St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27th OCTOBER 2021
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
09:30	1.	Employee of the Month - September & October 2021		Verbal	Assurance	Chair
09.45	2.	Apologies for Absence		Verbal	Assurance	Chair
09.50	3.	Declaration of Interests		Verbal		
09.55	4.	Minutes of the Board Meeting held on 29th September 2021		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.00	5.	Integrated Performance Report		NHST(21) 065	Assurance	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						
10.20	6.	Committee Report – Executive		NHST(21) 066	Assurance	Ann Marr
10.30	7.	Committee Report – Audit		NHST(21) 067	Assurance	Ian Clayton
10.40	8.	Committee Report – Quality		NHST(21) 068	Assurance	Gill Brown
10.50	9.	Committee Report – Finance & Performance		NHST(21) 069	Assurance	Jeff Kozer
11.00	10.	Committee Report – Charitable Funds		NHST(21)076	Assurance	Paul Growney

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.10	11.	Board Assurance Framework	NHST(21) 070	Approval	Nicola Bunce
11.20	12.	Corporate Risk Register	NHST(21) 071	Assurance	Nicola Bunce
11.30	13.	Aggregated Incidents, Claims and Complaints	NHST(21) 072	Assurance	Sue Redfern
11.40	14.	Infection, Prevention and Control Annual Report 2020/21	NHST(21) 073	Approval	Sue Redfern
11.50	15.	Learning from deaths quarterly report	NHST(21) 074	Assurance	Rowan Pritchard-Jones
12.00	16.	Charitable Funds Annual Report and Accounts 2020/21	NHST(21) 075	Approval	Nik Khashu
Closing Business					
12.10	17.	Effectiveness of Meeting	Verbal	Assurance	Chair
	18.	Any Other Business		Information	
	19.	Date of Next Meeting – Wednesday 24th November 2021		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 27 OCTOBER 2021

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (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	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **Deferred due to COVID-19**	AM	**TBC**
37	29.09.21 (6.2.11)	RC to provide a report on the Cancer Networks plans to improve Head and Neck cancer performance at a future Finance and Performance Committee meeting.	RC	**TBC**
38	29.09.21 (6.4.4)	GB asked for more detail on the mandatory and essential skills training subjects. AMS confirmed that this detailed report was scrutinised at the Workforce Council meetings and she would circulate it to Board members for information.	AMS	**27.10.21**

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Public Board meeting held on Wednesday 29th September 2021 via Microsoft Teams

PUBLIC BOARD

Chair:	Mrs V Davies	(RF)	Non-Executive Director
Members:	Ms A Marr	(AM)	Chief Executive
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director (joined at?
	Mrs L Knight	(LK)	Associate Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Dr R Thind	(RT)	Associate Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr N Khashu	(NK)	Director of Finance and Information
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery and Governance
	Prof R Pritchard-Jones	(RPJ)	Medical Director
In Attendance:	Mr Alan Lowe	(AL)	Halton LA (Observer)
	Ms Yvonne Mahambrey	(YM) (NR)	Quality Matron Patient Experience (Patient Story)
	Mr NR	(DR)	Patient Family Member (Patient Story)
	Ms DR	(KF)	Patient Family Member (Patient Story)
	Ms Katie Fielding		Executive Assistant (Minute taker)
Apologies:	Mr R Fraser	(RF)	Chairman
	Ms Michelle Corrigan	(MC)	Insight Programme Placement

VD formally welcomed Dr Rani Thind to her first meeting of the Trust Board as a new Associate Non-Executive Director at the Trust.

1. Employee of the month

1.1. The employee of the month for August was Patricia Wainwright, Community Cardiac Specialist Nurse.

2. Patient Story

2.1. VD welcomed YM to her first Board meeting. YM explained that the patient story concerned the experience of the patient and her relatives who had experienced the DNACPR process.

The patient's son and daughter explained that their mother had been admitted to the Trust via the Emergency Department and had been extremely poorly.
When the son arrived at the hospital a DNACPR decision had been made for his mother. He did not know what this meant, he initially believed it to mean that treatment was being withdrawn and was distressed. But the staff had been patient and sensitive in explaining the DNACPR decision to him.

2.2. Throughout their mothers stay in hospital, the family were kept informed. They visited her one at a time and were allowed to sit with her until she started to improve. The family had assumed that once their mothers condition started to improve the DNACPR would automatically be rescinded and were initially shocked to find out that this was not the case. However, they had again had good conversations with staff who had respected their mothers religious beliefs and taken these into account in the decision-making process.

2.3. The patient's daughter was a clinician herself and had felt the staff handled the situation well, providing information and reassurance to the family.

2.4. The family had written to the Trust about their experience and to praise all the staff on the ward. The family had seen how busy the staff were but had been impressed by their kindness and compassion.

2.5. AM commented that this was an area which had resulted in a number of complaints from relatives, so it was good to hear about an instance where the family had felt fully informed. AM agreed that there is a common misconception that a DNACPR decision means a withdrawal of active treatment, which is incorrect. She asked that the good practice lessons from this story be shared with staff.

2.6. RPJ commented that the changes in recent years to medical education meant that Doctors were now better equipped to discuss the delivery of care and this made a big difference to the experience for patients and their families.

2.7. LK asked how the patient experience team feedback to ward staff. YM confirmed that the patient story had been shared with the senior nursing team for wider dissemination to the individuals who had been involved in this patients care.

2.8. VD thanked the family members for attending and sharing their experiences with the Board and sent the Trusts best wishes for a full recovery to their mother.

3. Apologies for Absence

As above

4. Declaration of Interests

RPJ declared that he had been appointed to the North West Region NHSE Adopt and Adapt programme.

It was noted that since the July Board meeting the Trust had entered into an Agreement for Long Term Collaboration with Southport and Ormskirk Hospital NHS Trust, which would involve all the Board members taking responsibility for the strategic and operational management of that Trust, as well.

5. Minutes of the Board briefing held on 28th July 2021

5.1. Correct Record

5.1.1. NK noted he was missing from the list of attendees
5.1.2. With this amendment the minutes were approved as a correct record.

5.2. Action List

5.2.1. Actions 30 and 36 remained deferred due to the impact of the pandemic.

6. Integrated Performance Report (IPR) – NHST (21)055

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.

6.1. Quality Indicators

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

6.1.2. There were 0 never events in August, and 1 year to date (YTD).

6.1.3. There had been 0 cases of MRSA in August, and 1 YTD.

6.1.4. There were 6 C. Difficile positive cases reported in August 2021 (4 hospital on-set and 2 community onset) and YTD 31 cases had been identified but a considerable number were still to be investigated and could result in appeals if it was determined that the C.Difficile was not attributable to the care provided by the Trust. SR also reported that the Trust had recently been issued with a C.Difficile tolerance level of 54 cases by NHSE

6.1.5. There were 3 falls resulting in severe harm in July, and 9 YTD.

6.1.6. There were 0 hospital acquired grade 3 pressure ulcer with lapse in care in June 2021 and YTD there has been 1.

6.1.7. The overall registered nurse/midwifery safer staffing fill rate (combined day and night) in August was 90.8% and this reflected the staffing challenges that had been experienced during the month.

6.1.8. VTE reporting remains suspended nationally due to COVID.

6.1.9. HSMR (April to May 2020/21) is 95.78.

6.1.10. SR also reported that there had been no new nosocomial infections at the Trust in the previous 7 days.

6.1.11. The report was noted.

6.2. **Operational Indicators**

6.2.1. RC presented the update on operational performance.

6.2.2. Performance against the 62-day cancer standard was above the target of 85.0% in month (July 2021) at 86.2% and YTD was 85.9%.

6.2.3. The 31-day target was achieved in July 2021 with 96.9% performance in month against a target of 96% and YTD was 98.3%.

6.2.4. The Cancer 2 week wait rule performance in July 2021 was 91.1% and 88.6% YTD against a target of 93.0%. (Performance in June was 86.0%). RC noted that the volume of 2 week wait referrals to the Trust had increased significantly and the main challenge in achieving the target was now capacity.

6.2.5. Accident and Emergency (A&E) 4-hour performance for August was 54.3% %, YTD 59.5% (all types mapped). There had been a total of 9,823 attendances in the month. RC reported that attendances were 5% higher than for the same period in 2019/20.

6.2.6. There were 2,431 ambulance conveyances in August and the average ambulance turnaround time was 48 minutes, which did not achieve the 30-minute standard, but lots of work was being undertaken to improve performance against this target by reducing congestion in the department and increasing patient flow through the hospital.

6.2.7. St Helens Urgent Treatment Centre had seen 5,068 patients in August, a decrease of 14% compared to July. However, August 2021 had been 5% busier compared to August 2019. 98% of patients were seen and treated in 4 hours

6.2.8. St Helens community nursing service had received 641 new referrals in July. This increase has come from all sources including GP, hospital and direct patient referrals. Community Matron caseloads had remained consistent. The community services were vital in helping to prevent avoidable admissions.

6.2.9. The average number of super stranded patients in August was 103 (compared with 81 in July). Work is being undertaken both internally and externally, with system partners, to improve the current position with high acute bed occupancy which caused the subsequent congestion in ED.RC explained how the Directors of Adult Social Services from St Helens, Knowsley, Halton and Liverpool had all directly engaged in reviewing the super stranded patients from their borough, which was starting to unblock some of the delays. However, there remained concerns about care home and domiciliary care capacity. RC also reported that a “Perfect Week” exercise was being planned for week commencing 18th October.

6.2.10. The referral to treatment (RTT) performance in August was 75.3%, YTD 75.3%, against the target of 92%, and the 6-week diagnostic waiting time performance in August was 79.5% against the target of 99%. There were now 1163 patients who had waited for over 52 weeks for their procedure. All elective performance measures were incrementally improving as the Trust delivered its recovery plans and the situation was continually monitored to prioritise the most clinically urgent patients.

6.2.11. IC asked about the Head and Neck Cancer pathway performance, recognising this was a system issue as the pathway involved several different providers. He asked that RC provide a report on the Cancer Networks plans to improve performance and it was agreed that this would be presented at a future Finance and Performance Committee meeting. AM asked if there was any other systems who were better at delivering the Head and Neck pathway and if there was anything that Cheshire and Merseyside could learn. **ACTION:RC**

6.2.12. GB asked if the perfect week included patient experience and RC agreed to work with the patient experience team to ensure this was part of the structured evaluation.

6.2.13. The report was noted.

6.3. **Financial Indicators**

6.3.1. NK presented the update on financial performance.

6.3.2. For H1 (April – September 2021), the Trust's final financial plan was to achieve a breakeven position. In July, thresholds for achievement of ERF income in Q2 (M4-M6) were increased from 85% to 95% of 2019/20 delivery, and as a result, the Trust forecast a H1 deficit of £3.3m in Month 4 reporting.

6.3.3. At the end of Month 5, the Trust has reported a £2.3m deficit. This is now expected to be recovered utilising Trust and system solutions to deliver a H1 breakeven outturn at the end of Month 6.

6.3.4. Year to date expenditure on agency staff was £3.8m, including agency costs incurred in relation to COVID (£0.2m) and the Mass Vaccination Programme (£0.4m).

6.3.5. At the end of M5, the cash balance was £59.3m. The current NHSE/I assumption is to utilise cash balances instead of Emergency PDC capital to support the capital programme, which could deteriorate the Trust's cash balance over the longer term.

6.3.6. A capital programme of £10.97m (excluding PFI lifecycle expenditure), supported by an application for £5.43m Emergency PDC capital has been submitted to NHSE/I. This is not expected to be agreed.

6.3.7. The Trust continues to plan internally for a higher efficiency target in H2, but this would be confirmed when the H2 planning guidance was published

6.3.8. NK also reported that the Trust continued to deliver over 95% performance against the Public Sector Better Payments Practice target.

6.3.9. The report was noted.

6.4. **Workforce Indicators**

AMS presented the update on workforce performance and noted the impact the pandemic still had on the performance against these metrics.

6.4.1. Appraisal compliance has improved however is below target at 56.1%. Mandatory training compliance remains below the target at 74.0%.

6.4.2. In August overall sickness was 6.7% which was a 0.2% increase compared to July. Nursing, Midwifery and HCA's sickness was 9.1% a decrease of 0.8% from July. These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, or pregnant workers over 28 weeks on medical suspension.

6.4.3. AMS confirmed that all mandatory training was now available for staff to undertake online to increase the flexibility and minimise the time away from work.

6.4.4. GB reflected that these figures were not a surprise but asked for more detail on the mandatory and essential skills training subjects. AMS confirmed that this detailed report was scrutinised at the Workforce Council meetings and she would circulate it to Board members for information. **ACTION: AMS**

6.4.5. GB also asked what impact the current fuel shortages were having on staff. SR confirmed that the situation was being monitored nationally via the EPRR cascade system and the trust was submitting a daily situation report by exception if there were impacts on staff attendance, the delivery of goods and services or hospital transport. To date there had not been any impact, although there was increased anxiety for staff. VD asked that an update be provided to Board members if the situation escalated.

6.4.6. The report was noted.

7. Committee Report – Executive – NHST (21)056

7.1. AM presented the report and highlighted the key issues considered by the Executive Committee at the seven meetings held during July and August 2021.

7.2. The new investment decisions made were:

- To start the process of recruitment so that Ward 1A could be re-opened as a winter escalation ward
- Approval of a patient booking system for the phlebotomy service

7.3. At every meeting the Executive Committee discussed the COVID-19 pandemic and its impact on the Trust. The Committee also considered regular assurance reports covering, Risk Management Council and Corporate Risk Register, and the integrated performance report.

7.4. Medical Bed Capacity
AM explained that the Executive had agreed to start the recruitment of staff to be able to re-open ward 1A following the summer lifecycle ward refurbishment programme. Being able to secure sufficient staff was the biggest challenge to being able to open these additional beds.

7.5. Whiston Hospital – Additional Theatres
AM highlighted the decision to proceed to design stage for two additional theatres on level 4 adjacent the existing theatre complex at Whiston Hospital, a full business case would then be developed which would be brought to the Board for approval. It was hoped that, if approved the scheme would start in 2022/23. JK asked if theatre capacity at other sites locally had been taken into account and AM confirmed that it had, but the modelling work undertaken had indicated that the acuity and complexity of the cases predicted, even after the COVID backlog had been cleared, indicated that there would be a need for additional theatre capacity on the acute site which had the ICU facilities collocated.

7.6. Inpatient Survey – 2020
AM also drew attention to the Trust results from the 2020 national inpatient survey. There had been some pleasing improvements in the Trust results compared to previous years, especially where targeted effort had been focused via the 2020/21 Trust objectives. Areas for further improvement from this set of the results included support for patients at mealtimes, patient and family involvement in discharge planning and information about discharge/aftercare. A full report and action plan would be presented to the Quality Committee once the national comparative data had been published.

7.7. Phlebotomy Service Booking System Business Case
GB commented that it was pleasing that action had been taken to introduce a booking system for the Phlebotomy service and she felt this would improve patient experience by reducing the long queues. GB also asked whether the Trust was impacted by the current issues with blood bottles that had been reported in the media. AM explained that the Trust used a different analyser platform and was not dependant on these products so had not been directly affected. However, the Trust had been involved in the contingency planning and would have provided mutual aid to other Trusts, if this had proved necessary.

7.8. Risk Management Council (RMC) and Corporate Risk Register (CRR) Report
IC asked for details of the new high risk that had been added to the CRR in August and NB clarified that this related to implementation of the new maternity triage system.

7.9. VD commented that this was a useful report to understand the range of issues discussed at the Executive Committee and provided good assurance. She was pleased that the Trust had stood ready to support others in the ICS during the blood bottle crisis.

7.10. The report was noted.

8. Audit Committee Chair's Assurance Report including Audit Letter Approval – NHST (21)057

8.1. IC presented the Audit Committee Chair's Assurance Report

8.2. The Audit committee had met solely to receive the auditor's report on the 2020/21 Annual Report and Accounts and the Trust's letter of representation.

8.3. This was the first set of accounts under the new accounting standards that had been introduced from April 2021.

8.4. IC confirmed that the audit had been clean with no adjustments. This was an impressive achievement given the challenges of 2020/21. The committee was happy to recommend the accounts for approval.

8.5. NK thanked the Audit Committee members for adapting to the challenges of the past year. NK also extended his thanks to the Finance team and NB who had produced the reports and provided the requested information to Grant Thornton during the audit.

8.6. VD congratulated NK for an excellent performance on behalf of the Board.

8.7. JK noted that the audit result reflected the way that NK and the finance team had handled the finance decisions throughout the year.

8.8. The Board approved the annual report and accounts.

9. Quality Committee Chair's Assurance Report – NHST (21)058

9.1. GB highlighted some key points from the report that she wished to bring to the Boards attention.

9.2. RC had provided assurance on the actions being taken with local system partners to reduce delayed discharges and improve patient flow.

9.3. It was pleasing to see the improvements achieved by Marshalls Cross GP Practice in the recent national GP survey. There were increased levels of patient satisfaction in being able to contact the practice by telephone and being able to see their preferred GP.

9.4. For the Maternity Service there had been assurance that the Trust was achieving the targets for one-to-one care. However, there had also been a number of red flag staffing incidents and the unit at Whiston had to close due to the high acuity of women in delivery suite. Although this was also happening at other maternity units, there was a cause for concern that the Trust's service was under pressure.

9.5. The committee had received significant assurance from the Safeguarding Annual Report. GB had been impressed by the case studies which provided examples of the extraordinary lengths the staff go to keep patients safe. The 2020/21 Safeguarding Annual Report had been approved by the Quality Committee.

9.6. The committee had also considered and approved the draft Clinical and Quality Strategy for 2021/22. This was an interim strategy focusing on recovery from the pandemic and would be reviewed again in 2022/23 once the ICS was established as a statutory NHS body.

9.7. NB noted that the risk identified by the committee to achieving compliance with appraisals and mandatory training was already on the Trust risk register.

9.8. The report was noted.

10. Finance & Performance Committee Chair's Assurance Report – NHST (21)059

10.1. JK presented the report

10.2. The committee had reviewed the operational and finance performance sections of the IPR.

10.3. The committee had also received the detailed finance report for month 5 and focused particularly on the impact of the loss of expected ERF income in months 4 and 5 and how the Trust was responding and planning for H2.

10.4. The committee received the report on the Trust objectives that have been aligned to the Finance and Performance Committee and noted the progress made to date.

NK had requested that the NED CIP deep dive programme resume for the 2021/22 programme to provide assurance on the quality impact assessments.

10.5. VD commented that the change to the ERF thresholds must have had an impact on the financial plans for many acute Trusts and asked how the system was working to support them. NK agreed that the impact had been significant and noted the conversations that were now happening at system level to recognise the different pressures for the Trusts across Cheshire and Merseyside.

10.6. The report was noted.

11. Medical Revalidation Annual Declaration – NHST (21)060

11.1. RPJ presented the report on behalf of Jacqui Bussin, the Revalidation Responsible Officer who could not attend the Board due to clinical commitments.

11.2. RPJ explained that the Covid-19 pandemic has been a huge challenge for the Trust and has meant some plans for development of the Trust's Medical Appraisal and Revalidation systems in 2020/21 had been delayed or put on hold.

11.3. The Trust had recruited and trained an additional 13 appraisers and 181 out of 480 medical staff had been appraised. 299 staff had agreed exemptions in line with NHS guidance for hard pressed specialities impacted by the pandemic and for special circumstances such as maternity leave. This number of exemptions was

expected to reduce in 2021/22.

11.4. A revised Medical Appraisal and Revalidation policy had been approved and is being implemented in 2021/22.

11.5. The GMC and NHS England are reviewing the requirements for appraisal in the light of the introduction of a streamlined process during the pandemic. Further national guidance is expected in 2022.

11.6. The Board approved the declaration to confirm compliance with the Responsible Officer Regulations

RPJ and AM expressed their thanks to Dr Bussin for all her efforts and acknowledged the improvements she was bringing to the Trust's revalidation processes.

12. EPRR Compliance Statement – NHST(21)061

12.1. SR presented the annual EPRR Compliance Statement for 2021/22

12.2. The purpose of the EPRR annual assurance process is to assess the preparedness of the NHS, (Commissioners and providers), against NHS EPRR Core Standards. As part of the NHSE EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

12.3. In 2019/20 the Trust achieved substantial compliance with 93.75%. 4 standards were assessed as partially compliant which all related to chemical, biological, radiological and nuclear defence (CRBN) training. In 2020/21 as a result of the pandemic the compliance requirements were "light touch" and the Trust had provided a progress report against the 4 standards where it was not fully compliant.

12.4. For 2021/22 the core standards have been reduced for 69 to 46, and the self-assessment against these standards shows that the Trust is fully compliant with 44 of the 46 standards and partially compliant with 2 standards. This achieves a substantial compliance score of 95.6%.

The 2 areas where the Trust is partially compliant are

- To increase number of HAZMAT/CBRN train the trainers to 6 - 3 have been trained in the last 18 months and more are planned, when they can be released
- CBRN staff training in decontamination – due to Covid -19 impact and staff turnover in the department this has not been achieved but the mitigation plan is that 85% of the required staff will have received refresher training by March 2022.

12.5. To mitigate these areas of partial compliance, the Emergency Department has issued every staff member with guidance on how to identify and respond to patients presenting at the department following incidents related to biohazards. The department staffing roster ensures a minimum of 5 HAZMAT/CBRN trained staff on each shift (24/7). A decontamination training programme is also in place.

12.6. The Trust also self-assessed against the 7 deep dive standards and is fully compliant with them all. This is monitored via the Trust's oxygen steering group which reports to the patient safety council.

12.7. The Board approved the Trust statement of compliance with the EPRR national core standards.

13. Workforce Race Equality Standard and Workforce Disability Equality Standard 2021 Reports – NHST(21)062

13.1. AMS presented the report.

13.2. AMS explained that Implementing the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) is a requirement for all NHS commissioners and NHS provider organisations. The WRES was introduced in 2015 and the WDES two years ago, meaning there was less national benchmarking data available.

13.3. AMS highlighted some key points for the Board.

13.3.1. For the WRES the Trust performed better on some indicators and less well on others compared to the national benchmarks, but there was still a great deal of work today as any bullying, harassment or discrimination against staff by patients, visitors or other staff was unacceptable.

13.3.2. In relation to the WDES there was more work to do to understand why 13.9% of staff were not willing to disclose their disability status

13.3.3. The action plans were centred around 3 themes; compassionate and inclusive leadership; giving staff a voice and education and raising awareness

13.4. AMS confirmed that the action plans had been developed with the six Trust staff networks.

13.5. LK queried WDES indicator 3 which seemed high. AMS clarified that the HR team had reviewed the records and found that there had been 12 capability reviews and in two of the cases the member of staff had a disability and in 3 the disability status was not declared.

13.6. GB asked if the Trust gives guidance to staff in relation to what is a disability. AMS agreed that some additional information in relation to the definitions for the protected characteristics might support more staff to feel able to disclose a disability.

13.7. NK commented that he chaired the ED&I steering group and understood that there needed to be a long-term commitment to addressing the issues flagged in these reports.

13.8. The Board approved the annual WRES and WDES reports and the proposed action plan

14. Gender Pay Gap 2020/21 – NHST(21)063

14.1. AMS presented the report

14.2. NHS Trusts are required as part of the public sector equality duty to publish gender pay gap information each year. This report covered the financial year 2020/21.

14.3. The analysis of the data shows that there remained some differences in pay between the genders at the Trust. The gender pay gap calculates the difference in average pay between all men and women in a workplace. The data is based on a

snapshot of pay on 31st March each year. The majority of staff employed by the Trust are paid at nationally negotiated pay and conditions of service. In order to better understand the causes of the disparities in the average hourly pay of men and women a number of actions were being undertaken:

- Analysis of flexible working requests to identify the working patterns of males and females (by department) and any barriers that females may face when pursuing career opportunities.
- Educate and support employees to be aware of the inclusive people practices they can access and utilise including reasonable adjustments, flexible working, carers passport and HWWB services.
- Ongoing work to identify flexible working options to be included on job adverts in order to promote the Trust as a supportive employer.
- Review of how we welcome back and support staff that may have had a significant amount of time away from work (i.e., maternity or adoption leave) and analysis of what the barriers are to further career progression when returning to work.
- Undertake a review of recruitment processes to remove any gender bias. i.e. at the shortlisting stage or during interviews.

14.4. AMS reported that the Trust benchmarked at 28th out of 112 and was therefore in the top performing quartile (lowest gender pay gap).

14.5. LK stated that this was an interesting report of a complex issue and she looked forward to monitoring the progress of the action plan at the Strategic Workforce Committee. LK asked if the Trust offered shared parental leave and AMS confirmed that this was an option open to staff and also clarified that maternity leave does not impact on length of service or incremental progression so is not a significant underlying cause of the pay gap.

14.6. RPJ asked of the calculations for Medical and Dental staff included clinical excellence awards and AMS clarified that they were not.

14.7. GB supported the proposal to work with staff to understand the impact of caring responsibilities on pay and career progression.

14.8. VD thanked AMS for an interesting report and supported the actions that had been proposed.

14.9. The report was noted.

15. Community Diagnostic Hub Development – NHST(21)064

15.1. RC presented an overview of national policy and local implementation of the fist Community Diagnostic Hub (CDH) at St Helens Hospital.

15.2. The CDH is a national initiative announced as part of recovery and restoration to provide increased access to diagnostic tests including imaging, pathology, endoscopy and cardiology., by maximising the capacity and hours of operation of existing services.

15.3. The St Helens CDH had gone live in July and undertaken 1353 additional diagnostic procedures to the end of August.

15.4. The biggest challenge for the CDH was securing the required workforce capacity.

15.5. RC commended the Trust team who had worked so hard to get the CDH up and running very quickly.

15.6. IC supported the moves to create more one stop shop pathways as these reduce the time for diagnosis which was critical for some conditions. He also commented that it was important that the results of tests could be shared with other partners who were involved in the treatment. RC explained that as an early adopter the objective for the CDH had been to reduce the Trusts diagnostic backlog initially and it would then offer capacity to the wider system.

15.7. VD thanked RC for a very informative presentation that gave the Board assurance that the Trust was taking every opportunity to address the challenges of restoration and recovery to ensure all patients on the waiting list were seen as quickly as possible.

16. Effectiveness of Meeting

16.1. VD asked RT for her reflections on the effectiveness of the meeting. RT commented it was a huge learning curve for her to get to grips with the acronyms and the challenges that the Trust was facing. However, she had felt assured that there was continued investment in increased capacity and in prioritising patient experience and support for staff.

17. Any Other Business

17.1. None to report

18. Date of Next Meeting
Wednesday 27th October 2021

Chairman: ……

Date: ……

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)065
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 September 2021. (YTD = 1).

There were no cases of MRSA in September 2021. (YTD = 1).

There were 9 C.Difficile (CDI) positive cases reported in September 2021 (4 hospital onset and 5 community onset). YTD there have been 37 cases (20 hospital onset and 17 community onset). A further 3 cases have been successfully appealed. The annual tolerance for CDI for 2021-22 has not yet been published (the 2019-20 limit is being used in the absence of publication of the 2021-22 objectives).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2021 was 88.5%. 2021-22 YTD rate is 91.4%.

The number of incidents reported in August was 64, which is a reduction from previous levels in July of 101.

During the month of August 2021 there were no falls resulting in severe harm. (YTD severe harm falls = 9)

There were no grade 3 hospital acquired pressure ulcers with lapse in care in July 2021. (YTD 2021-22 = 1).
One category 2 pressure ulcer with lapse in care in July 2021 (YTD = 6).

Performance for VTE assessment for February 2020 was 95.70% against a target of 95%. VTE returns for March 2020 to September 2021 have been suspended.

