the waiting area to improve patient experience
- Ward training on cancer pathways following feedback from staff about the barriers to talking to patients
- Developed a competency framework for new nurse specialists to ensure they are competent and can develop in their role
- Implementation of telehealth in skin cancer follow up
- Macmillan project on upper gastrointestinal cancer patient pathway and experience which will inform a service redesign and business case to include a dietitian

The Trust continues to strive towards improving patient experience and a comprehensive action plan has been put into place by the clinical teams to address any issues raised where the scores were below average for individual tumour sites.

The full report can be found at http://www.ncpes.co.uk

4. Annex

4.1. Statement of Directors' responsibilities in respect of the Quality Account

The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2019-20
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Richard Fraser
Chairman

Ann Marr
Chief Executive

4.2. Written statements by other bodies

4.2.1. Knowsley Clinical Commissioning Group and St Helens Clinical Commissioning Group

Nutgrove Villa
Westmorland Road
Huyton
Liverpool
Merseyside
L36 6GA

0151 244 4126

Ann Marr
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust
Warrington Road
Prescot
L35 5DR

Date: 19th November 2020

Dear Ann

Quality Account 2019/20

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group thank you for the opportunity to comment on the St Helens and Knowsley Teaching Hospitals NHS Trust draft Quality Account for 2019/20, and the presentation provided at the Mid-Mersey Quality Accounts 2019/20 Presentation Day on Friday 16th October 2020.

We would firstly like to acknowledge that the end of 2019/20 brought unprecedented challenges due to the COVID-19 global pandemic. The Trust responded by working in new ways, whilst remaining committed to maintaining safe, high quality care which has been reflected in the account.

CCGs have the following comments on the Quality Account 2019/20:

- Positive achievements, awards, and work in the Quality Account, including integration with CCGs and Health and Social Care;
- Acknowledgment of feedback from the Quality Account 2018/19 embedded into the Quality Account 2019/20;
- Praise for including relevant partners in setting objectives and priorities;
- Openness and transparency in accounting both successes and areas for improvement and learning. It was positive to see that quality priorities have been set around some of the improvement areas moving into 2020/21, including reducing the number of pressure ulcers;
- Excellent account of the improvements made with regard to the Learning from Deaths agenda and identified learning;
- Maintained a wide range of methods to speak up and provide support available to staff as part of Freedom to Speak Up.

Chair: Dr Andrew Pryce Chief Executive: Dianne Johnson

Knowsley.CCGCommunications@knowsley.nhs.uk

This account highlights the priorities identified in 2019/20 and provides a clear review of outcomes demonstrating how well the Trust did in achieving those priorities to deliver high quality care to patients. Commissioners note the Quality priorities for 2020/21 as:

Safety:
- Ensure timely and effective assessment and delivery of care within the Emergency Department;
- Reduce incidents of pressure ulcers due to possible lapses in care.

Effectiveness:
- Ensure patients in hospital remain hydrated.

Patient Experience:
- Increase the proportion of patients who report that they have received an appropriate amount of information to meet their needs in a way they can understand;
- Improve the effectiveness of the discharge process for patients and carers.

The Quality Account reporting arrangements for 2019/20 required Acute Providers to include a statement regarding progress in implementing the priority clinical standards for seven days hospital services. The CCGs note that whilst improvements have been made in Trust performance against the 7DS standards, further work is required to be undertaken to meet and maintain CS2 and CS8, 7 days a week. Actions for 2020/21 to further improve 7DS have been well documented within the quality account.

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group will continue to monitor St Helens and Knowsley Teaching Hospitals NHS Foundation Trust through the Clinical Quality and Safety Group meetings to gain assurance that the quality and safety of services delivered to patients continues to improve and that effective governance processes remain in place and embedded throughout the organisation.

Yours sincerely

Dianne Johnson Chief Executive NHS Knowsley Clinical Commissioning Group	Lisa Ellis Chief Nurse / Director of Quality NHS St Helens Clinical Commissioning Group

Chair: Dr Andrew Pryce Chief Executive: Dianne Johnson

Knowsley.CCGCommunications@knowsley.nhs.uk

4.2.2. Healthwatch Halton

Ann Marr
Chief Executive
St Helens & Knowsley Teaching Hospitals NHS Trust
Warrington Road
Prescot
L35 5DR

Healthwatch Halton
Suite 5, Foundry House
Widnes Business Park,
Waterside Lane
Widnes
WA8 8GT

Tel 0300 777 6543

12 November 2020

Dear Ann

Re: Quality Account 2019-2020

We welcome this opportunity to provide a commentary on St Helens & Knowsley Teaching Hospitals NHS Foundation Trust Quality Account for 2019-2020.

A draft copy of the Quality Account report was provided to Healthwatch Halton in a timely manner to allow for a response to be produced.

The Trust has once again produced a comprehensive Quality Account report which gives a very full picture of its performance and operation.

In reviewing the Quality Account, we considered the following questions:

- Does the draft Quality Account reflect people's real experiences as told to local Healthwatch by service users and their families and carers over the past year?
- From what people have told Healthwatch Halton, is there evidence that any of the basic things are not being done well by the provider?
- Is it clear from the draft Quality Account that there is a learning culture within the Trust that allows people's real experiences to be captured and used to enable the provider to get better at what it does year on year?
- Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?

Overall, we believe the Quality Account reflects accurately people's real experiences of using the service.

The report provided many examples of a learning culture with results showing improvements and successes in various comparative exercises.
Through Healthwatch involvement in the Patient Experience and Patient Safety Councils, and the regular quarterly meetings Healthwatch holds with the Trust, we have noted a continued willingness to learn and improve from the patient stories we have brought to the Trust.
The progress made on the 2019 quality goals was very positive to see. We noted the achievements and improvements in ensuring timely and effective assessment and delivery of care within the Emergency Department. It was pleasing to see the target for Sepsis screening being met. While Triage times saw a small improvement it's an area which we hope the Trust will still focus on during the coming year.

We were interested to read about the improved utilisation of new electronic systems to improve the timeliness and effectiveness of patient care. The benefits were highlighted in the improvements across a number of areas including reductions in the number of recorded medication incidents and the reduction in 'do not attend' incidents across the Trust.

We noted that there is still improvement to be made on the information provided upon discharge. This is an area we hope to see the Trust improve on during the coming year. We'd welcome the opportunity to work with the Trust during 2020-2021 on improving the discharge process for patients and carers.

We felt the Chief Executive's report was well balanced presenting some of the failures as well as the many successes.

We'd like to thank the Trust for working in such a collaborative manner with Healthwatch during the past year.

Finally, we would like to echo the comments in the report highlighting how staff had responded to the needs of patients during the pandemic. Everyone involved with Healthwatch Halton would like to offer their thanks, admiration and gratitude to the staff at the Trust on their efforts during the past year.

Kind regards

Dave Wilson

Dave Wilson
Manager - Healthwatch Halton

4.2.3. Healthwatch Knowsley

St Helens and Knowsley Teaching Hospitals NHS Trust – Quality Account Commentary 2019-20

Healthwatch Knowsley welcomes the opportunity to provide this commentary in support of the St Helens and Knowsley Teaching Hospitals NHS Trust Quality Account for 2019/20, which was provided to Healthwatch Knowsley in a timely manner to allow for a response.

We would like to thank the Trust for their willingness to work with Healthwatch Knowsley across the year, especially in such challenging times, and for providing us with the opportunity to meet with them on a quarterly basis to raise any issues and trends that are emerging. We also attend and report to the Patient Experience and Patient Safety Council on a monthly basis. This collaborative working has been a consistent theme over many years and is very much appreciated.

We welcome the opportunity to contribute to the positive shaping of the priorities as part of the Quality Account process and the levels of transparency and honest dialogue provides scope for meaningful engagement.

The positive progress in achieving the 2019-20 quality goals has been noted and is welcomed. The key achievements including Acute/Specialist Trust of the Year at the Health Service Journal (HSJ) awards 2019; being ranked best in the country for the Patient Led Assessments of the Care Environment (PLACE) and maintaining an outstanding CQC rating reflects the quality of the services Knowsley patients access.

All quality priorities for 2020-21 appear suitably challenging and appropriate, specifically, the timely and effective assessment and care of patients in the emergency department; the reduction of incidents of pressure ulcers; and improving the effectiveness of the discharge process.

Overall, the Trust currently holds a patient experience rating of 4.5 (good) out of 5 stars based on the 593 reviews held on the Healthwatch Knowsley online feedback centre. This rating has been collated through feedback provided by patients and family members. Listening Events and information stands at which we have engaged with patients and family members have also contributed to this rating and the Trust has proactively supported this work.

Healthwatch Knowsley wishes to place on record their appreciation of the Trust's work on behalf of our local community.

4.3. Amendments made to the Quality Account following feedback and written statements from other bodies

There were no required amendments following verbal feedback or written statements received from other bodies.

5. Abbreviations

AF	Atrial fibrillation
AHPs	Allied Health Professionals
AI	Artificial Intelligence
AKI	Acute Kidney Injury
AMD	Age-related Macular Degeneration
AMU	Acute Medical Unit
ANTT	Aseptic Non-Touch Technique
BAPEN	British Association of Parenteral and Enteral Nutrition
BAUN	British Association of Urology Nurses
BAUS	British Association of Urological Surgeons
BPH	Benign prostatic hyperplasia
BSI	Blood stream infection
BTS	British Thoracic Society
CCGs	Clinical Commissioning Groups
CDI	Clostridium Difficile Infection
CHPPD	Care Hours per Patient per Day
CMPA	Cow's milk protein allergy
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Airways Disease
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRAB	Copeland Risk Adjusted Barometer
CRN, NWC	Clinical Research Network, North West Coast Research
CT	Computerised tomography
Datix	Integrated Risk Management, Incident Reporting, Complaints Management System
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
ED	Emergency Department
EDS or EDS2	Equality Delivery System
ePMA	Electronic Prescribing and Medicine Administration
ePR	Electronic Prescribing Record
eTCP	Electronic Transfer of Care to Pharmacy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
GI	Gastrointestinal
GIRFT	Get It Right First Time
GNBSIs	Gram-negative bloodstream infections
GORD	Gastroesophageal reflux disease
GP	General Practitioner
GPSI	GP with special interest
HCAI	Healthcare associated infections
HF	Heart Failure
HNA	Holistic Needs Assessment

HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
HWWB	Health, Work and Well-being
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
IDDSI	International Dysphagia Descriptor Standardisation Initiative
IQILS	Improving quality in liver services
JAG	Joint Advisory Group
LARC	Long-acting reversible contraception
LGBT	Lesbian, gay, bisexual, transgender
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and questioning
LSCB	Local Safeguarding Children Board
LUTS	Lower urinary tract symptoms
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MDT	Multi-disciplinary Team
MEOWS	Modified Early Obstetric Warning System
MINAP	Myocardial Ischaemia National Audit Project
MLU	Midwife-led Unit
MMU	Manchester Metropolitan University
MOP	Medicine for Older People
MR	Magnetic Resonance
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MTI	Medical Training Initiative
NAOGC	National Audit Oesophago-Gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NG	Naso-gastric
NHSE	National Health Service England
NHSE/I	National Health Service England/Improvement
NICE	National Institute for Health and Care Excellence
NIPE	Newborn and Infant Physical Examination
NIHR	National Institute for Health Research
NIV	Non-Invasive Ventilation
NJ	Naso-jejunal
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMC	Nursing and Midwifery Council
NNAP	National Neonatal Audit Programme
NOAC	New oral anticoagulant

NoF	Neck of femur
NPCA	National Prostate Cancer Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting Learning System
NWAS	North West Ambulance Service
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OT	Occupational Therapist/Therapy
PALS	Patient Advice and Liaison Service
PBS	Patient Booking Services
PCN	Primary Care Networks
PCNL	Percutaneous Nephrolithotomy
PE	Pulmonary Embolus
PEG	Percutaneous Endoscopic Gastrostomy
PEWS	Paediatric Early Warning Score
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-Led Assessments of the Care Environment
PN	Parenteral Nutrition
PoCT	Point of Care Testing
PPE	Personal Protective Equipment
PROMs	Patient Reported Outcome Measures
QCAT	Quality Care Accreditation Tool
QIP	Quality Improvement Project
QOF	Quality Outcomes Framework
QSI	Quality Standard for Imaging
RACPC	Rapid Access Chest Pain Clinic
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RCM	Royal College of Midwives
RN	Registered Nurse
SALT	Speech and Language Therapy Team
SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit
SAU	Surgical Assessment Unit
SEQOHS	Safe Effective Quality Occupational Health Services
SCR	Summary Care Record
SHMI	Summary Hospital-level Mortality Indicator
SHSCR	St Helens Shared Care Record
SIRO	Senior Information Risk Owner
SLA	Service level agreement
SMR	Standardised Mortality Ratio
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
STI	Sexually Transmitted Disease
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network

TPN	Total Parenteral Nutrition
UKAS	United Kingdom Accreditation Services
US	Ultrasound
VTE	Venous Thromboembolism
2WW	Two week waits

TRUST BOARD

Paper No: NHST(20)082
Title of paper: Infection Prevention and Control Annual Report 2019/20
Purpose: To present the 2019/20 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 2019/20 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 indepth reports of the actions taken and lessons learnt. 4. The Trust has remained registered with the Care Quality Committee (CQC) and is rated as Outstanding. 5. The Trust continues to have appropriate arrangements in place for the prevention and control of infections in accordance with Health and Social Care Act 2008. 6. During 2019/20 the IPC performance improved in comparison to the previous year and the following were reported: 1. 42 cases of Clostridium difficile infection (CDI) against an objective of no more than 48) 2. 1 case of Meticillin Resistant Staphylococcus Aureus (MRSA) positive sample which as contaminant. This remained the same as the previous year 3. 25 cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia of which of which 17 were unavoidable as not health care related; compared to 31 cases the previous year 4. 51 Hospital Acquired E coli bacteraemia compared to 62 cases the previous year 5. Zero cases of CPE bacteraemia; 6. 2 surgical site infections following surveillance of 672 procedures in orthopaedics; which was a 50% reduction on the previous year 7. There were 20 outbreaks of infection: resulting in 278 lost bed days 8. The annual report also sets out the planned improvements for 2020/21. 9. Improvement in performance has been achieved in 2019/20, which has been 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 approve the 2019/20 IPC annual report.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 25th November 2020

Infection Prevention Annual Report 2019-2020

CONTENTS

EXECUTIVE SUMMARY 4
Summary of key performance indicators for 2019/20 4
Developments in 2019/20 5
Background 6
1. Infection Prevention Arrangements 6
2. Healthcare Associated Infections 9
3. Outbreaks and Incidence of Periods of Increased Incidence (PII) 18
4. Aseptic Non-touch Technique (ANTT) 19
5 Infection Prevention policies/publications 20
6 Education and training 20
7. Hand hygiene 21
8. Information Technology 21
9. Audits and Surveillance 22
10. Antimicrobial Stewardship. 23
11. Health, Work and Wellbeing 25
12. Decontamination 25
13 Estates, Facilities, Waste Management and Water Safety 26
14. Risk Register 27
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. 27
15. Glossary of abbreviations 27
Appendix 1 Forward Plan 29
Appendix 2 HIPG TOR 41
Terms of Reference 41

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 2019/20 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
- SARS CoV2

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 2019/20

- The Trust has remained registered with the Care Quality Committee (CQC) and is rated as Outstanding.
- The Trust continues to have appropriate arrangements in place for the prevention and control of infections in accordance with Health and Social Care Act 2008.
- The Trust Clostridium difficile infection (CDI) objective for 2019/20 was no more than 48 cases. The Trust reported 62 positive samples of which 20 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 the year was 42 .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 2019/20 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 Prevention Group (HIPG).

- During 2019/20, there were a total of 25 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases, of which 17 were unavoidable as not health care related
- During 2019/20,there were a total of 51 E.coli bacteraemia cases
- There were no cases of hospital acquired Carbapenemase Producing Enterobacterales **(**CPE).

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

April 2019 – March 2020	STHK	National
Hips 314	0.6%	0.9%
Knees 358	0.3%	1.2%

- Outbreaks: during 2019-20 there were 20 outbreaks of infection: VRE colonisation (3), Flu (8), Norovirus (5), PVL MRSA (1), Linezolid resistant staph. Epidermidis (1), Group A. Streptococcus (1), Covid -19 (2) which resulted in 278 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 Prevention 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 2019/20

- 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.
- 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.
- Collaboration 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.
- The IPT provided advice, support and input at a strategic and ward based patient facing level to the trust throughout the SARS-CoV 2 (COVID) pandemic. This has resulted in infection prevention resources being focussed on reviewing and producing ever changing guidance on COVID for staff and patients. Many of the IPT's routine audits and educational activity had to be suspended to manage the ever changing situation. This is ongoing.

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 Director of Infection Prevention and Control (DIPC) reports directly to the Trust board. 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 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.