YTD HSMR (April - May) for 2021-22 is 95.8

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 21/22 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: 27th October 2021

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (August 2021) at 85.6%. YTD 85.8%. Performance in July 2021 was 86.2%. The 31 day target was achieved in August 2021 with 98.2% performance in month against a target of 96%, YTD 98.3%. Performance in July 2021 was 96.9%. The 2 week rule target was not achieved in August 2021 with 92.3% in month and 89.3% YTD against a target of 93.0%. Performance in July 2021 was 91.1%. The situation with regard to patients not wanting to attend for appointments is continuing to improve and we are seeing further increases in the numbers of referrals and patients receiving treatment.

Accident and Emergency Type 1 performance for September 2021 was 54.5% and YTD 58.7%. The all type mapped STHK Trust footprint performance for September 21 was 77.6% and YTD 78.5%**.** The Trust saw average daily attendances of 338, which is up compared to August, at 317. Total attendances for September 2021 was 10,130.

Total ambulance turnaround time was not achieved in September 2021 with 39 mins on average. There were 2,261 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,431 in August 21.

The UTC saw 5955 in September 2021, which is an increase of 17% (887) compared to the previous month. This equates to a 24% increase when compared with September 2019. Overall 99% of patients were seen and treated in 4 hours. .

Community nursing referrals reduced slightly in month with 553 in August in comparison with 641 in July. In line with this position, the overall caseload size is within normal range at 1189 patients in August in comparison to 1205 in July.

Community matron caseloads have remained steady with 155 patients in August, compared to 161 reported in July. There is still availability within the service and we continue to engage with individual GP practices and community MDTs to support identification of appropriate patients.

The average daily number of super stranded patients in September 2021 was 111 compared with 103 in August. Note this excludes Duffy and Newton IMC beds. Work is ongoing both internally and externally, with all system partners, to improve the current position with acute bed occupancy remaining high with subsequent congestion in ED as a result.

The 18 week referral to treatment target (RTT) was not achieved in August 2021 with 75.3% compliance and YTD 75.3% (Target 92%). Performance in July 2021 was 75.8%. There were (1163) 52+ week waiters. The 6 week diagnostic target was not achieved in September 21 with 77.9% compliance. (Target 99%). Performance in August 2021 was 79.5%.

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. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust's final financial plan for H1 gave a breakeven position. In July, thresholds for achievement of ERF income in Q2 (M4-M6) were increased from 85% to 95% of 19/20 delivery, resulting in the loss of £3.3m planned H1 income. As a result, the Trust reported a deficit of £2.3m year to date at Month 5. Since then, additional system funding has been agreed to address this deficit alongside Trust solutions to bridge the remaining gap. The Trust's Month 6 reporting therefore reflects achievement of a breakeven position for H1. Funding for the second half of the financial year (H2) has not yet been confirmed. H2 plans are expected to be finalised and agreed with the ICS in November.

Surplus/Deficit - At the end of Month 6, the Trust has reported a breakeven position, with £257m expenditure offset by income.

Agency - Year to date agency expenditure is £4.6m, including agency costs incurred in relation to COVID (£0.2m) and Mass Vaccination (£0.4m).

Cash - At the end of Month 6, the cash balance was £62.0m. The current NHSE/I assumption is to utilise cash balances instead of Emergency PDC capital to support the capital programme, which could deteriorate the Trust's cash balance in time.

Capital - A capital programme of £10.97m (excluding PFI lifecycle expenditure), supported by £5.43m Emergency PDC capital was submitted to NHSE/I. Emergency PDC must be agreed by DHSC before the Trust is able to draw funds. Currently the Trust does not expect this to be agreed as there is an assumption that providers utilise their cash balances before PDC funding.

Human Resources

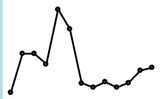
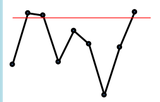
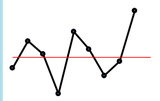
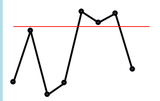
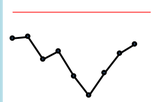
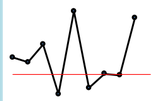
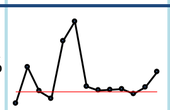
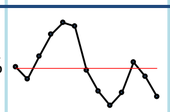
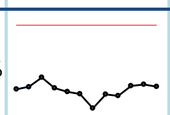
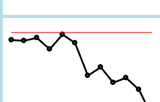
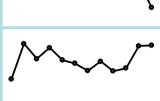
In September overall sickness remained static at 6.7% from the previous month. Front line Nursing, Midwifery and HCA's was 8.9% which was a decrease of 0.2% since August. Front line Nursing and Midwifery only was 7.2% which is a 0.2% decrease from August. These figures include normal sickness and COVID 19 sickness reasons only they do not include COVID 19 absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.
Appraisal compliance has improved however is below target at 62.0%. Mandatory training compliance remains below the target at 73.2%.

The following key applies to the Integrated Performance Report:

▲ = 2021-22 Contract Indicator
▲£ = 2021-22 Contract Indicator with financial penalty
● = 2021-22 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Sep-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Sep-21	2.8%	2.4%	No Target	3.1%		Post wave 3 of COVID, performance is encouraging. HSMR continues to be challenging in the pandemic due to disease groups needing three years worth of data.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits. We continue to independently benchmark performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	May-21	1.07		1.00						
Mortality: HSMR (HED)	Q	▲	May-21	102.2	95.8	100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	May-21	121.5	110.4	100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Apr-21	96.1	96.1	100.0	98.8		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	A spike in readmissions reflects COVID third wave but remains within expected range and is improving.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	May-21	94.5	93.7	100.0	90.3		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,	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	May-21	118.0	108.5	100.0	104.7					
% Medical Outliers	F&P	T	Sep-21	2.6%	1.4%	1.0%	1.6%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	The current number of medical outliers is above target owing to the full occupancy of the medical bed base. Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Sep-21	38.7%	44.0%	52.5%	58.8%		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 although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Aug-21	76.4%	75.7%	90.0%	74.8%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team also being involved to find a sustainable solution particularly in A&E. OP attendance letters - deterioration reflects staff sickness and increased activity pressures has caused a backlog in typing. Action plan is in place with operational colleagues.		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 daily updates of performance. The most challenged area in SDECC is moving discharges to the Medway system to support rapid, detailed discharges. This is ready for go-live with SOP, training and audit in place. Information teams are testing through to ensure data submissions are accurate.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Aug-21	63.2%	74.5%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Aug-21	97.4%	97.0%	95.0%	96.8%					

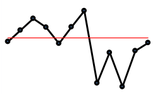
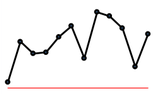
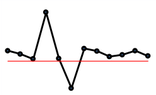
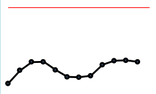
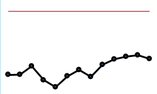
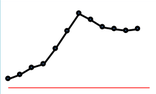
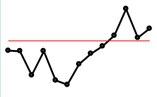
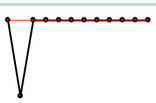
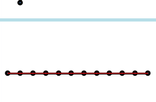
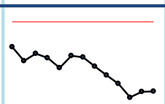
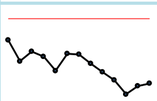
Sep-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	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	▲	Q1	86.5%	86.5%	83.0%	90.4%		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	▲ £	Sep-21	0	1	0	3		One never event reported in July 2021	Quality and patient safety	Investigation into previously reported incidents completed and actions in place to mitigate chances of recurrence. Local actions and monitoring procedures in place.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20			98.9%			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	Sep-21	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	▲ £	Sep-21	0	1	0	2		There were no cases of MRSA in September 2021. YTD = 1.	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	▲ £	Sep-21	9	37	48	28		There were 9 positive C Diff sample in September 2021. YTD there have been 40 cases of which 3 cases have been successfully appealed, leaving 37 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-21	3	20	No Target	29		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jul-21	0	1	No Contract target	1		No hospital acquired category 3 or 4 pressure ulcers with lapse in care in June 2021.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April 21.	SR
Number of falls resulting in severe harm or death	Q	▲	Aug-21	0	9	No Contract target	31		No fall resulting in severe harm category in August 21.	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			95.0%			**March 20 to September 21 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway with thematic review expected. All cases reviewed. Appropriate prescribing and care identified.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Feb-21			No Target	69					
To achieve and maintain CQC registration	Q		Sep-21	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-21	88.5%	91.4%	No Target	92.2%		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-21	4	22	No Target	49					

Sep-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Aug-21	92.3%	89.3%	93.0%	94.3%		There has been a significant increase in 2WW referrals. It is too soon to determine if this trend is the new normal or a result of catch up in the system.	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 continues to utilise Imaging capacity via temp CT facility at St Helens Hospital 4. Trust commenced Rapid Diagnostic Service early 2020 5.Cancer surgical Hub at St Helens to recommence 6. ESCH plans reignited 7. Funding approved to support RDS implementation aligned to CDH	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Aug-21	98.2%	98.3%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-21	85.6%	85.8%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Aug-21	75.3%	75.3%	92.0%	70.6%		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. Recovery plans are in place.	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 with application of P- codes effectively implemented. Application of D-codes is on target for delivery.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Sep-21	77.9%	76.4%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Aug-21	1,163	1,163	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-21	1.0%	0.9%	0.8%	0.4%		July's underperformance in cancelled ops has been due to staff sickness/absence, and theatre staff being re-deployed temporarily to support ITU, both at the end of July and in the first two weeks of August. In September, a mixture of consultant and theatre staff sickness has impacted this metric. The team is confident that this will recover going forward.	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	▲ £	Aug-21	100.0%	100.0%	100.0%	97.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0						
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Sep-21	54.5%	58.7%	95.0%	78.0%		Accident and Emergency Type 1 performance for September 2021 was 54.5% and YTD 58.7%. The all type mapped STHK Trust footprint performance for September 21 was 77.6% and YTD 78.5%. The Trust saw average daily attendances of 338, which is up compared to August, at 317. Total attendances for September 2021 was 10,130. Total ambulance turnaround time was not achieved in September 2021 with 39 mins on average. There were 2,261 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,431 in August 21.	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. <u>Flow through the Hospital</u> COVID action plan to enhance discharges commenced in April 20 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. The continued absence of face to face assessments from social workers is causing some delays.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Sep-21	77.6%	78.5%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Sep-21	0	0	0	0					

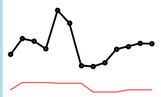
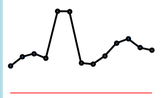
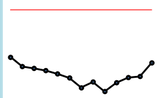
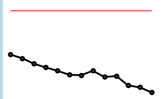
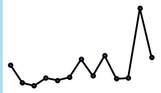
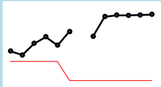
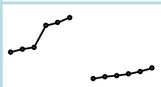
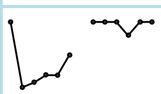
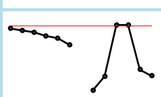
Sep-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-20			0			**March 20 to September 21 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	Sep-21	24	142	No Target	242		% new (Stage 1) complaints resolved within agreed timescales dipped below the 90% target in quarter 1 & 2 and continues to remain extremely challenging.	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 have been made aware 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%. Additional temporary resources are being sought to increase response rates within the Medical Care Group.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-21	27	120	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-21	77.8%	82.5%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to September 21 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. The absence of face to face assessments from social workers is causing some delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Sep-21	316	301		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Sep-21	111	96		72					
Friends and Family Test: % recommended - A&E	Q	▲	Sep-21	78.1%	77.8%	90.0%	88.4%		Recommendation rates remain consistently above target for inpatients, and postnatal community, but below target for the remaining areas.	Patient experience & reputation	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. At least two members of staff have been identified in each area to produce 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. Waiting times in ED are continuing to cause a higher number of negative responses and comments, with work ongoing to reduce this.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Sep-21	95.7%	95.7%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Sep-21	100.0%	92.9%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Sep-21	97.9%	92.9%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Sep-21	90.9%	94.6%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Sep-21	100.0%	100.0%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Sep-21	93.7%	93.6%	95.0%	94.2%					

Sep-21

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Sep-21	6.7%	6.3%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In September overall sickness has remained static at 6.7% from the previous month. Front line Nursing, Midwifery and HCA's was 8.9% which was a decrease of 0.2% since August. 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.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team undertake a review of sickness absence daily to try to analyse the hotspots and HWWB are contacting employees who are absent with Covid to provide support.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Sep-21	8.9%	9.0%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-21	62.0%	62.0%	85.0%	51.3%		Appraisal compliance has increased by 5.9% and is below target at by 23%. Mandatory training compliance has reduced by 0.8% and is below the target by 11.8%. In particular Mandatory training continues to be impacted by operational activity, recovery plans and higher than normal staff absence.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Compliance for Mandatory Training continues to be impacted by operational pressures and high staff absence. Appraisal has seen increasing compliance in month with both remaining below target. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area and continues to be monitored through Workforce Council.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Sep-21	73.2%	73.2%	85.0%	75.7%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			No Contract Target			NHSE/NHSI to resume from Q2 (July)	Staff engagement, recruitment and retention.	New Quarterly staff survey closed 12th August 2021. Publication of the results will take place on the model healthcare site on 25th October. The 2021 staff survey opened on 27th October.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Sep-21	1.3%		No Target	12.9%		Staff turnover remains stable and well below the national average of 14%.		The HR Advisory Team undertake a review of sickness absence daily to try to analyse the hotspots and HWWB are contacting employees who are absent with Covid to provide support.	AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Sep-21	Discontinued	Discontinued	N/A				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 2021/22.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Sep-21	5,875	5,875	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Sep-21	-	-	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-21	30	30	10						
Capital spend £ YTD (000's)	F&P	T	Sep-21	4,100	4,100	17,600						
Financial forecast outturn & performance against plan	F&P	T	Sep-21	-	-	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-21	83.6%	83.6%	95.0%						

APPENDIX A

			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021-22 YTD	2021-22 Target	FOT	2020-21	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	100.0%	38.5%	77.8%	100.0%	100.0%	96.3%	100.0%	97.4%	100.0%	94.7%	92.0%	89.5%	100.0%	95.2%	85.0%		91.1%		
	Total > 62 days		0.0	4.0	3.0	0.0	0.0	0.5	0.0	0.5	0.0	1.0	1.0	1.0	0.0	3.0			11.0		
	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	▲£	75.0%	85.7%	90.0%	80.0%	82.6%	78.9%	58.6%	87.5%	61.1%	78.1%	100.0%	86.7%	82.8%	82.5%	85.0%		78.7%		
	Total > 62 days		1.0	1.0	1.0	2.0	2.0	2.0	6.0	1.0	3.5	3.5	0.0	1.0	2.5	10.5			22.0		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	0.0	0.0	1.5	1.5			6.0		
Upper GI	% Within 62 days	▲£	100.0%	100.0%	80.0%	81.8%	83.3%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	77.8%	62.5%	86.2%	85.0%		83.1%		
	Total > 62 days		0.0	0.0	1.5	1.0	1.0	0.0	0.0	3.5	0.0	0.0	0.0	1.0	3.0	4.0			11.5		
	Total > 104 days		0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	1.0	2.0			4.0		
Urological	% Within 62 days	▲£	90.9%	95.7%	88.0%	79.5%	88.2%	82.8%	92.3%	79.2%	80.0%	88.6%	75.7%	84.2%	77.5%	79.4%	85.0%		85.6%		
	Total > 62 days		1.0	0.5	1.5	4.0	2.0	2.5	1.0	2.5	2.0	2.0	4.5	1.5	4.5	14.5			21.0		
	Total > 104 days		1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	0.5			6.0		
Head & Neck	% Within 62 days	▲£	50.0%	0.0%	20.0%	100.0%	0.0%	33.3%	57.1%	50.0%	0.0%	14.3%	50.0%	0.0%	0.0%	15.8%	85.0%		51.4%		
	Total > 62 days		1.0	1.5	2.0	0.0	1.0	1.0	1.5	1.0	1.0	3.0	1.0	2.0	1.0	8.0			9.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0			0.0		
Sarcoma	% Within 62 days	▲£		100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	85.0%		83.3%		
	Total > 62 days			0.0	0.0	1.0	0.0	0.0	0.0		0.0	0.0		0.0		0.0			1.0		
	Total > 104 days			0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0		0.0		0.0			0.0		
Gynaecological	% Within 62 days	▲£	100.0%	66.7%	73.3%	69.2%	66.7%	55.0%	60.0%	57.1%	83.3%	100.0%	90.9%	100.0%	44.4%	80.0%	85.0%		66.3%		
	Total > 62 days		0.0	1.0	2.0	2.0	1.0	4.5	1.0	3.0	0.5	0.0	0.5	0.0	2.5	3.5			17.5		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	▲£	60.0%	100.0%	86.7%	81.8%	75.0%	100.0%	80.0%	100.0%	100.0%	63.6%	100.0%	78.9%	100.0%	86.9%	85.0%		83.9%		RC
	Total > 62 days		2.0	0.0	1.0	1.0	2.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	0.0	4.0			10.0		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0			1.0		
Haematological	% Within 62 days	▲£	80.0%	100.0%	100.0%		100.0%	50.0%		75.0%	57.1%	100.0%	37.5%	37.5%	100.0%	50.0%	85.0%		77.9%		
	Total > 62 days		1.0	0.0	0.0		0.0	3.0		1.0	3.0	0.0	5.0	5.0	0.0	13.0			8.0		
	Total > 104 days		1.0	0.0	0.0		0.0	0.0		0.0	1.0	0.0	1.0	2.0	0.0	4.0			1.0		
Skin	% Within 62 days	▲£	100.0%	92.1%	92.4%	93.9%	100.0%	96.8%	86.0%	94.6%	92.9%	89.3%	92.8%	100.0%	97.1%	94.8%	85.0%		93.6%		
	Total > 62 days		0.0	3.0	3.0	2.0	0.0	1.0	4.0	2.5	2.5	3.0	3.0	0.0	1.0	9.5			25.5		
	Total > 104 days		0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	1.0			3.0		
Unknown	% Within 62 days	▲£	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	80.0%			50.0%		100.0%	75.0%	85.0%		92.3%		
	Total > 62 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5			1.0		0.0	1.0			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5			0.0		0.0	0.0			0.5		
All Tumour Sites	% Within 62 days	▲£	96.1%	92.3%	86.2%	85.8%	85.2%	90.4%	85.3%	82.0%	86.1%	85.5%	85.7%	86.2%	85.6%	85.8%	85.0%		86.7%		
	Total > 62 days		3.0	6.0	11.0	15.0	13.5	9.0	14.5	14.5	12.5	14.5	16.0	13.5	14.5	71.0			137.5		
	Total > 104 days		0.0	4.0	0.5	1.5	3.0	0.0	1.0	3.0	2.0	1.0	1.0	4.0	3.0	11.0			23.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%			100.0%		100.0%	100.0%	85.0%		100.0%		
	Total > 31 days		0.0		0.0		0.0	0.0	0.0	0.0			0.0		0.0	0.0			0.0		
	Total > 104 days		0.0		0.0		0.0	0.0	0.0	0.0			0.0		0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)066
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during September 2021. There were five Executive Committee meetings held during this period. The new investment decisions made were: 1. Medical Bed Capacity – revenue costs for pay and non-pay costs to open a winter escalation ward. 2. Emergency Department Same Day Emergency Care – Winter Plan 3. 2021/22 Pay Award – transitional sick pay over payments right off The Executive Committee discussed the COVID-19 pandemic and its impact on the Trust. The Committee also considered regular assurance reports covering; Risk Management Council and Corporate Risk Register, and the integrated performance report.
Trust objectives met or risks addressed: All 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: 27th October 2021

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were seven Executive Committee meetings in September 2021.

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

2. 2nd September 2021

2.1 Medical Bed Capacity

The Director of Operations and Performance introduced the follow up paper that had been requested in July detailing the staffing requirements for the medical escalation ward (1A) for winter 2021/22. The total revenue costs (pay and non-pay) to open the ward from 1st November until 31st March 2022 was £1.8m based on an acute medical ward patient acuity levels. The Executive Committee formally approved the allocation of these funds as part of the Trust winter plan. It was agreed that alternative and innovative staffing models may need to be explored if the recruitment to band 5 nursing posts was not successful.

2.2 Trust Board Agenda

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

2.3 COVID-19 Issues

The Director of Integration presented the latest published information about the incidence of COVID-19. This demonstrated a significant spike in cases in Scotland in the fortnight after children had returned to school. Any similar impact would be seen in England by mid-September, because of the differences in term dates. Locally the population incidence was reported to be relatively stable but still above the national average. The vaccination programme continued and 95% of all people over 75 had received both doses. There had been a slight increase in hospital admissions at the Trust, but this had reduced since the latest published data.

The Director of Nursing, Midwifery and Governance discussed the proposed new guidance to risk assess staff required to self-isolate and was working with the other Directors of Nursing across Cheshire and Merseyside to agree a consistent approach. If implemented this would reduce the impact of self-isolation on staff absence, which was currently a significant pressure. Committee members discussed in detail the action being taken to maintain safe staffing levels and the number of patients who needed 1 to 1 care. A review of the recruitment process for bank staff was in progress and the bank rates of pay were also being compared to other local Trusts.

The Director of Nursing, Midwifery and Governance reported that there were currently 5 active nosocomial outbreaks being managed which would all be closed in September (28

days after the last case) and there had been 3 nosocomial cases reported in the previous 7 days (2 probable hospital onset and 1 definite hospital onset). The overall nosocomial rate since 1st April was 2.8%.

2.4 Strategic Issues

The Chief Executive reported that the Agreement for Long Term Collaboration with Southport and Ormskirk Hospital NHS Trust had been signed by the two Trusts and NHSE/I on 1st September and would formally come into effect on 20th September.

It was also reported that Dr Rani Thind had been appointed as a new Associate Non-Executive Director to join the Board.

3. 9th September 2021

3.1 Pressure Ulcer Review

The Director of Nursing, Midwifery and Governance introduced a report which reviewed the incidence of pressure ulcers in quarter (Q)1 of 2021/22. The terms "lapses in care" and "no lapses in care" had replaced the terms avoidable and unavoidable in relation to causation. The committee agreed that because of the impact of the pandemic in 2020/21 the baseline year for comparing improvements in performance should be 2019/20 for all the quality key performance indicators. For pressure ulcers the standardised classification methodology needed to be used to reliably compare between years. In Q1 2021/22 there had been 22 category 2 or above pressure ulcers reported of which 19 had completed the investigation process. This had found that 6 of the pressure ulcers were due to lapses in care at the Trust and 13 were classed as no lapses in care and could not have been prevented. The actions being taken to raise awareness and ensure compliance with the risk assessment requirements were also discussed and it was agreed that a reminder should be included in the Careflow EPR to ensure that reviews were not missed when a patient's circumstances changed.

3.2 Bank Staff Pay

The Executive Committee reviewed the available evidence in relation to differential rates of pay being offered by different Trusts across Cheshire and Merseyside for both junior doctors and nurses. It was noted that because of the current staffing shortages the pay rates were being escalated by some Trusts to try and secure the staff they needed to maintain safe standards of care. The ICS Director of HR was working with the Chief Executive Forum to gather information of different escalated pay rates with a view to the local Trusts agreeing a standardised approach.

3.3 Clinical and Quality Strategy

The Medical Director presented a draft Clinical and Quality Strategy for 2021/22, reflecting that the level of change across the system meant it was not currently possible to agree a longer term strategy. The main focus of the draft was elective recovery, and the committee felt this scope should be widened to include responding to the urgent and emergency care pressures. Directors provided comments and feedback on the draft

which would be incorporated before the strategy was presented to the Quality Committee in September.

3.4 Agenda For Change (AFC) pay progression

The Deputy CEO/Director of HR recommended that automatic incremental pay progression continue for AFC staff in 2021/22 unless they were subject to formal disciplinary action. The proposal was approved recognising the pressures on management capacity to complete appraisals and that many staff had been redeployed to other areas during the year.

3.5 COVID-19 Issues

The Director of Integration presented the latest COVID-19 information. There had been a spike in cases in Halton which may have been linked to the Creamfields Music Festival. All local boroughs remained at about the national average for incidence per 100k population. Hospital admissions were higher, but it was noted that in many cases COVID-19 was not the primary reason for admission.

The Director of Operations and Performance reported from Gold Command that Health Work and Wellbeing were experiencing an increase in referrals for stress, anxiety and depression. The committee acknowledged that the impact of the pandemic and its aftermath continued to take a toll on staff. Gold Command had also reviewed visiting restrictions to see if they could be relaxed and had considered aspects of the Infection Prevention Control guidance to see if changes could improve productivity in theatres. The Executive Committee remained concerned about the recent spike in cases in Scotland and the increasing cases locally and agreed that all current restrictions should remain in place and be reviewed again in a few weeks.

3.6 Change of name – Neonatal Unit

The Director of Nursing, Midwifery and Governance explained that the Special Care Baby Unit (SCBU) had requested to be known as the Neonatal Unit to bring them in line with other similar units across Cheshire and Merseyside. This change was supported.

3.7 Southport and Ormskirk Hospital NHS Trust (S&O)

The Director of Corporate Services explained that S&O had provided a number of handover documents ahead of the commencement of the Agreement for Long Term Collaboration. It was agreed that each director would review the documents relevant to their portfolio and share a summary with the rest of the executive team.

4. 16th September 2021

4.1 Urgent and Emergency Care Capacity – Emergency Department Same Day Emergency Care (SDEC)

The Director of Operations and Performance introduced the paper which presented proposals to optimise the capacity of the Emergency Department SDEC unit. This alongside the additional bed capacity being created by the winter escalation ward (Ward 1A) would improve patient flow during winter 2021/22. Optimising SDEC would result in

fewer admissions and higher turnover of patients through the unit which in turn would reduce congestion in the Emergency Department (ED). The proposal was to temporarily increase nursing and HCA staff in the ED SDEC unit and also to permanently recruit a further part time Paediatric ED consultant (PEM) to increase the resilience in this area. The total non-recurring cost (6 months) was £332k and the recurring cost was £65k. The proposals were approved as part of the Trust's winter plan.

4.2 Falls Review

The committee received the presentation on falls and the actions being taken to prevent falls that had been requested by the Quality Committee. The presentation included a review of falls performance for the previous 3 years and quarter 1 for 2021/22. This included an analysis of the reasons for falls and where they occurred, and detail of the actions being taken to implement the falls prevention strategy. The number of falls resulting in moderate and severe harm had increased during 2020/21. The impact of the pandemic e.g., PPE requirements and staff being redeployed were felt to have been contributory factors as was the absence of visitors who could support patients at high risk of a fall. Public Health England research also showed that the national lockdowns had resulted in some older frail patients having a higher risk of falling. The Trust action plan had 30 actions in total, 15 had been completed and 15 were in progress. Similar to pressure ulcers it was agreed that a flag should be developed in the Careflow EPR to remind staff to undertake and review falls risk assessments. The Executive Committee made some suggestions to increase the assurance information in the presentation.

4.3 Weekly Overtime Payments Proposal

The Deputy CEO/Director of HR introduced a proposal that would enable staff who worked overtime to draw down this pay ahead of the monthly pay dates. Feedback from staff had indicated that not being able to access overtime pay on a weekly basis was a deterrent to taking additional shifts for some staff as it was different to working on the bank or for an agency. Running a weekly payroll service for these staff was complex and uneconomic but the proposal set out an alternative that would enable individuals to access these funds ahead of the monthly pay dates, for a small fee. The provider of the service was called Wage Stream and was already being used by several other local Trusts. The Executive Committee wanted to gain a better understanding of how the system would operate and any unintended consequences, so approved an initial trial with specific staff groups to evaluate the impact.

4.4 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2020/21 Reports

The Deputy CEO/Director of HR presented the WRES and WDES reports for 2020/21 and the proposed action plans. These reports were to be presented to the Board in September ahead of the national publication deadline.

4.5 Gender Pay Gap report 2020/21

The Deputy CEO/Director of HR presented the annual Gender Pay Gap information for the Trust and the actions that were being undertaken to better understand the differences in hourly pay. It was noted the gap had slightly reduced for both Medical and Dental and

Agenda for Change staff. This report would also be presented to the Trust Board in September ahead of the publication deadline.