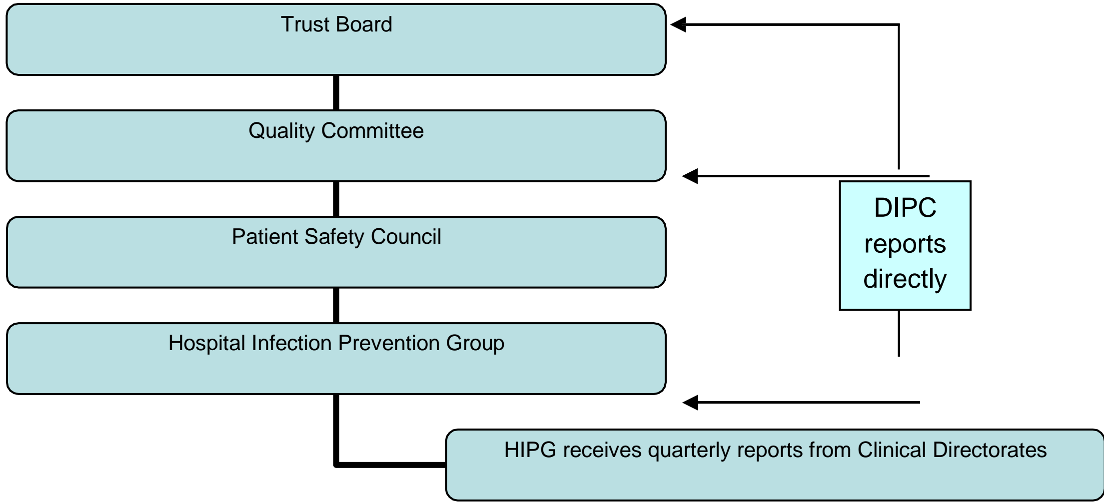
1.2.8. The IPT also works closely with the Matrons, Infection Prevention Link Professionals and Facilities Management.

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 The Trust continues to undertake a number of interventions in relation to infection prevention as detailed within the HCAI Reduction Plan 2019/20. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Infection Prevention Doctor and lead nurse IPT.

1.3 Hospital Infection Prevention Group (HIPG)

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



1.3.2 The Terms of Reference are reviewed annually and were amended in March 2020.

1.3.3 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.

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

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

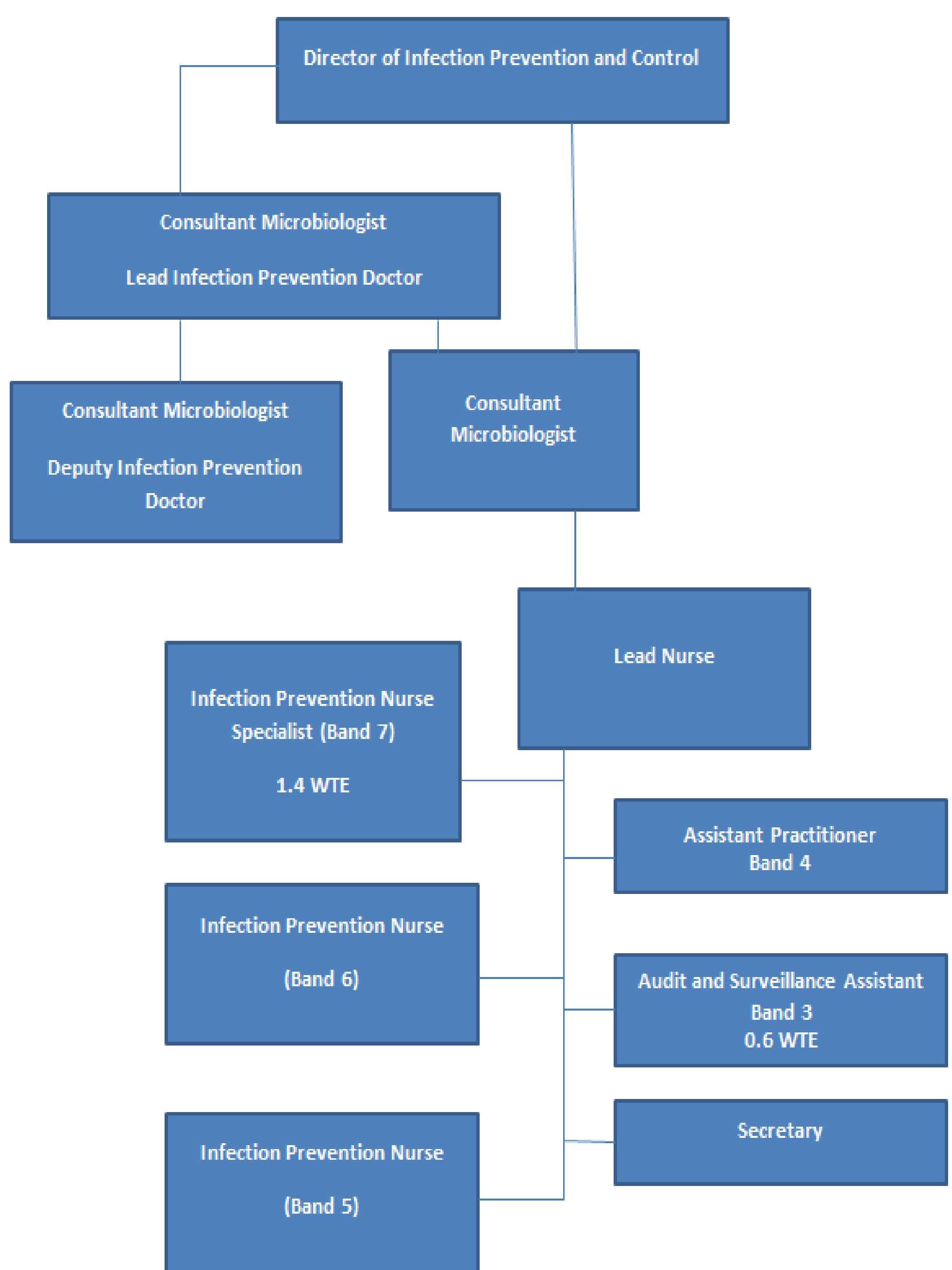
1.3.6 Isolation facilities
The current proportion of single rooms is 50% which supports the prompt isolation of patients with suspected or confirmed infections.

The target time for isolating patients with unexplained (and potentially infectious 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 throughout the year. This identifies who is managed in a side room and the reason for their isolation. This is used by the wards and the site team to enable the correct placement of patients.

1.3.7 The core members of the IPT consist of:
- Director of IPC (DIPC) - Director of Nursing, Midwifery and Governance
- Lead Infection Prevention Doctor
- 8B Lead Nurse IP (1.0 WTE)
- Band 7 Specialist IP Nurses (1.4 WTE)
- Band 6 IP Nurses (1.0 WTE)
- Band 5 IP Nurse (1.0 WTE)
- Band 4 Assistant Practitioner (1.0 WTE) (currently on part time student nurse apprenticeship)
- Band 4 IP Secretary (1.0 WTE)
- Band 3 Audit and Surveillance Assistant (0.6 WTE)
- Antimicrobial Management Pharmacists - 0.5 WTE band 8b and 0.5 WTE band 8A

1.3.8 IP organisational structure



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

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

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

1.4 Committee representation by members of the IPT:

- Hospital Infection Prevention Group
- Patient Safety Council
- RCA Executive Review Panel Meetings

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

2. Healthcare Associated Infections

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

2.2 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 Enterobacterales (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 Enterobacterales (CPE)
- Neisseria meningitides
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV
- SARS-CoV 2 (COVID)

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 contaminant	0
2019/2020	1 contaminant	0

During 2019/2020 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:

- Patients with wounds or skin breaks must have those sites swabbed as a part of the MRSA screen (regardless of whether there are clinical features of infection) in order to detect potential MRSA colonisation.
- Commence and complete topical suppression for previously known MRSA positive patients if a new MRSA positive is identified based on advice from the Infection Prevention Team.
- Follow the Blood Culture policy when taking blood cultures - in this case, the process stated in the policy was not followed and blood was drawn from the PICC line via a syringe and then inserted into blood culture bottles which would have increased the risk of contamination.

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 2019/20.

2.11 Clostridium difficile toxin infection (CDI)

The Trust CDI assigned by NHS England target for 2019/20 was no more than 48 cases.

In total there have been 42 cases of CDI, excluding 20 cases which have been successfully appealed as having no lapses in care and therefore are not included in the year-end performance figure.

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.