4.6 Pay award 2021/22 – interaction with transitional sick pay

The Deputy CEO/Director of HR explained that the delayed 2021/22 pay award announcement had impacted upon some lower paid staff. Those staff that had retrospectively breached the earnings thresholds to receive pay enhancements as part of their sick pay calculations during any periods of COVID-19 related sickness absence between 1st April 2021 and 31st August 2021. As a result, a small number of staff had received payments to which they were no longer entitled. The Cheshire and Merseyside HR Directors network had recommended that these overpayments were not recovered. The financial impact for the Trust was circa £2k. The Executive Committee approved the recommendation not to recover overpayments resulting from the pay award.

4.7 Integrated Performance Report (IPR) – August 2021

The Director of Finance and Information presented the IPR for review and agreed the narrative commentary. It was noted that the Business Information Team were looking into the weekend HSMR figures, but these remained within the expected range.

4.8 Southport and Ormskirk Hospital NHS Trust (S&O)

Members agreed that they would dedicate an entire Executive Committee meeting on 14th October to reviewing the handover documents from S&O and understanding the risks and opportunities in relation to the fragile services.

5. 23rd September 2021

5.1 Digital Collaboration

The Director of Informatics presented a proposal to establish a Digital Collaboration Group with Warrington and Halton NHSFT to explore opportunities for aligning digital strategies. The proposal was approved.

5.2 Safer Staffing Report

The committee received the monthly safer staffing report for August. This showed the overall Registered Nurse/Midwife (RN) fill rate of 90.8% and HCA fill rate of 104.3%. Members reflected that this was an average across the month but acknowledged that there had been times during August when there had been significant challenges due to the levels of staff absence.

The in-depth analysis of the July safer staffing position showed there were wards with RN staffing below 90% of planned and explored the reasons for this. It was noted that during July the bank fill rate had been 73% of RN requests and 45% of HCA requests, with agencies fulfilling 23% of shifts requested. It was agreed that for wards where beds were closed the required staffing should be amended to give an accurate picture of the requirement. No patient harms were reported at times when staffing was below the planned levels.

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

The Director of Corporate Services presented the monthly risk register report for August. Due to operational pressures the RMC meeting had been cancelled but the meeting pack had been produced and circulated. There were 715 risks reported on the risk register of which 21 were escalated to the CRR. One high risk had been downgraded in August (staffing for the Mass Vaccination Site) and one new high risk had been escalated to the CRR (availability of staff to meet the demand for 1 to 1 supplementary care). The RMC had also received the Chair's assurance report from the Claims Governance Group.

5.4 Capital Programme Update

The Director of Finance and Information presented an update on the 2021/22 capital programme. The Director of Corporate Services presented a progress report against the approved strategic estates schemes.

5.4 COVID Issues

Expenditure requests to extend; the employment of social distancing wardens across the Trust, free access to TV for patients and COVID-19 enhanced cleaning were approved.

The Committee reviewed the Government consultation on mandatory COVID-19 and flu vaccination of NHS Staff. The risk of increasing operational pressures was acknowledged, as had been seen in the social care sector.

5.5 Winter System Review

The Director of Operations and Performance confirmed that the Trust had been selected by NHSE/I for a winter system review. This would take place in the next few weeks and test the integration and collaboration across the local system to respond to winter pressures.

6. 30th September 2021

6.1 Digital Aspirant Programme (DAP) Quarterly Progress Report

The Director of Integration presented the latest quarterly report which gave assurance that the DAP remained on course to deliver Healthcare Information and Management Systems Society (HIMSS) level 5 by 2023. The relationship between the DAP and the new digital maturity index was explored. It was agreed that there should be wider communication about the programme and the prioritisation of developments to the electronic patient record systems.

6.2 Cheshire and Merseyside Allied Health Professional (AHP) Faculty

The Director of Operations and Performance introduced the paper which provided an update on the AHP Faculty which had been established in February 2020. Funding has been received from Health Education England to support and deliver a collective approach to workforce initiatives, by increasing placement capacity, supporting continuing professional development (CPD), developing Advanced Clinical Practice (ACP) roles, building partnerships with education providers and addressing other local training and education priorities.

Despite the challenges of the pandemic the faculty had achieved a number of successes and been awarded further funding to help secure the future supply of AHPs. The Executive Committee congratulated the team on their achievements and commended the approach which had created a community of practice with the aim of taking forward the potential of the combined AHP disciplines.

6.3 Patchwork Business Case – Benefits Realisation Report

The Deputy CEO/Director of HR introduced the report which reviewed the success of the implementation of Patchwork – which is software that enables the Trust to manage end to end temporary staffing requirements. The original business case to introduce Patchwork had been approved in July 2020 although implementation had been disrupted by the pandemic. The Patchwork roll out for medical staff in Cheshire and Merseyside had been completed in August 2021 and had resulted in a 147% increase of staff registered with the Medical Staff Bank, a reduction in requests for agency staff and a reduction in the requests for escalated rates and improved controls and reporting. The Trust would continue working with Patchwork and the collaborative bank across Cheshire and Merseyside to maximise the benefits of the system. The Executive Committee thanked the HR Recruitment Team for their hard work and success with the system.

6.4 Staff Survey 2020 – Action Plan

The Deputy CEO/Director of HR presented a progress report on the delivery of the 2020 staff survey action plan and the quarterly pulse surveys which had replaced the staff friends and family tests. The 2021 staff survey was also about to be launched and members were reminded that this year all staff were being given the opportunity to respond to the survey rather than a representative sample of staff. It was agreed that further analysis of the trends on the quarterly surveys locally and nationally compared to the annual staff survey results would be undertaken.

6.5 COVID-19 Issues

The Director of Integration reported that local population incidence rates remained relatively high, but hospital admissions at the Trust had stabilised. The surge of cases generated by children returning to school appeared to have passed and had not been as extreme in England as it had been in Scotland.

The Director of Operations and Performance reported that new Infection Prevention and Control (IPC) guidance had been published and had been considered by Gold Command. The committee agreed to assess the potential impact on elective productivity of relaxing some of the IPC rules and review this against the risk of an increase in hospital acquired infections. The first areas to be reviewed would be outpatients and theatres.

6.6 H2 Planning Guidance

The Director of Finance and Information provided an overview of the national H2 planning guidance which had been published and discussed the implications for the 2nd half of the financial year.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)067
Reporting from: Audit Committee
Date of Committee/Council Meeting: 13 October 2021
Reporting to: Trust Board
Attendance: Ian Clayton (Chair), Jeff Kozer, Gill Brown.
Matters discussed • **Losses and Special Payments** – report was discussed and accepted.
Assurance provided <u>External audit</u> • **Auditor's Annual Report 2020-21** – Grant Thornton UK LLP (GT) presented their new-format report – for publication. The report's focus is the Trust's Value for Money Conclusion. *No significant weaknesses were identified.* • **Certificate of Audit Closure** – this would not ordinarily be presented separately; this reflects the extraordinary 2020-21 timetable. *There were no matters arising.* <u>Internal audit</u> • **Progress Report** – MIAA outlined delivery to date of the 2021/22 internal audit plan, including two finalised reports – *Patient Discharge* [moderate assurance] and *Bank and Agency (Temporary Workforce)* [substantial assurance]. • **Follow up Report** – the Committee was pleased to note that eight reports' actions were now satisfactorily concluded, with progress made on the remaining three. <u>Anti-fraud</u> • **Anti-fraud Progress Report** – the Trust's Anti-Fraud Specialist presented an update, which was discussed and accepted. There are no substantial concerns around planned delivery in 2021-22. <u>Standing items</u> • **Audit Log –** the Trust's internal summary of progress in implementing MIAA recommendations was discussed and accepted. • **Aged Debt –** the Trust's M6 'over 90 day' debt balance is £7.8m, which is

significantly lower than in previous years. Recent progress with the individually largest invoices was noted. • **Tender and Quotation Waivers** – the Head of Procurement's assurance paper was noted.
Decisions taken None.
Risks identified and action taken None.
Matters for escalation None.
Recommendation None.
Committee Chair: Ian Clayton

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)068
Reporting from: Quality Committee
Date of Committee Meeting: 19th September 2021
Reporting to: Trust Board
Attendance: Gill Brown, Non-Executive Director (Chair) Val Davies, Non-Executive Director Rani Thind, Non-Executive Director Sue Redfern, Director of Nursing, Midwifery and Governance Rowan Pritchard-Jones, Medical Director Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Debbie Stanway, Head of Nursing and Quality, Medical Care Group Tracy Greenwood, Head of Nursing and Quality, Surgical Care Group Jacqui Scott, Head of Nursing and Quality, Community and Primary Care Group **In Attendance:** Rajesh Karimbath, Assistant Director of Patient Safety Anne Rosbotham-Williams, Deputy Director of Governance Sue Orchard, Head of Midwifery (agenda item 15) Susan Norbury, Assistant Director of Safeguarding (agenda item 11) Adam Rudduck, Assistant Director of Organisational Development (agenda item 18)
Matters Discussed: • The use of eNEWS as part of the deteriorating patient pathway project and the need to ensure the system is used to optimal benefit in improving patient safety was discussed. • **Integrated Performance Report** highlighting: o No never events, falls leading to severe harm or above, category 3 pressure ulcers due to lapses in care or MRSA bacteraemia in month. o 9 C. Difficile infections reported, 37 year-to-date against an annual threshold of 54. Three have been successfully appealed and 3 further appeals are ready to be submitted. Noted that there was good clinical engagement across the Care Groups, with focus on supporting wards with training and infection prevention summit/antibiotic awareness week planned. o Safer staffing fill rate of 88.5% in September, noting the ongoing challenges including the number of patients requiring supplementary care (including 1-1 nursing). o All thrombolytic events are being reviewed with no concerns identified to date o HSMR year to date of 95.8, noting weekend rate of 121.5, which remains within expected range (84-165) and continues to be closely monitored.

- 62 and 31 day cancer targets were met again this month, with work ongoing to achieve all targets.
- New requirement to submit date of staging for cancer patients has impacted on data accuracy, with actions being taken to improve the position.
- Urgent and emergency care targets remain challenging, with increased attendances at both Whiston and Urgent Treatment Centre (UTC). Noted that the UTC saw 99% of patients within 4 hours, which was commended. Work continues to divert appropriate patients from ED to primary care and the UTC.
- Very positive feedback received from NHSE/I following their review of the Trust in early October, with no negative feedback received on the work the Trust is doing to manage the current challenges and in its winter plans.
- A review of capacity and requirement for additional equipment and training is being undertaken in community services to increase the number/types of patients that can be treated out of hospital.
- A review of super stranded patients indicated the high acuity of many of the patients, who had ongoing needs for acute care.
- Focus continues on improving sickness absence, mandatory training and appraisal rates.

- **Clinical Effectiveness Council report** noted the presentations received from rheumatology, obstetrics & gynaecology and anaesthetics. The increase in anaesthetic cover was discussed by the Committee. The report listed the items discussed, including non-medical prescribing, development of the Acute Abdomen Pathway, critical care audit data and Quality Improvement/Clinical Audit report. The Committee noted the ongoing work to increase Orthogeriatrician input to further improve outcomes for fractured neck of femur patients.
- **6 monthly Clinical Audit Plan report** was discussed and the Committee was pleased to note the volume of audit activity that has continued with 259 audits completed and 97% compliance with the audit plan. Staff were commended for achieving this during the current challenges.
- **Patient Experience Council report** noted the following:
  - Slight improvement in complaint response times.
  - Volunteers' report highlighting the re-training and re-introduction of the volunteers to support patient mealtimes, successful university placements/ employment opportunities gained by a number of volunteers and launch of Pharmacy Responders to collect critical medications for patients.
  - Extension of information ward rounds to non-cancer wards.
  - Reports were received from the Bereavement Group and Cancer Patient Experience and Quality Assurance Group.
- **Complaints, PALS, Claims and FFT report** noted the following:
  - Additional resources that are being targeted to reduce the number of open complaints and improve response times.
  - The Parliamentary and Health Service Ombudsman has opened one investigation into a former complaint.
  - A number of actions taken as a result of complaints were included in the report. It was confirmed that all complaints, whether written or verbal are managed in the same way.
  - Four NHS Resolution instructed claims have been received, with a higher number of pre-action claims received. The Legal Services Team continue to provide support to manage inquests.
  - Inpatient Friends and Family Test recommendation rates remain above target, however a number of negative comments in the ED FFT responses relate to long waits in the department.

The Committee discussed the value of the family liaison role in keeping families updated about the patients' conditions and were informed that further work is being undertaken to look at increasing ward administrator hours to support clinical areas. It was suggested that consideration be given to creating a bespoke role to undertake this, noting the positive impact this had had previously.

- **Patient Safety Council report** highlighted the following:
  - Actions being taken to reduce the number of extravasation incidents.
  - Learning identified following review of serious incidents.
  - Reduced incidence of pressure ulcers.
  - Good compliance with controlled drug storage.
  - Reports from the Care Group reports were reviewed.

  The Committee received assurance that the number of incidents relating to maternity staffing had decreased, noting that the Birth Rate plus staffing review is ongoing.
- **Maternity Services Divert report** provided information for the Committee on 12 occasions noting the rationale for each divert/closure and that there were no incidents of harm following the closures. The Committee received assurance that staffing are deployed across the unit to manage any peaks in activity and noted a number of newly recruited midwives have commenced in post. The outcome of the maternity staffing review, which factors in the acuity of the women using the service, will inform future staffing requirements as part of the future direction.
- **Safeguarding Quarters 1 &2 report** highlighted the ongoing high levels of activity within safeguarding and learning disabilities, with further increases in Deprivation of Liberty Safeguard applications. Concerns were raised relating to the delayed release of the code of practice for implementing Liberty Protection Safeguards that are due to replace DoLS next April, however NHSE are due to release national training that will support this. The focus in the coming weeks will continue to be on increasing compliance with mandatory training and continued advice and support for clinical staff.
- **Medicines Management Audit report** highlighted improvements in compliance with storage audits, noting the benefits of using the Perfect Ward audit application for immediate results.
- **Serious incident thematic review** indicated the reasons for the increase in StEIS reportable incidents, noting the following contributed to this:
  - A number identified through the structured judgement process as part of the Trust's mortality reviews and learning from deaths framework.
  - Maternity Health Service Investigation Bureau (HSIB) cases.
  - Falls resulting in fractured neck of femur.
  - Cancer pathway incidents.
  - Laparotomy pathway incidents.

  A number of actions are being taken as a result of the investigations, including strengthening of the acute surgical patient pathway. Confirmation was provided that there are daily huddles to review patients, which are also good opportunities for learning.

  The Committee discussed the challenges in being able to provide the high number of supplementary care staff required for patients at risk of falling and the work that is being undertaken to recruit additional staff, as well as the use of protective equipment where suitable. The establishment reviews that have recently been completed have identified the additional requirements for supplementary care.
- **Infection Prevention Annual report** The Committee noted the report which outlined the processes in place for 2020-21 to maintain compliance with legal

requirements, noting the number of infections and outbreaks reported last year. The report included the forward plan for 2021-22. The report will be presented to the Board for approval.

- **Safer Staffing quarterly report** noted the continued work to deploy staff as effectively as possible across the Trust with detail provided where staffing levels fell below 85% to identify any related incidents. It was agreed to bring the report monthly going forward.
- **Mandatory Training report** included details on compliance with core skills, noting the actions being taken by the subject matter experts to improve training rates following the dip in performance due to operational pressures during the pandemic.
- **CQC insight report** highlighted that there had been an improvement with 22 indicators that were flagged in the previous report. There were 10 indicators with detailed action plans that are being monitored by the Executive Committee.

Assurance Provided:

- Regular review and redeployment of maternity staff across the whole unit to ensure optimal safety, with consistent application of regional escalation procedure when the decision to divert/close the unit is made.
- Continued increase in DoLS applications.
- Excellent progress with annual clinical audit programme.
- Increased compliance with medication security audits.

Decisions Taken:

No formal approvals were required.

Risks identified and action taken: The Committee requested the following actions be taken:

- Review of maternity staff safeguarding training dates to determine if these could be brought forward.
- Additional information and assurance relating to needle stick injuries noted in the Infection Prevention Annual Report.

Matters for escalation: None

Recommendation(s): That the Board note the report, the assurances provided and the actions being taken to address areas of concern.

Committee Chair: Gill Brown, Non-Executive Director

Date of Meeting: 27th October 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)069

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 21st Oct 2021

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton - NED
P Growney - NED
G Lawrence – Deputy Director of Finance & Information
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
R Pritchard Jones – Medical Director
A Bassi – Divisional Medical Director
A Matson – Assistant Director of Finance – Financial Management
P Nee - Assistant Director of Operations – Surgical Care
P Morgan – Senior Management Accountant – Surgical Care

Agenda Items

For Assurance

A) Integrated Performance Report

- Target 62 day and 31 day performance was met in August, at 85.6% and 98.2% respectively.
- Target 2 week wait cancer performance was not achieved in August, with delivery of 92.3% against a target of 93% due to the ongoing impact of the pandemic. This represents an improvement against July's performance which was 91.1%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 54.5% in September and 58.7% year to date. The all type mapped STHK Trust footprint performance was 77.6% in September and is 78.5% year to date. The Trust saw average daily attendances of 338, which an increase compared to August at 317. Total attendances for September 2021 were 10,130.
- The ambulance turnaround time target was not achieved in September, at 39 minutes on average. The Trust was the busiest in C&M and third busiest across the North West.
- In September, overall sickness remained at the August level of 6.7%. Front line Nursing, Midwifery and HCA sickness was 8.9% which is a decrease of 0.2% since August.
- The committee is assured that plans are in progress to address underachievement of appraisal and mandatory training compliance.

B) Finance Report Month 6

- The Trust has reported a breakeven position for H1, with £257m expenditure matched by income.
- System support funding was received in H1 to contribute towards addressing the deficit resulting from the changes to ERF thresholds, enabling delivery of a breakeven position.
- The system CIP requirement of £3.8m for H1 has been achieved recurrently.

- As at Month 6, the Trust has a cash balance of £62m and is achieving 98% Better Payment Practice Code (BPPC) performance against the 95% national target.

C) Benchmarking/GIRFT Update

- The 2021/22 benchmarking workplan includes 21 projects, the majority of which are coordinated by NHSE/I or the NHS Benchmarking Network.
- These cover a range of clinical and corporate areas, allowing for comparison of key metrics and financial information across NHS organisations in order to identify areas of opportunity for efficiencies and to support value for money assessments.
- Of the 21 NHSE/I and NHS Benchmarking Network projects on the workplan, 13 submissions have been made (with national reports and feedback yet to be received) and eight have initial submission dates later in the year.
- In addition to these, the Trust is engaging with the GIRFT programme. Visits from the GIRFT team have taken place. Recommendations and associated action plans resulting from these visits will be reported to the committee within future updates.
- The committee is assured that the Trust is progressing plans to participate in and learn from benchmarking opportunities.

D) HR Commercial Finance Report

- The committee reviewed the current commercial activities undertaken by the Trust.

For Approval/Escalation

E) H2 2021/22 Financial Plan

- Applying national guidance, the Trust's planned expenditure for H2 is £259.7m.
- This is based on H1 actual expenditure of £257m adjusted for known changes in the second half of the year, including winter pressures and transfer of the Widnes UTC and Bridgewater maternity services. Winter pressures are the only additional costs in H2 not currently backed by additional income.
- The draft H2 plan assumes delivery of 2.35% CIP in H2 (1.53% delivered in H1 plus an additional national efficiency requirement of 0.82%).
- H2 Elective Recovery Fund (ERF) income is dependent on the performance of all providers within the C&M system. The final mechanism for Trust allocations has not yet been finalised at system level.
- The Trust's H2 income allocation has not yet been finalised with the ICS. The draft H2 plan is therefore subject to change, dependant on final allocations.
- The committee recommends approval by the Board of the H2 2021/22 expenditure plan. The committee approved to delegate the final submission sign off to the Chief Executive and the Director of Finance given the current unknowns around the clinical income.

F) 2021/22 Capital Programme Assurance

- The committee is assured that the Trust will deliver its 2021/22 £9.0m forecast against the C&M ICS capital expenditure limit. This excludes DHSC Public Dividend Capital (PDC) funded schemes and PFI lifecycle expenditure.

For Information

G) Surgical Care CIP Presentation

- The care group currently have £1.3m CIP schemes identified against their 2021/22 CIP target of £4m. £0.8m is identified recurrently in relation to these schemes.
- £1.9m additional scheme ideas are in work up for 22/23 and recurrently.
- Focus remains on productivity – currently Theatres are performing 2.3 procedures per list compared to 2.66 per list pre-Covid-19, due to an increase in more complex procedures and the effects of IPC requirements which have now been relaxed to remove patient self-isolation.

CIP Programme Update – Update noted by committee
CIP Council Update – Update noted by committee
Capital Planning Council Update – Update noted by committee

Risks noted/items to be raised at Board

N/A

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: 26th October 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)076

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 21st October 2021.

Summary

1. Action Log: FOR INFORMATION
   - Items actioned - Liaising with the consultant around Breast Care Equipment Fund and contacting Knowsley Foundation to discuss potential funding.
   - Still to be finalised – Committee members review. Discussion about inviting clinical staff to the meetings to broaden knowledge of the Charity from all sides.

2. Financial position: FOR INFORMATION
   - The Committee noted the level of investments and recent income and expenditure.
   - Discussions on the ongoing effects of COVID on donations and fundraising and how this has been and is being addressed.
   - Discussed and noted that there are sufficient funds to accommodate current downturns in income.

3. Approval of expenditure: FOR DECISION
   - Wellbeing Sessions for staff £3.9k. Approved.
   - Review of Lilac Centre Complimentary Therapy and Counselling Services to make it equitable for all providers. Approved.

4. Fundraising update: FOR INFORMATION
   - The Committee were informed of continued attempts to raise the profile of the Charity to encourage fundraising outside of the Trust because of limited opportunities internally due to the ongoing COVID situation.

5. Other business: FOR DECISION
   - The Annual Report and Accounts 2020-21 was approved by the Committee on behalf of the Trust Board, subject to the independent examiner's report completed by MHA Moore and Smalley.
   - The Committee agreed up to £10.00 per patient to be spent on Christmas gifts. Discussions to be had as to how to enhance patients' experience over Christmas if present visiting arrangements are still in place.
   - The Committee gave approval of the Charitable Funds procedure documents that have had their 3 year review.

Risks noted / items to be raised at Board

The Board is asked to ratify the approval of the Annual Report and Accounts 2020-21, via a separate paper presented to this meeting of the Trust Board.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Paul Growney, Chair, Charitable Funds Committee

Date of meeting: 27th October 2021

Trust Board

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(21)070
Title of paper: Review of the Board Assurance Framework (BAF) – October 2021
Purpose: For the Executive Committee to review and agree any changes to the BAF to be presented to the Trust Board.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in July 2021. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Risk Scores - changes** It is proposed the score of risk 4 is increased to a score of 12 reflecting the additional challenges facing the Trust in delivering the Southport and Ormskirk Hospital NHST Agreement for Long Term Collaboration.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSE/I, CQC, Commissioners.
Recommendation(s): To review the BAF and approve the changes.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 27th October 2021

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2021/22 Objectives and Long Term Strategic Aims

2021/22 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Objective supports this aim		Change from previous year		New for this year	

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Risk 1 – Systemic failures in the quality of care	Initial Risk Score	Key Controls	Sources of Assurance	Residual Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSE/I Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium	To Board; • IPR • Patient Stories • Quality Ward Rounds and COVID staff reflections • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • COVID IPC Board Assurance Framework	5 x 4 = 20	~~Implementation of the improvement plan longer term solutions to ensure all patients whose treatment has been suspended are monitored and receive timely follow up (September 2021~~)	Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, inquests and mortality reviews Development of the 2020 – 2023 Nursing Strategy – currently subject to consultation (Revised to November 2021 for Board approval) Development of ward quality accreditation tool and real time quality dashboard (Perfect Ward) (Revised to November 2021) Reduce hospital acquired AKI (March 2022)	Review of patient information to improve accessibility and understanding (March 2022) Delivery of never event improvement plans and human factors training (May 2022) ~~Deliver the Ockenden 1st stage report action plan (September 2021)~~ Complete and provide assurance of compliance with all Ockenden actions – March 2022 ~~Pressure Ulcer review to be presented to Quality Committee (July 2021)~~ Deteriorating patient improvement project (January 2022) Development of the 2020 patient survey action plans (January 2022)	5 x 1 = 5	R P-J/ SR

Risk 2 —Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSE/I monthly reporting • Contract Monitoring Board • NHSE/I Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board • COVID-19 exceptional expenditure financial governance process	4 x 4= 16	Continue collaboration across C&M to deliver transformational CIP contribution Reporting of management plans to deliver GiRFT recommendations to the F&P Committee	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances	Seek all possible sources of capital funding including national bids to support capacity planning (Ongoing) ~~Deliver the financial and activity plan agreed with C&M ICS for the first 6 months of 2021/22 (October 2021)~~ Conclude H2 income allocation – September 2021 Submit H2 financial plans – November 2021 Deliver the financial and activity plan agreed with C&M ICS for the second 6 months of 2021/22 (April 2022)	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool • COVID-19 EPRR operational command and control structure in place	4 x 5=20	Implementation of routine capacity and demand modelling	Sustain the changes to the discharge process achieved during COVID-19 to maintain effective patient flow for winter 2021/22 and beyond COVID-19 and restoration escalation plans to release capacity and trigger mutual aid in place and operational.	Implement new contractual arrangements for Widnes UTC (Revised to August 2021) ~~Develop a urgent and emergency care improvement / winter plan with system partners for 2021/22 to cope with increasing demand (September 2021)~~ Clinical triage and prioritisation of patient elective waiting lists where treatment was delayed due to COVID (ongoing) Achievement of the elective activity recovery trajectories agreed with C&M ICS (March 2022) Implement the new emergency care and cancer national performance standards and incorporate into the new IPR (January 2022) ~~Implementation of a Community Diagnostic Hub at St Helens Hospital (September 2021)~~ Implement winter and patient flow improvement plans (February 2022)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • IPR • Staff Survey • COVID pandemic reflections staff feedback • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSE/I Segmentation Rating	~~4 x 2 = 8~~ 4 x 3 = 12	Regular media activity reports , including social media, to the Executive Committee	Establishment of a Strategic Workforce Committee of the Board (Revised to November 2021)	~~Finalise and~~ Implement the 2020 staff survey action plan (March 2022) ~~Update the Trust website (Revised to May 2021)~~ Maintain COVID staff communications bulletin and pandemic staff engagement, support and recovery initiatives (On-going) Work in partnership with S&O to send provide consistent messaging and communications channels for staff and stakeholders about the ALTC (April 2023)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending StHK Board and Trust NED attending Governing Body • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care System governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSE/I Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • ~~Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract~~ • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care partnerships in these Boroughs • ~~Achievement of the integrated working CQUIN~~ • Annual staff engagement events programme • COVID -19 Command and Control structure and Hospital Cell • ED&I Delivery Group	4 x 3 = 12	Work with the local Boroughs to develop plans for Integrated Care Partnerships (ICPs) from April 2022 Effective working with the Shaping Care Together programme in Southport and Formby and West Lancashire	C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks Understanding of the performance monitoring systems that will be established under the new NHS Bill that comes into effect on 1st April 2022	Continue participation with the Collaboration at scale board and work streams (Suspended due to COVID-19) Continued engagement with C&M ICS senior leadership as part of the system response to COVID-19 and restoration and recovery. ~~Membership and participation with the 2 Provider Collaboratives for C&M ICS – including ratification of the MOU and ToR (October 2021)~~ Continue as a full partner of St Helens cares, contributing to the delivery of the improvement objectives Work with NHSE/I and other Providers to provide management support for S&O fragile services	4 x 2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCG/LNG • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career and leadership development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management Strategy	To Board; • Strategic Workforce Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – Workforce Indicators • Staff Survey • Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES , WDES and Gender Pay Gap reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan • Employee Relations Oversight Group Other • Annual workforce plans • HR benchmarking • Nurse & Midwifery staffing benchmarking • C&M HR Work Stream • COVID-19 Staff risk assessment	5 x 4 = 20	~~Implementation of emergency staffing plans and ratios in line with national guidance.~~ Equality Delivery System 2 – action plan	Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3 Capacity to deliver the recovery and restoration plans for activities suspended due to COVID-19 Attendance management COVID-19 recovery plan Establish collaborative staff bank for C&M ICS for other services e.g. Radiology, Endoscopy, vaccination programme	Staff HWWB support during and post COVID-19 – including feedback from the Ward Check-ins (On going) ~~Develop the Trust longer term Agile Working Strategy (Revised to July 2021)~~ Delivery of the NHS People Plan local action plans for 2021/22 (Revised to March 2022) C&M Lead Provider role for the COVID vaccination programme – including planned winter booster programme for staff and the 12 – 15 year old school programme (On going) Restoration of appraisal and mandatory training compliance with the 85% target (Revised to March 2022) Refresh the ED&I Strategy and Action Plan (March 2022)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning and social distancing (COVID-19) • Compliance with NHS Estates HTMs	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • PAM benchmarking • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.	Implementation of new National Standards of Cleaning (May 2022) Implementation of the national Hospital Food Review recommendations and mandatory standards Compliance with the new Protect legislation for premises security – Consultation closed in July and draft legislation not yet published Development of s strategy to achieve the NHS Net Zero targets (January 2022)	3 year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2022) ~~Estates and accommodation strategy to respond to increasing demand and new ways of working (Revised to September 2021)~~ ~~Develop theatre expansion options to support COVID recovery and restoration (May 2021)~~ ~~Complete Whiston Theatres feasibility and option appraisal (July 2021)~~ ~~Premises Assurance Model (PAM) submissions (31st July 2021)~~ Delivery of approved 2021/22 capital schemes	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M STP Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval Annual Corporate Governance Structure review Technical Development	ISO27001 Service Improvement Plans IT Communications Strategy Digital Maturity Assessment	ISO27001 (revised to March 2022 due to COVID) Medway Careflow/ DAP benefits realisation programme delivery (revised to September 2022) Implementation of IPS Intrusion Prevention System) that detects cyber-attacks within the network. 50% complete (revised to December 2021 due to global component shortage) Migration from end-of -life operating systems – 85% complete. Extended support in place for the remaining 15%, which will be migrated by January 2022. Delivery of the Digital Aspirant Programme (2020 - 2022) Delivery of Community EPR (March 2022)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)076

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 21st October 2021.

Summary

1. Action Log: FOR INFORMATION
   - Items actioned - Liaising with the consultant around Breast Care Equipment Fund and contacting Knowsley Foundation to discuss potential funding.
   - Still to be finalised – Committee members review. Discussion about inviting clinical staff to the meetings to broaden knowledge of the Charity from all sides.

2. Financial position: FOR INFORMATION
   - The Committee noted the level of investments and recent income and expenditure.
   - Discussions on the ongoing effects of COVID on donations and fundraising and how this has been and is being addressed.
   - Discussed and noted that there are sufficient funds to accommodate current downturns in income.

3. Approval of expenditure: FOR DECISION
   - Wellbeing Sessions for staff £3.9k. Approved.
   - Review of Lilac Centre Complimentary Therapy and Counselling Services to make it equitable for all providers. Approved.

4. Fundraising update: FOR INFORMATION
   - The Committee were informed of continued attempts to raise the profile of the Charity to encourage fundraising outside of the Trust because of limited opportunities internally due to the ongoing COVID situation.

5. Other business: FOR DECISION
   - The Annual Report and Accounts 2020-21 was approved by the Committee on behalf of the Trust Board, subject to the independent examiner's report completed by MHA Moore and Smalley.
   - The Committee agreed up to £10.00 per patient to be spent on Christmas gifts. Discussions to be had as to how to enhance patients' experience over Christmas if present visiting arrangements are still in place.
   - The Committee gave approval of the Charitable Funds procedure documents that have had their 3 year review.

Risks noted / items to be raised at Board

The Board is asked to ratify the approval of the Annual Report and Accounts 2020-21, via a separate paper presented to this meeting of the Trust Board.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Paul Growney, Chair, Charitable Funds Committee

Date of meeting: 27th October 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)071

Title of paper: Corporate Risk Register

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

Summary:

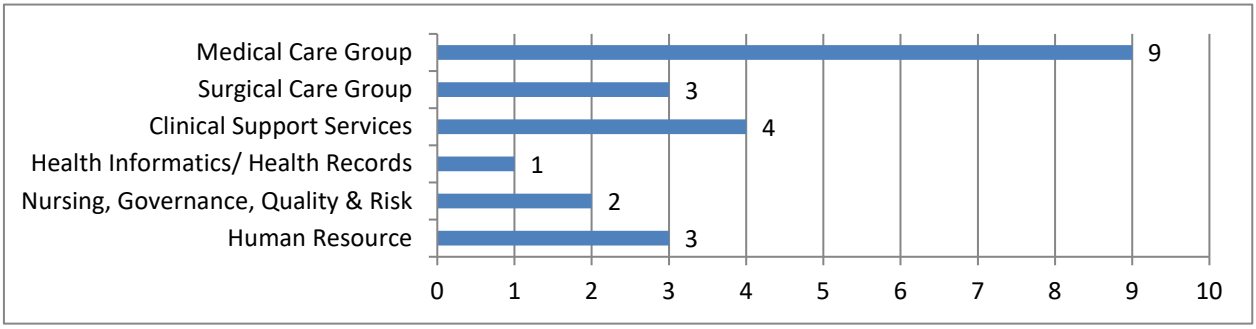
The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council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

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

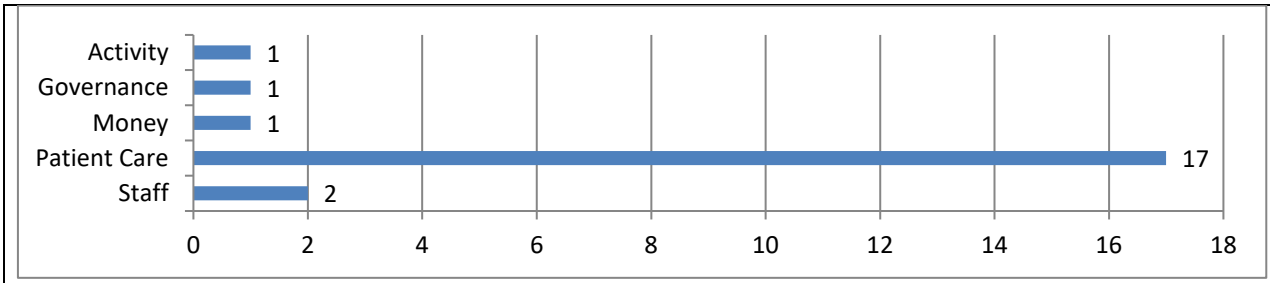
This report covers all the risks reported and reviewed until the end of September 2021 and is a snap shot, rather than a summary of the previous quarter. A comparison with the previous Board report in July 2021 is included to illustrate the movement in risks during the period. The report shows;

- The total number of risks on the risk register is 736 compared to 693 in July.
- 60% (435) of the Trusts risks are rated as moderate or high compared to 63% (439) risks in July.
- 22 risks that scored 15 or above had been escalated to the CRR (Appendix 1) which is the same number as reported in July.

The spread of CRR risks across the organisation is;



The risk categories of the CRR risks are;



The report also includes comparisons of the Trust risk profile with the previous quarterly report (July 2021) and against the same period last year – October 2020 (Appendix 2 and 3).

Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Commissioners, Regulators.

Recommendation(s): The Trust Board notes the risk profile of the Trust and the risks that have been escalated to the CRR

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 27th October 2021

CORPORATE RISK REGISTER – JULY 2021

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/10/2021	Previous Reporting Period 01/09/2021	Previous Reporting Period 01/08/2021
Number of new risks reported	30	8	38
Number of risks closed or removed	10	12	17
Number of increased risk scores	3	5	8
Number of decreased risk scores	16	5	10
Number of risks overdue for review	200	81	73
Total Number of Datix risks	**736***	**715**	**711**

*includes risks that have been reported but not yet scored in Datix as it is a live system.

The number of risks overdue for review had reduced to 73 (10%) by the time of the Risk Management Council (RMC) meeting on 12th October. The RMC periodically monitors how many risks have missed more than one planned review date and these are escalated to the Care Group Heads of Nursing and Quality.

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**25**	**14**	**81**	**8**	**139**	**64**	**169**	**35**	**145**	**8**	**7**	**7**	**0**
64 = 8.80%			**228 = 31.36%**			**413 = 56.81%**				**22 = 3.03%**			

Based on 727 scored and approved risks

3.1 Surgical Care Group – 139 risks reported 19.11% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**4**	**1**	**11**	**3**	**32**	**19**	**33**	**9**	**24**	**1**	**1**	**1**	**0**
5 = 3.60%			**46 = 33.09%**			**85 = 61.15%**				**3 = 2.16%**			

3.2 Medical Care Group – 120 risks reported 16.51% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
14	**7**	**1**	**10**	**0**	**23**	**4**	**22**	**13**	**17**	**3**	**1**	**5**	**0**
22 = 18.33%			**33 = 27.50%**			**56 = 46.67%**				**9 = 7.50%**			

3.3 Clinical Support Care Group – 118 risks reported 16.23% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**3**	**0**	**14**	**0**	**21**	**15**	**28**	**4**	**24**	**3**	**0**	**1**	**0**
8 = 6.78%			**35 = 29.66%**			**71 = 60.17%**				**4 = 3.39%**			

3.4 Primary Care and Community Services Care Group – 41 risks reported 5.64% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**0**	**0**	**5**	**0**	**4**	**7**	**10**	**3**	**12**	**0**	**0**	**0**	**0**
0			**9 = 21.95%**			**32 = 78.05%**				**0**			

3.5 Corporate – 309 risks reported 42.50% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**11**	**12**	**41**	**5**	**59**	**19**	**76**	**6**	**68**	**1**	**5**	**0**	**0**
29 = 9.38%			**105 = 33.98%**			**169 = 54.69%**				**6 = 1.94%**			

The highest proportion of the Trust's risks continues to be identified in the Corporate Care Group. The split of the risks across the corporate departments is:

Department	High	Moderate	Low	Very low	Total
Health Informatics/Health Records	1	17	15	5	**38**
Estates and Facilities Management	0	8	14	3	**25**
Nursing, Governance, Quality & Risk	2	16	9	3	**30**
Finance	0	9	10	5	**24**
Medicines Management	0	23	35	5	**63**
Human Resource	3	96	22	8	**129**
Total	**6**	**169**	**105**	**29**	**309**

3. The Trusts Highest Scoring Risks – Corporate Risk Register (CRR)

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

ENDS

Appendix 1

Corporate Risk Register – October 2021

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of Last Review	Target Risk Score I x L	Action plan in place with target completion date	Governance and assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	30/09/2021	4 x 2 = 8	Action plan in place	Workforce Committee
2	Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 4 = 16	3 x 5 = 15	17/03/2020 Sue Redfern	31/08//2021	4 x 2 = 8	Action plan in place	Executive Committee
3	Money	1152	**If** there is an increase in bank and agency **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	30/09/2021	4 x 3 = 8	Action plan in place	Quality Committee
4	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	23/07/2021	4 x 3 = 12	Action plan in place	Executive Committee
5	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	30/09/2021	4 x 2 = 8	Action plan in place	Finance and Performance Committee
6	Patient Care	2082	**If** there is no robust established daily process for review of all medical patients who remain in the ED/EAU due to the lack of an available bed on the ward **then** there is a risk to patient safety and experience	4 x 3 = 12	3 x 5 = 15	19/05/2021 Rob Cooper	09/09/2021	3 x 2 = 6	Action plan in place	Executive Committee
7	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	14/09/2021	2 x 2 = 4	Action plan in place	Executive committee
8	Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	31/08/2021	3 x 2 = 6	Action plan in place	Workforce Committee
9	Patient Care	2545	If the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, then there is a risk that compliance with this standard may not be maintained	4 x 4 = 16	4 x 4 = 16	21/07/2021 Sue Redfern	29/09/2021	4 x 2 = 8	Action plan not recorded in Datix	Quality Committee
10	Patient Care	2671	**If** there is not robust Consultant cover on Ward 3C **then** there is a risk to patient safety, quality of care and experience	3 x 3 = 9	3 x 5 = 15	28/04/2021 Rob Cooper	14/09/2021	3 x 2 = 6	Action plan in place	Executive Committee
11	Patient Care	2708	**If** a large number of senior medical staff are adversely impacted by the NHS pension tax rules **then** the Trust could experience reduced senior clinical capacity	4 x 4 = 16	4 x 4 =16	04/07/2019 Anne-Marie Stretch	31/08/2021	4 x 2 = 8	Action plan in place	Executive Committee
12	Patient	2750	**If** the Trust cannot access the national PDS (spine) **then** there	5 x 3 = 15	5 x 3 = 15	04/09/2019	01/09/2021	5 x 2 = 10	Action plan in	Executive

	Care		is an increased risk of not identifying the correct patient			Rob Cooper			place	Committee
13	Patient Care	2848	**If** the trust does not have sufficient anaesthetic and obstetric on call cover, **then** there is a risk of delayed medical management if there should be simultaneous medical emergencies.	5 x 3 = 15	5 x 3 = 15	21/02/2020 Rowan Pritchard-Jones	30/09/2021	5 x 2 = 10	Action plan in place	Quality Committee
14	Patient Care	2932	**If** a patient's fluid balance is not recorded, **then** there is a risk that the patient could become dehydrated or fluid overloaded.	4 x 5 =20	4 x 5 = 20	30/09/2020 Rowan Pritchard-Jones	27/08/2021	4 x 2 = 8	Action plan in place	Quality Committee
15	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.	5 x 4 = 20	5 x 4 = 20	21/10/2020 Rob Cooper	14/09/2021	5 x1= 5	Action plan in place	Executive Committee
16	Patient Care	2964	**If** there are not sufficient dieticians to meet the increased incidence of gastro-intestinal cancers **then** this could impact on their treatment outcomes	3 x 5 = 15	3 x 5 = 15	13/10/2020 Sue Redfern	17/09/2021	3 x 1 = 3	Action plan in place	Executive Committee
17	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	03/09/2021	3 x 2 = 6	Action plan in place	Executive Committee
18	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	29/10/2020 Sue Redfern	14/09/2021	3 x 2 = 6	Action plan in place	Executive Committee
19	Patient Care	3046	**If** Cardio-Respiratory is unable to provide sufficient staff to cover ECG provision throughout the whole of the Trust **then** here is a risk that ECG's are not undertaken in a timely manner.	4 x 5 = 20	4 x 4 = 16	21/04/2021 Rowan Pritchard-Jones	14/09/2021	4 x 2 = 8	Action plan not recorded in Datix	Executive Committee
20	Patient Care	3057	**If** the stroke service does not have 8 consultants in post **then** there is a risk to the level of service provision based on predicted activity	4 x 5 = 20	4 x 5 = 20	25/05/2021 Rob Cooper	14/09/2021	2 x 3 = 6	Action plan in place	Executive Committee
21	Patient Care	3166	**If** Bevan Court 2 is unable to provide appropriate Registered Nurse & HCA levels for patient care **then** there is a risk to patient safety, quality of care and experience	4 x 5 = 20	4 x 5 = 20	23/09/2021 Sue Redfern	24/09/2021	2 x 4 = 8	Action plan not recorded in Datix	Executive Committee
22	Patient Care	3180	**If** the Trust cannot secure sufficient staff to undertake supplementary care for the patients who need it, **then** there is a risk to the quality and safety of care	4 X 5 = 20	4 x 4 = 16	21/07/2021 Sue Redfern	20/08/2021	4 x 2 = 8	Action plan in place	Workforce Committee

Blue text = New risks escalated to the CRR since the July Trust Board report

Risks that have been de-escalated or closed from the CRR since July 2021 are;

New Risk Category	Datix Ref	Risk
Staff	2758	**If** DMOP wards do not have sufficient junior doctors to meet staffing requirements **then** there is a risk to patient safety and patient flows.
Money	2830	**If** the Maternity service does not achieve the maternity incentive scheme, **then** a 10% reduction on the annual CNST premium will not be delivered.
Patient Care	3161	**If** the required staff are not available to fill the rota for the Mass Vaccination Site **then** the service cannot be provided effectively

Appendix 2

Trust Risk Profile – July 2021

Comparison of the Trust risk profile in the last Board Report

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
13	**22**	**16**	**70**	**8**	**122**	**57**	**185**	**35**	**140**	**9**	**6**	**7**	**0**
51 = 7.39%			**200 = 28.99%**			**417 = 60.43%**				**22 = 3.19%**			

Trust Risk Profile – October 2020

Comparison of the Trust risk profile at the same point in the previous year

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
24	**32**	**23**	**88**	**9**	**134**	**54**	**128**	**31**	**138**	**3**	**7**	**3**	**0**
79 = 11.72%			**231 = 34.27%**			**351 = 52.08%**				**13 = 1.93%**			

Appendix 3

CRR – October 2020

Comparison of the CRR risks reported 12 months previously with the risks highlighted that remain or have been re-escalated to the current CRR

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

New Risk Category	Datix Ref	Risk	Current Risk Score I x L	Target Risk Score I x L	Action plan in place	Governance and Assurance
Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 2 = 8	Action plan in place	Quality Committee
Patient Care	1043	**If** there is a global pandemic **then** the trust will need to put in place business continuity, service escalation plans and recovery plans	4 x 5 = 20	4 x 2 = 8	Action plan in place	Executive Committee
Money	1152	**If** there is an increase in bank and agency **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1353	If activity at St Helens Hospital continues to be increased, **then** there is a risk that the current medical cover will not be sufficient	5 x 3 = 15	5 x 1 = 5	Action plan in place	Quality Committee
Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	4 x 3 = 12	Action plan in place	Executive Committee
Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance **then** it will fail the national access standard	4 x 5 = 20	4 x 2 = 8	Action plan in place	Finance and Performance Committee
Staff	2370	**If** the critical care department cannot recruit to all the established consultant posts **then** there will be a risk to the quality of patient care	4 x 4 = 16	3 x 2 = 6	Action plan in place	Quality Committee
Patient Care	2502	**If** there is a no deal Brexit **then** there could be an adverse impact on the supply of medical consumables and devices	4 x 4 = 16	3 x2 = 6	Action plan in place	Finance and Performance Committee
Patient Care	2708	**If** a large number of senior medical staff are adversely impacted by the NHS pension tax rules **then** the Trust could experience reduced senior clinical capacity	4 x 4 =16	4 x 2 = 8	Action plan in place	Executive Committee
Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient	5 x 3 = 15	5 x 2 = 10	Action plan in place	Executive Committee
Patient Care	2848	**If** the trust does not have sufficient anaesthetic and obstetric on call cover, **then** there is a risk of delayed medical management if there should be simultaneous medical emergencies.	5 x 3 = 15	5 x 2 = 10	Action plan in place	Quality Committee
Patient Care	2866	**If** the Lilac Centre cannot maintain the required level of specialist nurse staffing as a result of the additional COVID-19 restrictions **then** there is a risk to service continuity for cancer patients	4 x 4 = 16	2 x 2 = 4	Action plan in place	Executive Committee
Patient Care	2932	**If** a patient's fluid balance is not recorded, **then** there is a risk that the patient could become dehydrated or fluid overloaded.	4 x 5 = 20	4 x 2 = 2	Action plan in place	Quality Committee

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(21)072
Title of paper: Incidents, Complaints, Concerns & Claims – Quarters 1 & 2 2021-22
Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarters 1 & 2 2021-22

Summary
 	
Incidents
 	
• Total incidents reported in Q1 = 4206 (3.80% increase on Q4 2020-21) and Q2 = 4230 (0.57% increase on Q1 2021-22)
• Total patient incidents in Q1 = 3609 (5.65% increase on Q4 2020-21) and Q2 = 3539 (1.94% decrease on Q1 2021-22)
• Total patient incidents graded as moderate/severe/death in Q1 = 35 (also 35 in Q4 2019-20) and Q2 = 39 (11.43% increase on Q1 2020-21)
• The highest number of incidents reported relate to:
  ○ Pressure ulcers (Q1 = 808 and Q2 = 786) which include pressure ulcers acquired prior to admission to Trust services
  ○ Patient slips, trips or falls (Q1 = 544 and Q2 = 606)
 	
Complaints, PALS, and claims
• 77 complaints were received in Q1 and 73 in Q2, both representing an increase from the previous year's quarterly figures of 49 and 68 (57% and 7% respectively)
• 1226 PALS contacts were received in Q1 and 1222 in Q2, a slight increase from the same quarters in 2020-21 (1204 (1.8%) and 1215 (0.6%) respectively)
• 11 new claims were received in Q1 compared to 8 in Q1 2020-21 and 4 new claims were received in Q2 compared to 13 in Q2 2020-21 (representing 37.5% increase in Q1 and 70% decrease in Q2)
 	
The top reasons for patient complaints, PALS contacts and claims were broadly consistent with previous reports and include clinical care, communications, admissions and discharges, appointments, patient care/nursing care and values and behaviours of staff.

Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 27th October 2021

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during Q1 and 2 2021-22, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

During Q1 there were 4206 incidents reported, of which 3609 were patient safety incidents. This represents an increase from Q4 2020-21 of 3.80% in all incidents and 5.65% increase in patient incidents. During Q2, there were 4230 incidents reported (a small increase of 0.57% from Q1) with 3539 of those incidents affecting patients (a 1.94% decrease on Q1).

	21-22 Q1	21-22 Q2
Incidents affecting patients	3609	3539
Incidents affecting staff	356	378
Incidents affecting the Trust or other organisation	208	291
Incidents affecting visitors, contractors, or members of public	33	22
Total	4206	4230

Q1 had 14 incidents reported to StEIS, whilst Q2 had 22 incidents reported to StEIS compared to 19 in Q3 and 20 in Q4 2020/21. From the 14 StEIS incidents in Q1, 3 have been opened as inquests by the Coroner, while in Q2 there have been 2 opened as inquests from the 22 submitted.

During Q1 there were 35 patient safety incidents categorised as moderate harm, severe harm, or death whilst in Q2 there were 39 incidents reported. Again, in comparison, there were 48 categorised as moderate harm, severe harm, or death in Q3 and 35 in Q4 2020/21.

	20-21 Q1	20-21 Q2	20-21 Q3	20-21 Q4	21-22 Q1	21-22 Q2
Moderate	19	17	27	31	25	33
Severe	11	12	12	2	8	6
Death	4	1	9	2	2	0
Total	34	30	48	35	35	39

All patient safety incidents are categorised by the National Reporting and Learning System (NRLS) dataset. The highest reported categories are pressure ulcers (808 during Q1 and 786 during Q2), which includes all patients who are admitted with pre -existing pressure ulcers, and slips, trips, and falls (544 during Q1 21-22 and 606 during Q2 21-22). These are consistently the highest reported incidents as in Q3 2020-21 there were 779 pressure sores reported and 588 falls while in Q4 2020-21 there were 831 pressure ulcers and 604 falls.

Pressure ulcer figures include those acquired in the community and Trust acquired as detailed in the table below. Pressure ulcers have seen a rise of 31.19% in 2020-21 where 2978 incidents were reported, compared with 2270 incidents in 2019-20; this is largely due to the new Community Services taken on from 1st April 2020. This

includes both Trust acquired, and non-Trust acquired pressure ulcers and skin damage incidents.

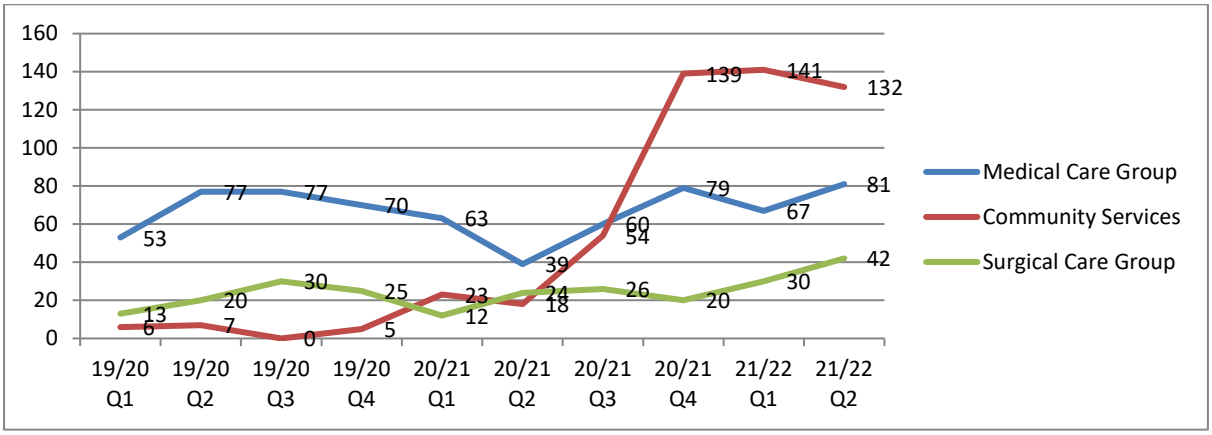
Pressure ulcers by quarter 2019-20 to 2021-22.

	2019-20				2020-21				2021-22	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Not STHK Acquired	455	449	522	461	561	628	639	593	570	531
STHK Acquired	72	104	107	100	98	81	140	238	238	255

STHK acquired pressure ulcers includes both acute services and Trust community care services. The increase is largely due to increase in community care group reporting, which has included new reporting criteria for community care, in line with Trust policy, to include moisture lesion and category 1 skin changes.

For Q1 2021-22, from acute care groups, 5 pressure ulcers category 2 and 1 pressure ulcer of category 3 with lapse in care have been identified, and 13 pressure ulcers have been identified with no lapse in care incidents. Q2 incidents are awaiting clinical validation.

For the same period in Q1 2021-22, there were 49 category 2 pressure ulcers identified from community services. The increase is due to significant increase in patients under end of life care across the Q1 period due to an increase in Covid positive patients both in residential homes and their own homes, therefore skin changes were found frequently. The District nursing service continued to visit housebound patients, however had limited to entry to care homes, due to restrictions placed by care home. In such circumstance, telephone triage process ensued to observe any low level risk wounds, the care home staff were then dressing as per the DN advice and care plan dressing. 1 category 3 pressure ulcer incidents were identified in Q1, which was deemed as no lapse in care, as all appropriate risk assessments had been completed and possible care interventions implemented.



	2019-20				2020-21				2021-22	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
None	9	18	7	3	7	6	15	84	82	123

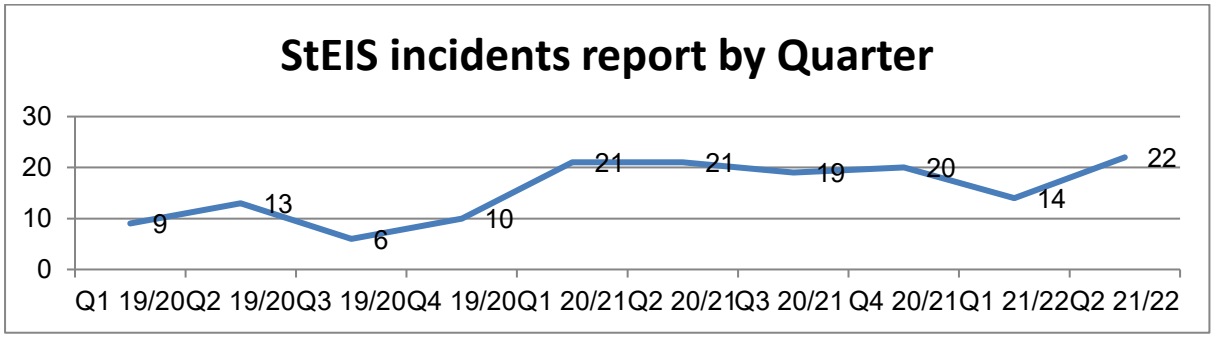
Low	56	79	94	95	84	75	119	148	152	109
Moderate	6	4	5	0	4	0	6	3	1	4
Severe	0	0	1	0	0	0	0	0	1	0
Ungraded to date	1	3	0	2	3	0	0	3	2	19
Total	72	104	107	100	98	81	140	238	238	255

2.1. Review of incidents reported to StEIS in Q1 and Q2 2021-22

In Q1, the Trust reported 14 incidents to StEIS and 22 in Q2, as outlined in the table below.