Due to NHS Improvement (NHSI) publishing revised definitions for attribution of Clostridium difficile infection in 2019-2020, it is not possible to directly compare this year's CDI rate with previous years'. Prior to April 2019, the CDI objectives for the Trust have only included cases that were detected in the hospital 4 or more days after admission (if day of admission is day 1).

From the 1 April 2019, the Trust objective for CDI cases includes the following two categories:

a) Hospital onset healthcare associated (HOHA) cases: i.e. cases that are detected in the hospital 3 or more days after admission.

b) Community onset healthcare associated (COHA) cases: i.e. cases that are detected in the community (or within 2 days of admission) when the patient has been an inpatient in the trust within previous 4 weeks.

This will increase significantly the number of cases which are attributed against the Trust's trajectory. The objective for this Trust for 2019-2020 was not more than 48 cases. If the new NHSI criteria for 2019-2020 were applied to all CDI cases identified at the Trust from 2018-2019, 45 cases would be attributed to the Trust in the same time period (compared with 25 when using the previous definitions). Of the additional 20 cases, 4 will due to the change in criterion a) above and 16 due to the additional criterion b).

The table below shows the number of Trust attributed CDI cases each year:

Baseline Data	**334**		
	Targets	**Actual**	
2008/09	302	170	
2009/10	235	75	
2010/11	169(DOH target)	74	

	71(PCT target)		
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). [Based on the new definitions for 2019/2020, the total number of cases attributed against the Trust's trajectory for 2018/2019 would have been 45].
2019/20	48	42	In total, there were 62 cases attributed to the Trust (45 HOA, 17 COHA), 47 of which had RCA review (until RCAs were suspended due to COVID pandemic in March 2020). 20 cases were deemed unavoidable by the CCG CDI appeals panel.

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 was 1 outbreak of CDI confirmed in 2019/20 (ward 5D – two patients).

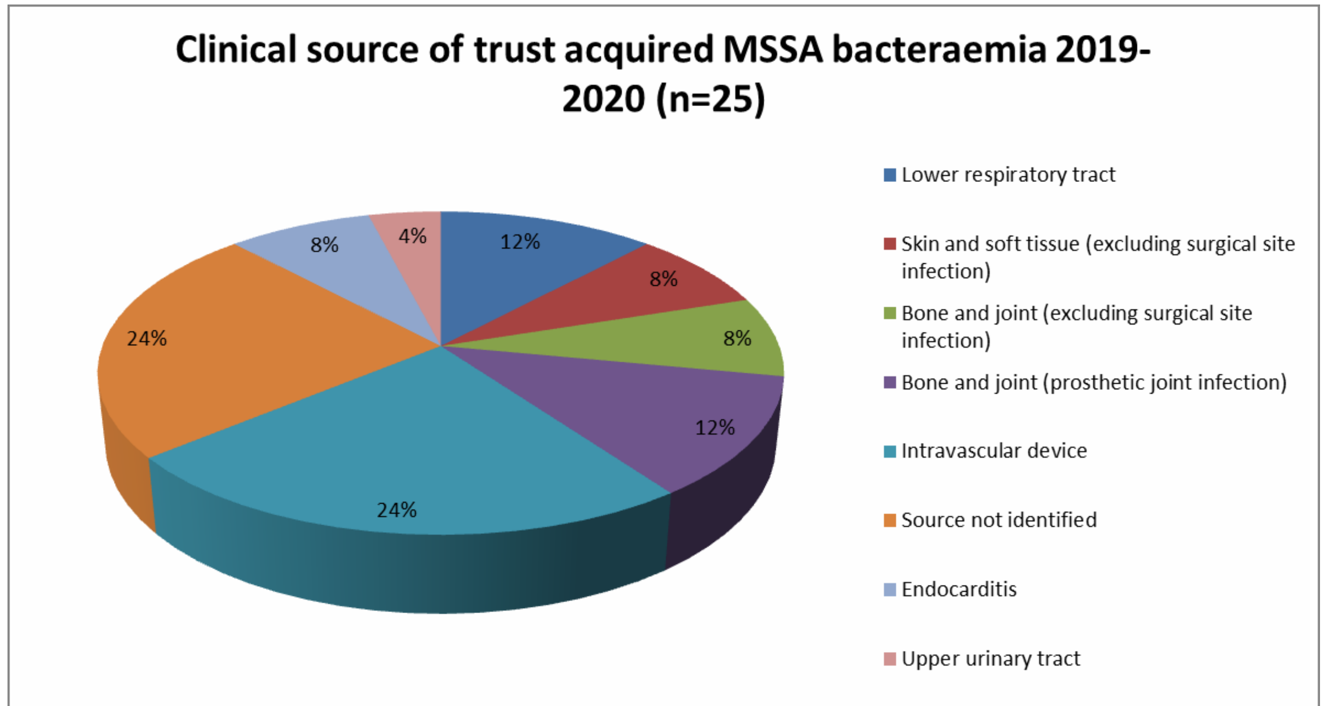
2.12 Meticillin-sensitive Staphylococcus aureus (MSSA)

There were 25 cases of Trust acquired MSSA bacteraemia in 2019/20

All cases of MSSA bacteraemia are subject to an Executive led Root Cause Analysis Review Panel. RCA was completed on 21 cases of which 14 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 2019/20 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 229; The key trainer sessions have been disrupted as a result of SARS-CoV 2 as IPN resources were redirected to managing the pandemic
- ANTT (aseptic non-touch technique) training and annual competency assessments are continuing 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 2019-2020, the Trust continued to carry out RCA review of all Trust acquired E. coli, Klebsiella and Pseudomonas aeruginosa bacteraemias until they were temporarily suspended due to the COVID pandemic in March 2020. 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 2019/20 there were 51 cases (compared with 62 cases in 2018/19, 66 in 2017/18 and 50 in 2016/17). Of these, 31 had RCA reviews completed, all of which were deemed unavoidable following review.

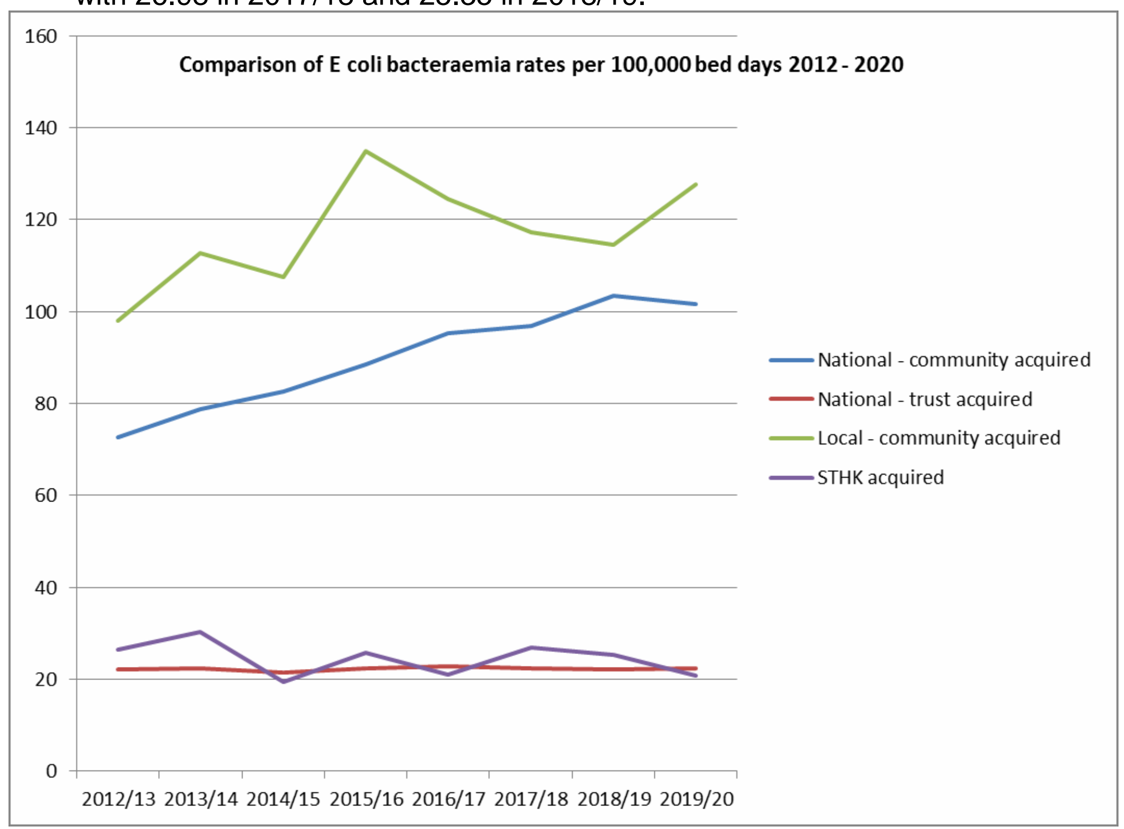
The Clinical Commissioning Group has been encouraging a whole health economy approach to reduce the total numbers of cases by 10%. The Trust has been involved in the working groups and set a reduction target during the year on previous cases. The surveillance data indicated that the majority of cases were unavoidable with no clear lessons learnt for the Trust. The Trust IPT 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 CAUTIs. This information is collated monthly and is compared with the patient safety thermometer data and reported monthly.