Q1	Total	Q2	Total
Inpatient falls sustaining fractured neck of femur	4	Maternity divert in place on service	9
Baby cooling incident meeting Healthcare Safety Investigation Branch (HSIB) criteria	2	Inpatient falls sustaining fractured neck of femur	5
Delay in urgent SCC treatment	2	Alleged abuse	2
Alleged abuse	1	Baby cooling incident meeting Healthcare Safety Investigation Branch (HSIB) criteria	1
Failure to escalate to emergency laparotomy	1	Maternal death	1
Fall subdural bleed	1	Never Event – Connected to airflow meter	1
Maternity divert	1	Medication not administered	1
Failure to diagnose/treat metastatic spinal compression	1	Delay in treating foreign object in eye	1
Prevention of Future Death notice	1	Category 3 pressure ulcer	1

During Q1 there were 15 StEIS reports submitted to the CCG whilst during Q2 there were 20 reports submitted, all of which were submitted within the agreed timeframe. Actions taken and lessons learned are shared both internally and with the CCG.



2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS in the table above. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm incidents and Level 1 incidents are monitored within the Care Groups.

2.3. Benchmarking

The table below shows the most recent data provided by NHS England comparing patient safety incidents reported to the NRLS by the Trust to the national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe or death vary due to the relatively small numbers.

% of all reported incidents	April 19 to March 20		April 20 to March 21	
	Trust %	National %	Trust %	National %
No harm	83.6%	74.7%	82.4%	72.7%
Low	15.9%	23.2%	17.0%	24.6%
Moderate	0.5%	1.8%	0.4%	2.2%
Severe	0.1%	0.2%	0.1%	0.3%
Death	0.01%	0.1%	0.02%	0.2%

2.4. Dissemination of learning

A summary of actions taken from incidents is provided to the Quality Committee and the Trust Board. Incidents are standing agenda items on the Patient Safety Council, Care Group, and ward governance meetings to ensure that lessons identified are disseminated and that actions are taken to improve the quality of patient care are embedded. Lessons learned are also shared at the weekly incident review meetings, monthly safety huddles, safety newsletters and forums including ward manager and matrons' meetings.

3. Complaints

The table below shows the number of received and opened first stage complaints by quarter. If this year continues at the same rate there will be a 13.9% increase compared to 2020-21, but a 13.6% decrease compared to 2019-20, pre-pandemic levels. There have been 11 2nd stage complaints so far this year (7 in Q1, and 4 in Q2). If this continues then this will represent a 4.5% reduction on the previous year. The main reasons that complainants lodge second stage complaints are because they want further information or do not agree with the findings.

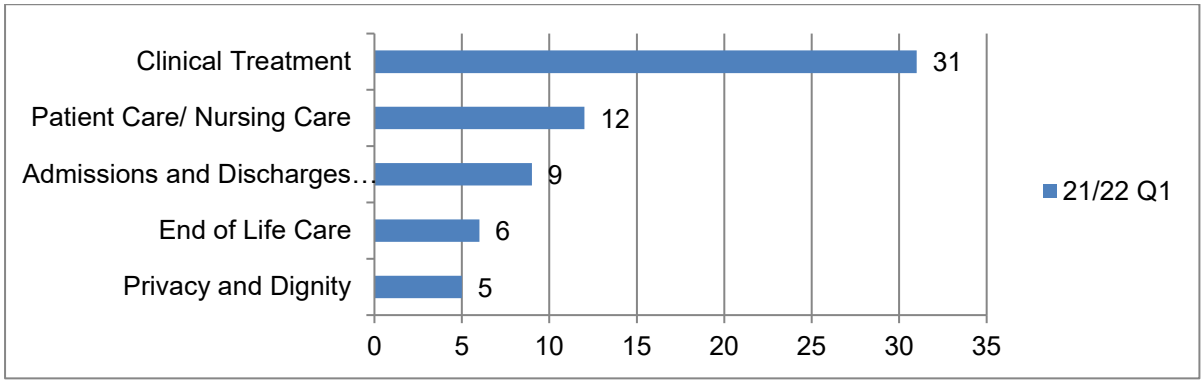
The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved in 2019-20 and 2020-21. The Trust's response time to first stage complaints decreased to 81.1% in Q1, due mainly to the impact of the pandemic and the suspension of requests for statements for complaints from clinicians at the end of 2020/beginning of 2021 due to severe operational challenges; however, this recovered slightly to 83.6% in Q2, and continued efforts are being made to improve the timeliness of responses. This

includes the provision of additional temporary resources within the Complaints Team and additional hours for existing staff.

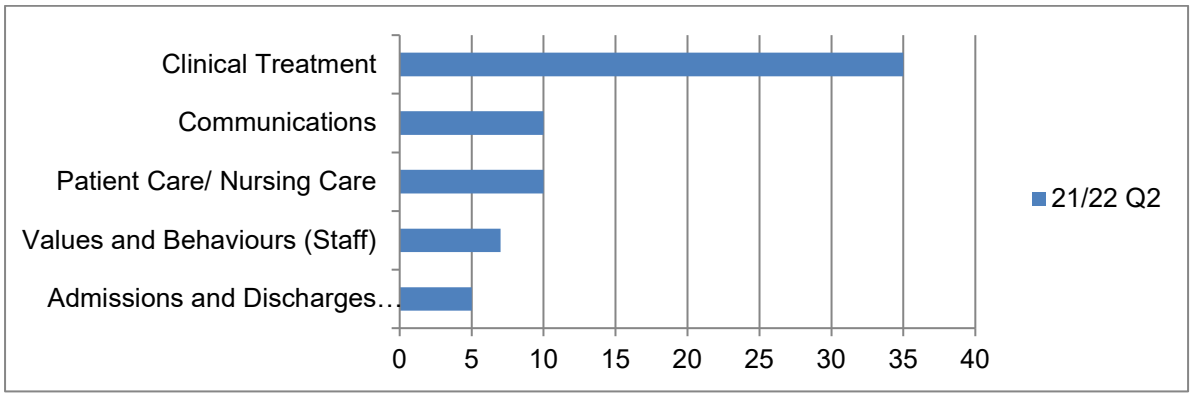
Indicator	2018-19	2019-20	2020-21	2021-2022	
				Q1	Q2
Total number of new complaints including community services	273	325	251	77	73
Total number of new complaints received (excluding community services)	267	320	242	69	73
Acknowledged within 3 days – target 100%	99.3%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	92.1%	93.4%	94%	81.1%	83.6%
Number of overdue complaints	1	1	4	3	1
Second stage complaints	36	36	23	7	4

The above data was correct at the conclusion of the financial year to which it relates. There may be some subsequent changes if complaints are discontinued or reclassified.

3.1. Top five reasons for complaints Q1 2021-22



3.2. Top five reasons for complaints Q2 2021-22



Clinical treatment remains the main reason for complaints, however, it is of note that communications, which consistently features within the top 5 reasons for complaints, was absent in Q1. End of life care featured in Q1 which is unusual, with three relating to DNACPR decisions; actions are being taken to ensure clear communication and appropriate reviews are undertaken when DNACPR decisions are in place.

3.3. Complaints by top location

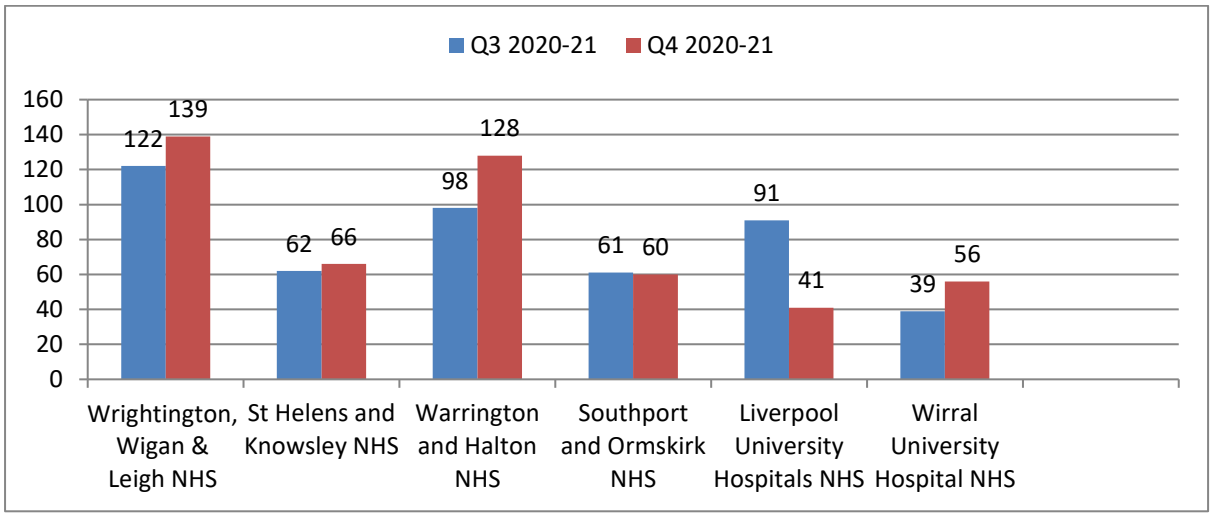
The Emergency Department received the highest number of complaints which can be attributed to the high levels of activity, with the Medical and Surgical Assessment Units, 4B and 1C receiving the next highest.

Location	Care Group	Q1	Q2	Total
Accident and Emergency	Medical Care Group	19	25	44
Ward 4b General Surgery	Surgical Care Group	1	4	5
Ward 1C AMU	Medical Care Group	3	2	5
Ward 1D Cardiology	Medical Care Group	2	2	4
Ward 1E Coronary Care Unit	Medical Care Group	2	2	4
Ward 2B Respiratory	Medical Care Group	2	1	3
Ward 2C Respiratory	Medical Care Group	2	1	3
Ward 3D Gastroenterology	Medical Care Group	2	1	3
Urgent Treatment Centre	Community Services	1	2	3
Burns and Plastics Clinic	Surgical Care Group	1	2	3
Total		35	42	77

There are no emerging themes relating to the complaints received in the other wards, although Q2 had a spike for 4B which will be monitored in the next quarter.

3.4. Comparison of complaints received with neighbouring trusts

NHS Digital publishes data on written complaints for each of the NHS trusts in the country on a quarterly basis. The latest figures to be published are for Q3 and Q4 2020-21. Please note the figures do not include verbal complaints. Also, unlike previous returns, it does not include figures for upheld, partially upheld, and not upheld complaints.



3.5. Closed complaints

53 complaints were closed in Q1 and 73 in Q2, which is a significant decrease on previous year's performance, due to the impact of the pandemic. It should be noted

that the majority of the complaints relating to clinical treatment are not upheld. Additional information on complaints is contained in Appendix 1.

3.6. Dissemination of learning

A summary of actions taken from complaints is provided to the Quality Committee. Each complaint response includes any learning that has been identified and the necessary actions for each area. Incidents and complaints are standing agenda items on the Care Group and ward governance meetings to ensure that lessons identified are disseminated and that actions taken to improve the quality of patient care are embedded.

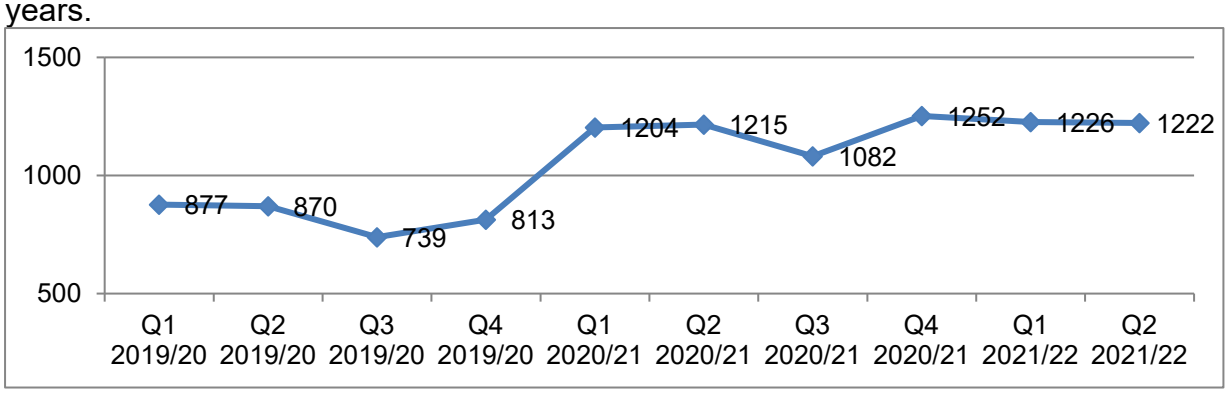
3.7. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

The PHSO commenced one investigation in Q2 and none in Q1.

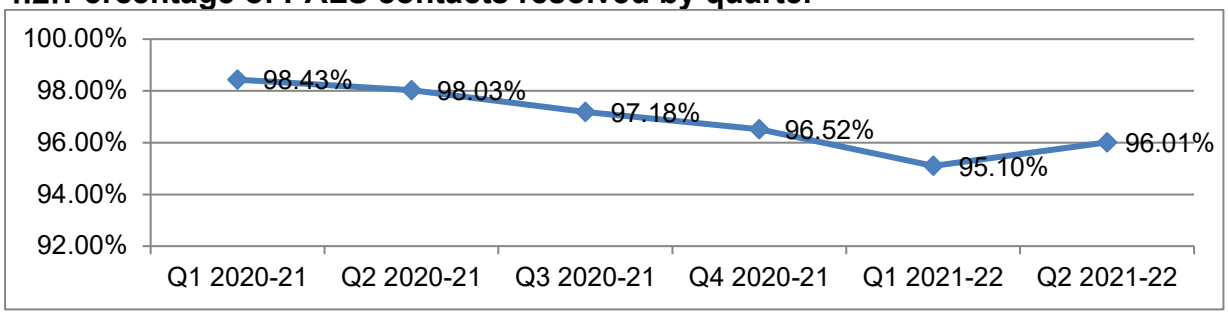
4. PALS

4.1. Number of PALS enquiries by quarter

The number of PALS contacts has increased in Q1 and 2 compared to previous years.



4.2. Percentage of PALS contacts resolved by quarter



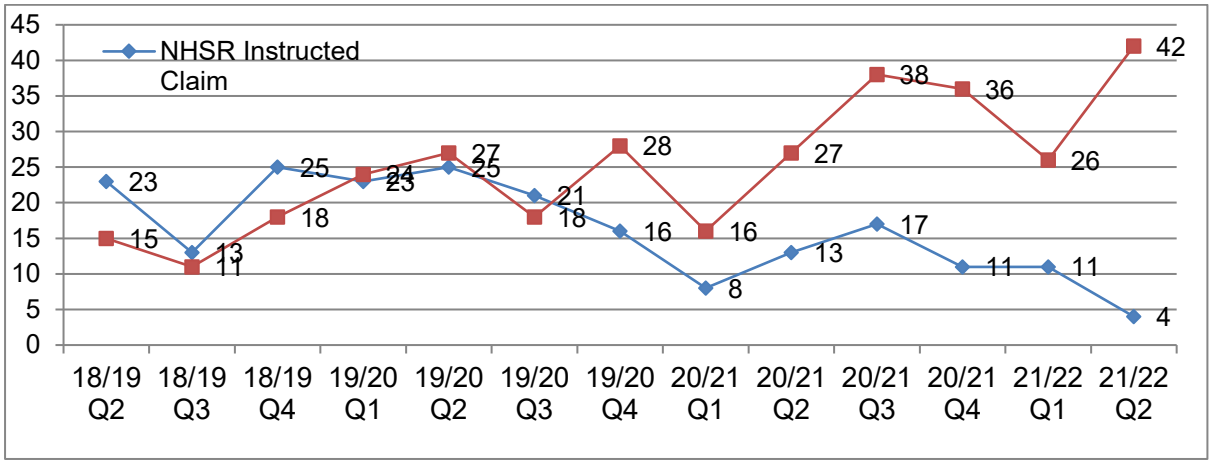
In Q1 2021-22, 95% of PALS enquiries were resolved and 96% in Q2 as shown in the table above. 41 PALS enquiries converted to formal complaints in Q2, a 3.99% conversation rate which is a decrease from Q1 when 4.9% of PALS enquiries were converted to formal complaints.

4.3. PALS enquiries by subject

The top 5 themes remain consistent with previous quarters. There has been a slight decrease in PALS enquiries relating to communication in Q2 (n275) compared to Q1 when there were 335 enquiries.

		2020-21					2021-22	
No	Theme	Q1	Q2	Q3	Q4	Total	Q1	Q2
1	Communications	590	372	362	422	1746	335	275
2	Signposting/Compliments	118	147	131	103	499	144	195
3	Appointments	109	154	124	159	546	138	149
4	Patient Care/Nursing Care	63	87	84	91	325	125	128
5	Clinical treatment	66	107	76	109	358	115	122

5. Clinical Negligence Claims

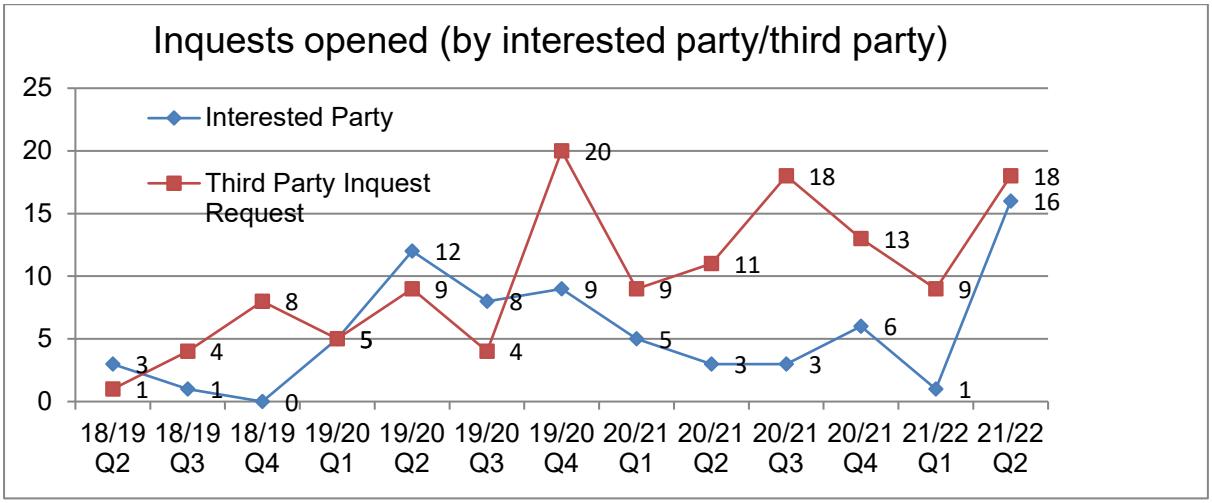


The number of new clinical negligence claims (NHS Resolution instructed claims) decreased significantly from the previous quarter and continued to follow an overall downward trend since the start of the pandemic. This may be a result of NHS Resolution agreeing a blanket extension of limitation on all claims as a result of the pandemic, meaning that claims may be delayed and may be received in the future. Pre-action claims (where requests for records have been received from solicitors, some with no indication of the allegations) have increased to 42. This is the highest number of requests for records and consistent with more potential claims being investigated.

The main reasons for claims in Q1 and 2 were failure/delay in treatment (9 claims) and failure/delay in diagnosis (5).

6. Inquests

The table below illustrates the number of inquest requests received by quarter, noting that there were 10 inquests opened in Q1 and 34 in Q2. 14 Inquests were closed in Q1 and 18 Inquests were closed in Q2. The Trust did not receive any Prevention of Future Death Orders during this period.



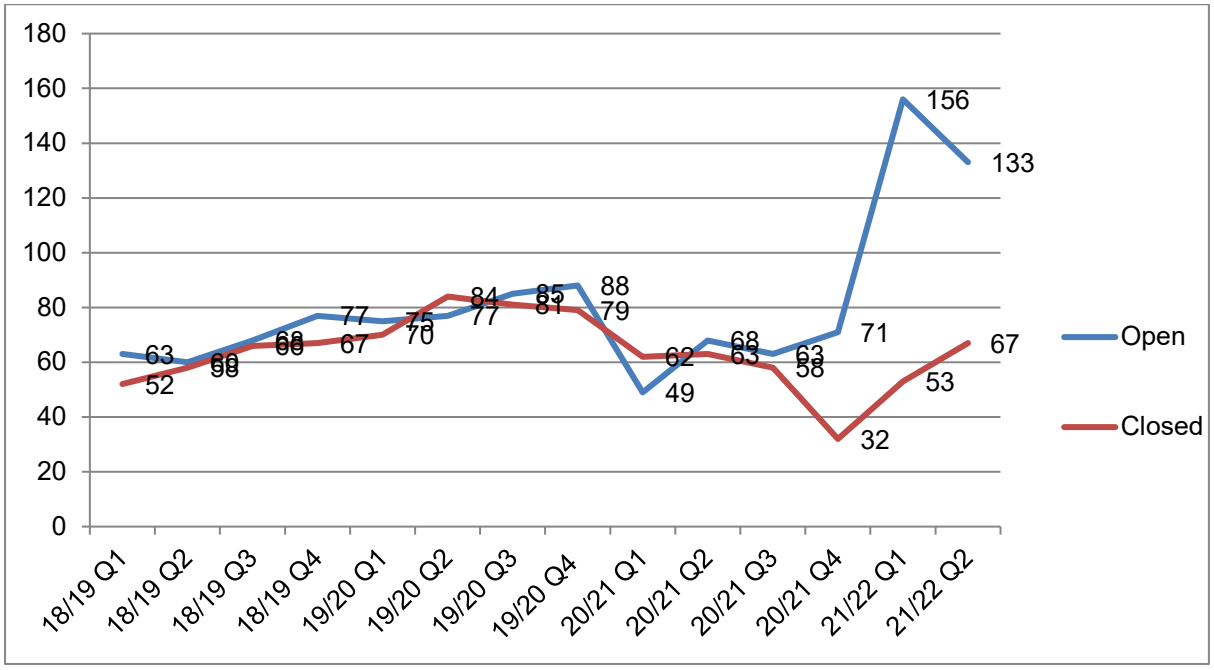
7. Recommendations

It is recommended that the Board note the report and the systems in place to manage incidents, complaints, PALS, and claims.

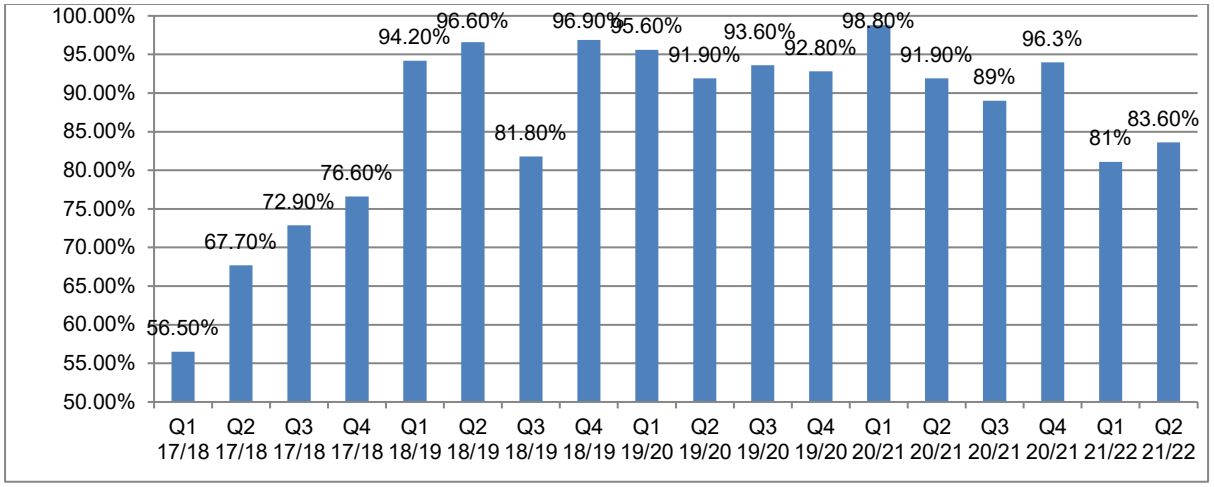
ENDS

Appendix 1 – Summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in 2020-21 & 2021-22

	Q3	Q4	Q1	Q2
Not Upheld Locally	22	9	33	41
Partially Upheld Locally	28	12	11	25
Upheld Locally	8	11	9	6
Total	58	32	53	72

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)073

Title of paper: Infection Prevention and Control Annual Report 2020/21.

Purpose: To present the 2020/21 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:

The Infection Prevention Annual Report is a two-part document, Part 1 outlines the developments and performance related to Infection Prevention (IP) activities during 2020/21 and Part 2 (Appendix 1) is the annual work plan for 2020/21 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.
The IPC programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code,
- Antimicrobial Stewardship:
- NHS England IPC BAF May 2020
- Infection Prevention & Control Board Assurance Framework (February 12, 2021. V1.6)

Key highlights

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 2020/21 financial year.
3. Health care acquired infections (HCAIs) are reported every month via the Integrated Performance Report (IPR) and the Board, via the Quality Committee, also gains assurance via regular in-depth reports of the actions taken and lessons learnt.
4. 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 2020/21 the IPC performance improved in comparison to the previous year and the following were reported:
   - 28 cases of Clostridium difficile infection (CDI) against an objective of no more than 48)
   - 2 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) positive samples of which 1 was deemed as unavoidable and the 2nd was community acquired however, was attributable to the Trust because of delays in taking blood cultures when the patient was admitted. This was compared to 1 case which was a contaminant the previous year

- 29 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases, of which 26 were unavoidable as not health care related. 3 cases identified lapses in care related to peripheral line or urinary catheter care.
- 46 Hospital E coli bacteraemia compared to 51 cases the previous year
- Zero cases of CPE bacteraemia.
- There were 47 outbreaks of infection: resulting in 1289 lost bed days. The majorly were related to Covid -19 pandemic
- The Trust's overall Nosocomial infection (NCI)rate was 9.4% (5.1% for Hospital onset definitive healthcare associated Covid cases and 4.3% for Hospital onset probable healthcare associated COVID cases. The Trust had the lowest NCI rate in Cheshire and Merseyside compared to benchmark of 14% of neighbouring Trusts.
- The IP mandatory training compliance at the end of March 2021 was 83.3% for level 1 and 52.7% for level 2. This was impacted by staff unable to be released for clinical competency training for level 2.
- Appendix 1: IPC forward plan

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 2020/21 IPC annual report.

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

Date of meeting: 27 October 2021

St Helens and Knowsley Teaching Hospitals NHS Trust

Infection Prevention Annual Report 2020-2021

CONTENTS

EXECUTIVE SUMMARY

1 The Infection Prevention Annual Report is a two-part document, Part 1 outlines the developments and performance related to Infection Prevention (IP) activities during 2020/21 and Part 2 (Appendix 1) is the annual work plan for 2020/21 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 Clostridiodes (previously known as 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
- Clostridiodes *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 Trust meet all the criteria outlined in the Infection Prevention and Control Board Assurance Framework (IPC BAF).

8 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 2020/21

- 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 Clostridiodes difficile infection (CDI) objective for 2020/21 was no more than 48 cases. The Trust reported 43 positive samples of which 15 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 28. Compared to 42 cases the previous year. 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 2020/21 the Trust reported 2 MRSA positive cases. 1 case was unavoidable, and the 2nd case was community acquired, but was attributable to the Trust because of delays in taking blood cultures when the patient was admitted.