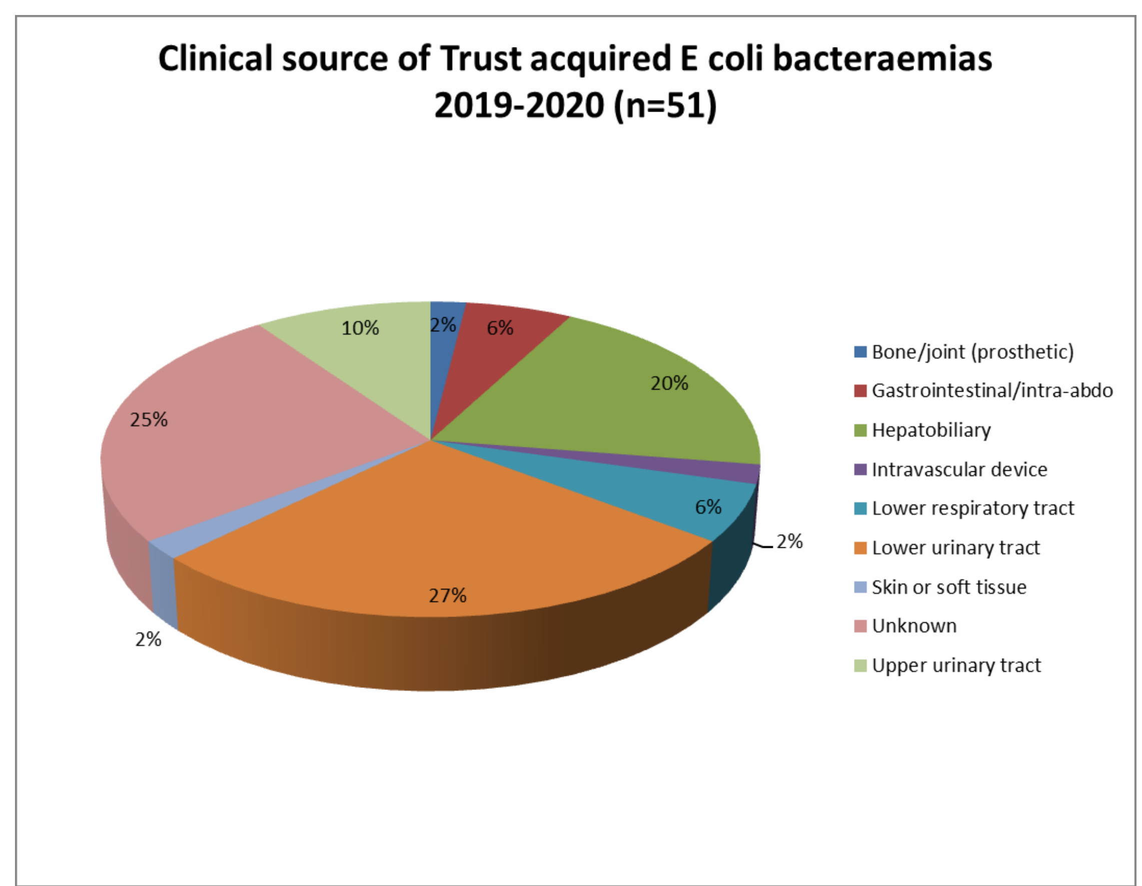
UCAM (Urinary Catheter Assessment and Monitoring) was introduced in 2011 in order to reduce urinary catheter associated urinary tract infection. All urinary catheter care is documented with the aim of:

- 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 in use.
- The Urinary Catheter Passport has been implemented within the Trust.

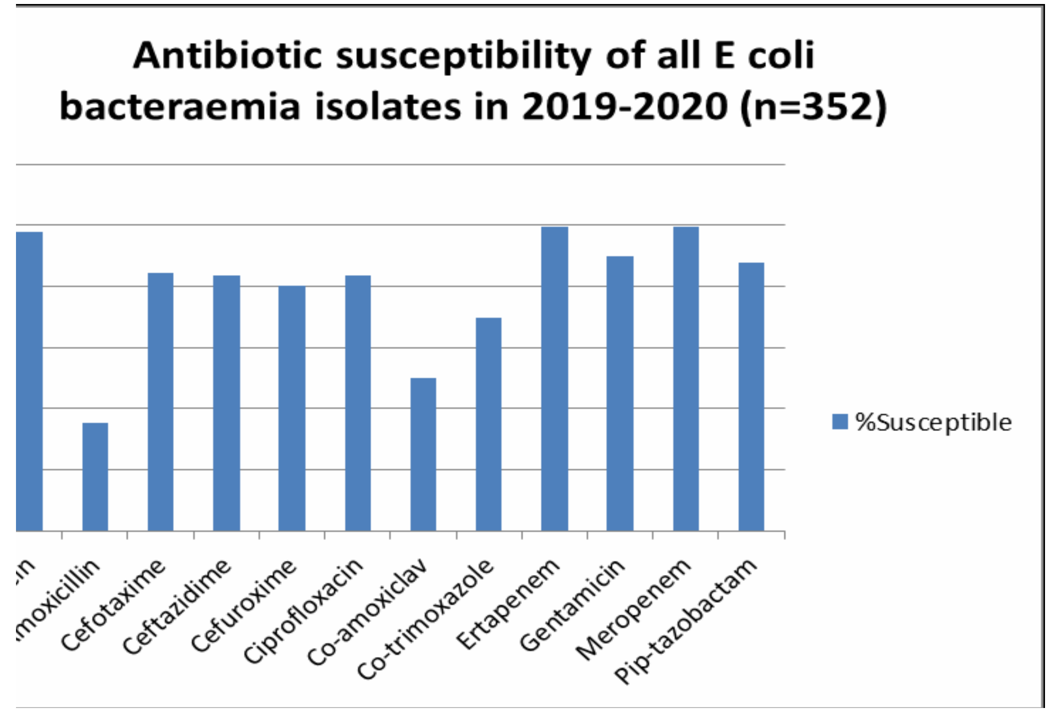
STHK apportioned E coli bacteraemia rate per 100,000 bed days in comparison with the overall national E coli bacteraemia rates and rate for community acquired cases identified in our Trust are as below. The Trust acquired E coli bacteraemia rate has was 20.81 per 100,000 bed days compared with 26.98 in 2017/18 and 25.35 in 2018/19.



The clinical sources of Trust acquired E coli bacteraemia in 2019/2020 are as below:

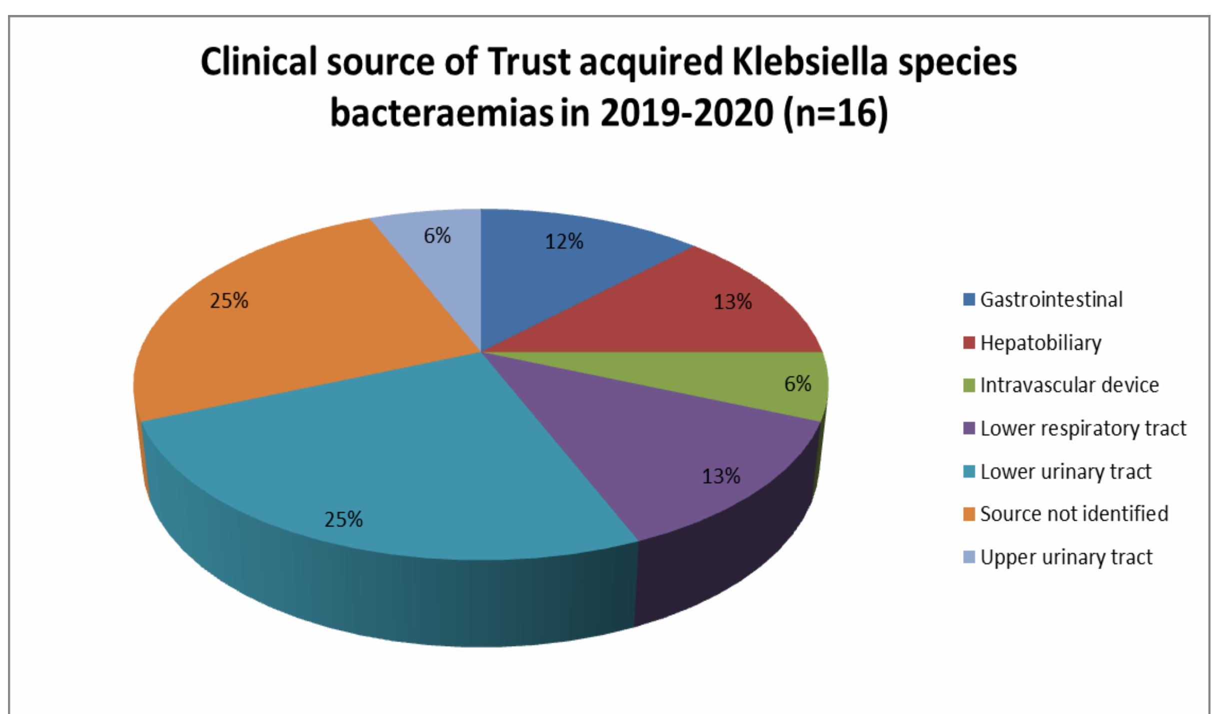


The overall antibiotic susceptibilities for all E coli bacteraemia (i.e. community and Trust acquired) identified at the Whiston Hospital Microbiology Laboratory in 2019/2020 are as below:



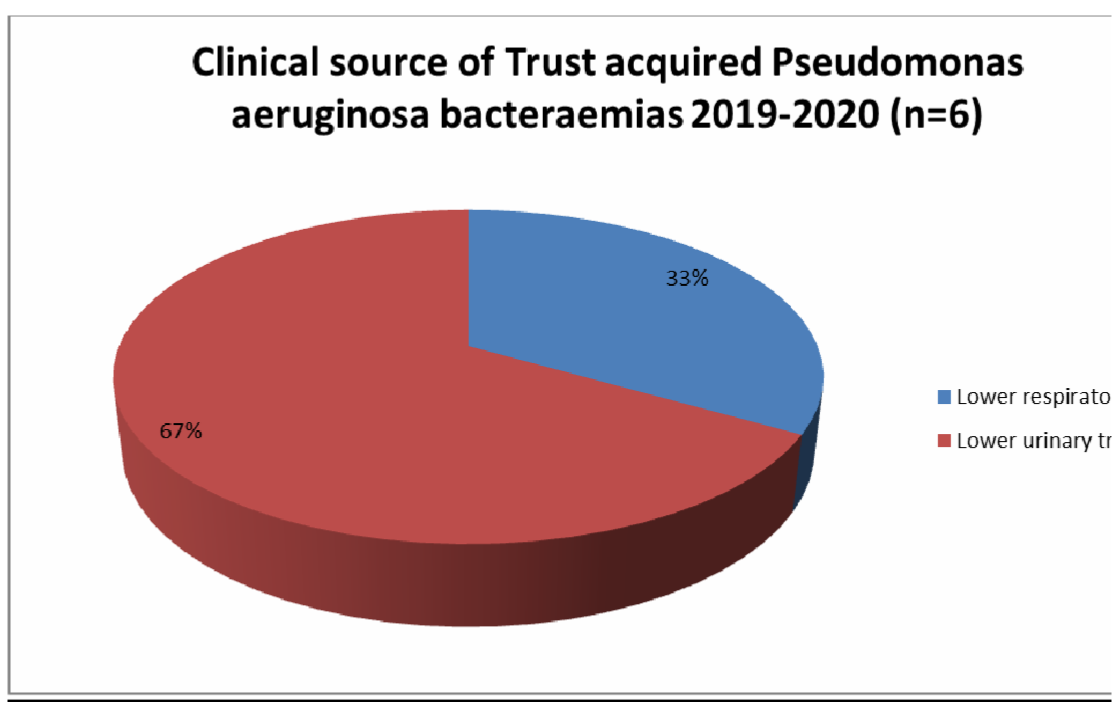
2.15 Klebsiella species bacteraemia.

There were 16 cases of Trust acquired Klebsiella bacteraemias in 2019/20 (compared with 22 in 2018/19 and 15 in 2017/18). Of these, 9 had RCA reviews completed following which 2 were deemed avoidable.



2.16 Pseudomonas aeruginosa

There were 6 cases of Trust acquired Pseudomonas aeruginosa bacteraemia in 2019/20 (compared with 9 cases in 2018/19 and 9 cases in 2017/18). Of these, 4 cases had RCA review following which none were deemed avoidable.



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 2019/2020, there was 1 Trust acquired VRE bacteraemia (which was deemed unavoidable following RCA review). 1% of all enterococcal isolates from blood cultures at STHK were resistant to vancomycin (11% compared with 2018/2019).

There were 3 outbreaks due to VRE colonisation in 2019-2020 (including the outbreak on 3D which continued in 2019/2020) compared with 6 in 2018/2019 (see section 3.1 for further details).

There were 285 hospital onset cases of VRE (non-bacteraemia) compared with 136 in 2018/2019 and 77 in 2017/2018. Most of these were asymptomatic colonisation detected on routine screening. In addition, 106 community onset non-bacteraemia cases of VRE compared with 134 and 77 in 2018/2019 and 2017/2018 respectively.

VRE rectal screening (on admission and then weekly) was continued on 4D, 4E, 3B and 2A. In addition, as an outbreak control measure, admission and then weekly screening for VRE was also implemented on 3D and 4C. 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 Enterobacterales (CPE)

CPE are a growing concern, nationally and regionally due to their resistance 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 importance.

There were no CPE bacteraemias in 2019-2020 (hospital or community acquired).

There were 9 cases CPE detected in a sample taken >48h after admission. Of these, 4 had risk factors for CPE prior to admission. In these cases, contacts were managed as per the PHE CPE Toolkit including screening. No cases of onward transmission were identified. There were also 18 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 22 confirmed outbreaks in 2019/20:

Month	No of outbreaks	Organism	Ward/Unit	Number of cases	No of bed days lost
2019					
Apr	1	VRE	3D	78 patients (all non-bacteraemia; primarily new colonisations) in 2019/2020 in addition to 20 cases Feb-March 2019 (two of which were bacteraemias) This outbreak continued throughout 2019/20 and is going at the time of this report (September 2020)	Complete information not available
May	2	VRE	4A	13 patients	27
		VRE	4C	59 patients (including 1 bacteraemia, others primarily new colonisations) in 2019/2020. This outbreak continued until June 2020.	12
Jun	2	Norovirus	Newton Community Inpatient Ward	3 patients; 1 staff	2
		Norovirus	5B	10 patients; 6 staff	6
Jul	1	Norovirus	2D	20 patients; 13 staff	41
Aug	0				
Sep	0				
Oct	2	Norovirus	1A	20 patients; 45 staff	127
		Norovirus	Duffy Suite	6 patients; 4 staff	30
Nov	0				
Dec	9	CDI	5D	2 patients	0
		Group A streptococcus	Newton Community Inpatient Ward	3 patients; 4 staff (all with non-invasive infections)	0
		Influenza A	1D	3 patients	1
		Influenza A	2A	2 patients	1
		Influenza A	2A	2 patients	0
		Influenza A	2C	3 patients	7

		Influenza A	3D	14 patients, 2 staff	12
		Influenza A	5C	2 patients	0
		Influenza A	Duffy Suite	4 patients	2
2020					
Jan	3	Influenza A	5D	1 patient; 1 staff	0
		Linezolid resistant Staphylococcus epidermidis	4E/ICU	4 patients	0
		MRSA (PVL positive)	4D/Burns Unit	2 patients	0
Feb	0				
Mar	2	COVID-19	Newton Community Inpatient Ward	15 patients; 10 staff	10
		COVID-19	3alpha	2 patients	0
Total	**22**			**268 patients; 86 staff**	**278**

3.1.1 3D and 4C VRE outbreaks

These two prolonged outbreaks were a challenge to control. Themes identified in relation to environmental hygiene and clinical practice. Multi-disciplinary outbreak meetings held with representation from Public Health England. Ongoing efforts are continuing to maintain the both the environmental hygiene and appropriate clinical practice. 3D had the ward closed to admission on four occasions and the ward deep cleaned. 3D had hydrogen peroxide fogging undertaken on three occasions following the deep clean. 3D continues to have side rooms deep cleaned and fogged when a patient with VRE is discharged.4C had the ward closed to admissions on two occasions and was deep cleaned and fogged

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.