- Both cases of MRSA bacteraemia were subjected to a multi-disciplinary Post Infection Review (PIR), one was deemed unavoidable, and one was community onset, however due to delay in obtaining blood cultures (>48 hours after admission) this was hospital attributable by date. Lessons learnt were disseminated and action plans were developed, these are monitored via the Hospital Infection Prevention Group (HIPG).

- During 2020/21, there were a total of 29 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases, of which 26 were unavoidable as not health care related. 3 cases identified lapses in care related to peripheral line or urinary catheter care.

- During 2020/21, there were a total of 46 E. coli bacteraemia cases as a result of urinary tract of infection abdominal/ biliary sepsis.

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

- Surgical site infection (SSI) surveillance in orthopaedics:

April 2020 – March 2021	**STHK**	**National**
Hips 77	1.3%	0.8%
Knees 94	1.1%	1.7%

- Outbreaks: during 2020-21 there were 47 outbreaks of infection: the majority of these were due to SARS-CoV19

- 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.

- 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 which went live in December 2014. was upgraded this year to improve the reporting function

- Engagement at ward level**.** Twenty three 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.

- 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.

Developments in 2020/21

- Continued Zero tolerance of MRSA bacteraemia 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 is available on Vitalpac.
- Collaboration with the healthcare community on the implementation of a toolkit and action plans to reduce the risk of E. coli and other gram negative bacteraemia.
- In conjunction with the sepsis team further embed the correct identification and management of sepsis.
- 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 will be undertaken by the IPT, Estates and Facilities Team and Medirest (Soft FM services provider) to wards and clinical areas.

Background

1. Infection Prevention Arrangements

1.1. As recommended in the Health and Social Care Act 2008, there is a duly constituted Hospital Infection Prevention Group (HIPG) which meets bi-monthly. The HIPG is a sub-group of the Patient Safety Council (PSC) which reports to the Quality Committee (QC). The 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 Clostridiodes 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 23 Consultant Infection Prevention Leads ('Consultant Champions') and 151 link nurses/workers.

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

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

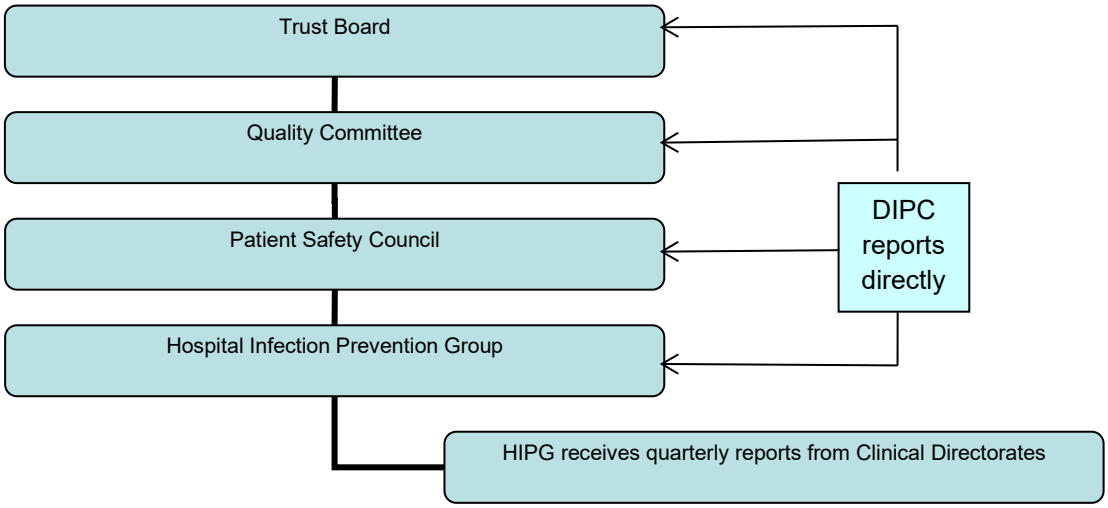
1.2.10. A monthly IP lessons learnt summary is circulated trust wide.

1.2 The Trust remains compliant withal the indicators in the Infection Prevention and Control Board Assurance Framework, this is monitor via the HIPG and had been reported to Quality Committee and Trust Board by the DIPC.

1.3 The Trust continues to undertake a number of interventions in relation to infection prevention as detailed within the HCAI Reduction Plan 2020/21. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Infection Prevention Doctor and lead nurse IPT.

1.4 Hospital Infection Prevention Group (HIPG)

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



1.4.2 The Terms of Reference are reviewed annually and were amended in March 2021.

1.4.3 The Infection Prevention Team (IPT) consists of specialist nurses, Medical Microbiology doctors, 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 sites on a regular basis.

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

1.4.5 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.

1.4.6 Isolation facilities

The Trust has 50% single rooms 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.

1.4.7 The core members of the IPT consist of:

- Director of IPC (DIPC) - Director of Nursing, Midwifery and Governance
- Lead Infection Prevention Doctor
- 8B Lead Nurse IP (1.0 WTE)
- Band 7 Specialist IP Nurses (2.4 WTE)
- Band 5 IP Nurses (2.0 WTE)
- 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

1.4.8 IP organisational structure

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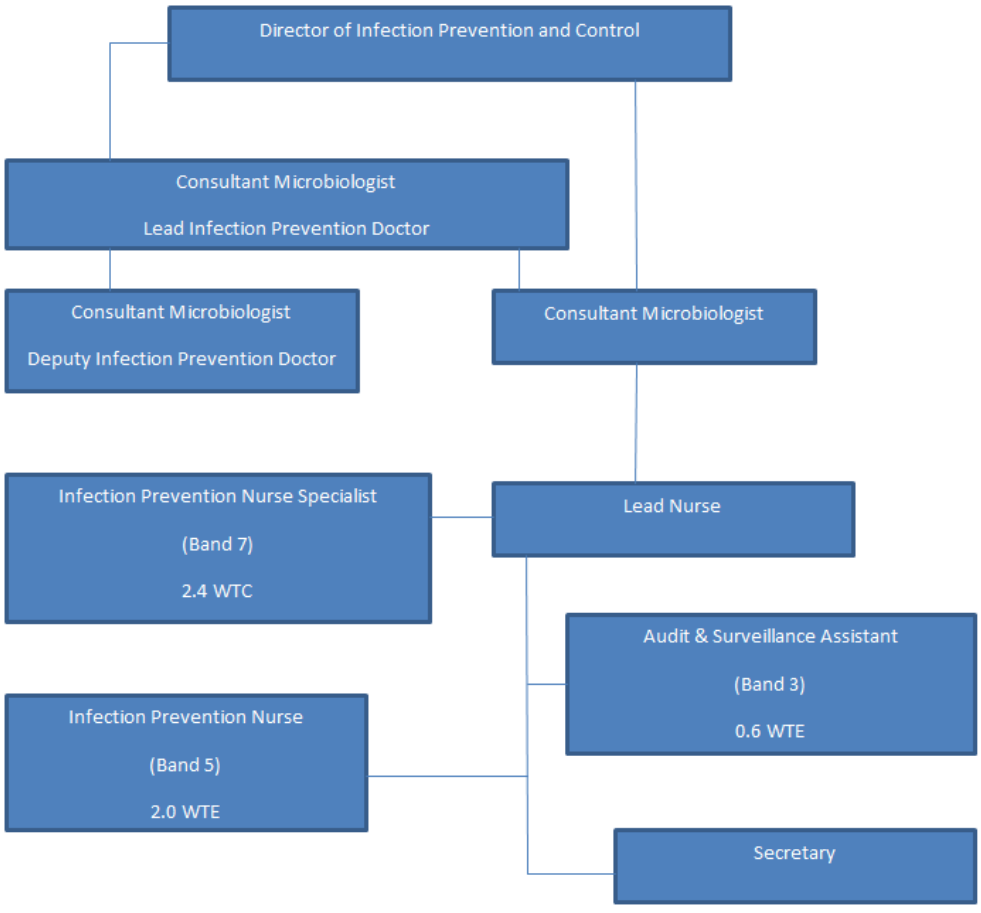


1.4.9 In addition, the IPT has a Link Nurse programme of over 151 personnel with study days/ meetings planned on a bi-monthly basis.

1.4.10 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.

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

1.5 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
- Waste 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
- North West IPC Regional Network Group
- Cheshire and Merseyside Antimicrobial Resistance Group

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 *Clostridiodes 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 Medical Microbiology Consultants conduct weekly antimicrobial stewardship ward rounds.

2.5 The Trust submits data on MRSA, MSSA, E. *Coli, Klebsiella, Pseudomonas aeruginosa,* VRE and *Clostridiodes 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 Trust undertook root cause analysis (RCA) case reviews of mandatory notifiable infections although this process was suspended temporarily between March 2020 and July 2020 and again during January 2021 and March 2021 due to the COVID pandemic.

2.9 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
- Clostridiodes 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 possible 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
2020/2021	2(1 unavoidable and 1 community onset, however delay in obtaining blood cultures, therefore trust attributable by date)	0

During 2020/2021 the Trust reported two MRSA bacteraemia's both of which underwent a robust multi-disciplinary root cause analysis process which was reviewed by the Executive Root Cause Analysis Panel.

The first case was on 4E/ICU
This patient was admitted to ICU with COVID. They had no history of MRSA previously and screened negative for MRSA on admission. The patient was identified as colonised with MRSA on repeat screen taken day 3 of admission and developed bacteraemia on day 5 of admission (likely from a lower respiratory tract infection). Patient was being proned (nursed face down). The Executive Post Infection Review Panel concluded that this was an unavoidable infection

Lessons identified not contributory to infection:

- Peripheral cannula must be re-sited at the latest every 72 hours. However, if there is a clinical indication to leave a cannula in for longer (e.g., patient with very difficult IV access), ensure that the rationale is clearly documented in the patient's clinical notes. In this case a peripheral cannula was in situ for 4 days with no indication of the rationale for this.
- Take paired line and peripheral blood cultures from patients with pre-existing central/arterial/long term lines when investigating source of infection/sepsis. In this case only arterial blood culture was sent.
- Use transparent pressure dressings to protect pressure areas for patients on CPAP which allow observation of the skin rather than opaque dressing such as Duoderm which obscure the skin underneath.

Case No 2 was deemed avoidable after RCA review:

In this case there was a delay in blood cultures being taken (from a patient diagnosed with radiologically confirmed bone/joint infection who did not have criteria for sepsis) prior to starting IV antibiotics for treatment of septic arthritis/osteomyelitis. MRSA was identified from blood cultures taken day 4 of admission. Clinical history and radiological findings on presentation were consistent with this patient having disseminated MRSA infection prior to admission. However, the diagnosis (therefore appropriate treatment) was delayed due to the delay in taking blood cultures. As first blood culture was only taken 4 days into the admission, according to national case attribution rules, this bacteraemia has been deemed hospital onset.

Lessons identified contributory to infection:

- Be aware that it is sometimes possible for patients to have bacteraemia without necessarily displaying overt signs of sepsis especially in the early stages of infection.
- Consider taking blood cultures if one or more of the following clinical symptoms/signs are present and there is a clinical suspicion of infection even if the patient does not fulfil sepsis criteria.

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 2020/21.

2.11 Clostridiodes difficile toxin infection (CDI)

The Trust CDI assigned by NHS England target for 2020/21 was no more than 48 cases. Due to the COVID pandemic, this was unchanged from the target from 2019/20.

In total there have been 28 cases of CDI attributed to the Trust excluding 15 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.
During the Covid- 19 pandemic a number of delays have been experienced in convening quorate RCAs . Actions taken includes the IPCT and care groups laeds have reviewed the methodology to enhance, streamline and make the IPC RCA process more effective, efficient and more meaningful wherein lessons can be learned and disseminated. This has resulted in improved engamnet and ownership.

The overall number of Trust attributed CDI cases in 2020/21 was lower than in 2019/20 however, it is not possible make a direct comparison between the two years due to the effect of the COVID pandemic.

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) 71(PCT target)	74	
2011/12	65	52	
2012/13	37	31	
2013/14	31	26	
2014/15 During this year CDI appeals were introduced	19	35	Avoidable cases (excluding 9 cases which were deemed unavoidable by the CCG CDI appeals panel)
2015/16	41	26	Avoidable cases (excluding 13 which were deemed unavoidable by the CCG CDI appeals panel)
2016/17	41	21	Avoidable cases (excluding 6 cases which were deemed unavoidable by the CCG CDI appeals panel)
2017/18	41	19	Avoidable cases (excluding 9 cases which were deemed unavoidable by the CCG CDI appeals panel)
2018/19	40	13	Avoidable cases (excluding 12 cases which were deemed unavoidable by the CCG CDI appeals panel).

			[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 HOHA, 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.
2020/21	48	28	In total, there were 43 cases attributed to the Trust (27 HOHA, 16 COHA), 15 of these 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.

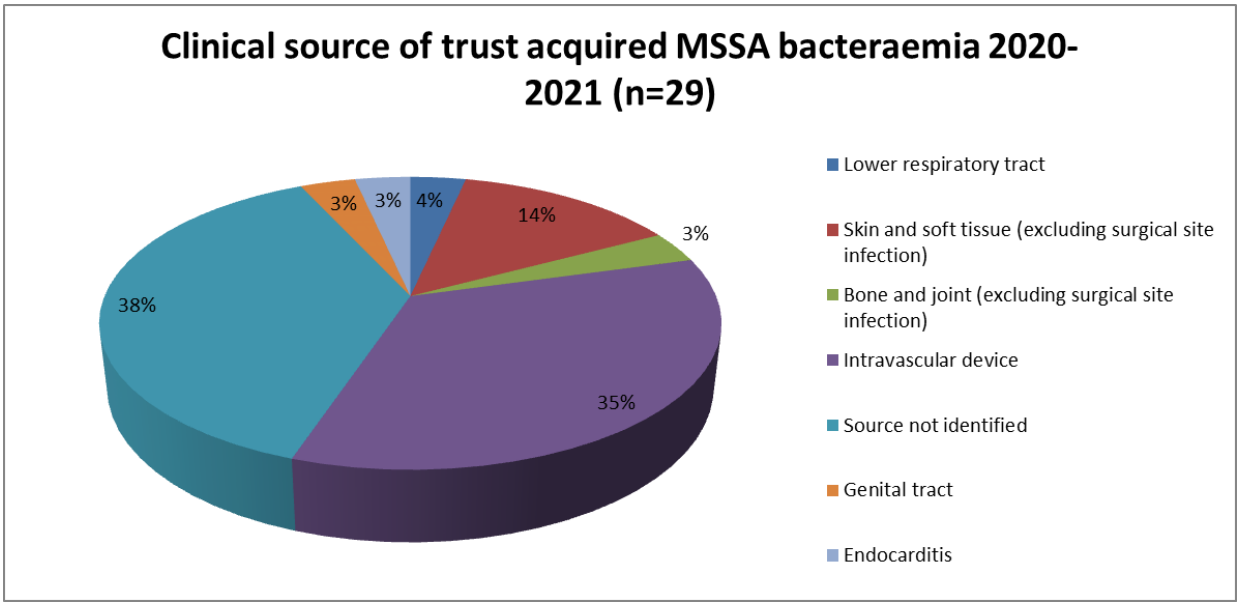
Outbreaks of CDI: There were no CDI outbreaks in 2020/21.

2.12 Meticillin-sensitive Staphylococcus aureus (MSSA)

There were 29 cases of Trust acquired MSSA bacteraemia in 2020/21.

Six cases of MSSA bacteraemia were subject to an Executive led Root Cause Analysis Review Panel of which 3 were deemed avoidable. The lessons identified were shared for learning.

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



- Since July 2015 the number of Key trainers in the Trust has risen from 24 to 180;
- While the key trainer sessions were disrupted as a result of the COVID pandemic, existing key trainers were given dispensation to continue to assess other staff throughout the pandemic in order to maintain ANTT competency compliance within 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.

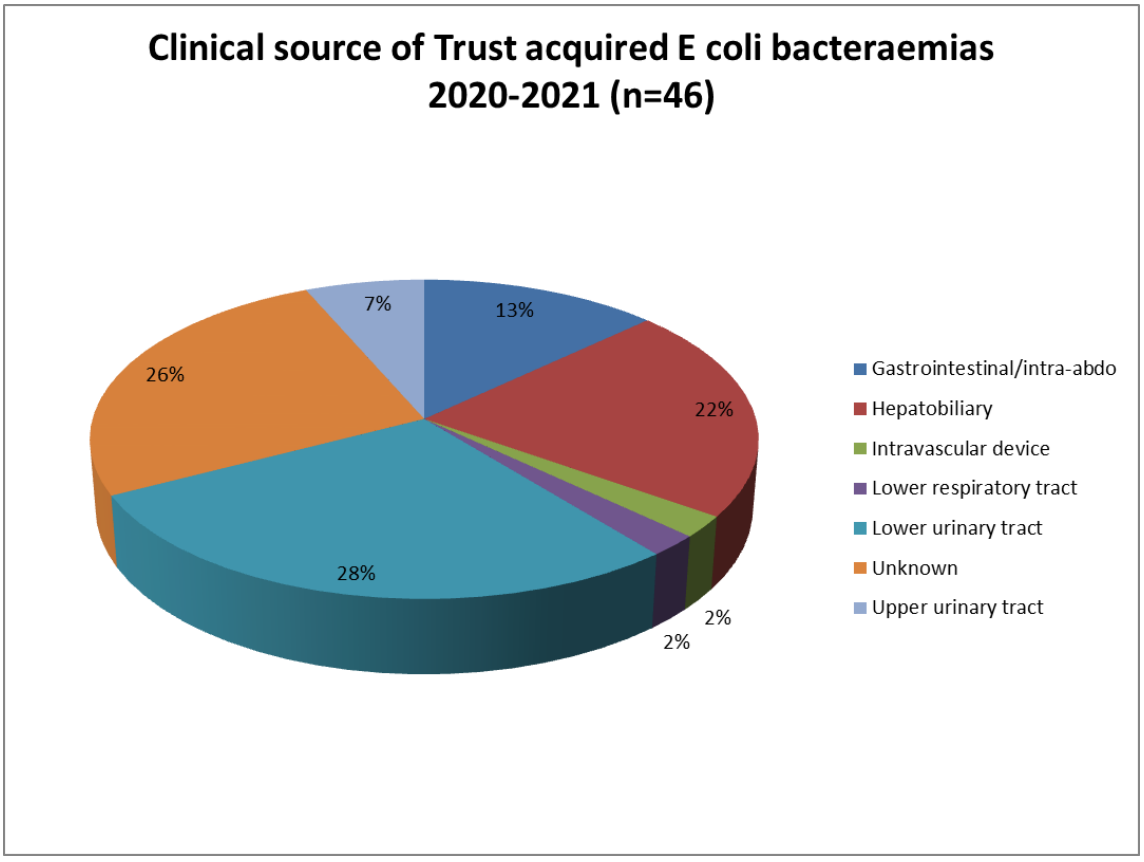
Pseudomonas aeruginosa is commonly found in the environment e.g. in water and soil and may transiently colonise humans. It normally causes infection in vulnerable patients e.g. those who are immunocompromised or those with indwelling devices.

2.14 E. coli.

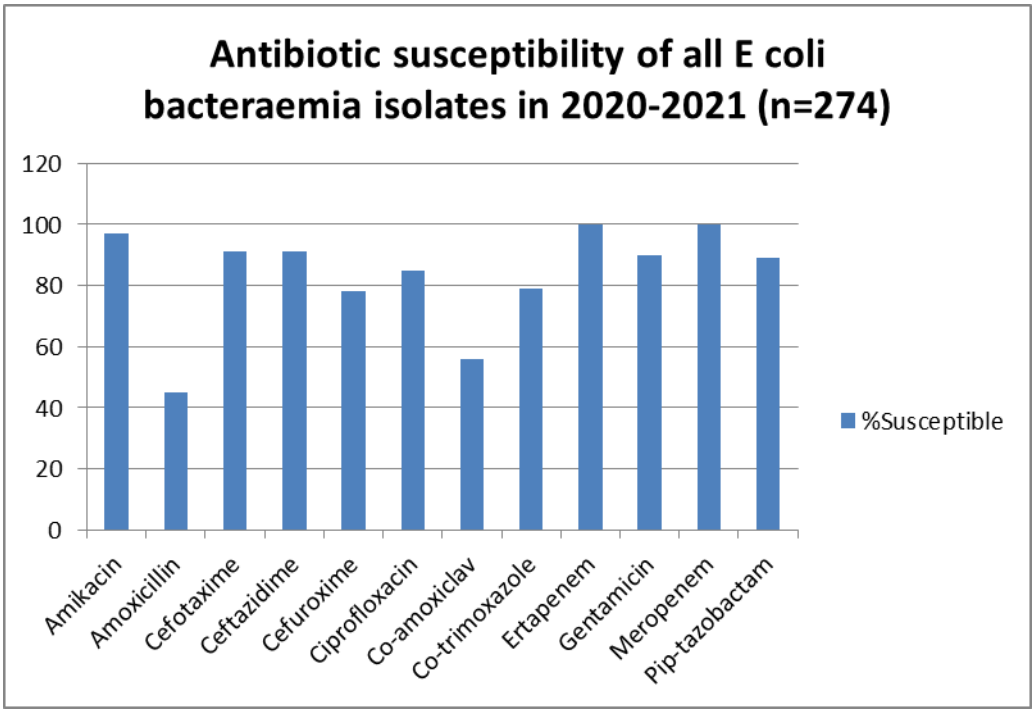
In 2020/21, there were 46 cases (compared with 51 cases in 2019/20, 62 in 2018/19, 66 in 2017/18 and 50 in 2016/17). Of these, 12 had RCA reviews completed, of which 3 were deemed avoidable following review.

The Trust acquired E coli bacteraemia rate (specimen taken day 2 of admission or later, if the day of admission is day 0) was 14.73 per 100,000 bed days compared with 26.98 in 2017/18, 25.35 in 2018/19 and 20.81in 2019/20.

The clinical sources of Trust acquired E coli bacteraemia in 2020/2021 are as below:

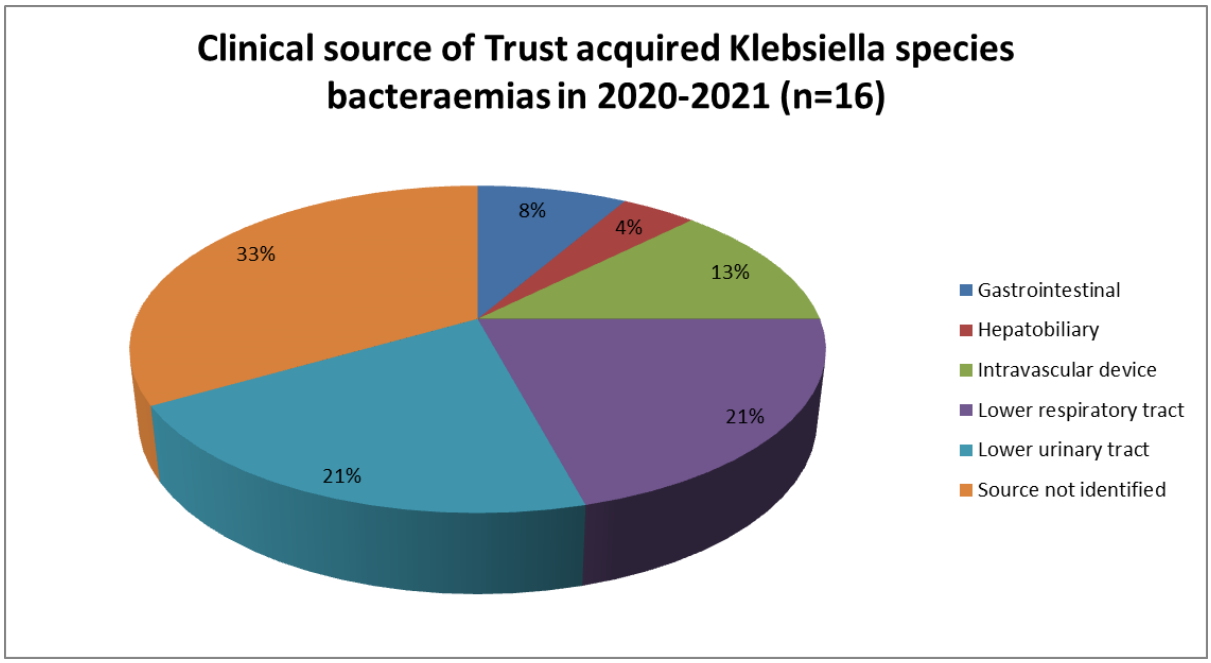


The overall antibiotic susceptibilities for all E coli bacteraemia (i.e. community and Trust acquired) identified at the Whiston Hospital Microbiology Laboratory in 2020/2021 are as below:



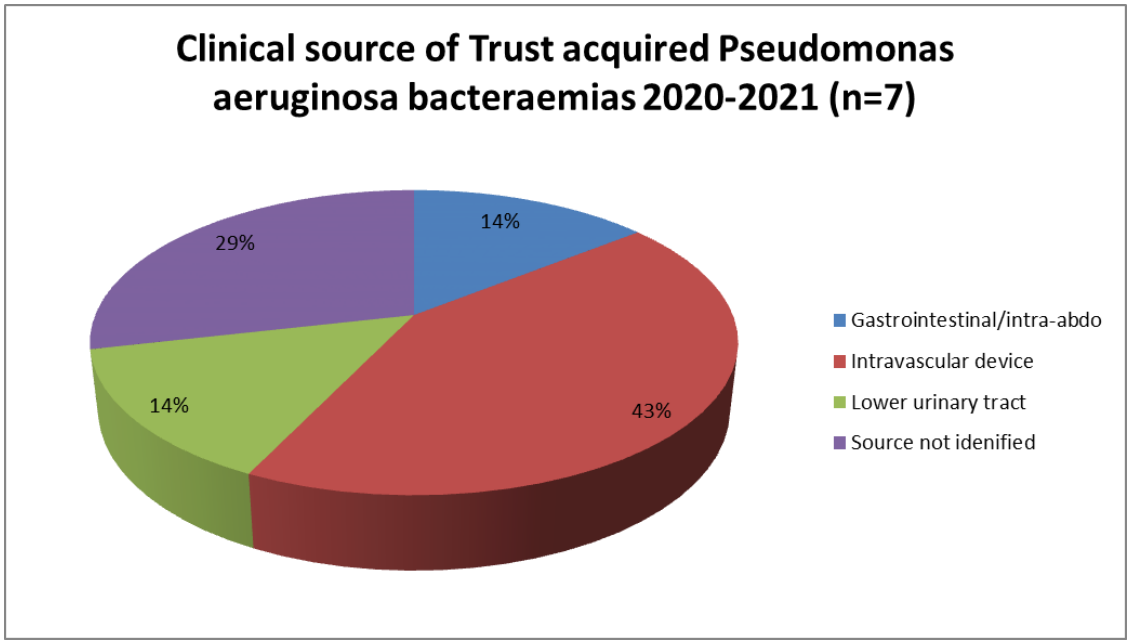
2.15 Klebsiella species bacteraemia.

There were 24 cases of Trust acquired Klebsiella bacteraemia's in 2020/21 (compared with 16 in 2019/20, 22 in 2018/19 and 15 in 2017/18). 12 (50%) of these bacteraemia's were acquired on 4E/ICU during periods of escalation due to COVID. Of the 24 cases following RCA review 5 were deemed unavoidable.



2.16 Pseudomonas aeruginosa

There were 7 cases of Trust acquired Pseudomonas aeruginosa bacteraemia in 2020/21 (compared with 6 cases in 2019/2020, 9 cases in 2018/19 and 9 cases in 2017/18). 3 cases at RCA review were deemed avoidable. All 3 infections related to intravascular devices were on 4E/ICU and were identified during the peaks of escalation due to the COVID pandemic.



2.17 Increase in incidence of HCAI on 4E/ICU during the COVID pandemic

Increases in incidence of HCAI were noted on 4E/ICU during the periods of escalation associated with peaks of the waves of the COVID pandemic.

The likely contributory factors as well as actions to address those are below:

- The significant increase in activity and patient acuity on the unit since the beginning of the COVID pandemic.
- Change in practice when attending to patients who required proning.
- Staff skill mix (buddying) who do not normally work in ICU were caring for patients on ICU.

2.18 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, patients 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 2020/2021, there was 1 Trust acquired VRE bacteraemia. 10% of all enterococcal isolates from blood cultures at STHK were resistant (infection does not respond to the antibiotics) to vancomycin (1% in 2019/20 and 11% in 2018/2019).

There were 5 outbreaks due to VRE colonisation in 2020-2021 (including the outbreak on 3D which started in February 2019 and is continuing) compared with 3 in 2019/2020 (see section 3.1 for further details).

There were 158 hospital onset cases of VRE (non-bacteraemia) compared with 285 in 2019/20, 136 in 2018/2019 and 77 in 2017/2018. Most of these were asymptomatic colonisation detected on routine screening. In addition, 131 community onset non-bacteraemia cases of VRE compared with 106, 134 and 77 in 2019/20, 2018/19 and 2017/18 respectively.

VRE rectal screening (on admission and then weekly) was continued on 4D, 4E, 3B, 3D and 2A. In the absence of national guidance on extending VRE screening further, as agreed by HIPG in 2017 current practice with regards to VRE screening was continued.

2.19 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 zero CPE bacteremia's in 2020-2021 (hospital or community acquired).

There were 11 cases CPE detected in 2020/21. All but one of these was detected on admission screening. The patient who was positive after admission was a long stay patient without known risk factors for CPE. In this case, contacts were managed as per the PHE CPE Toolkit including screening. No cases of onward transmission were identified.

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

- Document details peripheral cannula on VIP chart (at insertion, of monitoring at least once per shift and on removal). When the cannula is removed, the site needs to be continued to be monitored at least once per shift for at least another 48 hours, in order to detect in a timely manner, any evidence of infection post-removal. This must also be documented on the last page of the VIP chart.
- Peripheral cannula must be re-sited at the latest every 72 hours. However, if there is a clinical indication to leave a cannula in for longer (e.g. patient with very difficult IV access), ensure that the rationale is clearly documented in the patient's clinical notes.
- If a line is removed due to suspicion about line infection, send the removed line tip for culture.
- Take blood cultures and other relevant samples for culture in a timely manner (and whenever possible before starting antibiotics) in patients with sepsis. If there is a reason why blood cultures are not able to be taken, document this clearly in the patient's records.
- Document details of staff taking blood culture and where the specimen was taken from (e.g., line, if so which type, or peripheral) on the blood culture request card.
- Do not perform dipstick testing/urinalysis on urine from indwelling catheters or on patients aged over 65 years to check for evidence of urinary tract infection. The only exception to this is testing urine from a newly inserted catheter at the time of insertion. Asymptomatic bacteriuria, i.e., presence of bacteria in the urinary tract without causing symptoms is common in older patients and does not necessarily imply the patient has a UTI. Around 50% of older people have asymptomatic bacteriuria. In patients with a long-term urinary catheter, this rises to almost 100%. Positive urinalysis results (e.g., for nitrite or leucocytes) may be normal in older patients or patients with a long-term catheter because of the high proportion of such patients who have bacteria in their urine.
- If such patients have clinical features of urinary tract infection (e.g., sepsis/rigors/new confusion/supra-pubic pain), please send urine for culture rather than performing urinalysis and commence on antibiotics as per Trust Antibiotic Policy.

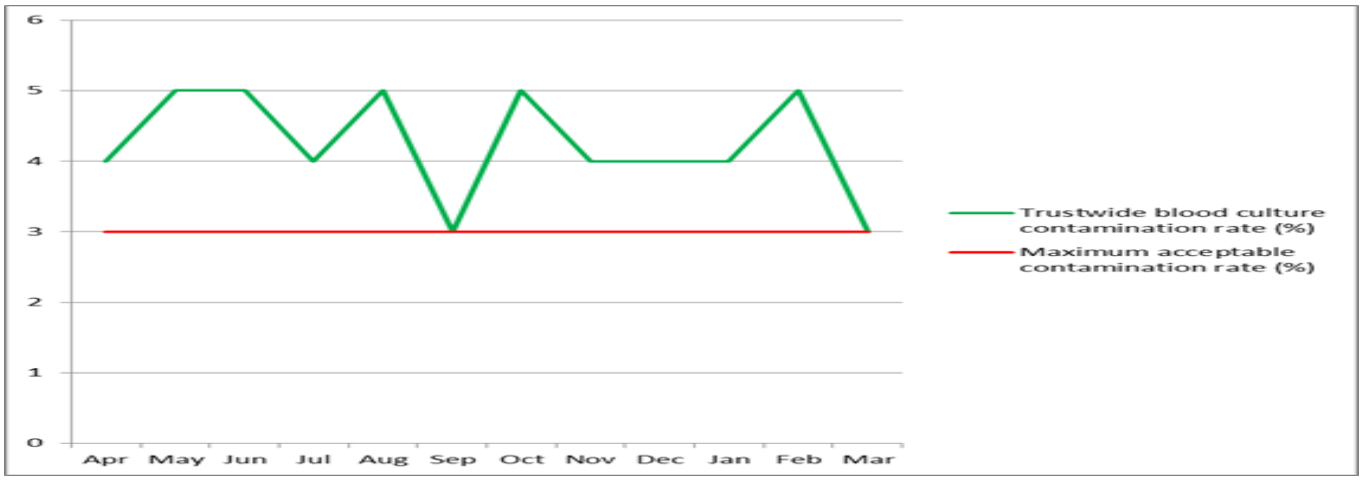
2.21. Blood Culture Contamination.

There will always been a potential for blood culture contamination, however this needs to be minimised through appropriate application of ANTT (Aseptic Non-touch Technique) otherwise patients will be

inappropriately treated for infections they don't have which may lead to increased hospital stay or even risk of CDI.
The chart below shows the red line at 3% which is considered to be the best achievable contamination rate.

The Overall contamination rate for 2020-2021 = 4% (498 contaminated BC out of 11435 specimens taken).

Data by month is in the table below:



Action: The ED Practice Education Facilitator provides training and monitoring of workplace practice assessments. The IPC team will continue to monitor and provide feedback to the staff.

3. Outbreaks, Incidence of Periods of Increased Incidence (PII) and nosocomial COVID-19

3.1 During the period 2020-21, there were 47 confirmed hospital outbreaks in 2020/21 – the majority were nosocomial COVID-19 outbreaks. This included 365 patients, 356 staff and resulted in 1289 lost bed days.

3.1.1 Nosocomial COVID

In accordance with NHSEI covid testing requirements, the Trust screened all patients on day 1 (day of admission), day 3, day 5 and every 5 days following this if the patient had a negative test.
NHSEI definition of nosocomial infection is a positive test on:

- 0-2 days post admission is considered community acquired,
- 3-7 days indeterminate healthcare associated
- 8-14 days probable healthcare associated
- 15 days and over definite healthcare associated.

The changes in testing protocols occurred due to the effects of asymptomatic carriage causing infections. The Trust remained compliant with the screening of patients and had 2891 positive results. The table below provides a summary of the reported nosocomial COVID-19 cases according to NHSE definitions/requirements in 2020/21. The chart below shows the number of patients who tested positive from 1St April 2020 to 31 March:

Year	Hospital onset DEFINITIVE healthcare associated COVID cases	Hospital onset PROBABLE healthcare associated COVID cases	Hospital onset INDETERMINATE healthcare associated cases	COMMUNITY onset cases
2020	61	53	97	1382

2021	85	71	86	1056
Percentage	5.1%	4.3%	6.3%	84.3%

Each nosocomial COVID-19 case was investigated as per the NHSE RCA guidance since these were issued in June 2020. All nosocomial COVID-19 outbreaks were reported to PHE/NHSE according to national requirements. The Trust had the lowest NCI in Cheshire and Merseyside.

The vast majority of patients testing positive were in the community onset category of patients who had acquired their infection in the community, The World Health Organisation (WHO) describes the incubation period as generally 4-6 days but can be up to 14 days.
In practice it is apparent that initial PCR COVID19 swabs may not detect the virus particularly if the patient is in the initial incubation period, this has led to patients with asymptomatic carriage transmitting the virus to others within the hospital setting and, in some instances, causing outbreaks. Most of the outbreaks involved single bays and movement of patients.
As the pandemic has evolved so too has the national guidance and in addition the Trust has innovated in enhancing processes and using technology. Prior to the national guidance to screen patients on admission then at 3 and 5 days, the Trust had already put this into action and then continued screening negative patients at 5-day intervals because experience showed that inadvertent transmission could occur between patients even if their initial tests were negative.

3.1.2 3D VRE outbreak

Themes identified in relation to VRE outbreak related to environmental issues and clinical practice. Multi-disciplinary outbreak meetings held with representation from Public Health England previously. Actions to date included the ward being closed to admission on four occasions and deep cleans of the whole ward being undertaken. 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. The number of new VRE acquisitions on the ward during 2020/21 (i.e. 59), was a reduction compared to 2019/20 where there were 78 new cases.

3.1.3 Community outbreak of group A streptococcus (GAS) related to St Helens District Nursing (Central Locality) Team.

Between November 2020 and March 2021, 4 patients were identified as having infection with a single type (emm 83.13) of GAS. Two of the 4 patients had invasive-GAS infection. All 4 patients were under the care of St Helens Central Locality District Nursing Team prior to identification of the infection. A multi-disciplinary incident investigation/management team was set up including input from PHE. All high-risk patients under the care of this district nursing team were screened for GAS (no positives identified), all relevant staff from the district nursing team were reviewed and screened by HWWB (no positives identified) – all relevant staff received antibiotic prophylaxis via HWWB; clinical practice and procedures were reviewed, and any issues addressed. No further cases have been identified since March 2021.

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 nominated leads 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 IPT.

- ANTT stickers, which are attached to the staff name badge 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 2020/21.Extensive advice on SARS-CoV19 has been produced and is available on the Trust intranet

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. During 2020-21. IP mandatory training has been challenged particularly in relation to IP level 2 training. The table below provides IP mandatory Training compliance, which is below the required level. This was impacted during the Covid -19 Pandemic due to the wards and departments were unable to release staff for clinical competency assessments. A plan is in place to address this over the next 6 months

Org L1 up to end of March 2021	NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|
409 St Helens and Knowsley Teaching Hospitals NHS Trust	**83.83%**	**52.27%**

6.4. 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 provided a rolling programme of Fit testing that all staff had access to. When the SARS CoV2 pandemic began the IPT provided a large number of additional fit testing Key trainer sessions. This service is now provided by the Health and Safety Team.

6.5. Link Personnel Programme

Link personnel meetings were held bi-monthly. An education session, usually from a guest speaker is normally incorporated into the meeting. These meetings were held electronically. Numerous topics were covered,

including hand hygiene, CDI, MRSA, CPE, SARS- Cov2 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 remotely, e.g. Infection Prevention Society (IPS), 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 was routinely performed on an annual basis; this was suspended due to the pandemic. Wards, Matrons and Link personnel were 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. Due to the COVID pandemic, the annual upgrade of the system was post postponed till later in 2021.

The Trust procured the ICNet Outbreak Manager Module via COVID related funding. The implementation of this module is expected in 2021 after the ICNet upgrade.

8.2 The IT changes in relation to SARS CoV2 implemented at the beginning of the COVID pandemic were continued in 2020/21 including:

- Automated transmission of COVID-19 results from Telepath (the laboratory results reporting system) into ICNet to enable real time reporting of COVID-19 results to the IPT from the laboratory.
- Automated electronic alerting of 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.
- Using ICNet to document clinical actions in relation management of individual COVID-19 positive patients (including RCA findings) and outbreaks.
- Use of multiple reports were set up on ICNet to enable data extraction in order to support local/regional/national reporting requirements related to COVID-19.

8.3 The IPT continued to contribute to the updating of 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 previously on Patientrack were transferred to the System C e-Vitals system in 2020-2021. The IPT provided extensive input into the development and testing of the CPE risk and screening assessment narrative forms on e-Vitals in collaboration with colleagues from Informatics.

8.5 To enable timely testing of patients, the Information Team set up two automated reports to be emailed to relevant staff daily which identify patients who require screening for MRSA or COVID-19.

8.6 As a routine part of clinical case management, the IPT continue to add infection prevention related alerts to inpatient records on JAC (the Trust's electronic prescribing system) 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 – not undertaken due to the pandemic
- Compliance with IP precautions audits throughout 2020/21
- Compliance with IP precautions throughout the 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 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). It is important to note that due to COVID-19 guidance elective operations were suspended to enable Trust to focus on non-elective admissions. This potentially will impact on the SSI rate

2020/21 data indicated that:

- There were 77 Hip operations performed of which 1 infection was noted (1.3% compared to 0.8% national average).
- There were 94 Knee replacements completed of which 1 infection was reported (1.1% compared to 1.2% national average). This infection was a patient- reported surgical site infection.

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 Prevention 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.
- Clostridiodes 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 Group (HIPG).

10.4 Key Achievements:

- Returned to providing antimicrobial stewardship ward rounds across Whiston Hospital which had been suspended due to the SARS –CoV 19 pandemic.
- Published and maintained up to date Antimicrobial Policies for Adults, Paediatrics and Neonates on the MicroGuide platform. All guidance is based on current national guidance and locally susceptibility data
- Maintained one of the lowest levels of consumption of broad spectrum agents (e.g. piperacillin/tazobactam and carbapenems) in the region.
- Maintained one of the highest levels of consumption of narrow spectrum "access" agents (e.g. amoxicillin, flucloxacillin, etc.) in the region.
- Continued to facilitate 171 episodes of outpatient parenteral antibiotic therapy (OPAT) in the absence of a formalised service.

10.5 Key challenges/issues**:**

- OPAT is an area for increased focus to support patient discharge and monitoring of patients

- COVID-19 has resulted in the increased use of broad spectrum antimicrobials (particularly co-amoxiclav.
- Staffing. Turnover, sickness absence and ward speciality changes during COVID-19 pandemic resulted in different ways for key members of staff for Microbiology. IPC and pharmacy teams

10.6 Actions taken to overcome challenges and issues:

- In house developed OPAT access database. Resource was developed to help monitor OPAT activity and patient management. Formalised service is integral to the success of this
- CCG targets addressed systematically with planned AMS activities adapted to fulfil requirements.
- Guidance on appropriate use of antibiotics in COVID-19 created and circulated to all medics via medical director and global email. National guidance from NICE later followed and was incorporated. Audit of antibiotic use carried out and results communicated.

10.7 Forward plan 2021/2022:

- Continue to undertake ward rounds and to maintain antibiotic policies.
- Junior doctor teaching in the August “induction” sessions for foundation trainees
- Produce Trust Antimicrobial Stewardship e-learning package
- Vancomycin and gentamicin to be prescribed on EPMA
- Work with North West Antibiotic Pharmacist Group to develop and deploy a region-wide gentamicin protocol and calculator.
- Work with Aseptic Dispensing Unit to provide ready-to-hang antibiotics in line with Lord Carter’s review of pharmacy aseptic services.
- Promote optimal antibiotic use Trust wide with particular regard to:
    - Antibiotics in patients at end of life
    - Early stepdown to oral antibiotics
    - Avoiding unnecessarily prolonged courses
    - Penicillin allergy de-labelling

11. Health, Work and Wellbeing (including Sharps)

11.1. The Health, Work and Well-being (HWWB) provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff. There is also a recall system in place in which staff are recalled (if appropriate) for vaccinations when due to ensure that they are kept up to date and our compliant.

11.2. The service has also supported advice and treatment in the event of outbreaks or incidents requiring staff screening or treatment. The Trust Health & Wellbeing Department report monthly to the IPC including vaccination updates.

11.3 Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on measles, chicken pox, HIV and hepatitis C have been incorporated for all ‘new starters’ and a catch up exercise is in place for staff already employed. The IPT supports the Health & Wellbeing Team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

11.4 **Flu**

Key Achievements:

- Flu vaccine uptake amongst front line clinical staff during pandemic was 94.95%
- 2nd highest flu vaccine uptake nationally in acute trust.
- Due to continue high uptake PHE requested STHK to deliver a presentation nationally to support low uptake trust

Key challenges/issues:

- Due to pandemic unable to use the roving flu model where visit numerous clinical areas targeting staff.
- Administering the vaccine to Staff who were shielding or working remotely.
- Usually have 6 months, however PHE 90% achieved by December 2020, which was 10 weeks.

Actions taken to overcome challenges and issues:

- Working as part of MDT, with ICP, ward managers and Matrons, Director of Nursing, Microbiology.
- Linking in the MDT team to ensure that when we went to ward areas it was safe (from covid viewpoint) to do so.
- Ensuring all vaccinators had the correct PPE and hand washing facilities.

Forward plan:

- Joint covid/ flu mass vaccine clinics are enabling staff to book and attend. This will therefore minimise queues.
- The roving flu model, when HWWB take over will be very targeted approach, targeting high risk, low uptake clinical areas first.
- Resources will be allocated to target all shift patterns to ensure all staff get every opportunity to have the flu vaccine.
- Health promotion and education is key to support staff to get the flu vaccine.

11.5 **Self-isolation team and Covid Swabs**

Key Achievements

- Since march 2020 staff who were unable to work on clinical areas were redeployed to HWWB and formed the Self-isolation team
- Throughout the last 18 months this team has changed and now they have a team clinical lead, and the team support clinical staff who cannot work in clinical areas to remain in work.
- From Jan 2021 to Sept 2021 they have swabbed 2353 staff member (this is not including household contacts)
- They have supported the 798 staff that tested positive, giving them appropriate guidance and advise.
- The Self-isolation team have supported managers in getting these staff safely back to work.

Key challenges/issues:

- Continuous change in guidance. This has often results in the process for referring into self-isolation team not being followed.
- Resources, lack of resources and change in demand has meant at times it can be difficult to meet the expectation on 24/7 service.
- Self-isolation guidance changed throughout the pandemic
-

Forward plan:

- The Self-isolation team guidance, in collaboration with Microbiology has now been updated and is available on covid intranet.
- Continued collaborative working with Self-isolation team, managers and execs will support safe return of staff to the work place.
- This will support high quality patient care and safety during the winter months.

11.6 **Group A Streptococcus (GAS)**

Key Achievements:

- Two major GAS outbreaks this year.
- Community HWWB collaboratively worked with Managers and Microbiology and got all staff involved swabbed and prescribed medication in the correct time frame.
- Internal GAS. HWWB swabbed all staff involved, with a mix of swabbing clinics in HWWB and HWWB staff attending the area to swab staff.

Key challenges/issues:

- Communication between managers and HWWB about identifying staff who needed swabbing
- Logistics and resources. Night shift staff found it difficult to attend HWWB for swabs alternative clinics in place (twilight clinics) and early morning clinics

Actions taken to overcome challenges and issues:

- Key leads in HWWB who will work collaborative with managers and Microbiology.
- Work from clear defined time frame.

Forward plan:

- Develop and internal SOP for GAS outbreaks.

11.7 **Needlestick Injuries**

Key Achievements:

- Working with datix and procurement to improve the quality of reporting in order to ensure that key areas have the support they need.

Key challenges/issues:

- Incomplete information on Datix report.
- Timeliness in completing RCA.
- Process of notification from ED to HWWB re staff presenting with NSI
- Staff training around what to do in NSI.

Actions taken to overcome challenges and issues and forward plan

- HWWB and Procurement are working collaboratively on addressing how to improve datix RCA reporting.
- HWWB are working on systemisation to support NSI who attend AED.
- HWWB working with ICP to educate and support staff who have has NSI.
- Using Datix to pull demographic data so we can analyse trends and address key issues.

Table 1. Top10 locations for NSI from 01/01/2021 to date (08/10/2021)

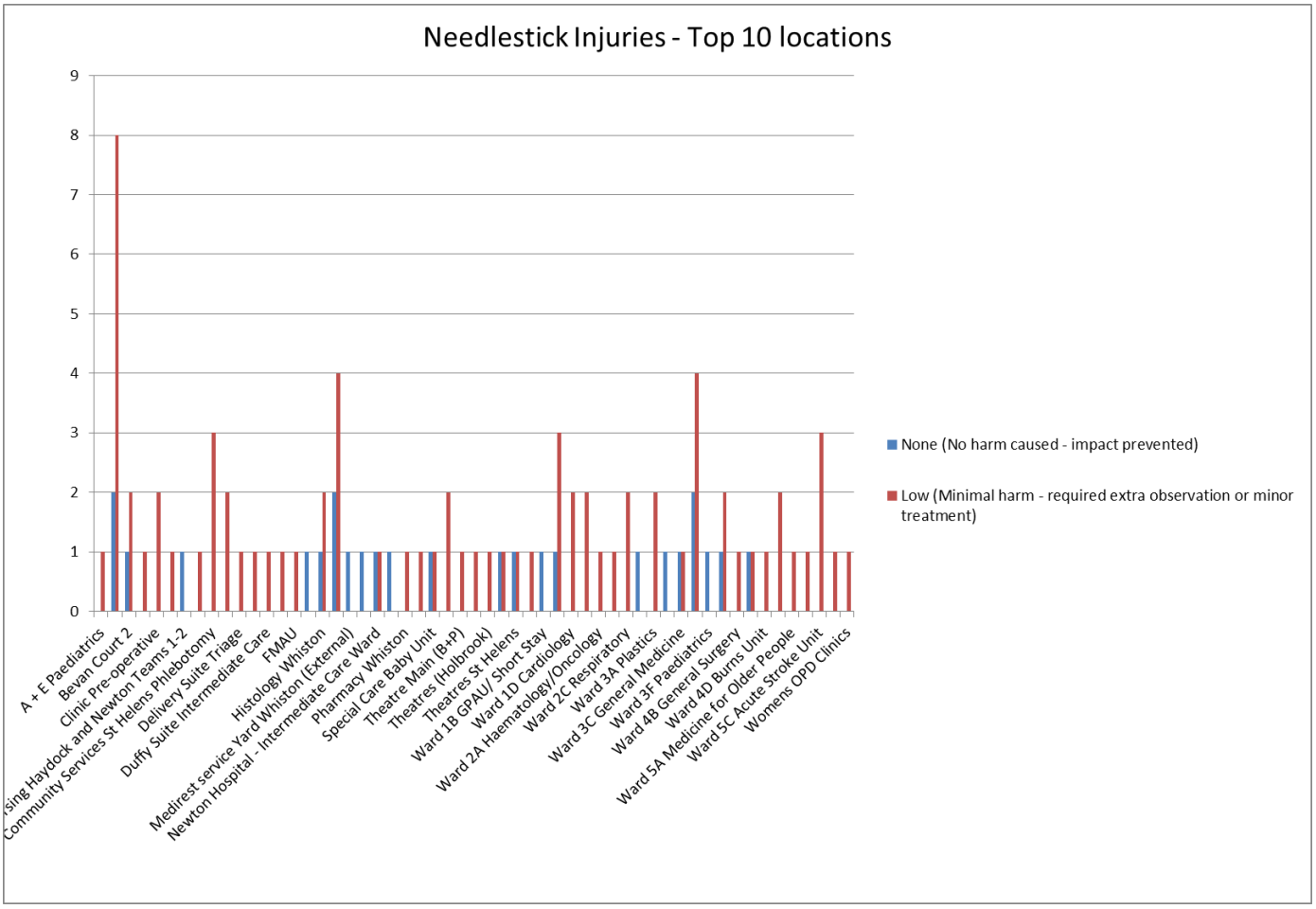
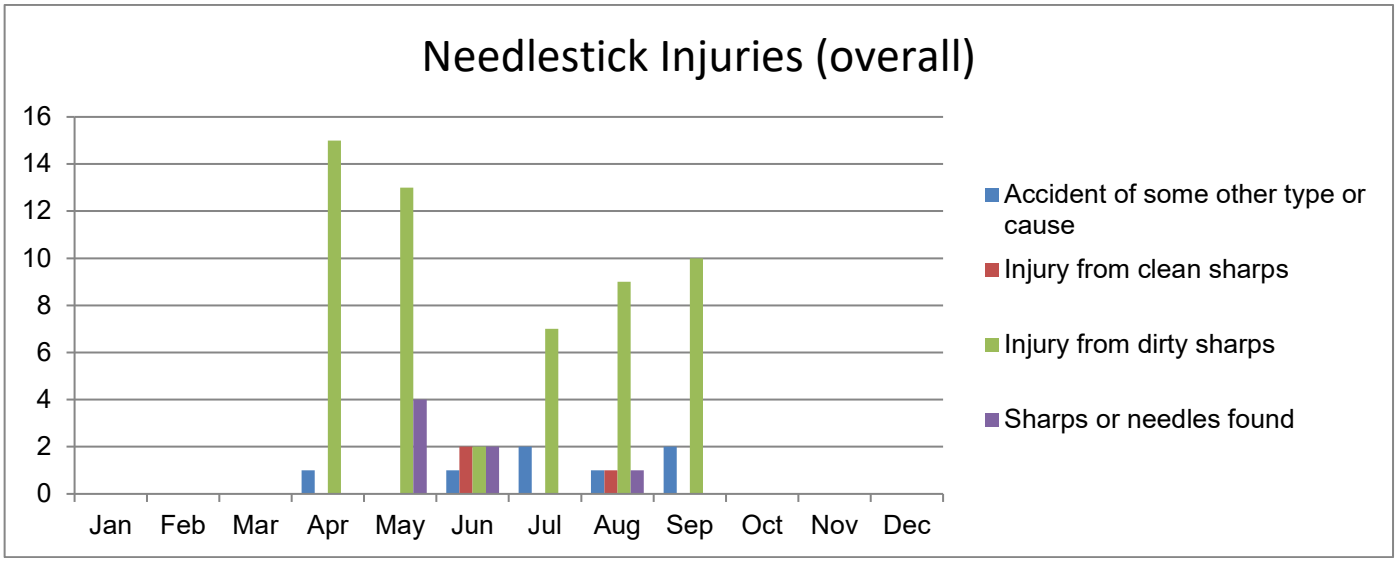


Table 2:

Cause of NSI from 01/04/2021 to date



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.

Key Achievements:

- Providing a safe and timely endoscope decontamination service in very challenging times due to the pandemic
- Achieving an amber, green rating in the annual IHEEM/JAG Audit carried in September 2021
- The installation of 6 rental RO units on both sites. The install was phased over 6 months to lessen the impact on capacity
- The commencement of quarterly environmental testing, this includes endoscope drying cabinet shelf life testing and endoscope bioburden micro testing
- The commencement of the build phase of the new St Helens decontamination unit due to open late spring 2022

Key challenges/issues:

- The decontamination equipment on both sites is now seen as near end-of-life cycle.
- Supporting service users to reduce patient backlogs again due to Covid
- Ensuring capacity and endoscope turnaround times where not impacted during the swap out of the old RO equipment on both sites

Actions taken to overcome challenges and issues:

- Letter of assurance from the current equipment service contact providers to ensure spare parts and manufacturer trained engineers are available
- Ensuring a schedule of planned preventative maintenance is in place for all decontamination equipment
- Liaising with service contract providers to ensure the least disruption to capacity and activity during the quarterly and annual testing of the decontamination equipment
- Fully comprehensive service contracts in place to provide Periodic Service, Validation and Testing of all decontamination equipment
- Extra microbial testing in place on all decontamination equipment to provide assurance to the Trust that safe systems are in place
- Recruitment of bank staff for decontamination training, which provides the units with extra staffing support when required

Forward plan:

- Spring 2022 should see the opening of the new Endoscope Decontamination Unit at St Helens. The unit will have 2 trolley washers and a class 8 clean room which is a first for an endoscope decontamination unit. The endoscope washers will utilise the latest endoscope recognition technology and the unit has been futureproofed to provide the ability to expand alongside the growth in endoscopy procedures
- Autumn 2022: the build phase of the new Endoscope Decontamination Unit at Whiston

13. Estates, Facilities, Waste Management and Water Safety.

13.1. The Estates and Facilities Management team and their PFI (private finance initiative) partners: New Hospitals, Vinci FM and Medirest continue to work closely with the Infection Prevention and 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

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.

13.2 Waste/sharps safety

13.2.1 Clinical Waste Collection

All clinical waste materials used are correctly disposed of as clinical waste (i.e., in clinical bins/Sharpsmart containers) in line with national guidance. this is closely monitored by the waste management team. Clinical waste is packaged in UN3291 approved waste bags, closed with an appropriate mechanism (cable tied or swan necked). Extra internal collections have continued to take place when requested during this testing period whilst clinical waste is being produced 24/7 in affected busy areas. All areas are being monitored daily and support is available to ensure all waste and linen is disposed of regularly.

Whiston Hospitals clinical waste collections has faced some disruption due to the unprecedented volume of waste being generated (disposal of PPE, mask, gloves etc. and the intensity of usage). To address this a range of mitigating actions were implemented including extensive use of third-party capacity also we had daily contact with the NHSI Logistics Cell and the National Contingency Co-ordinator (NCC).

Clinical Waste Bins

The Environmental Officer worked with the infection prevention team during recent infection prevention audits and all clinical waste bins which have been identified during the audits have been replaced with a 100% plastic type containers (rust free).They have a removable body for easy cleaning and aiding with manual handling. The Hands-Free frame aids with infection prevention to meet the NHS England 'Managing Healthcare Fire Safety (HTM-05-03)' guidelines and as a whole protecting our environment.

Key challenges/issues:

The waste service had been relying on its own contingency plans plus exta staff working in the service yard to keep the clinical waste running smoothly.

13.5. Water safety group

All parties represented at the Water Safety Group (the Trust, New Hospitals, Medirest, Vinci FM and HSL) have worked in close collaboration to reduce the risk of water borne infections to our patients

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.

Key Achievements:

- Six monthly sampling (PPM's) for Pseudomonas aeruginosa in augment care areas as per HTM 04 completed as planned.
- Supporting the multi-disciplinary investigation of the 4D/4E multi resistant pseudomonas with additional sampling and rectification of issues identified such as lime scale on taps.
- Supporting the multi-disciplinary investigation of Duffy and Seddon legionella positive results with additional sampling and rectification of issues identified.
- Investment into the descaling of all taps on a rotational basis by the domestic teams

Key challenges/issues:

- Ensuring that all relevant staff are aware of their responsibilities and carry these out correctly with regards to flushing of outlets on augmented care (as well as of little used outlets elsewhere.
- Effective contingency planning when undertaking emergency works and water shut down ensuring Infection Prevention Team are linked into the process.
- Ensure IPC are aware of all planned capital and small works schemes which impact on the building usage.

Actions taken to overcome challenges and issues:

- Training provided to augmented care staff and also IPC Link Professionals on water safety.
- All flushing to be audited and non-compliance to be reported in the Infection Prevention and Control monthly report.
- In augmented care areas, Medirest have an ongoing programme of twice weekly monitoring of taps for build-up of limescale.

Forward plan:

- Continue to monitor augmented care areas as per HTM 0401.

- Ensure that there is no water related risk in ward/ bed space areas which are being reconfigured within the Trust.

- Maintain engagement with ward staff (especially in augmented care) with regards to water safety.

- Infection Prevention Team to be informed of any works/ repairs/ refurbishments which may impact on the staff/ patient's ability to maintain effective infection Prevention to ensure they are involved in all new schemes (both capital and small works.

- Schemes in the near future include:
  Increase Theatre capacity Whiston
  Cold decontamination Unit St Helens
  Post discharge scheme
  Bed Bureau
  Extension and reconfiguration to CHOBS
  Community buildings – compliance assurance from our landlords

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	Clostridiodes 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

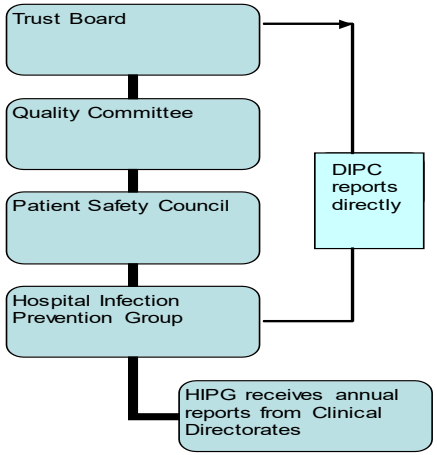
St Helens and Knowsley Teaching Hospitals NHS Trust

St Helens & Knowsley Teaching Hospitals NHS Trust
Infection Prevention Annual Work Plan 2020/2021

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

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

Infection Prevention Work Programme 2020/2021

IP Code and Trust Objectives	Plan and Priority Activities	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 3, 4, 8 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**1. Infection Prevention Team Staffing**						
	DIPC - Director of Nursing, Midwifery and Governance	Sue Redfen (SR)					
	Infection Prevention (IP) Doctor – Consu	Dr Kalani Mortimer (KM)					
	Deputy IP Doctor – Consultant Microbiologist	Dr Michael Fisher (MF)					
	Lead Nurse IP	Oonagh McGugan (OM)					
	1 x IP Specialist Nurse (Band 7)	Maureen Kendrick (MK) 0.4 WTE					
	1 x IP Specialist Nurse (Band 7)	Alice Cruz (AC) 1 WTE					
	1 x IP Specialist Nurse (Band 7)	Zoe Rushton (ZR) 1 WTE					
	1 x IP staff nurse (Band 5)	Joanna Pennington (JP)					
	1 x IP staff nurse (Band 5)	Tracey Kelly (TK)	Competed student nurse training 2021				
	1 x IP Secretary (Band 4)	Joy Davidson (JD)					
	0.6 Audit & Surveillance Assistant	Jackie Crute (JC)	JC moving to another department in STHK, vacancy advertised				
	Antimicrobial Management Pharmacists. (Pharmacy budget)	Andy Lewis (AL) Andrew Brush (AB) Elisha King (EK)					
	The Trust Antimicrobial Management Team (AMT) consists of AL, AB, KM & MF						
	Hospital Infection Prevention Group (HIPG)						
	The IPT reports to the Board via the HIPG. The HIPG meets 6 times per year. The reporting line to the Trust Board is shown below. The Terms of Reference(TOR) were reviewed and amended in June 2021.		TOR reviewed at HIPG Q1 2021				
							

Infection Prevention Work Programme 2020/2021

IP Code and Trust Objectives	Plan and Priority Activities	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. Introduction of a	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. New process introduced in Q2, continue to monitor effectiveness 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			
	Surgical Site Infection (SSI) surveillance for Orthopaedics	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.	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.	Ongoing			
	Flu, RSV, SARS CoV19	Microbiology and IPT	Automated transmission of COVID-19 results from Telepath (the laboratory results reporting system) into ICNet to enable real time reporting of COVID-19 results to the IPT from the laboratory. Automated electronic alerting of 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. Using ICNet to document clinical actions in relation management of individual COVID-19 positive patients (including RCA findings) and outbreaks. Use of multiple reports were set up on ICNet to enable data extraction in order to support local/regional/national reporting requirements related to COVID-19. Continue to contribute to the updating of COVID intranet micro-site implemented by the Communications Team which hosts all information and guidance relevant to the Trust 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. The IPT continues to provide advice and support trust wide in managing SARS CoV2.	Ongoing			

Infection Prevention Work Programme 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities.**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**3. Hand Decontamination**						
1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	Introduce new hand decontamination sign posting for the Trust	IPT, Deputy General Manager (Medirest),	Determine what resources are available, assess their suitability and roll out throughout the trust This has not been actioned due to the pandemic				
	Review current products and dispensers and investigate the possibility of upgrading to hand free dispensers for soap product.	Soap provider rep and procurement	Continue to audit and report on hand hygiene compliance				

Infection Prevention Work Programme 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**4. Policies and Patient Information Leaflets**						
1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	Review and update Infection Prevention Policies as required	DIPC	Polcies for review are discussed at biweekly IP team meetings and timeframes agreed.				
	System to be devised and implemented to remind nominated policy reviewers of when policies are due	JD	Electronic system in place to inform nominated policy reviewer of timing of policy review.				
	To provide advice and support on policies where IP is an integral component	IPT	Participation in updating relevant IP related policies				
	To review and update current patient leaflets. To devise further patient leaflets as required	IPT	All patient leaflets have been updated and sent for printing to an external company				
	To format policies and patient leaflets in Trust Format	JD	majority of the policies are in the most recent trust format				

Infection Prevention Work Programme 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Monitor Trust wide compliance and increase compliance rates.	OM,	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training	IPNs Nurse Consultant ICU	Key Trainer Training half day sessions are provided twice a month. This has been increased as sessions were suspended during some of the pandemic.				
	Liaise with ANTT experts to review and refine existing processes	IPNs Nurse Consultant ICU	Two infection prevention nurses attending the National ANTT conference in October IPN to attend North West IV Forum Meetings when re-established				
	To act as an advisory role for vascular access and therapy related issues.	IPNs Nurse Consultant ICU	To provide expert advice on matters relating to vascular access and therapy.Provide report to the HIPG every two months.Lead IP Nurse to co-chair along with Nurse Consultant ICU, the Intravenous Access & Therapy Group on bi-montly basis.				
	Undertake annual trust wide PIVC auidt	IPT and MET manager	provide report to HIPG and PSC. Address any issues, produce an action plan that will be monitored at the IV therapy group. Explore initiatives and innovations to address sub-optimal line care				
	Produce and e-learning package for clini	IPT	Content of e-learning package has been produced by KM.This has beenconverted into a web based education programme that has a test element added to it.				

Infection Prevention Work Programme 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**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 2021/22 To regularly attend local HCAI whole health economy meetings To attend local and National IP/relevant conferences as the service will allow. Attendand at the infection prevention society conference annually by at least one member of the team. undertake webinars hosted by HIS,IPS and other accredited organisations				
	Mandatory and induction	IPT	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. Induction training is online				
	Preceptorship	IP Team Antimicrobial Management Pharmacists (AL, AB)					
	ANTT Key Trainers	OM	twice a monty				
	Link Personnel	IPT	6 times per year				
	IP antibiotic prescribing	Antimicrobial Management Pharmacists/Consultant Microbiologists	AMU Junior Doctor training; Surgical Junior Doctor teaching (both minimum twice yearly); Fourth year Medical Student teaching (6 times per year); all medical staff inductions; Grand Rounds as required; pharmacist clinical meetings at least updates every month and clinical education sessions twice per year. Pharmacist teaching for FY1 and FY2 Junior Doctor cohorts each at least twice per year.				
	Ad hoc training to include: Volunteers Student Cadet Fundamental Training	IPT	As required throughout the year dependent on need and staff intake				

Infection Prevention Work Programme 2001/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 7, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**7.Audit**						
	To provide assurance to the Board and relevant committees of adherence to high quality IP practices. All findings are communicated to the relevant clinical staff and reported via the IP monthly report and the HIPG. All lessons learnt are disseminated to the relevant staff and other agencies as appropriate in a timely manner.	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and PSC				
	Audit Programme revised annually.	IPT	Due to staff changes in the IPT, the audit programme has been reviewed and revised to reflect the changes in staffing. 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	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.	IPNs	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	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	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 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**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/EK	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/EK	To be circulated Trust wide annually				
	Presentation of antimicrobial expenditure information	AL / AB/EK	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 / EK	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 / EK	Quarterly to HIPG and DTG				
	To Develop EPMA antibiotic data extraction for drug use audit and targeted ward rounds	AL / AB / EK	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 / EK	Quarterly to HIPG and DTG				

Infection Prevention Work Programme 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:	**9. Communications**						
1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	IP Monthly Report	IP Team and AMT	Unified IP monthly report, combining monthly reports for the Medical and Nursing staff.				
	Communication with other Trusts and agencies such as Public Health England (PHE)	IP Team	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IP investigations.				
	Trust intranet	IP Team	To maintain and update the Trust intranet site with relevant and up to date information for Trust staff.				
	Mersey Micro smart device app	AMT	To maintain and update the Mersey Micro app in line with changes to Trust antibiotic policy				
	Administration	JD	To provide administrative support to the IP Team to include: Co-ordination of relevant IP Meetings Diary management. Data collection for monthly reports.Co-ordinate RCA meetings and documentation.Signposting for wards and departments telephoning for IP advice. Taking and distribution of minutes for relevant IP meetings Co-ordination of IP documentation,e.g. audit programme, education programme. ESR administration, ICNet administration				

Infection Prevention Work Programme 2020/2021							
IP Code and Trust Objectives	**Plan and Priority Activities**	**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 in place To introduce further functions to the system as they become available via ICNet - which includes audit and surveillance. Introduction of an outbreak module, this has been purchased and will go live when ICNet is updated 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**	**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 2020/2021

IP Code and Trust Objectives	Plan and Priority Activities	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	OM	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Waste	IPNs	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	IPNs	To provide expert advice and support as required.				
	Mattresses	IPT	To be involved in the renewal of contract relating to bed frames and mattress decontamination				
	Health & Safety	IPNs	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.				

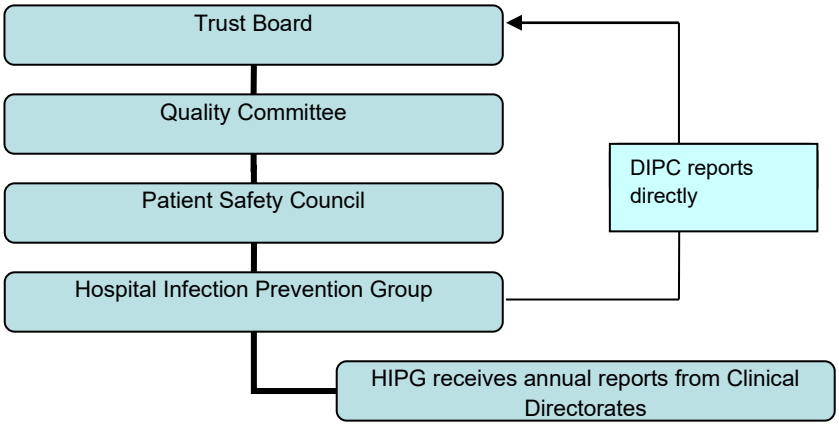
Appendix 2

HIPG TOR

Terms of Reference	NAME: HOSPITAL INFECTION PREVENTION GROUP (HIPG) FINANCIAL YEAR: 2021/22
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
	• Head of Nursing and Quality for Surgical Care Group (matron to deputise if not in attendance)
	• Head of Nursing and Quality for Medical Care (matron to deputise if not in attendance)
	• Head of Nursing and Quality for Community (matron to deputise if not in attendance)
	• Divisional medical director for:
	  ○ Medicine
	  ○ Surgery
	  ○ Paediatrics
	• PFI Contract and Performance Manager
	• Matron from each care group
	• Decontamination Manager
	• Antimicrobial Management Pharmacist
	• Health Work & Well-being representative
	• Estates and Facilities Manager
	• Medirest Manager (cleaning contractor)
	• Vinci Maintenance Services Manager
	• Consultant in Communicable Disease Control
	• Clinical Procurement Specialist
	• Environmental officer
	
	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 audit and surveillance assistant
	• Operational Services representative – Head of Patient Flows
	
	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.

<table>
<tr><td></td><td></td></tr>
<tr><td>Quorum</td><td>50% of the core membership (or appropriate deputies) must be present. To include at least one Infection Control specialist.</td></tr>
<tr><td>Accountability & Reporting.</td><td>The Hospital Infection Prevention Group was established by and is responsible to the Trust Board via the Patient Safety Council:
 

.</td></tr>
<tr><td>Meeting Frequency</td><td>6 times a year</td></tr>
<tr><td>Agenda Setting and Minute Production and Distribution.</td><td>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
<table>
<tr><th>Quality indicator report</th><th>Frequency of report</th><th>Reported by</th></tr>
<tr><td>Mandatory surveillance:
a. MRSA bacteraemia
b. C difficile infection
c. MSSA bacteraemia
d. Gram negative (E coli/Klebsiella/Pseudomonas aeruginosa) bacteraemia

e. SSI orthopaedics</td><td>At each meeting</td><td>Lead IPN

e. Orthopaedic SSI Nurse</td></tr>
<tr><td>Local surveillance results</td><td>As available.</td><td>Infection Prevention Nurses</td></tr>
<tr><td>External inspection reports and action plan progress (e.g. CQC)</td><td>As required (subject to reports being issued by external agencies)</td><td>Lead IPN</td></tr>
<tr><td>Antimicrobial Management Team report</td><td>At each meeting</td><td>Consultant Microbiologist and</td></tr>
</table></td></tr>
</table>

	(to include audit results and action plans, policy compliance and review)		Antibiotic Pharmacist
	Annual Report	Annual	DIPC or deputy
	Reports from Medical & Surgical and Community Directorates.	At each meeting	Heads of Nursing and Quality for Medicine, Surgery and Community
	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 from Water Safety Lead	At each meeting	Water Safety Group Representative
	Report from Trust Estates and facilities	At each meeting	Trust Estates and Facilities manager
	Report form IV access group	At each meeting	IV access group representative
	Report from Waste Management Group	At each meeting	Environmental officer
	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 the lead nurse infection prevention, to the 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:

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)074

Title of paper: Learning from Deaths Quarterly Report Q1 2021-2022

Purpose: To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths and key learning has been disseminated throughout the Trust.

Summary:

	No. of reviews	Green	Green with Learning	Green with positive feedback	Amber	Red
April 2021	33	21	3	3	1	0
May 2021	37	18	3	0	2	0
June 2021	30	14	5	5	0	0

Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, Communication

Financial implications: None arising from this report

Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners

Recommendation(s): To approve the report, policy and good practice guide

Presenting officer: Jane Bennett – Quality & Risk Coordinator

Date of meeting: 27th October 2021

1 EXECUTIVE SUMMARY

"Learning from deaths of people in our care can help us improve the quality of the care we provide to patients and their families, and identify where we could do more" NHSI 2017.

In Quarter 1 2021/22 a total of 100 SJR's were requested 72% (72n) of the reviews had an outcome of no concerns (Green, Green with learning/positive). 3% (3n) had an AMBER outcome 2 of which are receiving further input or investigation and one has been previously StEIS reported. There are 15 reviews outstanding from Q4. These have been impacted on by retrospective concerns.

See Appendix 1 for the case selection contributing to Mortality Surveillance Group MDT / Learning from Deaths Quarterly Report.

1.1. Shared learning for Q1

Learning disability deaths	**Falls that result in death**
Following an audit carried out on all patients who have a learning disability who have died in the Trust since SJR's began, we are able to confirm that all patients had received not only an SJR but also a LD review. The outcomes of all of these reviews were either green or green with learning, thus confirming that we have robust systems in place for looking after this complex cohort of patients. For any further advice or support in caring for LD patents or feedback on these reviews then please contact Kenny Jones, Learning Disability Specialist Nurse on ext 4946	*Falls are the most common cause of injury related deaths in people over the age of 75 – Age UK 2019* *Of 39 serious harm falls investigated between Jan 2020 – Apr 2021, 12 (30%) died within 28 days of the fall in hospital.* All patients aged 65 or over or anyone aged 55-64 with a condition that could increase their risk of falling (e.g. a neurological condition) must have a falls risk assessment carried out within 6hrs of attendance at ED/admission to a ward. This should be done from both a nursing and medical perspective and falls risk factors should be considered irrespective of the acute reason for attendance/admission. In addition, end of life and palliative patients should also be considered for their increased risk of falling. When the risk assessment has been completed, we must ensure that appropriate actions to minimise risks identified are taken and documented e.g. supervision level, low rise bed. If a fall does take place, it is essential that a post fall medical review and nursing proforma are completed/documented and the risk assessment and any associated care plan/actions are updated accordingly.

Previous learning can be found in the "Learning into Action" section of the Trust Intranet

1.2 Sharing and embedding learning

This learning is shared & evidenced in meeting minutes as per matrix in appendix 2.

2. ANALYSIS

2.1 Total number of reviews completed for Q1 2021/22

	No. of reviews	Green	Green with Learning	*Green with positive feedback	Amber	Red
April 2021	33	21	3	3	1	0
May 2021	37	18	3	0	2	0
June 2021	30	14	5	5	0	0

2.2 *Green with Positive Feedback

Our reviewers, during a mortality review, often pick out areas of excellent or exceptional practice. We have made a concerted effort to ensure that written feedback is sent to the individuals or the teams involved. Positive feedback helps motivation, boosts confidence and reinforces to our staff how much we value the job they do.

- "It was excellent to have post take in ED, this had a significant benefit to the patient journey"
- "Early discussions around ceilings of care and patient was involved in these discussions throughout"
- "Identified early that there was a significant possibility that the patient would die and a DNACPR was put in place"
- "Appropriate investigations, treatment and ceilings of care helped with good management of this patient"

2.3 Specified Groups breakdown for Q1 2021/22 (See Appendix 1)

	Apr 2021	May 2021	Jun 2021	Total
Cardiac Arrest Death	2	3	3	8
Concern Death	3	3	4	10
CRAB Mortality Triggers	12	11	13	36
Diagnosis Group Death	2	10	3	15
Learning Disabilities Death	1	0	2	3
Medical Examiner Referral	1	0	0	1
Post operative death	2	8	3	13
Random Selection Death	14	15	8	37

Severe Mental Illness Death	2	1	1	4
Total	39	51	37	127

**25% of all deaths or 30n (whichever is greater) are reviewed each month*

3 CRAB (Copeland Risk Adjusted Barometer)

When mortality reviews first started, we focused our attentions on HSMR and SHMI to ensure that we carried our SJRs on all patients who fell into the diagnosis's highlighted where we may be an outlier. However, we felt that this information may be somewhat out of date by the time we got to use it.

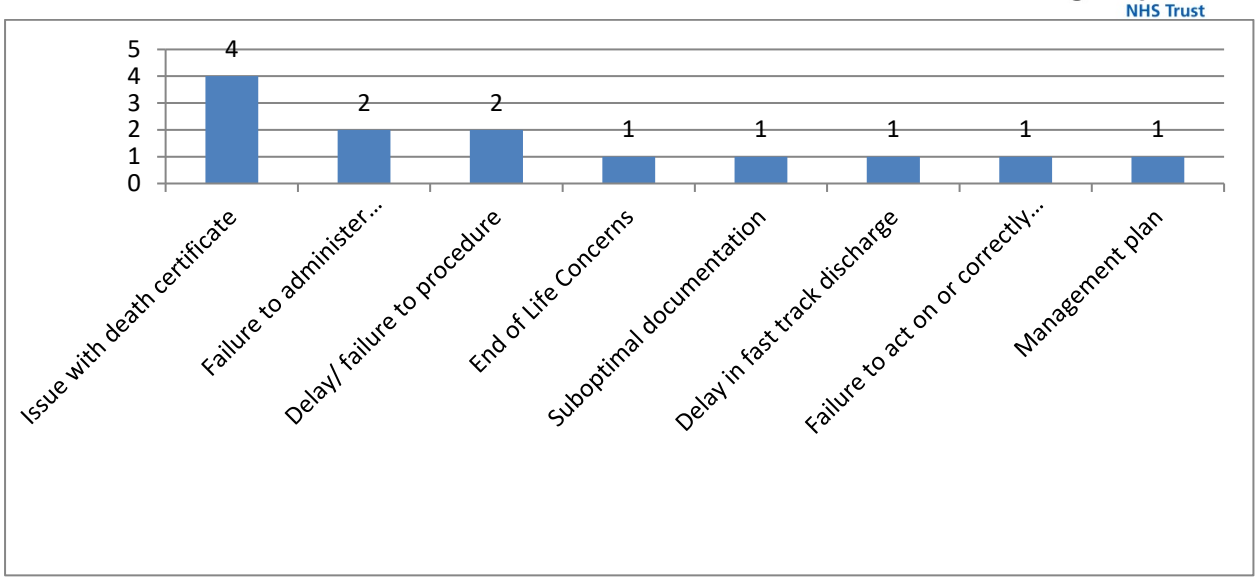
CRAB medical was introduced to the trust in 2020. This system uses specific alerts derived from the patients' hospital data as triggers to identify potential outlying care. We opted to include 50% of cases in the random selection group from this data from Q4 onwards to assist with identification of more current themes and trends as an alternative to the previous 'alert' groups. Further quarterly case allocations will be split between CRAB and random selection before making any definitive changes to TOR.

3.1 SJR outcomes of CRAB cases

To date, all CRAB cases have been reviewed and have received a GREEN / GREEN WITH LEARNING / GREEN WITH LEARNING POSITIVE outcome:

	GREEN	GREEN - WITH LEARNING	Green with learning - positive feedback	Total
Jan 2021	5	1	1	7
Feb 2021	4	4	0	8
Mar 2021	7	3	1	11
Apr 2021	8	0	3	11
May 2021	6	1	2	9
Jun 2021	5	3	0	8
Jul 2021	1	0	0	1
Total	36	12	7	55

3.2 Themes and Trends in Learning identified in CRAB cases this quarter



4 Learning Disability Patient Audit

Susan Norbury, Assistant Director of Safeguarding has recently carried out an audit of all learning disability patients who have died within the Trust to ensure that they have received an SJR. Conclusively all LD deaths had received an SJR and all had an outcome of GREEN or GREEN WITH LEARNING. All cases also received a safeguarding review and all cases were reported back to LeDeR.

5 CONCLUSION AND RECOMMENDATIONS

The Board is asked to note the contents of this report and receive assurance that:

- SJR process is now embedded within the organisation
- Lessons learned are shared widely in all care groups following Trust Board and care groups are expected to create action plans and evidence their completion to address any concerns / learning raised. (Appendix 2)
- Where concerns have been identified these have received further peer review and escalated as appropriate.

Appendix 1

Total Deaths in Scope[1]

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

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths; include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.
6. Random sample to ensure monthly we cover at n30 or 25% whichever is the greater
7. Cardiac Arrests that result in death

Appendix 2

Forum/Communication Channel	Chair	Support
Quality Committee	Gill Brown	Joanne Newton
Finance & Performance	Jeff Kozer	Laura Hart
Clinical Effectiveness Council	Rowan Pritchard-Jones	Helen Burton
Patient Safety Council	Rajesh Karimbath	Kim Jeffrey
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Elspeth Worthington	Jane Bennett
MCG Integrated Governance & Quality Meetings	Ash Bassi/Debbie Stanway	Joy Woosey
MCG Directorate Meetings	Debbie Stanway	Joy Woosey
SCG Governance Meetings	Tracy Greenwood/Wendy Harris	Gina Friar
SCG Directorate Meetings	Phil Nee	Julie Rigby
CSS Directorate Meetings	Caroline Dawn (Interim)	Sam Barr
ED Teaching	Ragit Varia/Sarah Langston/Clare O'Leary	Ann Thompson
FY Teaching	Cynthia Foster	
Grand Rounds	Cynthia Foster	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(21)075
Title of paper: Charitable Funds Accounts and Annual Report
Purpose: The Trust Board is asked to ratify the Charitable Funds Committee's approval of the Charitable Funds Draft Annual Accounts and Annual Report 2020-21, which took place at the meeting held on 21st October 2021.
Summary: The Charitable Funds Draft Annual Accounts and Annual Report 2020-21 were approved by the Charitable Funds Committee on behalf of the Trust Board, subject to the independent examiner's report completed by MHA Moore and Smalley. The accounts show that for the year 2020/21, income was £303.5k with expenditure of £244.9k and an unrealised gain on investments of £72.5k, giving an in year net movement of funds of £131.1k(gain). Brought forward into 2020/21 were fund balances of £541.7k and 2020/21 year end balances are £672.8k. A copy of the draft annual accounts and report can be made available on request.
Corporate objectives met or risks addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.
Financial implications: None as a direct consequence of this paper.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Trust Board is asked to ratify the approval of the Charitable Funds Draft Annual Accounts and Annual Report 2020-21.
Presenting officer: Nikhil Khashu, Director of Finance & Information
Date of meeting: 27th October 2021