3.1.2 4E/ICU linezolid resistant Staphylococcus epidermidis outbreak

Four patients identified between November 2019 and January 2020 with this novel organism in blood cultures taken from intravascular devices. This was the first time this organism has been identified in this Trust.
The patients' histories were reviewed including wards/ bed locations, line insertions, line care and antibiotic history. A review of the 4E (ICU and General Medicine) environment and practice was undertaken.
An outbreak meeting was held including Public Health England and the following actions agreed:
Commence screening of all patients to 4E (ICU and General Medicine) on admission and then weekly.

Bed spaces occupied by the patients were deep cleaned and decontaminated with hydrogen peroxide, the rest of the unit was deep cleaned.

Restricted staff and equipment movement from 4E.

New alert implemented on Medway for the organism

Use of linezolid restricted on 4E (ICU and General Medicine) unless advised by Microbiology.

Review of Trust Antibiotic Policy commenced to reduce indications for which linezolid is recommended.

The air handling units supplying 4E to be reviewed and confirmed as working satisfactorily.

Dedicated domestic staff assigned to 4E (ICU) and increased domestic supervision (daily) to be implemented on 4E.

Following the implementation of these measures, no further cases have been detected to date (September 2020).

4. Aseptic Non-touch Technique (ANTT)

Trust-wide ANTT continues to be monitored for compliance. Actions 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 2019/20.

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 is delivered by e-learning. Level 1 training has to be undertaken by all staff and level 2 has to be completed by clinical staff.

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. When the SARS CoV2 pandemic began the IPT provided a large number of additional fit testing Key trainer sessions. This is ongoing.

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 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 2019/20, ICNet NG was successfully upgraded to version 1.6.

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. In March 2020, the following to developments to this interface were completed:

- Development of an interface between ICNet and Medway in order to automate the updating of infection prevention alerts on Medway from ICNet (which removed the need for manual updating of alerts on Medway by the IPT).

- Incorporation of bed/bay numbers from Medway into ICNet in order to enable timely and efficient outbreak investigations and contact tracing.

8.3. IT changes in relation to SARS CoV2:

- In March 2020, changes were made to the ICNet/Telepath (the laboratory results reporting system) interface to enable real time reporting of COVID-19 results to the IPT from the laboratory.

- A clinical alert was implemented on Medway for COVID-19 positive patients.

- An electronic dashboard of inpatients with COVID-19 dash board was created by the Information Team to assist with patient flow and reporting requirements.

- ICNet was configured to enable documentation of clinical actions in relation management of individual COVID-19 positive patients.

- In addition, an electronic version of the COVID-19 RCA tool was incorporated into ICNet to enable documentation of the RCA information in an electronic and extractable format.

- Multiple reports were set up on ICNet to enable data extraction in order to support local/regional/national reporting requirements related to COVID-19.

- The Trust procured the ICNet Outbreak Manager Module via COVID related funding. The implementation of this module is expected in 2020.

- COVID intranet micro-site implemented by the Communications Team which hosts all information and guidance relevant to the Trust.

8.4. Electronic Bristol Stool Chart (BSC) and CPE assessments are continuing to be recorded on Patientrack although that system is expected to be discontinued in October 2020. Hence work is ongoing to develop a CPE assessment form in VitalPac to which end the IPT has worked collaboratively with colleagues from Informatics.

8.5. MicroGuide antibiotic app – the Trust Antibiotic Policy was published using the MicroGuide smart device app in November 2019 to coincide with the World Antibiotic Awareness Week. MicroGuide is available free of charge and includes all the content from the Trust Antibiotic Policy including dosing calculators.

8.6. Following the implementation of electronic prescribing (JAC) in the Trust in 2018-2019, as a routine part of clinical case management, the IPT continue to add 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 2019
- Compliance with IP precautions audits throughout 2019/20
- Compliance with IP precautions in preparation and during SARS CoV2 pandemic

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);

2019/20 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.Difficile 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 Key Achievements:

- Launch of antimicrobial policy on Microguide mobile app with regular updates (NICE, PHE culture and sensitivity information) and interactive gentamicin, vancomycin and renal function calculators.
- Achievement of UTI and surgical prophylaxis CQUIN targets for 19/20 with the launch of several UTI initiatives
- Successful AMR (antimicrobial resistance) strategies - StHK has reduced consumption of broad spectrum agents such as piperacillin/tazobactam and carbapenems by promoting the use of narrower spectrum "access" agents.

- Although not a formalised service, OPAT (outpatient parenteral antibiotic therapy) for 2019-20 managed 263 referrals saving in excess of 4850 bed days (potential saving of >£1.4 million) to the Trust. OPAT since 2010 has managed >2150 patients and saved in excess of 38,000 bed days or >£11.3 million.
- During COVID pandemic AMT (antimicrobial management) initiatives reduced allowing for the opportunity to trial an OPAT MDT (multidisciplinary team). Over a 4 week period the OPAT MDT reduced district nurse visits by 191 (with a potential saving of between £8-12,000) through patient review/optimisation and AMR strategies. Utilising this MDT approach to review inpatient's receiving OPAT related conditions (such as skin and soft tissue infection) identified that nearly 20% of these inpatients could be managed at home. this work has been essential for processing the development OPAT business case and developing relationships with key stakeholders in primary care.
- international and national level Poster Presentations at ECCMIDD and BSAC conferences regarding innovative patient management with dalbavancin use. Various external presentations at these events

10.5 Key challenges/issues:

- Increasing use of broad spectrum antimicrobials for multi drug resistant infections coupled with increasing winter pressures and the Coronavirus crisis.
- Launch of updated antimicrobial policy coupled with withdrawal of Mersey Micro app with no clear replacement. Multiple product evaluations with the implementation being solely undertaken by the antimicrobial management team
- Introduction of EPMA electronic prescribing led to a shift in prescribing practices leading to:
  - Increased course lengths
  - Decrease in documentation of indications and review dates

- Urinary tract infection CQUIN:
  - Audit of over 600 patients throughout the year to achieve the CQUIN data set
  - Several improvement projects implemented

- Increasing demand for OPAT without formalised service in place
- Implementation of new Antifungal CQUIN target
- Various stock shortages requiring immediate changes to antimicrobial policy
- Development and launch of a formalised OPAT service with a patient management system to record outcome data

10.6 Actions taken to overcome challenges and issues:

- Multiple weekly antimicrobial stewardship ward rounds.
- Implementation of antibiotic reporting using EPMA prescribing data to increase efficiency of ward rounds
- Point prevalence audit completed and submitted to North West Antimicrobial Pharmacist Group for benchmarking against other trusts.
- Quality improvement project completed on respiratory wards to improve antimicrobial prescribing including completion of 2 audit cycles.
- UTI CQUIN
  - Development of urinary tract infection e-learning package (accessed through Moodle)
  - Education and training provided in various areas including A+E and to all junior doctors
  - Switch to Urinalysis dipsticks which lack LEU and NIT in DMOP directorate (1A, 5A-D, Duffy, Newton) to reduce urine dipsticks being utilised as a source for UTI diagnosis in patients >65 years
- Education and training provided in various settings including A/E, Grand round, junior doctor teaching and biomedical scientist training.
- OPAT business case to the Trust executives and finance team
- Implementation of novel modes of therapy such as elastomeric infuser devices and long-acting glycopeptide dalbavancin to help facilitate discharging of patients.

10.7 Forward plan 2020/2021:

- Publication of paediatric antimicrobial policy on Microguide
- Finalisation of neonatal antimicrobial policy
- Working with the North West Antimicrobial Pharmacist Group to standardise the dosing of gentamicin within the area and work towards developing and deploying a regional dose calculator web app.
- Reintroduction of antimicrobial ward rounds post pandemic
- Increase in use of readymade antibiotics from the aseptic dispensing unit (ADU) and elastomeric infusers
- Development of an antibiotic renal dosing calculator which could be integrated into the antibiotic guidelines
- Further develop OPAT patient management database
- Further develop data extraction and reporting from EPMA to further develop innovative AMR strategies and targeted AMT ward rounds to reduce the over prescribing of broad spectrum antimicrobial agents.

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.

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: Progress on the project to install new flexible endoscope decontamination units at St Helens and Whiston sites
Installed interim measures for the reverse osmosis plants at St Helens to ensure the departments remain functional until the new unit opens in June / July 2021
Established as system for use of disposable ENT scopes for out of hours emergency use at Whiston to prevent scopes and patient tracking becoming lost
Working with Vinci facilities to set up an Authorised Person (Decontamination) service so that the Trust is compliant with HTM 01 -06
Maintained all the aged decontamination equipment in as best working order as possible so as to avoid patient cancellations and provide clean scopes as and when required
Set up a system working with our user departments to ensure that all flexible endoscopes have an annual health check to ensure safe use for patients
Maintained the service throughout the period of disruption caused by COVID 19
Decontamination technicians were successfully redeployed where available to assist as gowning assistants for ICU and theatres and work in the equipment pool

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.

Achievements:

- External PLACE - St Helens and Knowsley Teaching Hospitals were the Best Acute Hospital in the country with an overall score of 99.08% and a score of 100% for cleanliness. The national average for cleanliness was 98.6%. This was an amazing achievement that shows the commit all our staff throughout the Trust has to ensuring our patients are treated in the best environment and receive the highest quality of care.
- The Estates and Facilities Monitoring Team audits are carried out in all wards and clinical areas. Previous to 2019 the audits followed the same format as the External PLACE inspections focusing on patients areas only.
- In 2019/20 the audit format was changed to include non-clinical areas and ward/outpatients department e.g. Clean and dirty utilities, pantries, staff rooms. Each area was scheduled to be audited twice yearly by the E&F Team. Throughout 2019/20 102 audits were carried out by the team.
- Rapid Response Co-ordinator – was introduced to improve patient flow and the time taken to turn beds around on vacation. This allowed the domestic teams to continue cleaning.
- Discharge Team was increased to improve the cleaning times over the weekend and improve patient flow.
- Environmental Audits where set up – 2 weekly audits by the management teams (NewHospitals, Vinci, Medirest, E&F and IP)
- Commissioning of the new 60 bed ward (Bevan Court).
- Replacement bath for the Burns Unit installed and commissioned
- Glass screens installed in A&E Resuscitation to create individual cubicles aiding infection prevention.
- Completion of the new A+E waiting area to aid with patient flow.
- Reconfiguration within Burns and Plastics to provide a further treatment area to assist with improved patient care/ infection prevention.

13.3. All staff within the Trust worked well in supporting the Environmental /Waste Team who with the experience and guidance have continued to run the operational service correctly and safely in line with standards and infection prevention guidance.

Clinical Waste Collection Additional internal collections are continuing to take place as requested during this testing period as clinical waste is being produced 24/7 in cohort areas. All areas are being monitored daily and support is available to ensure all waste and linen is collected and disposed of efficiently.

Waste Bins

In recent Infection Prevention audits the waste bins have been highlighted as requiring replacement in a number of areas. The old metal bins have been replaced with 100% plastic containers which have a removable body for easy cleaning and the design aids in the reduction of manual handling issues. The Hands-Free frame meets infection prevention guidance and meets also the NHS England 'Managing Healthcare Fire Safety (HTM-05-03)' guidelines and helps to protect our environment.

13.4. Water safety group

The Water safety group (WSG) 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.

The WSG 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 SARS CoV2 pandemic.

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 IPC forward plan 2020-21

Infection Prevention Work Programme 2020/21							
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 2020/21

IP Code and Trust Objectives	Plan and Priority Activities 2019/2020	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**3. Hand Decontamination**						
	Introduce new hand decontamination sign posting for the Trust	IPT, 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 2020/21

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. Including national guidelines in relation to SARS covid -19	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 2020/21

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 Trustwide compliance and increase compliance rates.	AC	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training	AC	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	AC	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.	JE	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	AC	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 2020/21							
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 2020/21 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.				
	Training in infection prevention measures ie PPE , face fit for testing for SARS covid pandemic	IPT	Trust wide training and support				
	Ad hoc training to include: Volunteer Student Cadet Fundamental Training	IPT	As required, 2-3 times a year Monthly				

Infection Prevention Work Programme 2020/21							
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 2020/21							
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 2020/21

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, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IP Monthly Report	IP Team and AMT	Unified IP monthly report, combining monthly reports for the Medical and Nursing staff.				
	Communication with other Trusts and agencies such as Public Health England (PHE)	IP Team	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IP investigations.				
	Trust intranet	IP Team	To maintain and update the Trust intranet site with relevant and up to date information for Trust staff.				
	Mersey Micro smart device app	AMT	To maintain and update the Mersey Micro app in line with changes to Trust antibiotic policy				
	Administration	JD	To provide administrative support to the IP Team to include: Co-ordination of relevant IP Meetings Diary management. Data collection for monthly reports.Co-ordinate RCA meetings and documentation.Signposting for wards and departments telephoning for IP advice. Taking and distribution of minutes for relevant IP meetings Co-ordination of IP documentation,e.g. audit programme, education programme. ESR administration, ICNet administration				

Infection Prevention Work Programme 2020/21							
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 andsurveillance. 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 2020/2021

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 2020/21

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 bedframes 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.				

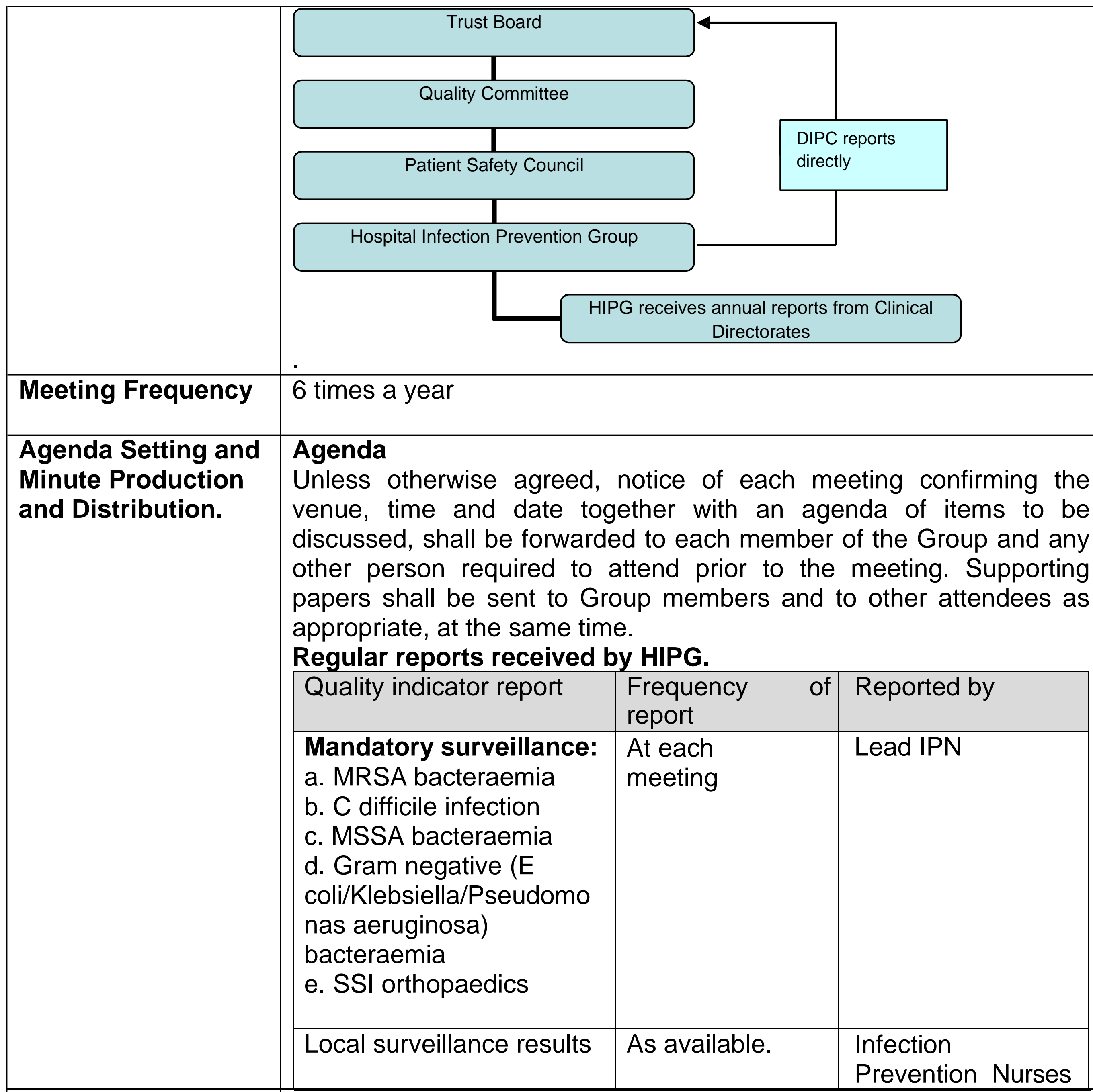
Appendix 2 HIPG TOR

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 3
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: