St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28th SEPTEMBER 2022
BOARDROOM, WHISTON HOSPITAL

AGENDA				Paper	Purpose	Presenter
10.00	1.	Employee of the Month Film - August 2022 - September 2022		Virtual Presentation	Assurance	Chair
10.10	2.	Patient Story		Virtual Presentation	Assurance	Sue Redfern
10.20	3.	Apologies for Absence		Verbal	Assurance	Chair
10.25	4.	Declaration of Interests		Verbal		
10.30	5.	Minutes of the Board Meeting held on 27th July 2022		Attached		
		5.1	Correct Record and Matters Arising	Verbal		
		5.2	Action log			
Performance Reports						
10.40	6.	Integrated Performance Report		NHST(22) 066	Assurance	Gareth Lawrence
		6.1	Quality Indicators			Sue Redfern
		6.2	Operational Indicators			Rob Cooper
		6.3	Financial Indicators			Gareth Lawrence
		6.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
11.00	7.	Committee Report – Executive		NHST (22) 067	Assurance	Ann Marr
11.10	8.	Committee Report – Audit		NHST (22) 068	Assurance	Ian Clayton
11.20	9.	Committee Report – Quality		NHST (22) 069	Assurance	Rani Thind

11.30	10.	Committee Report – Finance & Performance	NHST (22) 070	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
11.10	11.	Medical Revalidation – Annual Declaration	NHST (22) 071	Approval	Peter Williams (Jacqui Bussin)
11.20	12.	CMAST Governance – Committees in Common	NHST (22) 072	Approval	Nicola Bunce
11.30	13.	Workforce Disability Equality Standard (WDES) Report and Action Plan	NHST (22) 073	Assurance	Anne-Marie Stretch
11.40	14.	Workforce Race Equality Standard (WRES) Report and Action Plan	NHST (22) 074	Assurance	Anne-Marie Stretch
11.50	15.	Infection Prevention and Control Annual Report	NHST (22) 075	Assurance	Sue Redfern
Closing Business					
12.05	16.	Effectiveness of Meeting	Verbal	Assurance	Chair
	17.	Any Other Business		Information	
	18.	Date of Next Meeting – Wednesday 26th October 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

MINUTES OF THE TRUST BOARD PUBLIC MEETING
HELD ON WEDNESDAY 27TH JULY 2022
VIA MICROSOFT TEAMS

BOARD MEMBERS	
Richard Fraser (RF)	Chairman (Chair)
Geoffrey Appleton (GA)	Non-Executive Director
Jeff Kozer (JK)	Non-Executive Director
Paul Growney (PG)	Non-Executive Director
Ian Clayton (IC)	Non-Executive Director
Gill Brown (GB)	Non-Executive Director
Lisa Knight (LN)	Associate Non-Executive Director
Rani Thind (RT)	Associate Non-Executive Director
Anne-Marie Stretch (AMS)	Deputy Chief Executive & Director of Human Resources
Rob Cooper (RC)	Director of Operations & Performance
Nicola Bunce (NB)	Director of Corporate Services
Christine Walters (CW)	Director of Informatics
Peter Williams (PW)	Medical Director
Gareth Lawrence (GL)	Director of Finance & Information
IN ATTANDANCE	
Yvonne Mahambrey	(for patient story)
Diane Dearden	(for patient story)
Christine Rhall	(for patient story)
Denise Baker	Executive Assistant (Observer)
Katie Fielding	Executive Assistant (Minutes)
APOLOGIES	
Ann Marr	Chief Executive

1.	**Employee of the Month Film – July 2022**	
	1.1. The employee of the month for July 2022 was Emma Porter, Radiographer. 1.2. A video was shared showing PW reading out the citation and presenting Emma with her award. 1.3. PW commented that Emma's nomination epitomises the Trust's values. 1.4. LK asked if the patient who had nominated Emma for the award is notified. PW confirmed that he would write to the patient to let them know.	

2.	**Patient Story** 2.1. YM joined the meeting along with DD and CR. SR introduced the patient story and YM shared a video in which a patient described their experience at the Trust. The patient was sharing their story was a 52 year old nurse who had presented at Whiston Hospital as an emergency and was diagnosed with a brain tumour. Unfortunately, the patient's father had also been diagnosed with a brain tumour in 2015, but this meant that she could compare her experience on the new brain tumour pathway, with her father's experience in 2015. 2.2. The new brain tumour pathway has been in place at the Trust for 6 months and is continuously reviewed. Changes to the pathway have been made in collaboration with other departments and the pathway also now includes management of patients presenting with a new diagnosis of brain metastases. The pathway means that newly diagnosed patients are supported by the cancer team until a treatment plan is agreed, which can then mean the patients are transferred to the care of the Walton Centre or are offered best supportive care if the tumour is inoperable. It was noted that the work on this pathway had been shortlisted for a national award. The patient reported feeling less isolated and afraid because of the care received from the acute oncology team. 2.3. IC commented that this is so necessary, and he was pleased the Trust have taken the initiative to do this. 2.4. GB echoed IC's comments and asked if there are any other rare cancers where we could improve the patient experience in a similar way. CR explained that most cancers were linked to a specialist tumour group, but the team could review the data to see if there were any gaps in provision. 2.5. IC has asked to be kept updated with the work around metastatic cancers. 2.6. RF thanked the patient for sharing her story and the cancer team for the work they were doing to improve the services the Trust could offer.	
3.	**Apologies for Absence** 3.1. As above	
4.	**Declaration of Interests** 4.1. No new declarations	
5.	**Minutes of the Board Meeting held on 29th June 2022** 5.1. <u>Correct Record and Matters Arising</u> 5.1.1. The minutes were approved as an accurate record of the meeting.	

	5.2. Action Log 5.2.1. Action 44 – Professional Nurse & Midwifery Advocate – SR advised that this was a form of clinical supervision for nurses and was a model already embedded in midwifery which was now being expanded to other areas. The Trust was seeking to train 120 staff to undertake this role. **CLOSED** 5.2.2. Action 45 – RC to circulate Nursing & Midwifery Strategy Presentation – circulated on Friday 22nd July. **CLOSED** 5.2.3. SR provided an update on the improvements made following the patient story about the patient who was deaf. This meant that action 46 was also closed.	
Performance Reports		
6.	**Integrated Performance Report – NHST(22)054** 6.1. Quality Indicators 6.1.1. SR presented this section of the report 6.1.2. There had been no never events in June 2022 and there had been none year to date (YTD). 6.1.3. There were no cases of MRSA Bacteraemia in June 2022 and none YTD. 6.1.4. There were 11 C. Difficile (CDI) positive cases reported in June 2022, 9 were hospital onset and 2 community onset. YTD there had been 20 cases, 10 of which had been reviewed at RCA panels with 7 cases assessed as unavoidable with no lapses in care. 6.1.5. GB queried if CDI patients could relapse, and SR confirmed that this could happen, and these could be counted as separate cases if more than 30 days apart. GB asked if more information could be shared about the guidance and reporting criteria and SR agreed to do this. **ACTION: SR** 6.1.6. The overall registered nurse/midwife Safer Staffing fill rate for June 2022 was 94.4%. The YTD rate is 94.0%. 6.1.7. During May 2022, there was one fall resulting in severe harm or death. YTD there had been two. 6.1.8. There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in April 2022. 6.1.9. There were 107 community incidents reported in May,7 were low harm and the remainder were no harm. 6.1.10. VTE reporting remains suspended.	

6.2. Operational Indicators

6.2.1. RC presented this section of the report

6.2.2. Performance against the 62 day cancer standard was below the target of 85.0% in May 2022 at 83.2%. YTD performance was 86.7%. The dip in performance was due to some long waiting patients who had now all started treatment. RC added that as discussed in both quality committee and in finance and Performance Committee, the Cheshire and Mersey performance was 69.7% and the national performance was 61.5% for the same month.

6.2.3. The 31 day target was achieved in May 2022 with 98.9% performance in month against a target of 96%, YTD performance was 98.4%.

6.2.4. The 2 week rule target was not achieved in May 2022 with 88.3% in month and 85.6% year to date against a target of 93%. The performance was continuing to improve, but 2 week wait referrals remained high compared to the same period in 2019. This meant that capacity remained a challenge for the service. RC confirmed that the new 75% faster diagnosis standard was being achieved.

6.2.5. Accident and Emergency Type 1 performance for June 2022 was 47.3% and YTD 48.9%. The all type mapped footprint performance for June was 72.1% and YTD 73.1%**.** The Trust saw average daily attendances of 333, compared to an average of 340 per day in May. Total attendances in June 2022 were 10,004.

The total ambulance turnaround time target was not achieved in June 2022 with a 47minute average. There were 2,206 ambulance conveyances compared with 2,332 in May.

6.2.6. St Helens UTC had 5,498 attendances in May 2022, an increase of 3% compared to April. 99% of patients were seen and treated within 4 hours.

6.2.7. The average daily number of super stranded patients in acute medical beds, in June 2022 was 129 compared to 116 in May. Work is ongoing both internally and externally, with all system partners, to improve the current position but acute bed occupancy had remained high with the consequent congestion in ED.

6.2.8. The 18 week referral to treatment (RTT) target was not achieved in May 2022 at 69.5% against the 92% target. There were 1,711 52+ week waiters in May.

6.2.9. The 6 week diagnostic target was not achieved in May 22 with 86.3% compliance against the 99% target, but this was an improvement compared to April when performance was 80.5%.

6.2.10. District Nursing Service referrals remained within the average range in May 2022 (589). Caseload size also remained within the normal range (1,266 in May)

6.2.11. Community matron caseloads were 106 in May compared to 110 in April.

6.2.12. RF asked RC about the current impact of COVID on patient flow. RC responded that although there remained many patients in the hospital who had tested positive for COVID the peak of this wave of infections now seemed to have passed and the numbers were starting to gradually reduce.

6.3. Workforce Indicators

6.3.1. AMS presented this section of the report.

6.3.2. In June 2022, all staff sickness was 6.2% which was an increase from May (6.0%). The rate for Nursing and Midwifery sickness absence was 7.7% which had remained static from May (7.7%).

6.3.3. Appraisal compliance in June is 59.1% which is a slight reduction from May (60%). Mandatory training compliance continues to slowly improve at 78.0% for June (May 77.1%).

6.4. Financial Indicators

6.4.1. GL presented this section of the report.

6.4.2. At the end of Month 3, the Trust reported a deficit position of £3.3m, with £127.6m income and £130.9m expenditure year to date. This is in line with plan.

6.4.3. The Trust's final CIP target is £28.1m for 2022/23, of which £22.1m is to be delivered recurrently and £6m non-recurrently. At Month 3, low risk schemes either delivered or at finalisation stage total £13.2m with £7.8m of recurrent schemes implemented.

6.4.4. Capital expenditure at month 3 [including PFI lifecycle maintenance] was £1.9m. It was noted that the Trusts internally generated depreciation exceeds the 2022/23 capex plan. The plan has been agreed at ICS/ICB level and assumes £15.5m of PDC funding.

6.4.5. GL reported that the NHS has now received notification of the pay awards for 2022/23. It has been reported that Trusts will be funded for the pay award but the NHS as a whole, will not receive any additional funds. This puts some national programmes at risk if these funds are diverted. NHSE are also re-introducing agency reduction targets, seeking a minimum of 10% reduction compared to the 2021/22 spend on agency staff.

6.4.6. RF commented that at a recent team talk, staff had expressed concerns about the workforce crisis impacting the whole of the NHS. AMS acknowledged that in some areas it was increasingly difficult to recruit, and that exploration of new roles was happening across the Trust to optimise the workforce. NB confirmed that staff had reported increased turnover amongst temporary staff and that it had been suggested that more

	innovative ways of employing staff who could fill similar roles across the organisation could be considered. 6.4.7. NB commented that with the current workforce shortages and the restoration and recovery targets, combined with the elective pressures it would be difficult to reduce agency spend and maintain safe staffing levels. GL agreed that there was a significant policy tension between the different targets being set for the NHS. 6.4.8. IC asked if the Trust ran recruitment open days and AMS confirmed that this was something the Trust did on a regular basis, which would be reported in more detail as part of the Workforce Indicators report later on the agenda. 6.4.9. The report was noted.	
Committee Assurance Reports		
7.	**Committee Report – Executive NHST(22)055** 7.1. AMS presented the Executive Committee Chair's Report 7.2. There were 2 Executive Committee meetings during the month of June. 7.3. Committee had approved a business case to increase capacity to respond to the growing Equality, Diversity, and Inclusion (EDI) agenda and meet statutory, mandatory, and contractual obligations. The additional funding was for some permanent and some non-recurrent capacity to develop the Trust plan to meet best practice standards and address the issues raised in the 2021 Staff Survey. 7.4. Committee had also approved a capital scheme to increase the provision of visitor disabled car parking spaces in response to the increased demand. This proposal was designed as a temporary solution to maintain patient experience, site safety and access for emergency vehicles until a substantive hospital entrance roadway and parking redesign scheme could be completed. 7.5. There were no questions in relation to the rest of the report, which was noted by the Board.	
8.	**Committee Report – Audit NHST(22)056** 8.1. IC presented the report and thanked JK for chairing the meeting on his behalf. 8.2. The committee had reviewed and accepted the annual report and annual governance statement. 8.3. The committee had received the annual accounts for 2021/22, the draft audit findings report and the letter of representation. It was noted that the audit findings report was not complete, and that audit work in relation to the value for money opinion was ongoing.	

	8.4. The committee reviewed the actions within the audit report and were happy that the proposed changes going forward would mitigate these in future years. 8.5. The committee recommended the Annual Report and Accounts to the Board for approval, subject to the final audit report and opinion being received from Grant Thornton. It was agreed that the final report would be circulated to all members of the committee on completion. 8.6. This had been done on 26/07/2022 and the Board approved the 2021/22 Annual Report and Accounts.	
9.	**Committee Report – Quality NHST(22)057** 9.1. RT presented the report and highlighted key points for the Board. 9.2. The new ED performance (CRS) metrics were presented and discussed, and the committee had been assured that this provided for appropriate prioritisation of attendances reported in categories of majors, minors, and paediatrics. 9.3. The Committee noted that work is being undertaken to agree the maternity metrics to be included in the new IPR. 9.4. The Committee also received assurance that the Radiology Department was included in the review of scans following an obstetric haemorrhage to enable any learning to be identified. 9.5. The committee had commended the patient safety team for the reduction in the number of falls. 9.6. The committee had received the quarterly safeguarding report and been assured by the work to respond to the increased demand for looked after children health assessments, the timeliness of DoLS applications and the increasing number of referrals to the Learning Disability Specialist Nurse. 9.7. The report was noted.	
10.	**Committee Report – Finance & Performance NHST(22)058** 10.1. JK presented the report 10.2. There were no new risks to be escalated to the Board. 10.3. The committee had reviewed the month 3 finance report and noted that decisions are awaited regarding the Trust bids against the national funding for additional restoration and recovery capacity and to increase bed capacity. Committee had also noted that all trusts had been instructed to include Elective Recovery Fund (ERF) earnings in their Quarter 1 position, irrespective of performance.	

	10.4. Committee was assured that the capital programme was being delivered to plan and that the Better Payment Practice Code (BPPC) target of 99% (non-NHS invoices by value), was being achieved. 10.5. The committee had received a report on the Trust's CIP programme and was assured with the level of schemes that have been identified for 2022/23 especially given the increased CIP target following the revision of the operational plan. The committee noted that the recurrent CIP position had improved compared to M2 with over 1/3 of the recurrent target delivered. 10.6. The committee reviewed the progress on the elective recovery programme and noted the operational challenges in delivering the plan but was assured by the progress that had been made despite the urgent and emergency care demand. The committee noted that more work was to be done throughout the year but the progress in reducing 104 week waits etc had been very positive. 10.7. The committee reviewed the progress on the Clinical Support Services care groups CIP delivery and noted the clinical engagement that was demonstrated in developing the CIP plans. 10.8. The committee reviewed and approved the process being followed to complete the national cost collection exercise. 10.9. The committee received chair's assurance reports from the CIP Council and the Procurement Council. 10.10. The report was noted	
11.	**Committee Report – Strategic People NHST(22)059** 11.1. LK presented the report. 11.2. The Strategic People reporting dashboard was discussed and will continue to be developed to provide assurance to the committee and Board have oversight of all key workforce metrics. 11.3. Committee received the Quarter 1 progress report against the relevant Trust objectives/People Plan Strategy. 11.4. The committee also received a report from the Employee Relations Oversight Group. 11.5. The committee approved a number of operational plans to support the delivery of the Trust People Strategy 2022 – 2025 Workforce Development Operational plan 2022 – 2025 Recruitment & Retention Operational plan 2022 – 2025 Health, Work & Wellbeing Operational plan 2022 – 2025 11.6. PW asked if the Rainbow flag accreditation application had been successful. AMS confirmed that the evidence has been submitted and is currently being assessed but the trust has not yet heard the outcome.	

	11.7. The report was noted	
	Other Board Reports	
12.	**Data Security Protection Toolkit 2021/22 – NHST(22)060** 12.1. CW presented the Data Security Protection Toolkit paper. 12.2. CW advised that the purpose of the paper was to provide assurance to the board that STHK is operating within parameters defined in the toolkit. 12.3. All organisations that have access to and process patient / personal data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly and in line with data protection legislation 12.4. The submission date for the submission of DSPT evidence is the 30th June. 12.5. The Trust was able to submit evidence for all the assertions in the toolkit and achieved a "standards met" rating for the submission. 12.6. The DSPT submission was then audited by MIAA (internal auditors) to assess compliance against the standards and received an assessment of Substantial Assurance. 12.7. GB asked if there had anon compliance because of more staff working from home. CW confirmed that this formed part of the assessment and the Trust had demonstrated that it had the controls and processes in place to continue to meet the required standards. 12.8. The report was noted.	
13.	**Board Assurance Framework (BAF) Quarterly Review – NHST(22)061** 13.1. NB presented the BAF Quarterly Review 13.2. NB provided a summary of the proposed changes to the BAF, following the review by the Executive Committee. The Board members agreed the proposed changes. 13.3. IC commented that given the continued financial uncertainty the score of risk 2 should be kept under review and may need to increase again at the next quarterly review. 13.4. GB agreed, especially given the news that the NHS would not be funded for the pay award, which could have implications for the Trusts financial plans. 13.5. GL agreed that risk 2 would need to be kept under careful review. It was expected that the planning guidance for 2023/24 would be	

	released in the early autumn and it was hoped that this would provide clarity on the future NHS financial regime. 13.6. The Board approved the BAF	
14.	**Corporate Risk Register (CRR) Quarterly Report – NHST(22)062** 14.1. NB presented the report. 14.2. The report provides assurance that the Trust has an effective risk management system in place and provides a snapshot of the risk register and the changes to those risks escalated to the CRR over the previous quarter. The report showed there were 811 risks on the risk register with 31 escalated to the CRR, the majority of these being escalated from the Medical Care Group and reflecting the operational pressures being experienced. 14.3. IC commented that the themes seen from the CRR risks reflected the issues discussed at Board and in the committees i.e., Bed occupancy, staffing, I.T/Cyber Security and Finance. 14.4. The report was noted	
15.	**Learning from Deaths Quarterly Report – NHST(22)063** 15.1. PW presented the Learning from Deaths Quarterly Report covering Q3 and Q4 2021/22. 15.2. For quarter 3 2021/22, a total of 131 SJRs were requested, to date 70 have been completed. 69 of the reviews had an outcome of no concerns. One of the reviews had an amber outcome and related to a complex presentation involving a multifactorial delay in ECG in ED which led to cardiac arrest before all treatments had been initiated. There is local action is underway to address this. 15.3. In Quarter 4 2021/22, a total of 50 SJRs have been requested so far. 37 had been completed and received an outcome of no concerns. 15.4. A Deteriorating Patient Quality Improvement Lead has been appointed (12 months secondment), with the aim of building the wider governance structure in respect of deteriorating patients, with representation from the relevant specialist teams, and extending the NEWS2 pilot work carried out on ward 2B, to all other wards. 15.5. The current model of Trust Mortality Review at STHK was started in 2017 and is now fully embedded both as a stand-alone system and within the wider Patient Safety and Serious Incidents process. 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.	

	Where concerns have been identified these have received further peer review and escalated as appropriate. Following review improvements are now proposed to increase the efficiency of the review process to ensure valued time can be spent on cases which identify concern without losing the safety of the review process. 15.6. GB referred to appendix 1 on page 5. She asked if it is 25% of deaths, we should expect to do the judgement review on. PW advised that it is 25% plus any others that occur in the specified groups. 15.7. RT asked if in the new process the team would do random checks. PW agreed to clarify this with Elspeth Worthington. **ACTION: PW** 15.8. The Board noted the report and supported the revised review process subject to clarification from PW on the point raised by RT.	
16.	**People Plan - Key Indicators Report – NHST(22)064**	
	16.1. AMS presented the HR Key Indicators Report. 16.2. AMS advised that the paper provides the Board with details of the progress against the Trust's Workforce strategy metrics since April 2022 and provides assurance on the effective management of workforce matters. 16.3. AMS highlighted that the report is aligned to the 4 People Plan pillars; • Looking after our people – with quality health and wellbeing support for everyone • Belonging in the NHS – with a particular focus on the discrimination that some staff face • New ways of working and delivering care – capturing innovation, much of it led by our NHS people • Growing for the future – how we recruit, train, and keep our people, and welcome back colleagues who want to return 16.4. RT commented on new ways of working and asked if the Trust was planning to introduce Physician Assistant roles. AMS advised that at the current time the Trust was seeking to develop its advanced nursing roles and she felt the role of Physician Assistants in the UK was still developing. PW commented that ENPs have been a key part of the ED workforce for a long time and are a highly valued part of the team. 16.5. PG commented on the initiatives for local engagement with young people to attract them into NHS careers. 16.6. AMS confirmed that the "New to care" initiative was designed to let young people experience different aspects of the NHS and find their niche.	

	16.7. RF asked how many international nurses the Trust had now recruited in total and SR reported that to date it was circa 270. 16.8. The report was noted	
17.	**Information Governance Annual Report – NHST(22)065**	
	17.1. CW presented the IG Annual Report (including the Freedom of Information Annual Report). 17.2. The IG Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. The framework allows the Trust to ensure all personal and confidential data is handled legally, securely, efficiently, and effectively. 17.3. During 2021/22 the Trust had not been fined by the ICO but there had been a number of complaints concerning the processing of subject access requests. The Trust is reviewing the subject access request process and management arrangements as a result of these complaints. 17.4. IC asked if the Trust reported the 4 incidents, or this was done by the patient. CW advised that the Trust reported the incidents to the Information Commissioners Office (ICO) and does this within 72 hours. If it is unclear if an incident should be reported the Trust always does so to be sure it remains compliant. 17.5. IC asked for further information of the nature of the SARs incidents. Had the Trust been criticised for not responding in a timely manner or for not providing the information that had been requested. CW advised timeliness of response and keeping the requesters informed of the timescales had been the issues in these cases. 17.6. In respect of the Freedom of Information Annual Report advised that anyone could make a request to the Trust under the provisions of the act and the Trust must respond within 20 working days. Failure to do so could result in a fine or warning from the ICO. 17.7. The Trust's overall compliance had improved significantly during 2021/22. There is now executive leadership on all FOIs and the process has been streamlined. 17.8. CW concluded that the Trust are still not fully compliant with the response timescales, but the performance has improved, and these improvements are expected to continue into 2022/23 as the final improvement actions are implemented. 17.9. The Board noted the report.	
	Closing Business	
18.	**Effectiveness of Meeting**	

	18.1. RF commented that the reports for this meeting had been very clear and easy to read, and he thanked the Executive.	
19.	**Any Other Business**	
	19.1. None to report.	
Date of Next Meeting: Wednesday 28th September 2022		

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 28TH SEPTEMBER 2022

No	Date of Meeting (Minute)	Action	Lead	Date Due
~~44~~	~~29.06.22~~	~~SR to provide detail about the proposed role of Professional Nurse and Midwifery Advocate~~ **CLOSED**	~~SR~~	~~27.07.22~~
45	~~29.06.22~~	~~RC to circulate Nursing and Midwifery Strategy presentation from Operational Meeting to Board members~~ **CLOSED**	~~RC~~	~~27.07.22~~
46	~~29.06.22~~	~~SR to provide an update on June patient story.~~ **CLOSED**	~~SR~~	~~27.07.22~~
47	27.07.22	SR to provide information on the criteria for reporting recurrent C.Diff infections	SR	28.09.22
48	27.07.22	PW to ask Elspeth Worthington about the inclusion of spot checks in relation to the revised Learning from Deaths process.	PW	28.09.22

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(22)066
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 August 2022. (YTD = 1).

There were no MRSA cases in August 2022. (YTD = 0).

There were 4 C. Difficile (CDI) positive cases reported in August 2022 (3 hospital onset and 1 community onset). (YTD = 31). Of the 31 cases, 18 have been reviewed at RCA panel, 14 cases were deemed unavoidable as no lapses in care. Two of the cases had previously been C. Diff positive. The annual tolerance for CDI for 2022-23 is 56.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for August 2022 was 93.2%. 2022-23 YTD rate is 93.9%.

During the month of July 2022 there were 3 falls resulting in severe harm or death category . (YTD severe harm or above category falls = 9).

There were no validated grade 3 hospital acquired pressure ulcer with lapse in care in July 2022. (YTD = 0).

Community incident reporting levels decreased to 83 in July compared to 88 in the month of June. All were classified as no harm.

YTD HSMR (April) for 2022-23 is 96.4

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 22/23 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: G Lawrence
Date of Meeting: 28th September 2022

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (July 2022) at 77.6%. YTD 84.0%. The 31 day target was achieved in July 2022 with 96.2% performance in month against a target of 96%, YTD 98.0%. The 2 week rule target was not achieved in July 2022 with 75.7% in month and 81.7% YTD against a target of 93%. The deterioration in performance for 2 week rule, is related to the significant increase in referrals, compared to the same period in 2019, resulting in capacity challenges.

Accident and Emergency Type 1 performance for August 2022 was 44.0% and YTD 47.3%. The all type mapped STHK Trust footprint performance for August 22 was 70.8% and YTD 72.4%**.** The Trust saw average daily attendances of 300, which is down compared to July, at 319. Total attendances for August 2022 was 9,296.

Total ambulance turnaround time was not achieved in August 2022 with 57 mins on average. There were 2,032 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,152 in July 2022.

The UTC had 5,246 attendances in July 2022, compared to 5,392 in June 2022, a decrease of 2.5%. Overall, 99% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in August 2022 was 147 compared with 132 in July. 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 July 2022 with 66.6% compliance and YTD 66.6% (Target 92%). Performance in June 2022 was 68.8%. There were (2,009) 52+ week waiters. The 6 week diagnostic target was not achieved in July 22 with 81.9% compliance. (Target 99%). Performance in June 2022 was 82.2%.

There was a slight increase in referrals received within the District Nursing Service in July however, the levels are still within average range (552 in July compared to 535 in June). The overall caseload size is within normal range (1,280 in July compared to 1,297 in June). Community matron caseloads have increased to 134 in July compared to 124 in June. Work has been undertaken with individual PCNs to look at a collaborative approach to patient care.

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

Following resubmission of plans to support submission of an updated system wide plan in June 2022, the Trust has agreed a final 22/23 financial plan at a deficit of £4.9m, including a CIP target of £28.1m (5%). Included within the plan were agreed non recurrent savings to support the position. As at Month 5 (August), the Trust is in line with plan (£3.1m deficit).

Surplus/Deficit - At the end of Month 5, the Trust is reporting a deficit position of £3.1m for the year to date, with £216m income and £219.1m expenditure year to date. This is in line with plan. Included within the financial position is £5.7m of non recurrent benefits which are offsetting the non achievement of National ERF and non-pay inflation (excluding energy & PFI) over and above funded levels.

CIP - The Trust's final CIP target is £28.1m for financial year 2022/23, of which £22.1m is to be delivered recurrently and £6m non-recurrently, as agreed with C&M ICS. As at Month 5, low risk schemes either delivered or at finalisation stage total £21.9m in year and £13.8m recurrently.

Cash - At the end of Month 5, the cash balance was £62.2m.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £3.8m. Internally generated depreciation exceeds the 2022/23 capex plan. The plan has been agreed at ICS/ICB level, and includes PDC funding (£15.1m) which is not fully signed off nor drawn down from DHSC.

Human Resources

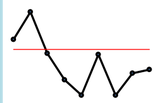
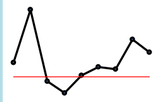
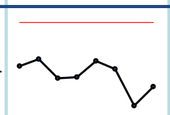
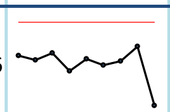
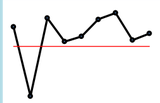
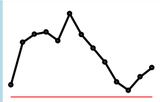
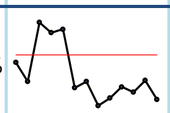
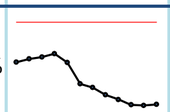
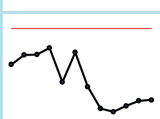
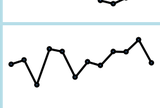
In August 2022, all staff sickness was 6.1%, a decrease of 1.3% from July (7.4%). The rate for Nursing and Midwifery staff group was 7.1% which was a reduction from July's figure (8.5%).
Appraisal compliance in August is 65.8%, an improvement of 7.0% from July (58.8%). Mandatory training compliance has also improved by 1.2% to 79.1% in August (July 77.9%).

The following key applies to the Integrated Performance Report:

▲ = 2022-23 Contract Indicator
▲£ = 2022-23 Contract Indicator with financial penalty
● = 2022-23 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Aug-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

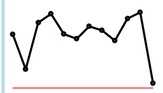
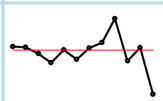
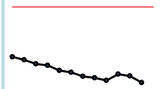
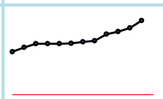
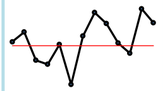
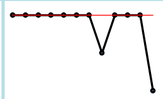
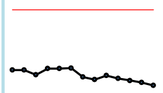
	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Aug-22	2.0%	2.2%	No Target	2.6%		Post wave 3 of COVID, performance is encouraging.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits. We continue to independently benchmark performance using CRAB data.	PW
Mortality: SHMI (Information Centre)	Q	▲	Apr-22	1.07		1.00						
Mortality: HSMR (HED)	Q	▲	Apr-22	96.4	96.4	100.0	96.9					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Apr-22	110.8	110.8	100.0	105.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Mar-22	89.5		100.0	93.1		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	Performance remains within expected range.	PW
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Apr-22	72.3	72.3	100.0	88.6		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	Apr-22	105.3	105.3	100.0	103.9					
% Medical Outliers	F&P	T	Aug-22	1.9%	1.6%	1.0%	2.1%		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	Aug-22	29.4%	33.7%	52.5%	46.8%		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	▲	Jul-22	62.0%	62.3%	90.0%	74.3%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team has been involved to find a sustainable solution particularly in A&E. This has now gone live and reporting will reflect it subsequently 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. Audit confirms >90% urgent letters sent in 7 days.		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. Work currently in process with admin team to review capacity to meet demand for outpatient clinic letters and provide alternative solutions if required. ED performance improving due to change in system for completion and sending of eDischarges from SDEC Area. Dip in reporting reflects the changeover of process and current reporting evidences 82%.	PW
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Jul-22	32.1%	28.1%	95.0%	65.2%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jul-22	97.4%	97.9%	95.0%	97.2%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	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	87.1%	87.1%	83.0%	84.8%		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	▲ £	Aug-22	0	1	0	1		One never event YTD	Quality and patient safety		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	Aug-22	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.	PW
Number of hospital acquired MRSA	Q F&P	▲ £	Aug-22	0	0	0	2		There were no MRSA cases in August 2022. (YTD = 0). There were 4 C. Difficile (CDI) positive cases reported in August 2022 (3 hospital onset and 1 community onset). (YTD = 31). Of the 31 cases, 18 have been reviewed at RCA panel, 14 cases were deemed unavoidable as no lapses in care. Two of the cases had previously been C. Diff positive. The annual tolerance for CDI for 2022-23 is 56. Internal RCAs on-going with more recent cases of C. Diff.	Quality and patient safety	The annual tolerance for CDI for 2022-23 is 56. Improvement actions in place and completed based upon RCA .	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Aug-22	4	31	56	32					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Aug-22	2	11	No Target	49					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jul-22	0	0	No Contract target	2		No validated category 3 pressure ulcer YTD.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from reported pressure ulcer incidents and learning.	SR
Number of falls resulting in severe harm or death	Q	▲	Jul-22	3	9	No Contract target	22		3 falls resulting in severe harm category in July 2022 (Ward 5C, Bevan Court 2 and Ward 1C).	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	SR
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-21			No Target	12			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. eVTE assessment tool currently undergoing rollout in ED as part of Electronic Medical Assessment Proforma.	PW
To achieve and maintain CQC registration	Q		Aug-22	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	Aug-22	93.2%	93.9%	No Target	92.1%		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	Aug-22	1	10	No Target	30					

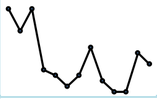
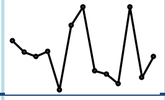
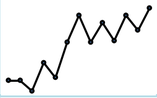
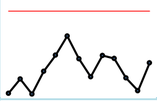
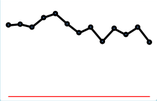
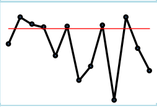
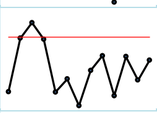
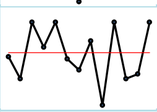
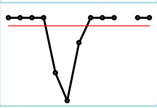
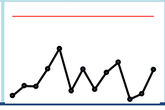
Aug-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

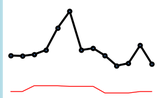
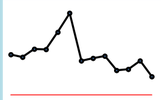
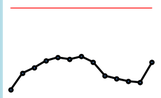
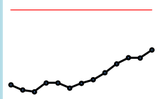
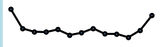
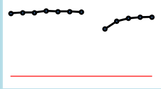
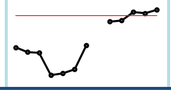
	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jul-22	75.7%	81.7%	93.0%	84.6%		2WW referrals remain high. This has been accepted as the new norm. Capacity remains a challenge due to increased demand coupled with staff sickness and vacancies.	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity, including communication with GPs around correct process and management of waiting lists/patient hot lines. 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 CDC 8. Cancer Specific PTL supporting to expedite delays prior to patient breaches.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jul-22	96.2%	98.0%	96.0%	98.3%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jul-22	77.6%	84.0%	85.0%	85.2%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jul-22	66.6%	66.6%	92.0%	68.2%		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. urgent, cancers and long waiters remain the priority patients for surgery at Whiston with application of P- codes effectively implemented. This is being worked through. Removal of P5 is on target and of D5 is complete.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Jul-22	81.9%	82.8%	99.0%	78.4%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jul-22	2,009	2,009	0	1,461					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Aug-22	1.0%	1.0%	0.8%	0.82%		Underperformance in cancelled ops has been due to staff sickness/absence and medical NEL pressures. The team is confident that this will recover going forward, although performance remains at risk.	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	▲ £	Jul-22	96.2%	98.8%	100.0%	99.8%					
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	▲	Aug-22	44.0%	47.3%	95.0%	55.8%		Accident and Emergency Type 1 performance for August 2022 was 44.0% and YTD 47.3%. The all type mapped STHK Trust footprint performance for August 22 was 70.8% and YTD 72.4%. The Trust saw average daily attendances of 300, which is down compared to July, at 319. Total attendances for August 2022 was 9,296. Total ambulance turnaround time was not achieved in August 2022 with 57 mins on average. There were 2,032 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,152 in July 2022.	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	▲	Aug-22	70.8%	72.4%	95.0%	77.1%					
A&E: 12 hour trolley waits	F&P	▲	Aug-22	0	0	0	0					

Aug-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Aug-22	0	0	0	0		Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Aug-22	18	79	No Target	254		% new (Stage 1) complaints resolved within agreed timescales remains below the target.	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 remain in place to increase response rates within the Medical Care Group which has the largest number of open complaints, although the total number of open complaints is reducing.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Aug-22	17	90	No Target	268					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Aug-22	76.5%	72.2%	No Target	79.5%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to August 22 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	Aug-22	365	355		317					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Aug-22	147	132		108					
Friends and Family Test: % recommended - A&E	Q	▲	Aug-22	80.9%	79.7%	90.0%	79.0%		Recommendation rates are 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.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Aug-22	94.3%	94.9%	90.0%	95.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Aug-22	90.9%	94.0%	98.1%	95.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Aug-22	95.0%	93.5%	98.1%	93.3%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Aug-22	100.0%	93.3%	95.1%	95.4%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Aug-22	100.0%	100.0%	98.6%	97.7%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Aug-22	94.0%	93.9%	95.0%	93.8%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2022-23 YTD	2022-23 Target	2021-22	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Aug-22	6.1%	6.5%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	7.0%		In August 2022, all staff sickness was 6.1%, a decrease from July (7.4%). The rate for Nursing and Midwifery staff group was 7.1% which was a reduction from July's figure (8.5%). N.B This includes normal sickness and COVID19 sickness reasons.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Employees who are absent from work due to sickness are contacted early to provide them with appropriate support and advice to aid their recovery and return to work. The support includes referral to occupational health and the implementation of reasonable adjustments, where applicable. Meaningful discussions take place between employees and managers during the absence and when employees return to work in the form of welfare, return-to-work, and attendance review meetings. There is a bi-weekly review of Trust absences. This is done by the HR Team and the Health, Work and Wellbeing Clinical Lead to ensure that the wellbeing of staff remains a priority.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Aug-22	7.1%	8.0%	5.3%	9.6%					
Staffing: % Staff received appraisals	Q F&P	T	Aug-22	65.8%	65.8%	85.0%	65.9%		Appraisal compliance in August is 65.8% which is a 7.0% improvement from July (58.8%). Mandatory training compliance is 79.1% which has also improved by 1.2% from July (77.9%)	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Despite higher than expected staff absence in month efforts to recover both Appraisal and Mandatory Training compliance are showing some improvement in performance. For both, recovery plans and actions to meet compliance continue to be monitored through People Council.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Aug-22	79.1%	79.1%	85.0%	74.7%					
NHS National Quarterly Pulse Survey : % recommended Care	Q	▲	Q2 2022-23	66.8%					Staff Friends and Family test superseded by the Quarterly staff survey in 2020-21.	Staff engagement, recruitment and retention.	Q2 survey results published at the end of August. All actions associated with the responses to these 2 questions form a key component of the Staff Survey action plan for 2022. This action plan continues to be monitored through the Executive Committee and People Council. Q3 survey will form part of the Annual Staff Survey	AMS
NHS National Quarterly Pulse Survey : % recommended Work	Q	▲	Q2 2022-23	50.6%								
Staffing: Turnover rate	Q F&P UOR	T	Aug-22	1.9%		No Target	14.0%		Staff turnover remains stable and below the national average of 14%.			AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Aug-22	Discontinued	Discontinued	N/A			The Trust financial position contains non-recurrent savings of £5.7m which are supporting delivery of the plan. The non recurrent savings are offsetting the non delivery of National ERF and increased inflation pressures (excluding energy and PFI) above funded levels. The capital plan includes external funding that has still not yet been received by the Trust.	Non-recurrent benefits will impact the underlying position of the Trust going into next financial year. Delays in the capital being received could impact the delivery of the capital programme.	The Trust will continue to liaise with the ICS so that they are fully aware of the non recurrent support within the Trust. The Trust is liaising with National supply chain who are working on plans to minimise inflation impacts. The Trust continues to do all preparatory work to ensure there will be no slippage in the capital programme.	GL
Progress on delivery of CIP savings (000's)	F&P	T	Aug-22	10,196	10,196	28,100						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Aug-22	(3,145)	(3,145)	(4,949)						
Cash balances - Number of days to cover operating expenses	F&P	T	Aug-22	28	28	10						
Capital spend £ YTD (000's)	F&P	T	Aug-22	3,800	3,800	26,100						
Financial forecast outturn & performance against plan	F&P	T	Aug-22	(4,949)	(4,949)	(4,949)						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Aug-22	96.8%	96.8%	95.0%						

APPENDIX A

			Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022-23 YTD	2022-23 Target	FOT	2021-22	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	89.5%	100.0%	100.0%	93.1%	83.3%	100.0%	100.0%	93.8%	85.0%		96.0%		
	Total > 62 days		1.0	0.0	0.5	0.5	0.0	1.0	1.0	0.0	0.0	1.0	2.0	0.0	0.0	3.0			6.0		
	Total > 104 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.5		
Lower GI	% Within 62 days	▲ £	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	81.0%	80.0%	86.7%	90.5%	76.5%	79.3%	65.2%	77.8%	85.0%		79.7%		
	Total > 62 days		1.0	2.5	0.0	3.0	4.0	3.0	2.0	1.0	1.0	1.0	2.0	3.0	4.0	10.0			24.5		
	Total > 104 days		0.0	1.5	0.0	0.0	1.5	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0			4.0		
Upper GI	% Within 62 days	▲ £	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	100.0%	100.0%	36.4%	90.0%	84.6%	100.0%	85.7%	87.8%	85.0%		83.2%		
	Total > 62 days		1.0	3.0	1.0	0.0	0.0	1.0	0.0	0.0	3.5	0.5	1.0	0.0	1.0	2.5			9.5		
	Total > 104 days		1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.0	0.0	0.0	0.5			3.0		
Urological	% Within 62 days	▲ £	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	65.3%	88.0%	93.9%	90.0%	81.0%	79.2%	78.1%	80.2%	85.0%		80.5%		
	Total > 62 days		1.5	4.5	2.0	1.0	3.5	0.5	8.5	1.5	1.0	1.5	4.0	2.5	3.5	11.5			32.5		
	Total > 104 days		0.0	0.5	2.0	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	0.5	1.5	2.0			4.0		
Head & Neck	% Within 62 days	▲ £	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	16.7%	0.0%	44.4%	0.0%	20.0%	85.0%		24.4%		
	Total > 62 days		2.0	1.0	1.0	2.0	0.5	2.0	0.0	1.0	1.0	2.5	3.5	2.5	1.5	10.0			15.5		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.5	0.0	2.5			2.0		
Sarcoma	% Within 62 days	▲ £	100.0%									100.0%				100.0%	85.0%		100.0%		
	Total > 62 days		0.0									0.0				0.0			0.0		
	Total > 104 days		0.0									0.0				0.0			0.0		
Gynaecological	% Within 62 days	▲ £	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	100.0%	37.5%	60.0%	75.0%	66.7%	100.0%	45.5%	63.6%	85.0%		67.3%		
	Total > 62 days		0.0	2.5	2.0	1.0	0.5	3.0	0.0	5.0	2.0	1.0	2.0	0.0	3.0	6.0			17.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.0	1.0	0.0	0.0	2.0	3.0			2.5		
Lung	% Within 62 days	▲ £	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	64.3%	76.9%	55.6%	50.0%	92.3%	69.6%	30.8%	63.6%	85.0%		77.2%		RC
	Total > 62 days		2.0	0.0	2.5	3.0	1.5	1.0	2.5	1.5	2.0	1.5	0.5	3.5	4.5	10.0			18.0		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	1.0	1.0			1.5		
Haematological	% Within 62 days	▲ £	37.5%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	0.0%	100.0%	100.0%	75.0%	75.0%	80.0%	85.0%		60.5%		
	Total > 62 days		5.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	2.0	0.0	0.0	1.0	2.0	3.0			17.0		
	Total > 104 days		2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0			5.0		
Skin	% Within 62 days	▲ £	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.9%	93.4%	100.0%	97.7%	93.4%	95.5%	86.9%	93.3%	85.0%		93.3%		
	Total > 62 days		0.0	1.0	3.5	4.0	4.5	3.0	3.0	2.0	0.0	1.0	2.5	1.5	5.5	10.5			29.5		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	2.0	4.0			1.5		
Unknown	% Within 62 days	▲ £		100.0%		100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	85.0%		88.2%		
	Total > 62 days			0.0		0.0	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		
All Tumour Sites	% Within 62 days	▲ £	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	83.4%	85.4%	86.3%	90.3%	83.2%	85.4%	77.6%	84.0%	85.0%		85.2%		
	Total > 62 days		13.5	14.5	12.5	14.5	15.5	15.5	17.0	12.0	12.5	10.0	17.5	14.0	25.0	66.5			170.5		
	Total > 104 days		4.0	3.0	2.5	1.5	2.0	1.5	0.5	2.0	3.0	1.5	3.0	3.0	7.5	15.0			24.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%	100.0%	100.0%		100.0%			100.0%	66.7%	100.0%	100.0%		83.3%	85.0%		100.0%		
	Total > 31 days			0.0	0.0	0.0		0.0			0.0	1.0	0.0	0.0		1.0			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 (22)067

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 July and August 2022.

There were seven Executive Committee meetings held during this period. The new investment decisions made were:

1. To increase mileage reimbursement rates for staff who claim more than 3500 miles per annum (after which a lower mileage would normally be paid).
2. Creation of the Head of Nursing and Quality post for ED
3. Increased capacity for the discharge coordinator team to create a 6 day per week service
4. Creation of a Surgical Skills Coordinator post
5. Increase the capacity of the cancer care navigation and tracking team
6. Emergency Department substantive nurse establishment increases
7. Non-Elective Bed Capacity – substantive staffing for Ward 1A
8. Safeguarding Team increased capacity

At each meeting the committee discussed the actions taken to support the Southport and Ormskirk Agreement for Long Term Collaboration.

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: 28th September 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were seven Executive Committee meetings in July and August 2022. No meeting was held on 11th August.

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

2. 7th July 2022

2.1 Mileage Reimbursement Rates

The Deputy Director of HR presented a report which set out proposals to increase the mileage rates paid to staff travelling as part of their role, to recognise the increased costs of fuel. The increased rates would apply to staff who travel more than 3500 miles per annum (after which a lower mileage rate is usually paid). In addition, a facility to reclaim travel expenses on a weekly basis was also to be introduced so that staff would not be out of pocket. The revised rates were being introduced across Cheshire and Merseyside for an initial period of 3 months as it was anticipated the national reimbursement rates would be reviewed by NHS Employers. The proposals were approved.

2.2 Emergency Department Staffing

The Director of Operations and Performance introduced a review of the nurse staffing in the emergency department which included proposals to consolidate the temporary staff that had been approved to respond to the urgent and emergency care pressures into the staffing establishment. Due to the recurrent value of the substantive investment a business case was required, and the committee clarified the additional information that would be required to ensure this was a robust case with quantifiable benefits.

The review also included a proposal to establish a permanent Head of Nursing and Quality for Urgent and Emergency Care following a recent trial of this post. The committee supported the proposal to create a dedicated Head of Nursing and Quality for this part of the Medical Care Group to support the delivery of high quality patient care.

2.3 Trust Board Agendas - July

The committee reviewed the draft Trust Board agendas for the July meetings.

2.5 Southport and Ormskirk Hospitals NHST (S&O) update

The committee reflected on the outcome of the Board workshop on 1st July and arrangements to support the transaction process. Plans for the S&O Board workshop on 3rd August were also discussed.

2.6 COVID 19

The Director of Nursing, Midwifery and Governance reported on increased community incidence and rising nosocomial infections. The committee agreed to recommend staff and patients return to wearing masks in all clinical areas and to reinstate enhanced touch point cleaning on any outbreak wards.

3. 14th July 2022

3.1 Discharge Coordinators Business Case

The Director of Operations and Performance introduced a business case to consolidate the funding for discharge coordinators so that ahead of winter all medical wards would have access to a dedicated discharge coordinator on a substantive basis. The case demonstrated the benefits of these posts in bringing forward discharge dates and times of patients ready for discharge from an acute medical setting. The case also included an option to increase the discharge coordinator presence to 6 days per week to optimise weekend discharges. The case was approved.

3.2 Operational Site Manager Business Case

The Director of Operations and Performance introduced a business case to increase the size of the operational site management team to respond to the challenges of maintaining an effective patient flow. Following consideration, the committee agreed to request further information, including a wider understanding of the role of other managers during the day. It was therefore agreed that the business case should be revised to better articulate the case for change and expected benefits and would then be reconsidered by the committee.

3.3 Review of Nursing, Midwifery and Health Care Assistant shift patterns

The Director of Nursing, Midwifery and Governance presented the proposal to hold a formal consultation with ward staff across the Trust about changing the Trust shift patterns from 3 shifts a day to 2. The committee reviewed the findings of the pilot of 12.5 hour shifts that had taken place in 11 areas since January 2022. The long shift patterns had been popular with most staff, although the proposal included the option to retain 8 hour and split shifts to support flexible working requests.

The consultation would take place during August and if agreed the new rotas would come into effect in November 2022. The committee approved the request.

3.4 Additional Bed Capacity Proposals

The Director of Operations and Performance presented review of options for increasing bed capacity in 2022/23 in response to recent national and ICB policy decisions. The potential for progressing the modular build at St Helens hospital was considered and whilst it was acknowledged that this could have been achieved before the end of the financial year, there was uncertainty about funding of the recurrent revenue implications. As a result, the committee agreed the strategy for 2022/23 would be to pursue an off site bed capacity that could be utilised for patients who were ready for discharge from the acute setting.

3.5 Discharge Lounge Improvement Pilot

The Director of Operations and Performance reported on the results of the improvement pilot which had altered the opening hours and staffing levels to increase utilisation of the discharge lounge to achieve discharges before midday. The pilot had demonstrated some improvement and highlighted other areas of focus that would now be taken forward.

3.6 Evaluation of the impact of Foetal Cardiotocography (CTG) central monitoring

The Director of Nursing, Midwifery and Governance introduced the report which reviewed safety incidents in the maternity unit since the introduction of CTG monitoring in 2020. The aim had been to improve situational awareness for obstetricians and Delivery Suite shift coordinators when supporting the clinical midwives. The paper compared still births, % of babies requiring cooling or diagnosed with a Hypoxic Ischemic Encephalopathy (HIE) before and after the introduction of centralised CTG monitoring. All indicators showed an improvement following the introduction, although in all measures the absolute numbers were small. The paper also explored legal claims that involved interpretation of CTG results over the previous 10 years, their status and potential value. There had been no new legal claims since January 2020 that has included an alleged failure to monitor or interpret CTG results appropriately.

3.7 Board Assurance Framework (BAF)

The Director of Corporate Services presented the draft BAF for review ahead of presenting the quarterly update to the Trust Board.

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

The Director of Corporate Services presented the chair's assurance report from the July RMC meeting. There remained 31 high risks escalated to the CRR, including one new risk escalated during June. This risk related to the capacity of therapy services to provide consistent input to Bevan Court because of staff absence and vacancies. A mitigation plan was in place to reduce the risk. Three other risks had been de-escalated from the CRR during June.

3.9 Integrated Performance Report (IPR)

The Director of Finance and Information presented the June IPR for review and approval of the commentary. It was agreed that further detail was required in relation to e-discharge performance and plans for improvement and a clearer explanation was required in relation to C-Diff performance and the current number of reportable cases following the RCA and appeal process.

3.10 Southport and Ormskirk Hospital NHST Update

The Director of Finance and Information reported on discussions with LUHFT in relation to the proposed revenue costs of the Hyper Acute Stroke Unit.

The Director of Corporate Services confirmed that the potential transaction advisors had been contacted to confirm if they could still support the trusts in the planned timescales.

The responses to these requests had been evaluated and a preferred firm had been identified based on previous experience and capacity.

4. 21st July 2022

4.1 Care Quality Commission (CQC) – Insight Report

The Director of Nursing, Midwifery and Governance presented the May 2022 CQC Insight Report. Overall, the Trust performance was categorised as "about the same" as previous periods across all the domains. The committee focused on any metrics which had declined compared to national performance or previous Trust levels and the proposed response where action was needed.

4.2 Safer Staffing – Month 3

The Director of Nursing, Midwifery and Governance introduced the June 2022 safer staffing headline figures and May 2022 deep dive which triangulated fill rates, professional judgement, and any correlation with patient safety incidents.

4.3 International Nurse Recruitment

The Director of Nursing, Midwifery and Governance introduced a paper which detailed the plans to recruit and support 100 new international nurses to the Trust each year. To date the annual target had been 50 international recruits but this year a cohort of 20 had arrived in July and another 32 were planned to arrive in September with a final cohort of 31 in November. Central funding was available to support the increase in line with national policy. The committee was supportive of the proposals but asked for more detail in respect of the associated costs, to ensure that there was a clear understanding of all the costs and whether the proposed funding was sufficient.

4.4 Evaluation of the Winter Pay Incentive Scheme 2021/22

The Director of Nursing, Midwifery and Governance introduced the paper which evaluated the effectiveness of the three cycles of the winter pay incentive scheme that had been implemented between November 2021 and February 2022 in three 5 week cycles to incentivise nursing staff to work additional shifts. Overall, the number of bank shifts worked had increased, but this was not consistent across cycles and sickness absence (including COVID absences) had increased over the same period. The committee concluded that there were many other variables which had also impacted on staffing fill rates at this time, including turnover and other Trusts introducing similar schemes. Proposals for adjusting the scheme to make it easier to administer and track the impact were also considered.

4.5 Withdrawal of the COVID 19 staff terms and conditions

The committee noted the changes to the national staff terms and conditions in relation to COVID 19 and the reinstatement of the previous contractual sick pay entitlements, irrespective of the reason for absence. Arrangements for communicating these changes to staff generally and specifically to those staff who remained off work with long COVID were agreed.

4.6 Maternity indicators

The Director of Nursing, Midwifery and Governance proposed that intrapartum still births should be added to the IPR, following the removal of length of stay, in line with the recommendations of the Ockenden Report.

4.7 Appraisal Compliance

The committee received the appraisal compliance figures for June 2022. The detailed report included a breakdown by staff group and by service. There was discussion on the appraisal window for agenda for change staff, which was to close at the end of September and the actions that could be taken to support managers to undertake appraisal discussions with their staff and the potential impact on pay progression if this deadline was not met.

4.8 Elective Recovery Plan

The Director of Operations and Performance presented the latest performance against the elective recovery plan and reported on the discussions held at the Finance and Performance Committee meeting. The quarter 1 performance was on track to deliver the key milestones for reducing long waiting patients. The greatest risk to activity levels was pressures from non-elective care when medical patients had to be accommodated in surgical care beds, which meant planned surgery then had to be cancelled.

4.9 Southport and Ormskirk Hospitals NHST Update

Committee discussed the follow-up maternity insight visit, the development of an SLA for StHK to host the S&O IT servers, the IT requirements for day 1, post transaction, and the national digital funding that might be allocated to S&O to improve digital capability. It was also noted that the business case for approval of the advisors to support the transaction process had been submitted to NHSE, in line with national policy.

4.10 Mental Health Patients

The Director of Nursing, Midwifery and Governance briefed the committee on the actions being taken to ensure that the young inpatients with mental health problems were moved to an appropriate placement to meet their needs. This involved working with the local authorities in respect of the patients who were under 18.

5. 28th July 2022

5.1 Surgical Skills Coordinator Business Case

The Director of Finance and Information presented a business case to create a band 6 surgical skills coordinator position within the Clinical Education Department to deliver the Royal College of Surgeons practical skills courses. The role would benefit StHK doctors but also create an income generation opportunity for other trainees. The business case was approved.

5.2 Cancer Patient Pathway Business Case

The Director of Operations and Performance introduced a business case to enhance the capacity of the cancer care navigation and tracking team. Some of the proposals were interim requirements until the EPR clinic redesign project was completed and the remainder were to enhance the quality of the service by bridging the gap between the national monitoring systems and ensure that patients were supported throughout the pathway, from initial diagnosis until the patient was on the surveillance list. The business case was approved.

5.3 Northwest Ambulance Service (NWAS) Escalation Process

Representatives from NWAS attended the meeting to explain the new NWAS escalation process that had been introduced across the region following a trial that had started in October 2021. The objective had been to create a single escalation protocol that was used throughout the northwest, that would ensure crews were released to respond to emergencies.

5.4 Emergency Department (ED) Nurse Staffing Business Case

The Director of Operations and Performance presented the business case to substantively fund the nurse and health care assistant establishment that was needed to support the overcrowding in ED resulting from the challenges with patient flow.

The case detailed the pressures on ED resulting from increased demand for medical admissions, increased patient acuity, delayed discharges, and the national shortages of ED medical trainees. It was recognised that nurse and health care assistant staffing had historically been increased on a temporary basis to respond to winter pressures, but these pressures were now being experienced all year, and there were benefits to having permanent staff rather than relying on bank and agency for this additional capacity.

The case also outlined the additional staffing required to optimise the potential of the ED Same Day Emergency Care (SDEC) unit to avoid admissions.

The Executive Committee approved substantive funding for the main ED but requested additional information in relation to the benefits of increased funding for the SDEC.

5.5 Non-Elective Bed Capacity Funding Business Care

The Director of Operations and Performance introduced the case for permanent funding for ward 1A, including nursing and medical staff to sustain the ED in-reach service. It was agreed that the demand for inpatient beds and the ED in-reach service to identify suitable patients and improve patient flow remained essential. It was also acknowledged that the NHS nationally had now recognised the need for additional beds. The business case was therefore approved.

5.6 Southport and Ormskirk Hospital NHS Trust

The Deputy CEO/Director of HR reported on the Specialist Commissioning team visit and the planned review of maternity and neonatal services across C&M.

5.7 Monkey Pox

The Medical Director provided a briefing on the latest guidance from NHSE and the World Health Organisation about Monkey Pox and testing of high risk patients.

6. 4th August 2022

6.1 Safeguarding Team Capacity Business Case

The Director of Nursing, Midwifery and Governance introduced the business case, which set out the significant increases in activity and changes to statutory duties since the last review in 2019. It was noted that the increase was partly driven by increased awareness and compliance by staff and partly by an increase in the number and complexity of safeguarding issues because of the pandemic. Approval was given to supplement the team including a specialist safeguarding midwife and a second learning disability specialist post.

6.2 Workforce Race Equality Scheme (WRES)

The Deputy CEO/Director of HR presented a briefing on the WRES reporting process and timetable for the 2021/22 submissions.

6.3 Hospital Sterile Services Contract

The Director of Corporate Services presented an update on the re-procurement of Hospital Sterile Services when the current contract ends in 2025. The development of the national framework had been delayed by 3 months and although this was still manageable, the risk to the procurement process had increased slightly if a new provider needed to develop facilities to deliver the contract. The situation would continue to be monitored and escalated if there was a further delay in releasing the framework.

6.4 Human Factors Training Proposal

The Director of Nursing, Midwifery and Governance introduced the paper which set out the plan to re-introduce human factors training for theatre staff. The plans were supported, and it was agreed that the training would start in Q3.

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

The Chief Executive reported on the workshop with the S&O Board and the positive discussions that had taken place.

Committee were concerned that there was no explanation why S&O had been categorised in tier 2 for elective recovery support and it was noted that this was being challenged with NHSE.

The North Mersey Stroke Service business case had been approved by the C&M ICB and phase 1 of the service would start in September.

The S&O Targeted Investment Fund (TIF) had been approved to support additional community beds.

6.6 Social Value Award

The Director of Integration reported that the Trust had been successful in its application for the Social Value Award demonstrating its contribution to the wider community. The next target was to develop plans to address health inequalities via the Prevention Pledge which had 14 core commitments and it was estimated would take 9 months to complete. It was also noted that the Trust was supporting S&O towards achieving the Social Value Award.

7. 18th August 2022

7.1 Mandatory Training and Appraisal Compliance

The Deputy CEO/Director of HR presented the report for July, which showed that mandatory training compliance was stable at 78% or staff, and appraisal compliance had reduced slightly since June. Committee discussed the importance of AfC staff completing the appraisal within the appraisal window to be eligible for incremental pay progression and agreed further actions to support managers to complete with their staff.

7.2 Integrated Performance Report

Committee reviewed the July IPR and agreed changes to update the narrative. The final IPR would be circulated to Board members as there was no Board or committee meetings in August. Committee discussed the development of the new IPR which was planned to go live in September and the opportunities for aligning the StHK and S&O IPRs.

7.3 Aintree Hospital Fire

The Director of Corporate Services reported that following the serious fire at Aintree Hospital, Merseyside Fire and Rescue Service were visiting all hospitals to review their fire safety and access arrangements. The fire service had been at StHK for the planned annual fire inspection and had confirmed that all fire safety arrangements were satisfactory.

8. 25th August 2022

8.1 Lead Employer Contracts

The Deputy CEO/Director of HR introduced a paper that provided an update on the status of the different lead employer contracts delivered by the Trust, and a market assessment of those coming to the end of their term and those that the Trust would wish to bid for as the opportunity arose.

8.2 Southport and Ormskirk Hospital NHST

The Director of Informatics presented a paper which detailed the considerations and risks to providing the minimum integrated IT systems, should the proposed single Trust become operational.

Confirmation had been received that the Community Diagnostic Centre bid for Southport Hospital had been approved, which would include a second CT scanner for the site.

8.3 COVID-19

The Director of Operations and Performance reported that national guidance had been received to stop routine asymptomatic COVID-19 testing for staff and patients from 31st August. This did not impact the care home discharge guidance and patients would still require a test prior to discharge. It was also confirmed that non-elective patients would still be tested on admission. The staff guidance was being revised the reflect these changes.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)068

Title of paper: Committee Report – Audit

Purpose: To report to the Trust Board on the Audit Committee, 21st September 2022

Summary

Meeting attended by:

I Clayton – NED & Chair
J Kozer – NED
G Brown – NED
G Lawrence – Director of Finance & Information
N Bunce – Director of Corporate Services
C Oakley – Deputy Director of Finance & Information
J Farrar - Engagement Lead, Grant Thornton UK LLP
G Philip - Senior Manager, Grant Thornton UK LLP
A Poll - Senior Audit Manager, MIAA
R Barker - MIAA Anti-Fraud Specialist

Agenda Items

For Assurance

A) External Audit

- Annual Auditor's report resulted in no risks of significant weakness identified in the three categories tested; Financial Sustainability, Improving economy, efficiency and effectiveness and Governance.
- The committee recieved four recommendations for improvements.
- Following some minor adjustments to the report Grant Thornoton will issue the audit certificate, confirming the conclusion of the 21/22 audit.

B) Internal Audit

- Reviews in the following areas have been finalised in 2022/23, four with Substantial Assurance: Clinical Audit, Tendable Ward Assessment, Waiting List Management, IT Asset Management, Data Security & Protection Toolkit. One with High Assurance: Recruitment.
- A change to the audit plan was noted to include the HFMA Financial Sustainability Self Assessment in place of the regular financial systems audit.
- Three follow up reviews have been completed in 2022/23.

C) MIAA Anti-Fraud Services

- Four referral queries were received in the reporting period, with two carried forward.
- Six IMO Cases/Investigations are ongoing.

D) Financial Sustainability Assessment

- The committee noted the requirement for the Trust to undertake the HFMA Financial Sustainability Checklist and accepted the Trusts plan to complete the checklist and add it to the Internal Audit plan.

E) Audit log

- The committee noted progress against actions from previous audits including four finalised reports, three reports removed following completion and twelve reports containing recommendations not yet implemented.

F) Losses and Special Payments

- £86k losses and special payments registered ytd 2022/23, 30% of 2021/22 full year total of £289k.

G) Aged Debt

- Total NHS invoiced debt: £19.1m of which £5.5m has been due for more than 30 days.
- Total Non NHS invoiced debt: £4.5m of which £3.2m has been due for more than 30 days.

H) Tender and Quotation Waivers

- The committee noted that 37 waivers have been registered for the period April- August

For Approval

I) External Audit

- The committee approved the Annual Auditor's Report 2021/22

Risks noted/items to be raised at Board

Corporate objectives met or risks addressed: Finance and Performance
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: Ian Clayton, Non-Executive Director
Date of meeting: 21st September 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22) 069
Reporting from: Quality Committee
Date of Committee Meeting: 20th September 2022
Reporting to: Trust Board
Present: Rani Thind, Non-Executive Director (Chair) Gill Brown, Non-Executive Director Geoffrey Appleton, Non-Executive Director Peter Williams, Medical Director Rob Cooper, Director of Operations Nicola Bunce, Director of Corporate Services Gareth Lawrence, Director of Finance **In attendance:** Teresa Keyes, Deputy Director of Nursing and Quality Rajesh Karimbath, Assistant Director of Patient Safety Anne Rosbotham-Williams, Deputy Director of Governance Tracy Greenwood, Head of Nursing and Quality **Observer:** Nicholas Brooks, Non-Executive Director, Liverpool Heart and Chest Hospital NHS Foundation Trust
Matters Discussed **Action Log** One action closed and one not due, with no overdue actions. **Integrated Performance Report** (IPR) highlighted: • No Never Events or MRSA bacteraemia reported in August and no category 3 or 4 hospital acquired pressure ulcers reported in July • 4 cases of C difficile reported in August • 3 falls resulting in severe harm reported in July • Safer staffing fill rate for registered nurses/midwives for August 2022 was 93.2% and year-to-date rate 93.9% • HSMR for 2021-22 was 96.4 • Continued achievement of 31-day target in July, although 62 day target was below target in month at 77.6% and slightly below target year to date • 2-week rule target was not achieved in July • Continued challenges in meeting emergency care access targets, however 99% of patients were seen and treated within 4 hours at the Urgent Treatment Centre. The Committee noted the actions being taken to ensure patient safety is

maintained for all patients within the Emergency Department, including investment in additional substantive staff
- Ambulance turnaround times were not achieved
- Average daily number of super stranded patients (length of stay over 21 days) increased to 147 in August and the Committee noted the work that is being undertaken with system partners to improve discharge pathways
- 18-week referral to treatment and 6-week diagnostic targets were not achieved
- Improvements noted in sickness absence, mandatory training and appraisals with ongoing work to achieve the targets. Additional information was sought by the Committee on the outcomes of the latest pulse survey of staff and it was agreed this would be provided at September's Board meeting

Monitoring of the Trust Annual Objectives Aligned to the Quality Committee
An update on progress in achieving the 8 objectives was presented, noting that progress was being made in most areas. The report noted the appointment of a lead nurse for the deteriorating patient programme and improvement in number of patients being discharged before lunch in particular. It was noted that the number of ward administrator hours is being reviewed, which could support further reductions in concerns relating to call answering.

Patient Safety Council Report
A number of reports were received, including patient safety report which noted 6 StEIS reportable incidents in June and 6 in July 2022 and reduction in patient falls; CAS report which noted that all alerts were actioned, including close monitoring of the global shortage of two medications used in stroke and cardiac services; medicines safety report highlighted improved audits in medicines and CD storage; infection prevention report noted a reduction in COVID outbreak areas and improved training figures for sepsis. A number of procedural documents were approved.

The Committee were given assurance that there was an adequate supply of falls prevention equipment, including falls alarms.

Incidents, Never Events and Serious Incidents Thematic Review Quarter 1 2022-23
No never events were reported in Q1 and the number of incidents reported increased over the previous quarters, indicating a positive reporting culture. The report noted that the rate of severe harm/deaths is lower than the national average as a % of all harms reported. There were 80 open StEIS reported incidents in Q1, with 32 completed reports submitted to Commissioners. The most common theme of incidents reported related to falls resulting in a fractured neck of femur. Details of the actions taken/being taken following the incidents were provided, including focussed work being undertaken in the Emergency Department.

Infection Prevention Annual Report 2021-22
The Committee received the annual report, which included the forward plan for 2022-23. The report provided details of compliance with the Trust's statutory responsibilities and the policies and procedures in place. It was noted that the Trust had reported 2 cases of MRSA bacteraemia (one not attributed to lapses in care) and 54 cases of Clostridium Difficile of which 29 were confirmed as having no lapses in care. In addition, details of the 7 other nationally reportable infections were provided. It was noted that mandatory training for level 1 was at 90%, with level 2 at 76%, with ongoing work to increase this, set against the challenges of releasing staff from

clinical areas. There has been an increase in engagement from medical colleagues, which has enhanced the review process and enabled wider learning.

Patient Experience Council report
The Council met in August and September and received a number of reports, including patient stories noting the work undertaken by the prevention of delirium volunteers and the Community Frailty Team. A detailed quarterly update was received outlining the range of mechanisms in place for patient/carer engagement and gaining feedback, with actions taken to share and respond to this noted, including close working with local Healthwatch partners. The timeframe to respond to complaints has been reduced from the 6 months set during the pandemic to 100 days, with a view to further reductions as soon as practicable.

The Trust has sustained the increase in Deprivation of Liberty Safeguards applications and has increased the number of staff receiving dementia training.

Quality Ward Round
The Committee received an update on the Quality Ward Round programme which recommenced in July, noting the positive feedback received from staff about the opportunity to engage with members of the Board. 9 have been completed to date.

Clinical Effectiveness Council report
The Council met in September and received a number of reports, including presentations from Gastroenterology and Ophthalmology, noting the increased levels of activity for both compared to 2019-20. The Trust has trained the First Gastrointestinal Physiology Clinical Endoscopist in the UK and has successfully implemented the programme for faecal immunochemical testing(FIT) to reduce waiting time for suspected colorectal cancers. Nurse-led laser eye surgery clinics and Botox clinics for treatment of facial palsy have been developed in Ophthalmology. The Council were updated on the timescale to add blood glucose monitoring results to Careflow which will be part of the upgrade due next year.

A number of procedural documents were approved.

CQC Insight report
A report on the latest CQC Insight report was provided, which detailed the Trust's performance benchmarked against the national averages and the Trust's previous position. Overall performance remained about the same, with fluctuation in a few indicators, including latest staff survey performance and emergency readmissions, which are being reviewed in detail.

Assurance provided:

- Decreased level of falls being maintained
- Improvements in audit scores for storage of medicines and controlled drugs
- 94% compliance with NICE guidance in 2021-22
- Substantial assurance given to Quality Improvement Clinical Audit Team by Mersey Internal Audit Agency

Decisions taken:

- No formal approvals required

Risks identified and action taken: The Committee requested the following actions be taken: • Review of emergency readmissions for fracture neck of femur patients • Continued support to release staff for mandatory training
Matters for escalation: • Deep dive into findings of pulse survey of staff
Recommendation(s): That the Board note the report, the assurances provided and the actions being taken to address areas of concern.
Committee Chair: Rani Thind, Non-Executive Director
Date of Meeting: 28th September, 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)070

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance & Performance Committee, 22nd Sep 2022

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton – NED
P Growney – NED
G Lawrence – Director of Finance & Information
R Cooper – Director of Operations & Performance
N Bunce – Director of Corporate Services
P Williams –Medical Director
C Oakley – Deputy Director of Finance & Information
J McCabe – Associate Medical Director

Agenda Items

For Assurance

A) Integrated Performance Report

- 62 day performance was below the target of 85.0% in month at 77.6%. YTD 84.0%.
- Target 31 day performance was met in month, at 96.2% against a target of 96.%.
- Target 2 week wait cancer performance was not achieved in July 2022 with 75.7% in month and 81.7% YTD against a target of 93%
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 44.0% in August and 47.3% year to date. All type mapped STHK Trust footprint performance was 70.8% in August and is 72.4% year to date. The Trust saw average daily attendances of 300, which is down compared to July. Total attendances for August 2022 were 9,296.
- Total ambulance turnaround time was not achieved in August 2022 with 57 mins on average. There were 2,032 ambulance conveyances (busiest Trust in C+M and 3rd in North West) compared with 2,152 in July 2022.
- In August all staff sickness was 6.1% which is a reduction from 7.4% in July.

B) Finance Report Month 5

- At Month 5, the Trust is reporting a YTD deficit of £3.1m which was in line with plans.
- Included within the financial position is £5.7m of non recurrent benefits which are offsetting the non achievement of National ERF and non-pay inflation (excluding energy & PFI) over and above funded levels.
- As at M5 the Trust has identified and delivered CIP schemes of c£21.9m in year and continues to work towards the recurrent target.
- The Trust's full capital allocation is expected to be utilised by the end of the 22/23 financial year.
- At Month 5, the Trust has a cash balance of £62.2m and is acheiving the Better Payment Practice Code (BPPC) target.

C) CIP Programme Update (CIP)

- The committee received the report on the Trust's CIP programme.
- The committee were assured with the level of schemes that have been identified for this year especially given the increased CIP target following the revision of the plan.

D) Financial Sustainability Assessment

- The committee noted the requirement for the Trust to undertake the HFMA Financial Sustainability Checklist and accepted the Trusts plan to complete the checklist and add it to the Internal Audit plan.

E) Benchmarking update

- The committee noted progress on the 15 benchmarking workstreams the Trust is participating in.

F) Business Case Benefits Realisation update

- The committee noted progress on with tracking and delivery of business case benefits under the 2022/23 Benefits Realisation proramme.

G) Medical Care Group - CIP

- The committee reviewed the progress on the care groups CIP delivery
- They noted the engagement that was demonstrated in identifying the financial plans.
- The committee were assured around the ownership of the plan and the progress in delivery.

For Information

H) Council Updates

- The committee noted the updates from:
  - CIP Council
  - Procurement Council
  - Capital Council

I) National Cost Collection

- The National Cost Collection for 21/22 was submitted on time.
- The committee noted the publication of the 20/21 National Cost Collection score and the presentation of results at future meetings.

Risks noted/items to be raised at Board

- The impact of the new Royal Liverpool Hospital was discussed, in particular risks around the reduction of beds and the knock on impact on LUHFT's elective recovery.
- The risk of a reduction in additional clinical sessions available relating to the BMA ratecard was raised.

Corporate objectives met or risks addressed: Finance and Performance
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: 22nd September 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)071
Title of paper: 2021-2022 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance
Purpose: To provide assurance to the Board that the Trust is compliant with the Responsible Officer regulations.
Summary: Since the last Board Report, the Trust has provided the Responsible Officer with additional resources to support medical appraisal, revalidation and fitness to practice. The Trust has implemented new NHS England guidance on appraisal for doctors which includes focussing on doctors' wellbeing. Clinical pressures in both acute and elective services have resulted in some doctors finding it difficult to arrange an appraisal meeting date. Recruiting appraisers remains a challenge, but we have several doctors booked onto the new appraiser training session over the coming months and we will continue to promote the benefits of being an appraiser.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce
Financial implications: none
Stakeholders: Trust Board, Medical Director, all doctors
Recommendation(s): Recommend that the Board approves this document.
Presenting officer: Dr Jacqui Bussin
Date of meeting: 28th September 2022

2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:	St Helens & Knowsley Teaching Hospitals NHS Trust	
	Name	Contact information
Responsible Officer	Dr Jacqueline Bussin	0151 430 1725
Medical Director	Dr Peter Williams	0151 430 1477
Medical Appraisal Lead	Dr Stephen Allsup	0151 430 2419
Appraisal & Revalidation Manager	Colette Hunt	0151 430 2279
Additional Useful Contacts	Michelle Langton	0151 430 1650

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Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West Section 1 – General:

The board of St Helens & Knowsley can confirm that:

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

   Yes, Dr Jacqueline Bussin is the Responsible Officer.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes. St Helens & Knowsley Teaching Hospitals NHS Trust ("the Trust"), has invested additional funds for a number of roles to support the Responsible Officer. This includes the Medical Appraisal and Revalidation Governance Lead, Fitness to Practice Governance lead and Medical Workforce Administrator. The additional resources will also provide dedicated time to enhance the role of the Clinical Appraisal Lead. The plan for the following year is to complete a gap analysis of the whole service and create an action plan.

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

   Yes.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Yes.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

   No.

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

The Trust provides support with appraisal and revalidation for all doctors, including those on short term contracts and those doctors who work solely via the Trust's medical bank and for whom we are the Designated Body.

A doctor can request their own individual information in the form of complaints and significant events from the Quality and Risk Department.

For doctors with a prescribed connection to another organisation, the Trust will provide information to the doctor and their Responsible Officer to assist their revalidation when requested.

7. Where a Service Level Agreement for External Responsible Officer Services is in place

The Trust has a service level agreement with Willowbrook Hospice to provide Responsible Officer services.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

The Trust adopted the Appraisal 2020 model with effect from October 2020. The Responsible Officer and Clinical Appraisal Lead continue to receive positive feedback from doctors, particularly due to the reduced requirements and preparation time required.

8. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

The Trust has implemented the Appraisal 2020 model.

Following the recent communication from NHS England, the Trust will be adopting the Appraisal 2022 model which maintains the focus on wellbeing and the reduction in the preparation time.

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

Yes.

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust currently has a total of 105 trained appraisers with an additional 5 doctors booked on to the new appraiser training between September and December 2022. During the last year, a total of 10 doctors completed the new appraiser training course. The Trusts target number of appraisers is 130. We are planning to deliver several information sessions for doctors in addition to the appraiser support groups where we will promote the role of the appraiser and speak to doctors who may be interested in the role. The Responsible Officer also speaks Clinical Directors during the CD forum meetings to encourage them to identify doctors suitable to become appraisers.

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Appraisers are expected to attend an in-house appraiser support group once a year. These groups are facilitated by the Trust's Clinical Appraisal Lead.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The appraisal system is reviewed by the Trust's Responsible Officer Advisory Group (ROAG). The minutes from the ROAG meeting are shared with the People Council Group.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022	**527**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**333**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**122**
Total number of agreed exceptions	**72**

Section 3 – Revalidation Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations to the GMC:	**138**
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	**103**
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	**35**
Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	**0**
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	**3**

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

The Responsible Officer informs the doctor when a positive recommendation has been made. If the Responsible Officer plans to make a recommendation of deferral, the doctor is informed prior to the deferral and a supportive plan is put in place to avoid further deferrals.

Going forward we plan to register doctors to start their multi-source feedback during year 3 of their revalidation cycle, which should reduce the number of deferrals due to insufficient evidence.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

Yes.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Any concerns raised about trust doctors are managed using the relevant policies.

All doctors are required to document any complaints and significant events within their appraisal.

All doctors can contact the Quality and Risk department to access their individual information relating to complaints and incidents.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> The Trust has several policies in place to include Remediation, Handling Medical Concerns, Raising Concerns and Respect and Dignity at Work.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

> The Trust has an Employee Relations oversight Steering Group (ERSOG) which reports to the Trust Board via the Quality Committee. The ERSOG oversees local investigation and disciplinary procedures for all staff groups. The Equality, Diversity and Inclusion Lead ensures the Workforce Race Equality Standard (WRES) reports are completed and actioned. The reports around exclusion and exception data are presented and discussed by the Board.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

> The Trust continues to use the Medical Practice Information Transfer (MPIT) forms when a doctor takes up or leaves employment. This allows the Trust to share information with a doctor's new Responsible Officer. When concerns are raised about a doctor, the Responsible Officer will contact other Responsible Officers or Clinical Governance leads when required.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

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

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes, when necessary, the Trust will seek advice from the GMC's Employee Liaison Advisor (ELA) and from NHS Resolution.

Section 5 – Employment Checks

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

The Trust adheres to the NHS Safer Recruitment Standards.

Section 6 – Summary of comments, and overall conclusion

Since the last Board Report, the Responsible Officer was successful in securing funding for additional resources within the Medical Appraisal and Revalidation Team.

The team will be undertaking a gap analysis and making changes whilst also reviewing priorities for the coming year.

Clinical pressures in both acute and elective services have resulted in some doctors finding it difficult to arrange an appraisal meeting date.

The current number of appraisers also remains a challenge, but we have 5 doctors booked onto the new appraiser training session over the coming months.

Overall conclusion:

The Trust can confirm they are compliant with the Responsible Officer Regulations.

Section 7 – Statement of Compliance:

The Board of St Helens & Knowsley Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: St Helens & Knowsley Teaching Hospitals NHS Trust

Name: Ms Anne-Marie Stretch Signed

Role: Deputy Chief Executive

Date: 20.09.22

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST (22) 072

Title of paper: Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common

Purpose: To secure Board agreement and sign up to the CMAST Joint Working Agreement and Committee in Common.

The Trust has a duty to collaborate and to be part of one or more provider collaboratives. Trust approval of the Joint Working Agreement and Committee in Common TOR is an important step in formalising the governance arrangements to enable CMAST to operate effectively.

Summary:

Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. Working together achieved real and tangible benefits during the pandemic, with much of CMAST's foundations emerging from these activities but also building upon, wider and existing, local collaborative strengths such as the Cancer Alliance.

In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures and now, also require all providers to be part of a collaborative. Furthermore, such a policy imperative is seen to ensure all providers support the delivery of the *triple aim* through:

- Aligning priorities, and
- Supporting establishment of the ICS with the capacity to support population-based decision-making, and
- Directing resources to improve service provision.

C&M Trust leaders have been working together to explore collaborative potential, develop ways of working and defining priorities over the last year. This work has included working with Hill Dickinson and external facilitators and both, Chief Executives and Chairs.

In addition to the triple aim priorities CMAST has identified complimentary key functions, that the collaborative can and should perform:

- Prioritising key programmes for delivery on behalf of the system
- Creating an environment of innovation, challenge, and support to deliver improved performance and quality of service provision

Following the success of previous CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB it has been proposed, by CMAST members, and is now advocated that CMAST's ways of working should be embedded through a Joint Working Agreement. Such an approach provides a means to document the progress made, together within C&M, and provides an opportunity for Boards to demonstrate a shared commitment to the vision, priorities, and programmes of work that they have identified and initiated. Both internally and externally.

It is also proposed that CMAST more formally establish its governance to provide a route for shared and formalised decision making as and when required. This decision-making framework aims to underpin existing ways of working and provide a foundation to build from, as necessary, to fulfil either the need, potential or ambition of CMAST Boards.

The full documents are provided at Appendix A and Appendix B with summary details of both below:

- Joint Working Agreement (JWA) - to be read in conjunction with Committee in Common (CiC) Terms of Reference (ToR):

    - Covers: vision; function; priorities and 2022/4 work programme
    - Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
    - Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

- Committee in Common - Terms of Reference - to be read in conjunction with JWA:

    - Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
    - Committees in Common: Staged levels of Committees in Common decision making; rules-based approach; will underpin clear and consistent communication supporting Board awareness and assurance
    - Sets aims and objectives of CiC
    - Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
    - Quorum
    - Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA

    To note: NWAS is proposed as a participant of the meeting rather than as a member.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

The document delivers both a foundation and framework for CMAST development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMAST develops and the ask of the system, for it, expand, vary or diminish.

Trust objectives met or risks addressed:

This paper provides an update on the actions in respect of continued approach to collaborative working through the CMAST Provider Collaborative.

Accordingly, it supports delivery against the following Trust objectives:

- We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable, and fit for their purposes (5)
- We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services (9)

Financial implications: None directly as a result of this paper

Stakeholders: CMAST, Cheshire and Merseyside NHS Trusts, NHS Cheshire and Merseyside

Recommendation(s):

The Board is asked to

i. Approve the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board
ii. Approve the establishment of a Committee in Common with Terms of Reference as proposed
iii. To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals

Presenting officer: Nicola Bunce, Director of Corporate Services

Date of meeting: 28th September 2022

Draft No: 1 - 6
Date of Draft: 5 September 2022

Appendix A

Dated 2022

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

Between

(1) COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

(2) LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

(3) SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST

(4) WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

(5) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

(6) THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

(7) LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST

(8) THE WALTON CENTRE NHS FOUNDATION TRUST

(9) LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

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

(11) EAST CHESHIRE NHS TRUST

(12) ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

(13) MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

and

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

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1 Introduction

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

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

	NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

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

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

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

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

2 Background

Vision

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

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

Key functions

2.3 The key functions of CMAST are to:

2.3.1 Deliver the CMAST vision;

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

2.3.3 Align priorities across the member Trusts,

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

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

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

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

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

2.4.1 Reduce health inequalities;

2.4.2 Improve access to services and health outcomes;

2.4.3 Stabilise fragile services;

2.4.4 Improve pathways;

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

2.4.6 Achieve financial sustainability.

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

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

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

2.6.2 Cancer Alliance delivery and enablement – subject to the request of the Alliance;

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

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

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

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

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

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

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

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

12. CMAST CiC Paper NHST(22) CMAST Governance NHST (22)072

3 Rules of working

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

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

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

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

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

3.1.6 Support each other to deliver shared and system objectives;

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

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

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

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

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

4 Process of working together

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

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

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

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

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

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

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to

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

act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the current lead arrangements for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].

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

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

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

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

5 Future Involvement and Addition of Parties

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

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

6 Exit Plan

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

6.1.1 termination of this Agreement;

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

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

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

7 Termination

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

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

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

7.2 If:

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

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

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

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

7.3.1 Revoke their delegations and terminate this Agreement; or

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

8 Information Sharing and Competition Law

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

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

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

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information

relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

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

8.4.2 Trusts' manner of operations, staff or procedures;

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

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

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

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

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

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

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

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

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

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

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

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

8.10 The Trusts will seek to agree a protocol to manage the sharing of information to facilitate the operation of CMAST across the Trusts as envisaged under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement. Once agreed by the Trusts (and

their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

9 Conflicts of Interest

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

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

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

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

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

10 Dispute Resolution

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

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

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

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

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

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

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

12. CMAST CiC Paper NHST(22) CMAST Governance NHST (22)072

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

and who shall:

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

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

10.6.1 terminate the Agreement;

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

10.6.3 agree that the Dispute need not be resolved.

11 Variation

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

12 Counterparts

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

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

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

13 Governing law and jurisdiction

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

……
For and on behalf of **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

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

This Agreement is executed on the date stated above by

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Not applicable]

APPENDIX 15 - EXIT PLAN

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 16 - INFORMATION SHARING PROTOCOL

[to be inserted once agreed]

Appendix B

V 5-2 September 2022

ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

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

TERMS OF REFERENCE

1 Introduction

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

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

St Helens and Knowsley Teaching Hospitals NHS Trust	St Helens and Knowsley Teaching Hospitals NHS Trust of Warrington Road, Rainhill, Prescot, L35 5DR;
St Helens and Knowsley Teaching Hospitals NHS Trust CiC	the committee established by St Helens and Knowsley Teaching Hospitals NHS Trust, pursuant to these Terms of Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
Trusts	Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "Trust" shall be interpreted accordingly;
Working Day	**a day other than a Saturday, Sunday or public holiday in England;**
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "Trust" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The St Helens and Knowsley Teaching Hospitals NHS Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

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

own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

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

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

2 Aims and Objectives of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC

2.1 The aims and objectives of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the St Helens and Knowsley Teaching Hospitals NHS Trust CiC under Appendix A to these Terms of Reference to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Establishment

3.1 The St Helens and Knowsley Teaching Hospitals NHS Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the St Helens and Knowsley Teaching Hospitals NHS Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC.

3.2 The St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The St Helens and Knowsley Teaching Hospitals NHS Trust CiC is a committee of St Helens and Knowsley Teaching Hospitals NHS Trust's board of directors and therefore can only make decisions binding St Helens and Knowsley Teaching Hospitals NHS Trust. None of the Trusts other than St Helens and Knowsley Teaching Hospitals NHS Trust can be bound by a decision taken by St Helens and Knowsley Teaching Hospitals NHS Trust CiC.

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

4 Functions of the Committee

4.1 Paragraphs 15(1) and (2) of Part 3 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990/2024) allow for any of the functions of a Trust to be delegated to a committee of the Trust consisting wholly or partly of directors of the Trust.

4.2 St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Trust

Any functions not delegated to the St Helens and Knowsley Teaching Hospitals NHS Trust CiC in paragraph 4 of these Terms of Reference shall be retained by St Helens and Knowsley Teaching Hospitals NHS Trust's Board. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of St Helens and Knowsley Teaching Hospitals NHS Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the St Helens and Knowsley Teaching Hospitals NHS Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to St Helens and Knowsley Teaching Hospitals NHS Trust's Board for inclusion on the private agenda of St Helens and Knowsley Teaching

Hospitals NHS Trust's next Board meeting in order that St Helens and Knowsley Teaching Hospitals NHS Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall send the minutes of St Helens and Knowsley Teaching Hospitals NHS Trust CiC meetings to St Helens and Knowsley Teaching Hospitals NHS Trust's Board, on a monthly basis, for inclusion on the agenda of St Helens and Knowsley Teaching Hospitals NHS Trust's Board meeting.

6.3 St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall provide such reports and communications briefings as requested by St Helens and Knowsley Teaching Hospitals NHS Trust's Board for inclusion on the agenda of St Helens and Knowsley Teaching Hospitals NHS Trust's Board meeting.

7 Membership

7.1 The St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall be constituted of directors of St Helens and Knowsley Teaching Hospitals NHS Trust. Namely the St Helens and Knowsley Teaching Hospitals NHS Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each St Helens and Knowsley Teaching Hospitals NHS Trust CiC Member shall nominate a deputy to attend St Helens and Knowsley Teaching Hospitals NHS Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for St Helens and Knowsley Teaching Hospitals NHS Trust's Chief Executive shall be an Executive Director of St Helens and Knowsley Teaching Hospitals NHS Trust.

7.4 In the absence of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend St Helens and Knowsley Teaching Hospitals NHS Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of St Helens and Knowsley Teaching Hospitals NHS Trust CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a St Helens and Knowsley Teaching Hospitals NHS Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

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

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of St Helens and Knowsley Teaching Hospitals NHS Trust CiC. The St Helens and Knowsley

Teaching Hospitals NHS Trust's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – as set out in the CMAST Agreement under clause 4) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of St Helens and Knowsley Teaching Hospitals NHS Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of St Helens and Knowsley Teaching Hospitals NHS Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of St Helens and Knowsley Teaching Hospitals NHS Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, St Helens and Knowsley Teaching Hospitals NHS Trust CiC meetings shall take place monthly.

9.2 The St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

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

9.4 Meetings of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall be confidential to the St Helens and Knowsley Teaching Hospitals NHS Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of the St Helens and Knowsley Teaching Hospitals NHS Trust Board.

10 Quorum and Voting

10.1 Members of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC have a responsibility for the operation of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall have one vote. The St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

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

11 Conflicts of Interest

11.1 Members of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall comply with the provisions on conflicts of interest contained in St Helens and Knowsley Teaching Hospitals NHS Trust Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in St Helens and Knowsley Teaching Hospitals NHS Trust Standing Orders also apply to conflicts which may arise in their position as a Member of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC.

11.2 All Members of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC shall declare any new interest at the beginning of any St Helens and Knowsley Teaching Hospitals NHS Trust CiC meeting and at any point during a St Helens and Knowsley Teaching Hospitals NHS Trust CiC meeting if relevant.

12 Attendance at meetings

12.1 St Helens and Knowsley Teaching Hospitals NHS Trust shall ensure that, except for urgent or unavoidable reasons, St Helens and Knowsley Teaching Hospitals NHS Trust CiC Members (or their Nominated Deputy) shall attend St Helens and Knowsley Teaching Hospitals NHS Trust CiC meetings (in person) and fully participate in all St Helens and Knowsley Teaching Hospitals NHS Trust CiC meetings.

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

13 Administrative

13.1 Administrative support for the St Helens and Knowsley Teaching Hospitals NHS Trust CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

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

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

13.1.3 take minutes of each St Helens and Knowsley Teaching Hospitals NHS Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant St Helens and Knowsley Teaching Hospitals NHS Trust CiC meeting.

13.2 The agenda for the St Helens and Knowsley Teaching Hospitals NHS Trust CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

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

APPENDIX A – DECISIONS OF THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST CIC

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

Subject to St Helens and Knowsley Teaching Hospitals NHS Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the St Helens and Knowsley Teaching Hospitals NHS Trust CiC to decide are set out in the table below.

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

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

	Decisions delegated to St Helens and Knowsley Teaching Hospitals NHS Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the St Helens and Knowsley Teaching Hospitals NHS Trust CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;

	Decisions delegated to St Helens and Knowsley Teaching Hospitals NHS Trust CiC
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements;

12. CMAST CiC Paper NHST(22) CMAST Governance NHST (22)072

	Decisions delegated to St Helens and Knowsley Teaching Hospitals NHS Trust CiC
	d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY THE BOARD OF DIRECTORS: [DATE] 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22)073

Title of paper: Workforce Disability Equality Standard Report (WDES) 2021-2022

Purpose: This report provides and overview and analysis of the Trust's Workforce Disability Equality Standard (WDES) and proposed action plan for 2022-23.

Summary:

The following is an overview of the WDES Highlights for 2021/22

Workforce data metrics:

- A marginal **increase** in staff recording disability on ESR.
- A marginal increase in the relative likelihood of non-disabled candidates being appointed from interview compared to disabled candidates, from **1.02** to **1.20**.

Staff survey data:

- An **increase** across all sources of harassment, bullying or abuse for disabled staff since 2020.
- A **13.7% decrease** in disabled staff believing that Trust provides equal opportunities for career progression or promotion, compared to a **2.7% decrease** for non-disabled staff.
- A **12.3%** gap between disabled staff and non-disabled staff saying they have felt pressure to come to work despite not feeling well enough.
- An **11.5% satisfaction gap** between disabled staff and non-disabled staff relating to the extent to which the organisation values their work
- A **15.9% decrease** in disabled staff saying their employer had made adequate adjustments.

A revised WDES Action Plan is provided at the end of this data report, identifying existing, ongoing, and proposed activity to address the themes identified in the WDES.

Our actions will be informed by our Staff Networks and monitored by the Trust's Equality and Diversity Steering Group, Strategic People Committee, JSNC and People Council and reported to the NHSE WDES Implementation Team and NHS Cheshire and Merseyside ICB.

Corporate objectives met or risks addressed: This relates to the 'Developing our Organisational Culture and Supporting our Workforce' objective.

Financial implications: None as a direct consequence of this paper

Stakeholders: Staff, the Trust, NHSE WDES Implementation Team, ICB and Regulators
Recommendation(s): The Trust's Executive Committee are asked to note the content of the report to approve that the WDES report and action plan is presented to the Trust Board to provide assurance against contractual reporting of WDES.
Presenting officer: Anne-Marie Stretch, Deputy CEO/Director of HR
Date of meeting: 28th September 2022

Workforce Disability Equality Standard Report
April 2021 – March 2022

1.0 Executive Summary

This paper provides the Trust Board with an overview of the Workforce Disability Equality Standard (WDES) and the Trust's data and responses to the various metrics against the 10 metrics within the Workforce Disability Equality Standard (WDES).

2.0 Introduction

NHS England introduced the Workforce Disability Equality Standard (WDES) in 2019. The WDES is a data-based standard that uses a series of measures (metrics) to improve the experience of disabled staff in the NHS.

The WDES comprises of a set of metrics. All the metrics draw from existing data sources (recruitment dataset, ESR, NHS Staff Survey, HR data) except for one; Metric 9b asks for narrative evidence of actions taken, to be written into the WDES annual report. The annual collection of the WDES metrics will allow the Trust to better understand and improve the employment experiences of disabled staff in the NHS. This WDES report applies only to substantive posts and excludes Bank workers.

3.0 Key Data

For the period April 2021 to March 2022 trust figures on ESR reported that:

- 3.1% of STHK staff had recorded a disability on Electronic Staff Record
- 84.96% recorded no disability
- 11.94% recorded unknown/null

This compares with 'yes' responses from 24.4% of staff out of the 2,358 who completed the NHS Staff Survey proxy question for disability, ("do you have a physical or mental health condition or illness lasting or expected to last for 12 months or more?")

The percentage of disabled staff being appointed from shortlisting is **23.38%** for disabled compared to **28.18%** for non-disabled staff.

Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff is **1.2** (A figure below 1:00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting).

ESR data highlights the relative likelihood of staff entering the formal capability process for disabled is **9.96**, an increase from 5.63 in 2021. (A figure above 1:00 indicates that disabled staff are more likely than non-disabled staff to enter the process.)

Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public is **13% higher** than for non-disabled staff.

Disabled staff experiencing harassment, bullying or abuse from managers is **10.6% higher** than non-disabled staff.

Disabled staff experiencing harassment, bullying or abuse from other colleagues is **10.4% higher** than non-disabled staff.

Percentage of Trust staff believing that the Trust provides equal opportunities for career progression or promotion is **54.5%** for disabled staff, compared to **65.4%** for non-disabled staff, a difference of **10.9%**.

3.1 Workforce Profile

As of the 31st March 2022, St Helens and Knowsley Teaching Hospitals NHS Trust employed 6,676 staff of whom 3.1% has recorded on ESR that they consider themselves to have a disability. 84.96% of staff have recorded that they did not consider themselves to have a disability, and 11.94% of staff had not stated or their status was unknown.

Staff Headcount	Disabled Staff	Non-disabled staff	Unknown/ Null
Non-Clinical AfC Workforce	71 (3.9%)	1503 (81.9%)	261 (14.2%)
Clinical AfC Workforce	129 (3%)	3693 (86.2%)	461 (10.8%)
Medical and Dental Workforce	7 (1.25%)	476 (84.96%)	75 11.94%)

4.0 WDES Metrics 2021-22

The information below provides a comparison for the WDES reports for 2021-22 and 2020-21. All figures are self-populated taken from the WDES template provided by NHS England and generated using the automated template on Electronic Staff Record for assurance, and from the Staff Survey Coordination Centre.

Note: Definitions for these categories are based on Electronic Staff Record occupation codes except for medical and dental staff, which are based upon grade codes.

For each of workforce metrics, the standard compares the metrics for disabled and non-disabled staff where the figures do not equate to 100% this is due to the information not stated / not given. In recognition that Staff Survey data for 2020 was impacted by the pandemic, 2019 data is also included in these metrics for reference.

4.1 Metric 1: Workforce

Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Clusters by Band

Cluster 1 (Bands 1 - 4), Cluster 2 (Band 5 - 7), Cluster 3 (Bands 8a - 8b), Cluster 4 (Bands 8c - 9 & VSM), Cluster 5 (Medical & Dental Staff, Consultants), Cluster 6 (Medical & Dental Staff, Non-Consultants career grade), Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades).

	2020/2021		2021/22	
Non-Clinical	**% Disabled**	**% Non-disabled**	**% Disabled**	**% Non-disabled**
Cluster 1	3.8	78	4.2	79.9
Cluster 2	2.2	88.5	2.1	89.3
Cluster 3	5.7	78.2	4.4	81.1
Cluster 4	2.4	87.8	7.9	84.2
Clinical	**% Disabled**	**% Non-disabled**	**% Disabled**	**% Non-disabled**
Cluster 1	2.1	84.4	2	87.2
Cluster 2	3.5	84.4	3.7	85.8
Cluster 3	1.6	84.1	1.8	84.9
Cluster 4	6.3	87.5	5	90
Medical & Dental	**% Disabled**	**% Non-disabled**	**% Disabled**	**% Non-disabled**
Cluster 5	0.34	78.62	0.33	79.87
Cluster 6	2.13	85.11	3.75	82.5
Cluster 7	2.63	92.11	1.71	96
Overall Workforce	**2.95**	**83.1**	**3.1**	**84.96**

Overall, there has been a slight increase in the number of staff with a disability recorded on ESR from 2.95% to 3.1%. Rates continue to be below the national average of 3.7%, which are still below the benchmarked STHK Staff Survey result of 24.5%.

The Trust have made efforts towards improving this information in 2022 through the WDES Innovation project.

4.2 Metric 2: Relative likelihood of non-disabled staff to disabled being appointed from shortlisting across all posts

	Disabled	Non-disabled	Unknown/ Null
Number of shortlisted applicants	201	3368	750
Number appointed from shortlisting	47	947	133
Relative likelihood of staff shortlisted/appointed %	23.38	28.12	17.73
Relative likelihood of relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff. (Number of times more likely)			**1.2**

This is an increase on 2021, when the figure was 1.02. However, this relates to a small number of candidates involved, with many 'unknown/null' responses, and a difference equivalent to 0.7% of appointments. As such the result would fall well within the margin of error, and the priority is improving the quality of data and information.

4.3 Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Average over 2 years	Entering formal capability Process	Trust Headcount and %	Relative likelihood of staff entering the formal capability process
Disabled	2	207 - 3.1%	0.01
Non-Disabled	5.5	5672 - 84.96%	0
Unknown/Null	1.5	797 - 11.94%	0
Total	9	6676	
Relative likelihood of Disabled staff compared to non-disabled staff	9.96		

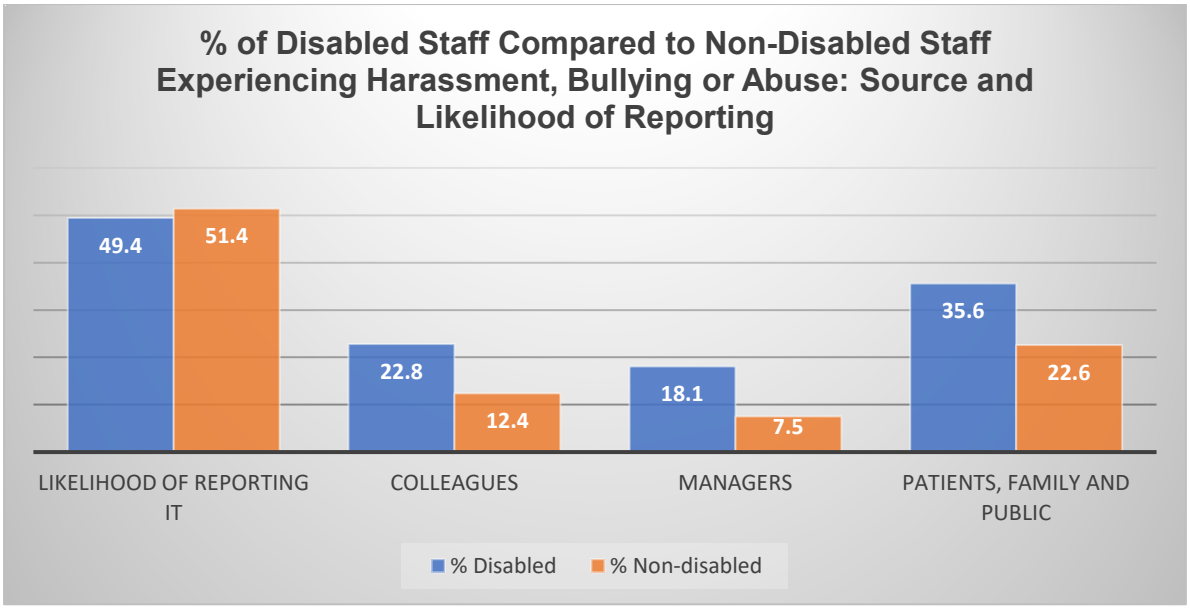
Note: This metric is based on data from a two-year rolling average of the current year and the previous year.

This result is an increase on 2021, up from 5.63%, however it is statistically unreliable due to the insufficient numbers involved in the use of this policy. The Trust is encouraging the use of the new Reasonable Adjustments policy and the Disability

Adjustment passport and has provided management training to raise awareness of how to support staff with disability and this is being delivered by the Business Disability Forum.

4.4 Metric 4a: Harassment, Bullying and Abuse

The metric firstly considers the percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from Patients/Service users, relatives, or other members of the public, their managers and colleagues. It then considers the percentage of disabled staff compared to non – disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



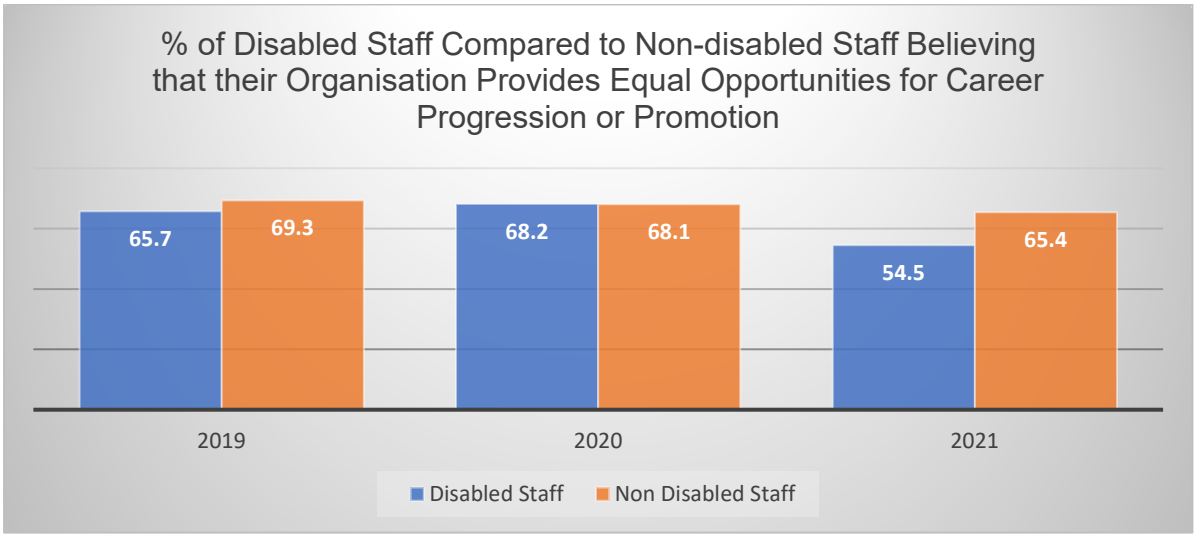
Disabled staff report higher incidence from all sources but are similarly as likely to report it as non-disabled colleagues.

- The results have **increased** from 2020-21 for 'patients, family and public' by **6.6%** for disabled staff, with a **4.3% increase** for staff without disabilities.
- The results have **increased** for 'colleagues' by **6.9%** for disabled staff and **1.7%** for staff without disabilities.
- Responses relating to 'managers' have **increased by 6.2%** for disabled staff and **decreased by 0.7%** for non-disabled staff.

Actions have been identified to better understand this information and directly relate it to process reviews around behaviour, conflict resolution and security, with links into the equality, diversity and inclusion (ED&I) governance structure.

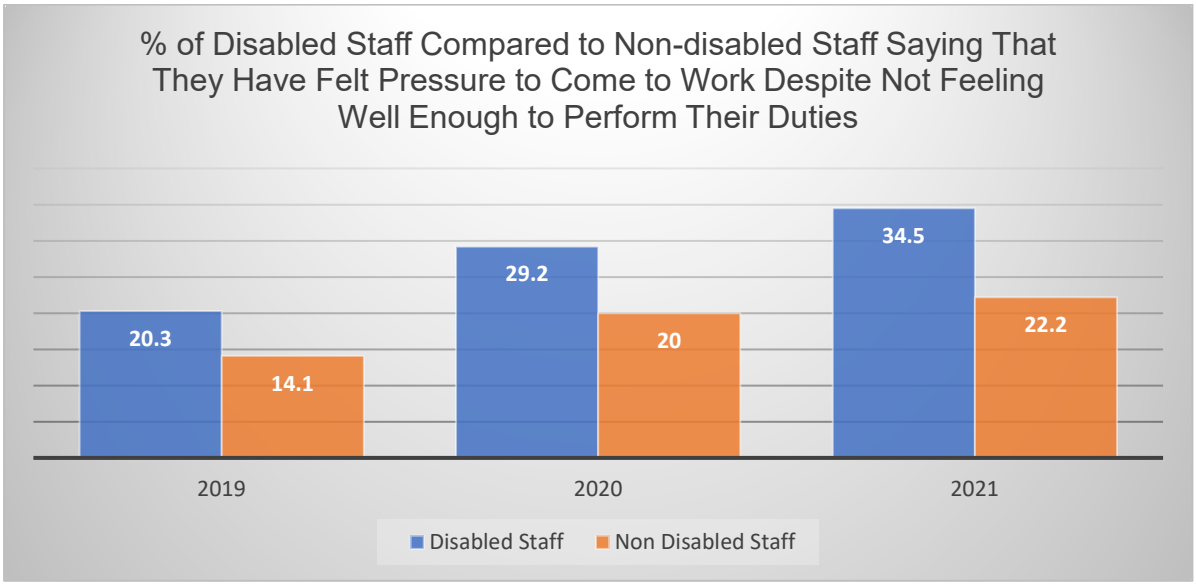
4.5 Metric 5: Percentage believing that Trust provides equal opportunities for career progression or promotion

The historic results for this metric have been adjusted due to change in the staff survey question weighting. The question now includes 'don't knows' where they were previously excluded. Previous years' results included for context.



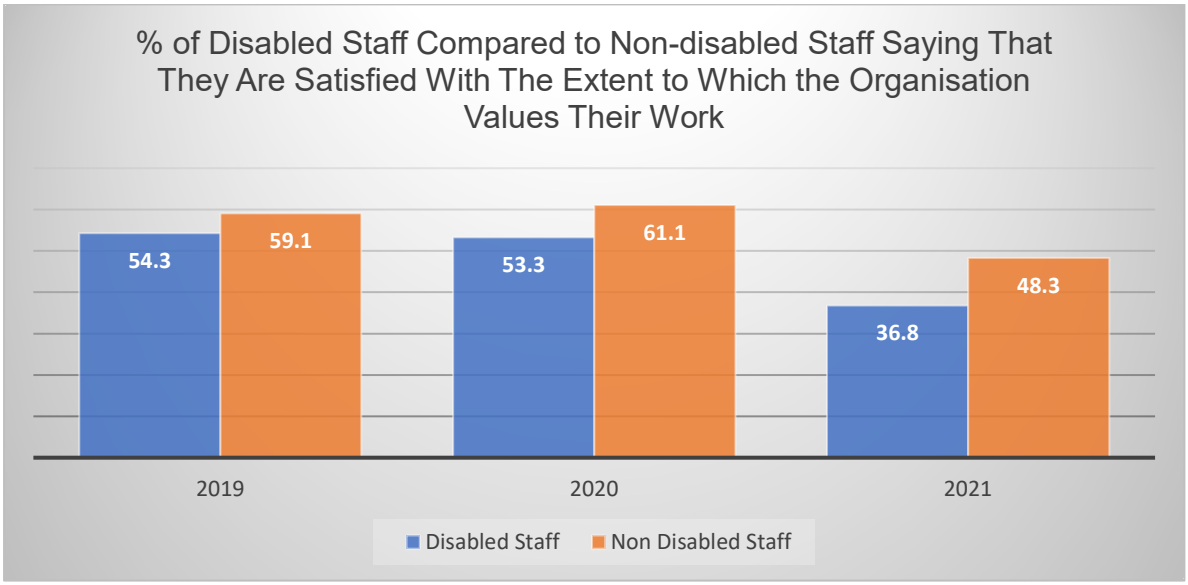
Disabled staff's belief that the Trust provides equality of opportunity has decreased since 2020-21. The 2020 result was originally higher prior to the new weighting, with less disparity between disabled and non-disabled responses (94.2% and 93.6% respectively).

4.6 Metric 6: Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



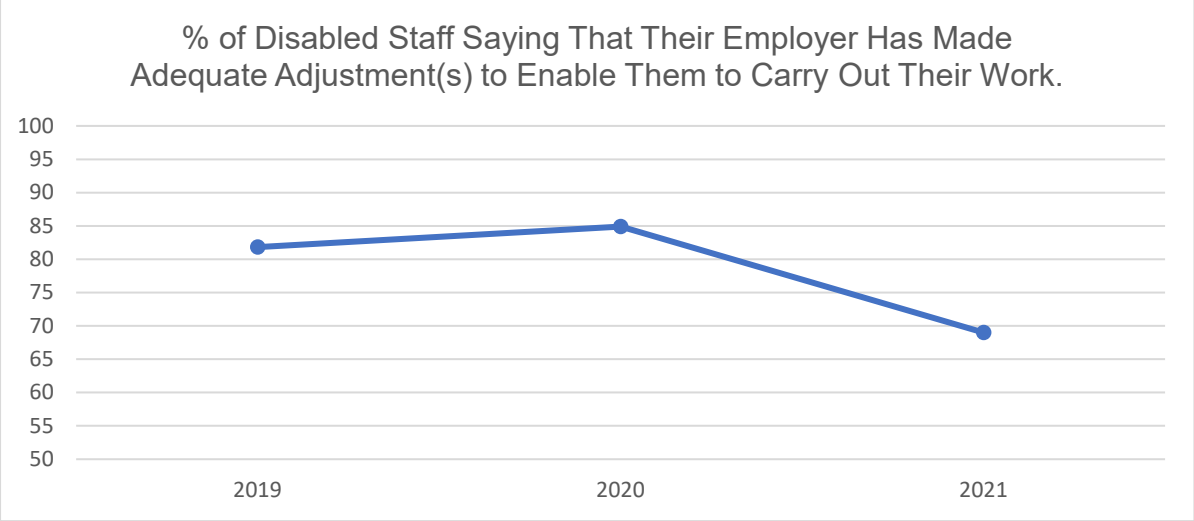
The increase in disabled staff reporting on this metric (+12.3%) is greater than the increase for non-disabled staff (+2.2%). Action has been taken in 2022 to address the disparity found in the 2020 results, with the introduction of a new Adjustments passport, new Reasonable Adjustments Policy, and a new management training scheme.

4.7 Metric 7: Percentage of disabled staff compared to non–disabled staff saying that they are satisfied with the extent to which their organisation values their work



The gap between disabled and non-disabled staff's responses to the question has increased from 7.8% in 2020, to 11.5% in 2021**.** Both groups have seen a reduction, since 2020 with non-disabled staff satisfaction reduced by 12.8% and disabled staff by 16.8%. Results to this will be consulted on with stakeholders.

4.8 Metric 8: Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work



There has been a 15.9% reduction in positive responses to this question from disabled staff. This has already been subject to significant resource investment via the WDESIP project as described in 4.6 and will continue to be an area of high priority throughout 2022-23.

4.9 Metric 9a: The staff engagement score for disabled staff, compared to non-disabled staff

Category	2021	Average from Trusts	Difference
Non-Disabled	7.30%	7%	0.3% above average
Disabled	6.80%	6.40%	0.4% above average
Trust Average	7.1		

4.10 Metric 9b: Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (Yes)

We have a Staff Network for staff with disabilities which is represented on our Strategic Advisory Group and Equality and Diversity Steering Group.

4.11 Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

Disability	Headcount	Headcount %	Board Headcount	Board Headcount %	Variance
No	5672	84.96%	14	87.50%	2.54
Not Declared & Other	797	11.94%	2	12.50%	0.56
Yes	207	3.10%	0	0.00%	-3.1

5.0 Our People Plan

The purpose of Our People Plan is to identify the Trust's people priorities and to ensure that everyone connected to the Trust understands the contribution they make. There are multiple actions attached with specific emphasis on ED&I and the culture and behaviours we are working towards.

The following key actions taken from our overarching action plan which have been identified for the next 12 months, along with actions already consulted on with staff as part of our detailed WDES Innovation Fund research project carried out in 2022, will form the basis of our WDES Action Plan for 2022-23. The impact of these actions will be measured by improvements to the WDES metrics.

5.1 We will focus on real and measurable progress

The Trust is committed to identifying measurable and tangible improvements on ED&I and will agree new KPI's and dashboards to support our forthcoming ED&I Operational Plan, with clear governance oversight.

5.2 Compassionate Culture and Leadership

The Trust leadership will continue to embed a compassionate, kind and inclusive work environment based on common values and a shared purpose. We will review our behavioural standards around civility and respect with reference to the WDES and will develop and deliver culturally appropriate training and support for managers and staff.

5.3 Workforce Development and career development for staff from underrepresented groups

Specific programmes of work addressing disability awareness will continue to be rolled out aimed at supporting staff with protected characteristics, including staff with disabilities. We will be working in partnership with the Royal College of Nursing to introduce their Cultural Ambassadors programme to the Trust, which will be specifically addressing disability in formal procedures, as well as reviewing recruitment, promotion practices and talent management plans for accessibility.

5.4 We will ensure that each voice counts

The Trust will encourage more staff with disabilities to become actively involved in shaping practices across the Trust. We will do this by enhancing the support for staff networks, including the Building Abilities Network to encourage staff from across the organisation to share experiences, shape and influence Trust policies and procedures, identify opportunities and help prioritise improvement in areas such as recruitment and selection.

5.6 We will promote and celebrate ED&I

We will develop and maintain an annual calendar of events and communications activity to celebrate difference and increase awareness of ED&I.

6.0 Trust Actions to Comply with the WDES

- WDES reporting template completed and sent to NHS England (Aug 2022)
- WDES report completed, to be hosted onto the Trust website (October 2022)
- WDES report and action plan to be sent to the NHS Cheshire and Merseyside ICB
- WDES action plan in place and reviewed bi-monthly with monitoring via the Equality and Diversity Steering group and People Council

7.0 Recommendations

The People Council is asked to note the WDES metrics, and the actions identified to address the gaps highlighted.

WDES Action Plan 2022-2023

Objective	Action	Action Owner	By When
1.0 Inclusive and Compassionate leadership			
1.1 Place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment.	Enhance data to inform actions through surveys, deep dives and focus groups including in relation to their lived experiences and how staff with protected characteristics could be better supported in the workplace.	Deputy Director of HR & Governance/ Head of ED&I	Mar 2023
1.2 Ensure that an understanding of Disability and inequality is woven through both discussion and decision making at the highest levels of leadership.	Appoint a Trust board lead (outside of Human Resource responsibility), to act as ambassador for the work area.	Director of HR/Deputy Director of HR & Governance	March 2023
1.3 Advance the learning and gains made through the WDES Innovation Fund Project.	Video campaign for the intranet including senior leaders showcasing the benefits of the Adjustments Passport. Continued Delivery of the Managing Disability with Confidence programme Working Group to be established to process map best practice in adjustment provisions including IT, IG, Facilities, HWWB and Procurement.	Head of ED&I	March 2023
1.4 Ensure that the workforce leadership is representative of the overall Disabled workforce including at senior level.	Participate in national and regional development programmes to support future leaders; enhance communications around how to share information for existing leaders.	Head of Strategic Resourcing/Head of Equality Diversity & Inclusion	Sep 2023

1.5 Introduce and support a culture of civility and respect to include a review of behavioural standards and their link to the Trust's corporate values.	Launch the NHSE Toolkit for civility and respect, when released.	Head of Learning & OD and Deputy Director of HR	TBC
1.6 Ensure that the differential experiences of Disabled staff are represented in the development of the Trust's approach to security strategy.	Deep dive into the data on staff experiences of bullying and harassment to ensure appropriate ED&I Metrics are routinely reported as part of the implementation of the new Security Group and Violence Reduction Strategy.	People Protection and Asset Manager/Head of ED&I	Dec 2023
2.0 We Will Actively Listen and Give Everyone a Voice			
2.1 Continue to listen to our staff to ensure we remain an employer of choice.	WDES will be monitored bi-monthly at the Equality and Diversity Steering Group.	Head of Equality Diversity & Inclusion	Ongoing
	Develop our Staff Networks to align their deliverables to the ED&I strategy, ensure the workforce are supported to undertake their network roles and encourage membership of Staff Networks.	Head of Equality Diversity & Inclusion	Jan 2023
2.2 Improve the quality of data held on staff with disabilities to better understand the workforce and target support.	Renew communications efforts to enhance support and awareness of our Disability Confident Leader status utilising the ESR Self-Service Portal, Adjustments Passport, and opportunities to promote at events.	Head of Equality Diversity & Inclusion	Mar 2023
2.3 Have an active network of ED&I Champions in place to support staff in the Trust.	Terms of reference and membership of networks to be reviewed and recruitment campaign to refresh membership to be rolled out during 2022/23.	Head of Equality Diversity & Inclusion	Jan 2023
3.0 Supported Workforce who are Educated and Aware			
3.1 Continue to build on and extend the Managing Diversity with Confidence programme to upskill and support managers on understanding Disability.	Include Disability in the Employment Law training modules for all line managers, develop eLearning/video modules	Deputy Director of HR & Governance and Head of ED&I	Oct 2023

	on undertaking an adjustments conversation.		
3.2 Establish an EDI/Cultural Ambassadors programme to support the Just Culture and Inclusive Recruitment agendas, supporting staff and incorporating lived experience and staff voice into decision making and people processes.	Train and support Ambassadors through the RCN's Cultural Ambassador programme, underpinned with a supporting programme of organisational development.	Deputy Director of HR and Governance/ Head of ED&I	Mar 2023
3.3 Review recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Work in collaboration to review the recruitment processes of the Trust to ensure they are appropriate and accessible to all.	Head of Strategic Resourcing/Head of Equality Diversity & Inclusion	Mar 2023
	Identifying links (via the ED&I regional Task & Finish Group) with local community organisations to promote vacancies to under-represented groups, including Project Search.	Head of Strategic Resourcing/Head of Equality Diversity & Inclusion	Mar 2023
	Work in collaboration to implement succession planning and talent management that takes account of the needs of diverse groups	Head of Learning & OD/Head of Equality Diversity & Inclusion	Mar 2023
3.4 Promotion of annual calendar of events for ED&I and Wellbeing	Develop and promote events calendar and celebration opportunities to tie into calendar of national celebration and awareness events, utilising knowledge and feedback from Staff Survey Network as to needs and demand.	Head of Equality Diversity & Inclusion	Ongoing

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST (22) 074
Title of paper: Workforce Race Equality Standard Report (WRES) 2021-22
Purpose: This report provides and overview and analysis of the Trust's Workforce Race Equality Standard (WRES) and proposed action plan for 2022-23 and is being presented to the Trust Executive Committee in advance of the September Trust Board.
Summary: The following is an overview of the WRES Highlights for 2021/22 **Workforce data metrics:** • An **increase** in BME staff in non–clinical bands 3,5 & 7. • An **increase** in BME staff in clinical bands 2,4,5,6,7, & 8a. • A reduction in the relative likelihood of white staff being shortlisted compared to BME staff of 0.32 • No ethnicity gap on entering the disciplinary process. **Staff survey data:** • A **9.2% increase** in BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months compared to a **5.3% increase** for white staff. • A **3.9% increase** in BME staff experiencing harassment, bullying or abuse from staff in last 12 months compared to a **3.1% increase** for white staff. • An **1.8% reduction** in BME staff experiencing discrimination at work from any of the following manager/team leader or other colleagues compared with a **3.2% increase** for white staff. • A **1.8% increase** in BME staff believing that Trust provides equal opportunities for career progression or promotion, compared to a **5.9% decrease** for white staff. The activities to address differences between the experience of BME and white staff have been refreshed to align with the priorities identified in the WRES Organisational Report developed by the national WRES team, ongoing objectives identified in the Trust's 'People Plan' and priorities deriving from the Staff Survey. Our actions will be informed by our Staff Networks and monitored by the Trust's Equality and Diversity Steering Group, Strategic People Committee, JSNC and People Council and reported to the NHSE WRES Implementation Team and NHS Cheshire and Merseyside ICB.
Corporate objectives met or risks addressed: This relates to the 'Developing our Organisational Culture and Supporting our Workforce' objective.

Financial implications: None as a direct consequence of this paper
Stakeholders: Staff, the Trust, NHSE WRES Implementation Team, ICB and Regulators
Recommendation: The Trusts Executive Committee are asked to note the content of the report to approve that the WRES report and action plan is presented to the Trust Board to provide assurance against contractual reporting of WRES.
Presenting officer: Anne-Marie Stretch, Deputy Chief Executive and Director of HR
Date of meeting: 28th September 2022

Workforce Race Equality Standard Report
April 2021 – March 2022

1.0 Executive Summary

This purpose of this report is to inform and provide the Trust Board with an update relating to the Workforce Race Equality Standard (WRES) results and actions. Implementation of the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations as part of the NHS Standard Contract.

STHK's 2021-22 data was collated and submitted to the WRES Implementation Teams for analysis in August 2022. The following report summarises that data and refers to the period April 2021 to March 2022 with the staff survey results from November 2021.

2.0 Introduction

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. The WRES exists to highlight any differences between the experiences and treatment of white staff and BME staff in the NHS and places an onus on NHS organisations to develop and implement actions plans to bring about continuous improvements.

The WRES is made up of nine indicators: four focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses on BME representation on boards.

The main purpose of the WRES is to:

- to help NHS organisations (and other organisations providing NHS services) to review performance on race equality, based on the nine WRES indicators
- to produce action plans to close any gaps in workplace experience between white and Black and Ethnic Minority (BME) staff
- to improve BME representation at the Board level of the organisation.

In the 2011 Census (the last available ONS verified data[1]), the population of St Helens and Knowsley were 98% and 97.2% White British respectively, compared to the NW average of 90.2% and England average of 85.4%. This is, however, not a measure against which NHS organisations recruiting from multiple complex national and international talent pools can be appropriately benchmarked. The NHS nationally employs over 100 nationalities in over 350 health related careers[2], representing a far

[1] KS201UK (Ethnic group) - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)
[2] Additional information for the NHS Workforce Race Equality Standard (WRES) June 2022)

broader demographic pool from which organisations can recruit than a single local authority. A key feature of the WRES therefore, is measurement of staff's progression and opportunities and staff experience within their own organisation and measured by peer comparators.

Different professions within the NHS also have markedly different talent pipelines and demographic makeups, most notably Medicine and Dentistry, which are nationally more diverse for a variety of reasons, more geographically mobile, and operate in career and pay structures distinct from NHS staff on Agenda for Change contracts. Due to this complexity, a separate Bank WRES (BWRES) and Medical WRES (MWRES) are planned by the NHSE's WRES Implementation Team for 2022/23 and the annual staff survey has been amended this year to include bank staff.

This WRES report applies therefore only to substantive posts and excludes Bank workers, and analysis of the medical workforce metrics has been more limited in anticipation of the pending MWRES.

In recognition that Staff Survey data for 2020 was impacted by the pandemic, 2019 data is also included in these indicators for reference.

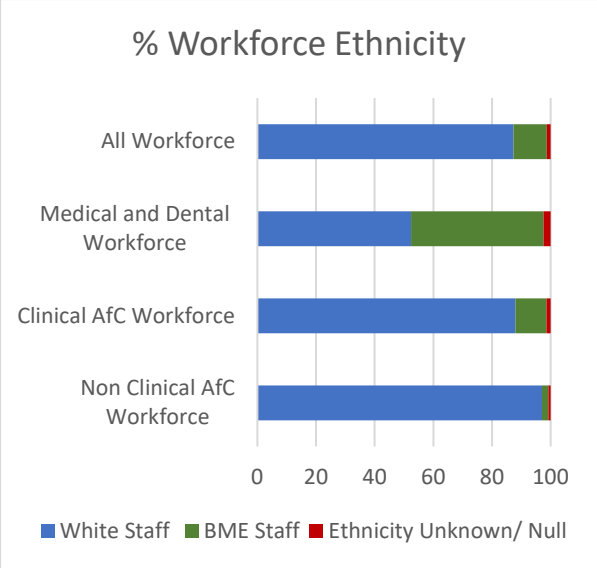
3.0 Key Data

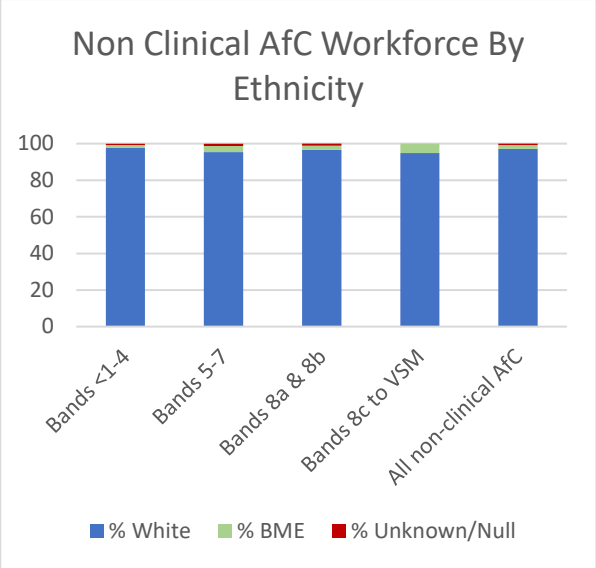
3.1 Workforce Overview

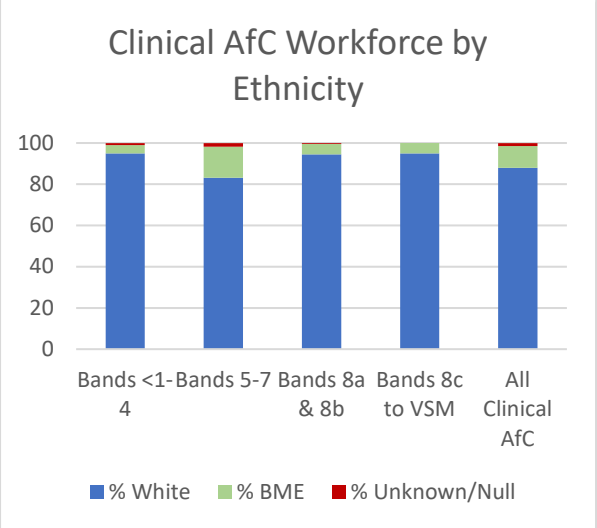
For the period April 2021 to March 2022, St Helens and Knowsley Teaching Hospitals NHS Trust employed 6697 staff which consisted of:

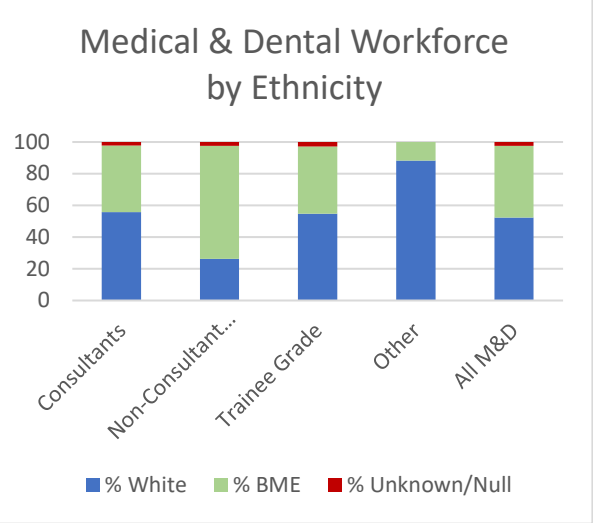
- 11.29% Black or minority ethnic staff
- 87.37% White staff
- 1.34% Not Stated/ unspecified / prefer not to answer.

The ethnic background of staff varies across the different staffing groups, with non-clinical support roles more closely reflecting the local population, and increased diversity among Medical and Dental and AfC clinical roles.









4. WRES Indicators 2021-22

The information below provides a comparison for the WRES reports for 2021-22 and 2020-21. The information provides the Trust figures compared to the average for combined acute and community hospitals. All figures are self-populated taken from the WRES template provided by NHS England and generated using the automated template on Electronic Staff Record for assurance, and from the Staff Survey Coordination Centre.

4.1 Indicator 1: Workforce Staff Data

There have been increases in BME staff across clinical, non-clinical and Medical and Dental bands.

- Non-clinical roles saw an increase in BME representation at bands 3, 5, 7 and VSM level.
- Clinical AfC roles saw an increase in bands 2,4,5,6,7 and 8a.

- Medical grades saw an increase in BME staff within non-consultant career grades and trainee grades.
- BME staff are not evenly represented throughout the workforce and are represented at a proportionally higher level within two workforce sub-groups at the following grades:
  - Clinical AfC: Band 5
  - Medical grades: non consultant career grades.

It should be noted that there is a correlation between higher numbers of staff who have not declared their ethnicity and the AfC and medical grades where there are clusters of BME staff.

	2020-21		2021-2022	
1a) non-Clinical workforce	**WHITE %**	**BME %**	**WHITE %**	**BME %**
Band 1	98.85	1.15	100.00	0.00
Band 2	96.47	1.93	97.18	1.88
Band 3	97.47	1.77	96.77	2.49
Band 4	98.28	0.86	98.63	0.82
Band 5	96.77	2.58	94.12	4.58
Band 6	95.18	2.41	96.59	1.14
Band 7	98.80	1.20	96.51	3.49
Band 8A	95.35	2.33	95.83	2.08
Band 8B	95.45	4.55	97.62	2.38
Band 8C	100.00	0.00	100.00	0.00
Band 8D	100.00	0.00	90.00	10.00
Band 9	100.00	0.00	100.00	0.00
VSM	92.86	7.14	85.71	14.29
Non-Clinical Average	**97.17**	**1.78**	**97.09**	**2.09**

	2020-21		2021-22	
1b) Clinical workforce of which non-Medical	**WHITE %**	**BME %**	**WHITE %**	**BME %**
Band 1	9.09	0.00	100.00	0.00
Band 2	97.61	2.39	95.22	3.72
Band 3	89.91	3.47	96.40	2.52
Band 4	88.64	5.00	91.11	8.33
Band 5	75.52	22.31	73.32	24.47
Band 6	93.69	4.54	91.84	6.63
Band 7	92.84	6.00	92.71	6.19
Band 8A	93.67	5.06	93.41	6.04
Band 8B	100.00	0.00	100.00	0.00
Band 8C	88.89	11.11	92.31	7.69
Band 8D	100.00	0.00	100.00	0.00

Band 9	0.00	0.00	100.00	0.00
VSM	100.00	0.00	100.00	0.00
Clinical AfC Average	**88.60**	**9.19**	**87.93**	**10.65**

	2020-21		**2021-22**	
Of which Medical & Dental	**WHITE %**	**BME %**	**WHITE %**	**BME %**
Consultants	55.33	42.61	55.78	41.91
Consultants also Senior medical manager	100.00	0.00	100.00	0.00
Non-consultant career grade	29.79	68.09	26.25	71.25
Trainee grades	65.13	32.89	54.86	42.29
Other	83.33	16.67	88.24	11.76
M&D Average	54.04	43.93	52.43	45.14
ALL STAFF Average	**88.23**	**9.91**	**87.37**	**11.29**

4.2 Indicator 2: Relative likelihood of BME and white staff being appointed from shortlisting across all posts:

Overall, there has been a reduction in roles appointed, potentially reflecting the impact of the pandemic and workforce mobility on recruitment in 2020-21. This has corresponded with a change in the relative likelihood of candidates being appointed from shortlisting as follows:

Relative Likelihood of appointment from shortlisting	**White**	**BME**	**Unknown**
2020-2021	42.31%	39.85%	43.45%
2021-22	26.65% (-16.16%)	35.91% (-3.94%)	16.74% (26.71%)

- Shortlisted BME candidates had a higher success ratio from shortlisting to appointment than white candidates with a relative likelihood of appointment from shortlisting of 35.91%, compared to white candidates with a rate of 26.65%.
- The relative likelihood of white staff being appointed compared to BME staff stands at 0.74 in 2022, compared to 1.06 in 2021.

4.3 Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

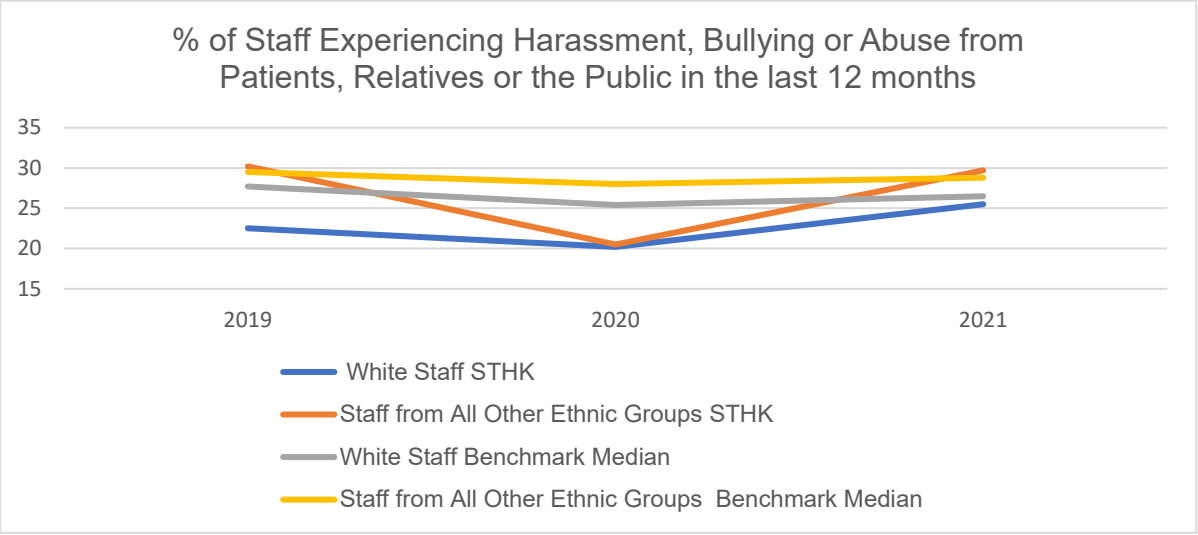
The relative likelihood measure for this indicator was 1, meaning there was no difference in the relative likelihood of white and BME staff entering the disciplinary process in the reporting period. This a positive result and shows sustained improvement which indicates the measures being undertaken as part of the Just Culture agenda are having effect.

4.4 Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

- 1467 staff accessed non-mandatory training and CPD
- The relative likelihood measure for this indicator was 1.03, meaning there was no difference in the relative likelihood of white and BME staff accessing non-mandatory training and CPD in the reporting period.

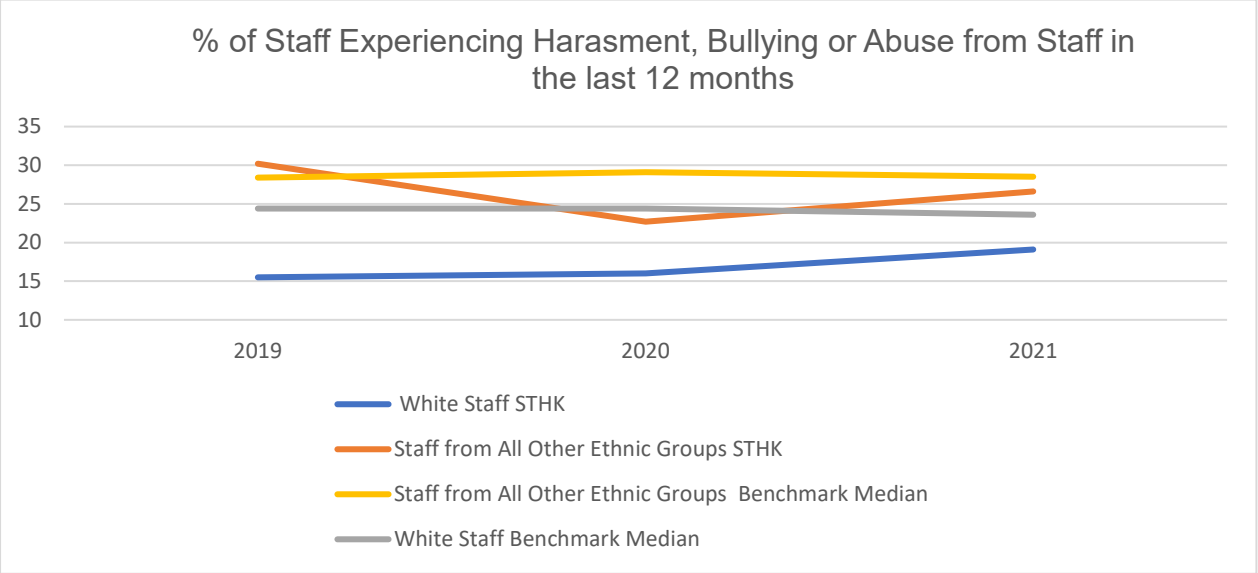
4.5 Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months

For this indicator, the experiences of all staff improved in 2020 during the first year of the pandemic, however the pre-pandemic pattern of disparity re-emerged in 2021, with the response for white staff increasing by 3%.



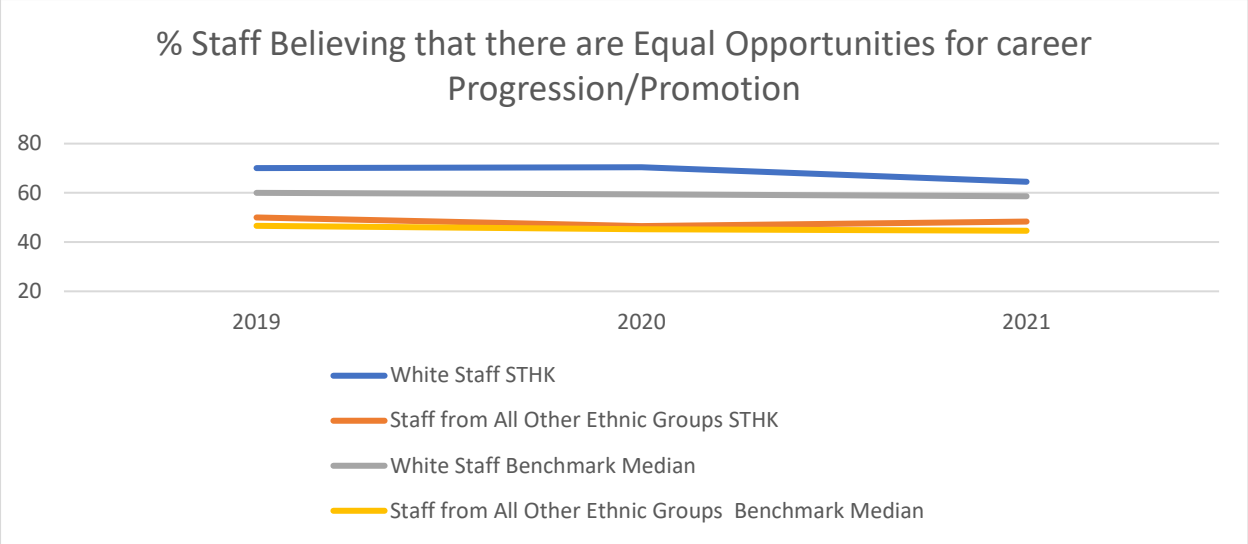
4.6 Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Staff experience of abuse from other staff has increased by 3.1% for white staff and 3.9% for BME staff. The disparity between white and BME staff experiences was 7.5 percentage points in 2021.



4.7 Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

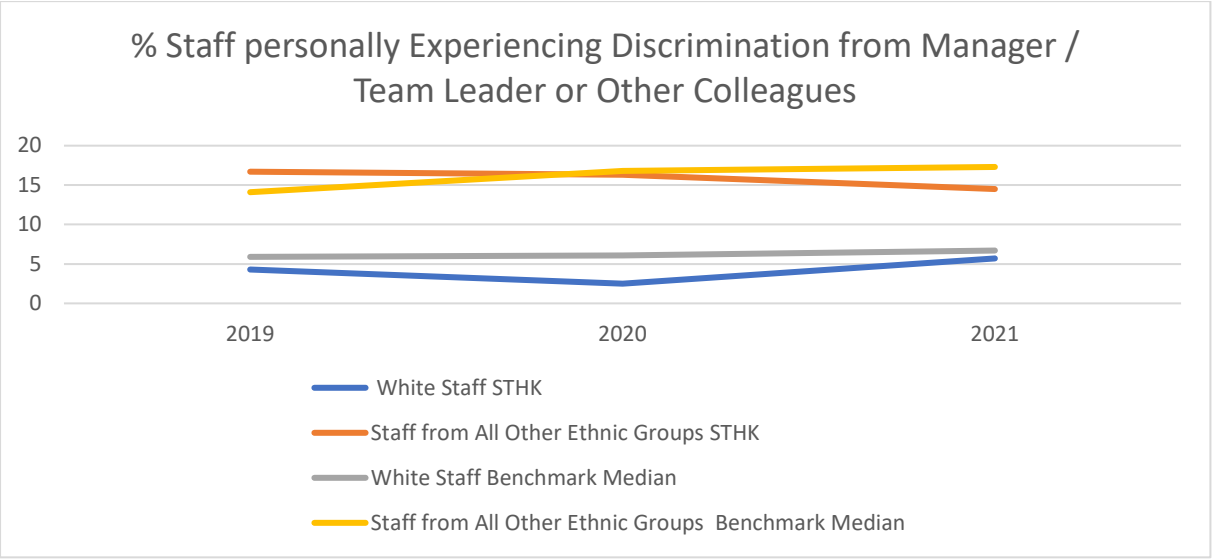
There has been a 5.9% decrease in this result for white staff at the Trust, and a 1.8% increase in for staff from all other ethnic groups. There is a 16.2% ethnicity gap for this indicator, making it a priority area. This data relates to question 15 of the NHS Staff Survey, for which the formula was changed in 2022 to include the 'don't know' responses, meaning all historical data on this metric has been updated with the WRES Implementation team. Actions towards addressing this disparity are outlined below, and include a deep dive and review of recruitment and progression, and introduction of Cultural Ambassadors program.



4.8 Indicator 8: Staff who have personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months

There has been a 3.2% increase in this result for white staff at the Trust, and a 1.8% decrease in for staff from all other ethnic groups. There was an 8.8% difference between the experiences of staff based on ethnicity in 2021, compared to an average 11.44% difference for the five-year period, representing a reduction in the overall disparity of experience.

Action has been taken in 2021-22 towards addressing this disparity including the updating of the Grievance and Resolution Policy, and a Cultural Ambassadors program aimed at increasing cultural competence is scheduled to launch in early 2023.



4.9 Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce

Percentage difference between the organisations' Board membership and its overall workforce disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The information below provides information on the percentage difference between the organisations board membership and its overall workforce for BME and white Staff. In 2021-22 the Trust Board was slightly more representative of white groups overall, with a 6.4% over representation of white executives compared to BME executives. Due to the small numbers involved this would be considered within the margin of error for proportionality.

	2020-21		2021-22	
	White %	**BME %**	**White %**	**BME %**
Total Board members - % by Ethnicity	93.30%	6.70%	93.80%	6.30%
Voting Board Member - % by Ethnicity	80%	20%	80%	20%
Non-Voting Board Member - % by Ethnicity	100%	0%	100%	0%
Executive Board Member - % by Ethnicity	80.00%	20%	80%	20%
Non-Executive Board Member - % by Ethnicity	100%	0.00%	100%	0%
Overall workforce - % by Ethnicity	88.2	9.90%	87.40%	11.30%
Difference (Total Board -Overall workforce)	**5.10%**	**-3.20%**	**6.40%**	**-5%**

5.0 Our People Plan

The purpose of Our People Plan is to identify the Trust's people priorities and to ensure that everyone connected to the Trust understands the contribution they make. There are multiple actions attached with specific emphasis on equality, diversity and inclusion (ED&I) and the culture and behaviours we are working towards.

The following key actions taken from our overarching action plan have been identified for the next 12 months. The impact of these actions will be measured by improvements to the WRES indicators.

5.1 We will focus on real and measurable progress

The Trust is committed to identifying measurable and tangible improvements on equality, diversity and inclusion (ED&I), and will agree new KPI's and dashboards to support our forthcoming ED&I Operational Plan, with clear governance oversight.

5.2 Compassionate Culture and Leadership

The Trust leadership will continue to embed a compassionate, kind and inclusive work environment based on common values and a shared purpose. We will review our behavioural standards around civility and respect with reference to the WRES and will develop and deliver culturally appropriate training and support for managers and staff.

5.3.1 Workforce Development and career development for staff from underrepresented groups

Specific programmes of work addressing cultural bias and career development opportunities will be rolled out aimed at supporting staff with protected characteristics, including BME staff. We will be working in partnership with the Royal College of Nursing to introduce their Cultural Ambassadors programme to the Trust, as well as reviewing recruitment, promotion practices and talent management plans for accessibility.

5.4 We will ensure that each voice counts

The Trust will encourage more staff from BME backgrounds to become actively involved in shaping practices across the Trust. We will do this by enhancing the support for staff networks, including the Building a Multicultural Environment (BAME) Network to encourage staff from BME backgrounds to share experiences, shape and influence Trust policies and procedures, identify opportunities and help prioritise improvement in areas such as recruitment and selection.

5.5 We will promote and celebrate ED&I

We will develop and maintain an annual calendar of events and communications activity to celebrate difference and increase awareness of ED&I.

6.0 Trust Actions to Comply with the WRES

- WRES reporting template completed and sent to NHS England (Aug 2022)
- WRES report completed, to be hosted onto the Trust website (October 2022)
- WRES report and action plan to be sent to the NHS Cheshire and Merseyside ICB
- WRES action plan in place and reviewed bi-monthly with monitoring via the Equality and Diversity Steering group and People Council

7.0 Recommendations

The Trusts Executive Committee is asked to note the WRES indicators, and the actions identified to address the gaps highlighted.

WRES Action Plan 2022-23

Objective	Action	Action Owner	By When
1.0 Inclusive and Compassionate leadership			
1.1 Place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment.	Enhance data to inform actions through surveys, deep dives and focus groups including in relation to their lived experiences and how staff with protected characteristics could be better supported in the workplace.	Deputy Director of HR & Governance/ Head of ED&I	Mar 2023
1.2 Ensure that an understanding of race and inequality is woven through both discussion and decision making at the highest levels of leadership.	Appoint a Trust board lead (outside of Human Resource responsibility), to act as ambassador for the work area, incorporating the NW BAME Assembly deliverables.	Director of HR/Deputy Director of HR & Governance	March 2023
1.3 Ensure that the workforce leadership is representative of the overall BAME workforce including at senior level.	Working towards targets set out in the Model Employer Ten Year Aspirational Plan.	Head of Strategic Resourcing/Head of Equality Diversity & Inclusion	Sep 2023
1.4 Introduce and support a culture of civility and respect to include a review of behavioural standards and their link to the Trusts corporate values.	Launch the NHSE Toolkit for civility and respect, when released.	Head of Learning & OD and Deputy Director of HR	TBC
1.5 Ensure that the differential experiences of BME staff are represented in the development of the Trust's approach to security strategy.	Ensure that ED&I Metrics are routinely reported as part of the implementation of the new Security Group and Violence Reduction Strategy.	People Protection and Asset Manager/Head of ED&I	Dec 2023

2.0 We Will Actively Listen and Give Everyone a Voice			
2.1 Continue to listen to our staff to ensure we remain an employer of choice.	WRES will be monitored bimonthly at the Equality and Diversity Steering Group	Head of Equality Diversity & Inclusion	Ongoing
	Develop our Staff Networks to align their deliverables to the ED&I strategy, ensure the workforce are supported to undertake their network roles and encourage membership of Staff Networks	Head of Equality Diversity & Inclusion	Jan 2023
2.2 Have an active network of ED&I Champions in place to support staff in the Trust.	Terms of reference and membership of networks to be reviewed and recruitment campaign to refresh membership to be rolled out during 2022/23.	Head of Equality Diversity & Inclusion	Jan 2023
3.0 Supported Workforce who are Educated and Aware			
3.1 Review existing training offer and develop programmes to upskill and support managers on understanding equality in the workplace specifically to include and address race discrimination.	Develop and launch Employment Law training modules for all line managers, training on Unconscious Bias and review mandatory training package.	Deputy Director of HR & Governance/ Head of ED&I	Oct 2023
3.2 Establish an EDI/Cultural Ambassadors programme to support the Just Culture and Inclusive Recruitment agendas, supporting staff and incorporating lived experience and staff voice into decision making and people processes.	Train and support Ambassadors through the RCN's Cultural Ambassador programme, underpinned with a supporting programme of organisational development.	Deputy Director of HR and Governance/ Head of ED&I	Mar 2023
3.3 Review recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional	Work in collaboration to review the recruitment processes of the Trust to ensure they are appropriate and accessible to all.	Head of Strategic Resourcing/Head of Equality Diversity & Inclusion	Mar 2023

and national labour markets.	Identifying links (via the ED&I regional Task & Finish Group) with local community organisations to promote vacancies to under-represented groups.	Head of Strategic Resourcing/Head of Equality Diversity & Inclusion	
	Work in collaboration to implement succession planning and talent management that takes account of the needs of diverse groups.	Head of Learning & OD/Head of Equality Diversity & Inclusion	Mar 2023
3.4 Promotion of annual calendar of events for ED&I and Wellbeing.	Develop and promote events calendar and celebration opportunities to tie into calendar of national celebration and awareness events such as Black History Month.	Head of Equality Diversity & Inclusion	Dec 2023
3.5 Ensure our employees are supported to participate in national development programmes including the NHS Leadership Academy 'Stepping Up' programme for aspiring black, Asian and minority ethnic (BAME) colleagues.	To actively promote and market the schemes in conjunction with heads of service, such as the NHS Leadership Academy 'Stepping Up' programme and the NExT Director Scheme.	Head of Learning & OD	Annual
3.6 Ensure our leadership is well networked within regional activities e.g., the North West BAME assembly.	New Head of ED&I to engage regionally and across the ICS when commences in January 2023.	Director of HR/Deputy Director of HR & Governance	March 2023

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)075

Title of paper: Infection Prevention and Control Annual Report 2021/22.

Purpose: To present the 2021/22 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 2021/22 and Part 2 (Appendix 1) is the annual work plan for 2021/22 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 2021
- Infection Prevention & Control Board Assurance Framework (May 2021. V1.7)

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 2021/22 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 2021/22 the IPC performance improved in comparison to the previous year and the following were reported:
7. 25 cases of Clostridium difficile infection (CDI) against an objective of no more than 54)
8. 2 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) positive samples of which 1 was deemed as avoidable and 1 unavoidable as no lapses in care was identified .

9. There was a total of 50 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases. 24 were hospital onset healthcare associated and 26 were community onset healthcare associated.
10. During 2021/22, there were a total of 81 E. coli bacteraemia cases. 40 were hospital onset healthcare associated and 41 were community onset healthcare associated.
11. There were no cases of hospital acquired Carbapenemase Producing Enterobacterales **(**CPE).
12. Outbreaks: during 2021-22 there were 69 outbreaks of infection: the majority of these were due to SARS-CoV19
13. 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.
14. Training**:** Infection prevention induction and mandatory training sessions were provided for all clinical staff.
15. The Trust's overall Nosocomial infection (NCI)rate was 10.3%, the Trust had the lowest NCI rate in Cheshire and Merseyside compared to benchmark of 14% of neighbouring Trusts.
16. The IP mandatory training compliance at the end of March 2022 was above 90 % for level 1 and 74% for level 2. This was impacted by staff unable to be released for clinical competency training for level 2.

Appendix 1: IPC forward plan 2022-23.

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 2021/22 IPC annual report.

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

Date of meeting: 28 September 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

Infection Prevention Annual Report 2021-2022

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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 2021/22 and Part 2 (Appendix 1) is the annual work plan for 2022/23, 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 Emerging key issues: The rapid changes to UKHSA guidance regarding COVID 19 have continued over the course of 2021-22, with significant changes being noted both nationally and locally. The team have continued to react quickly reviewing and advising the organisation on any operational changes required. These are managed through the Infection Prevention group meetings, weekly tactical meetings, and weekly operational bulletins. In parallel the team have been required to react to an escalating position for our other mandatory reportable HCAI's.

6 There are national contractual reduction objectives for MRSA blood stream infections (BSI) and

Clostridiodes 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

7. 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.

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:

- Integrated Care Systems (ICS)
- UKHSA Cheshire and Merseyside
- Community IP teams
- NHSI/NHSE

Summary of key performance indicators for 2021/22

- 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 2021/22 was no more than 54 cases. The Trust reported 54 positive samples of which 29 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 25. 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 2021/22 the Trust reported 2 MRSA bacteraemias.
  - The cases of MRSA bacteraemia were subjected to a multi-disciplinary Post Infection Review (PIR), one was deemed unavoidable, and one deemed avoidable. Lessons learnt were disseminated and action plans were developed, these are monitored via the Hospital Infection Prevention Group (HIPG).
  - During 2021/22, there were a total of 50 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases. 24 were hospital onset healthcare associated and 25 were community onset healthcare associated.
  - During 2021/22, there were a total of 81 E. coli bacteraemia cases. 40 were hospital onset healthcare associated and 41 were community onset healthcare associated.
  - There were no cases of hospital acquired Carbapenemase Producing Enterobacterales **(**CPE).
  - Outbreaks: during 2020-21 there were 69 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.
  - 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 with meetings being organised/co-ordinated by the care groups.
  - Surgical site infection (SSI) surveillance in orthopaedics:

April 2021 – March 2022	STHK	National
Hips 240	1.3%	0.8%
Knees 297	1.3%	1.1%

The Trusts SSI data was slightly above the national average for hips and knees. Root cause analysis executive panels has been conducted and action plans are in place.

Developments in 2021/22.

- 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.
- Work alongside the sepsis team on the correct detection, reporting and management of sepsis.
- Participation into refurbishment projects as required, together with Infection Prevention advice.
- Continued education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.
- The 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.

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.

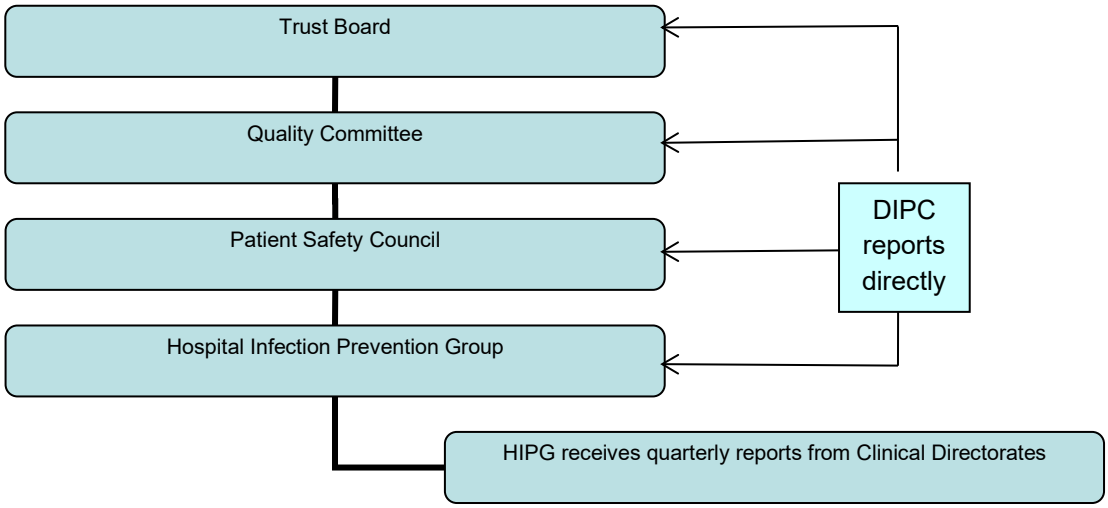
1.2.8. The IPT also works closely with the Matrons, Infection Prevention Link Professionals and Estates and Facilities Management.

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. The Trust continues to undertake a number of interventions in relation to infection prevention as detailed within the HCAI Reduction Plan 2021/22. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Infection Prevention Doctor and lead nurse IPT.

1.3 Hospital Infection Prevention Group (HIPG)

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



1.3.2 The Terms of Reference are reviewed annually and were amended in March 2022.

1.3.3 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.

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

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

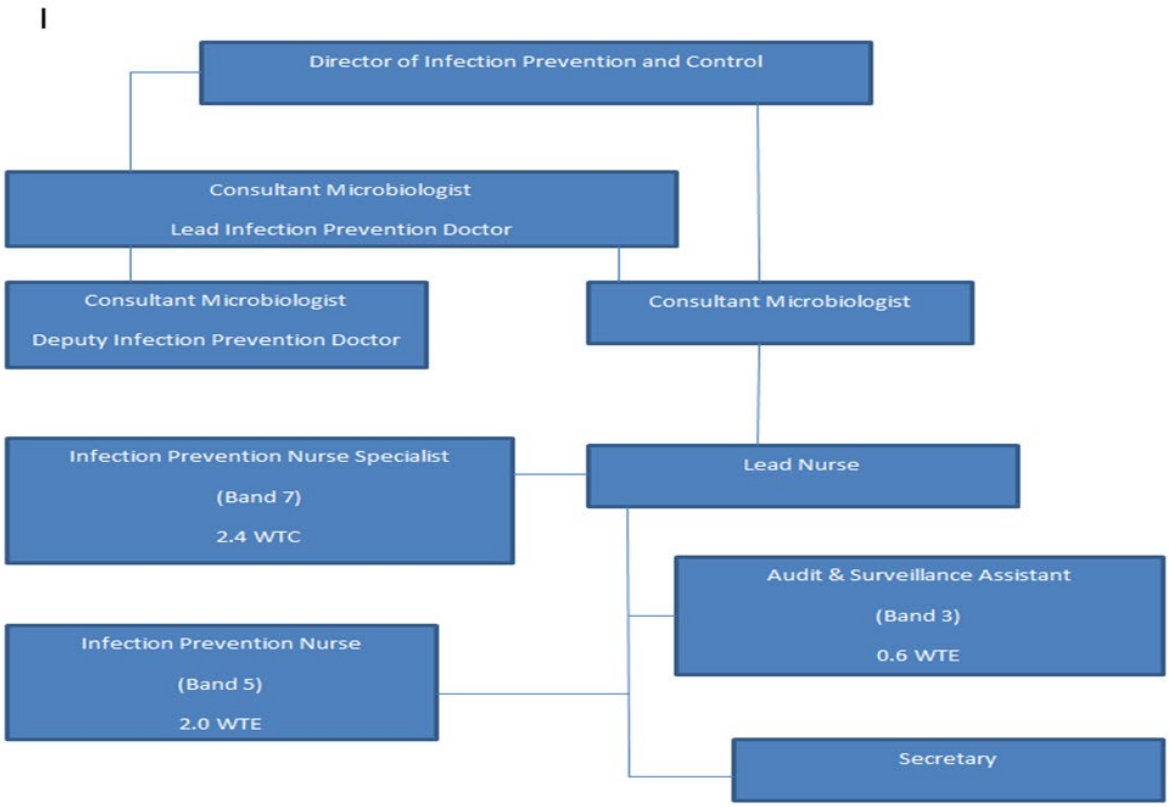
1.3.6 Isolation facilities
The current proportion of single rooms is 50% which supports the prompt isolation of patients with suspected or confirmed infections.

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

1.3.7 The core members of the IPT consist of:

- Director of IPC (DIPC) - Director of Nursing, Midwifery and Governance
- Lead Infection Prevention Doctor
- 8B Lead Nurse IP (1.0 WTE)
- Band 7 Specialist IP Nurses (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 - 0.2 WTE band 8B, 0.5 WTE band 8A and 0.5 WTE band 7

1.3.8 IP organisational structure



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

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

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

1.4 Committee representation by members of the IPT:

- Hospital Infection Prevention Group
- Patient Safety Council
- RCA Executive Review Panel Meetings
- Health Economy Healthcare Associated Infection Group (Knowsley)
- Health and Safety Group
- Sharps Safety Group
- Water Safety Group
- Drugs and Therapeutics Group
- Decontamination Group
- Waste Group
- Medical Devices Group
- Matrons' Infection Prevention and Facilities Meeting
- Cheshire and Merseyside UKHSA Healthcare Associated Infections (HCAI) Group
- Trust IV Access and Therapy Group
- St Helens and Knowsley NHS Trust Major Incident Planning
- Northwest Antibiotic Pharmacy Group
- Northwest IV Forum Group
- Northwest 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 Trust remained compliant with all elements of the IPC BAF.

2.3 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.

2.4 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.

2.5 These alerts include positive *Clostridiodes difficile*, new Carbapenemase Producing Enterobacterales (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.

2.6 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)

2.7 All isolates of 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.

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

HCAI Target/Alert Organisms include:

- MRSA
- Clostridiodes difficile
- Group A Streptococcus
- Salmonella species
- Campylobacter species
- Mycobacterium tuberculosis
- Glycopeptide/vancomycin resistant Enterococci
- Multi - resistant Gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers; multi-drug resistant pseudomonas
- Carbapenemase-producing Enterobacterales (CPE)
- Neisseria meningitides
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV
- SARS-CoV 2 (COVID)

Alert Conditions

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

2.10. 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	1 and 1 unavoidable	0

During 2021/2022 the Trust reported two cases of MRSA bacteraemia, both of which underwent a robust multi-disciplinary root cause analysis process which was reviewed by the Executive Root Cause Analysis Panel:

Case 1: Hospital onset healthcare associated: Avoidable

Lessons identified – contributory to infection:
Cannula care

- 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.
- Peripheral cannulae must be re-sited at the latest every 72 hours. However, if there is a clinical indication to leave a cannula in for longer (e.g., patient with very difficult IV access), ensure that the rationale is clearly documented in the patient's clinical notes.
- Cannula/line sites (current and previous) should be reviewed as a part of medical review in a deteriorating patient. In patients who deteriorate/develop sepsis, infected cannula sites should be considered as a potential site/source of infection.
- Information about cannulae (and other indwelling devices) should be discussed in medical and nursing handover,especially where there is concern about device related infection.

Antibiotic use

- If a patient colonised with MRSA develops an infection, include MRSA cover in the empirical antibiotic treatment as per the Antibiotic Policy.
- Nursing staff administering antibiotics to a patient with MRSA should also be vigilant whether the antibiotics provide MRSA cover and query this with the medical team if indicated.

Good practice identified:

- Patient screened for MRSA appropriately on admission.

- Patient was isolated in a side room throughout admission
- All medical records (paper and electronic) were tagged with MRSA alert.
- Patient was commenced on correct antibiotic therapy following identification of the MRSA bacteraemia.

Case 2: Hospital onset healthcare associated: Unavoidable.

The patient had a history of MRSA colonisation in the past. It was not possible to determine the precise source of infection however the patient was managed appropriately. No lapses of care contributing to the bacteraemia were identified following Post Infection Review.

This infection was therefore deemed healthcare associated but unavoidable.

Good practice identified:

- Patient screened for MRSA appropriately on admission.
- Patient was isolated in a side room throughout admission.
- Topical suppression was prescribed in a timely manner as administered as soon as possible.
- Good documentation of IV device care
- Appropriate antibiotic agents were used as surgical prophylaxis and pre-emptive treatment

2.11 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 Trust reemained 100% compliant for MRSA screening of eligible patients requiring screening.

2.12 Clostridiodes difficile toxin infection (CDI)

The Trust CDI assigned by NHS England target for 2021/22 was no more than 54 cases.

The Trust reported 54 positive samples of CDI, of which 29 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 25. The objective for CDI was achieved.

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, up to February 2022, the case was heard by the CCG CDI Appeals Panel with a view to removing the case for performance purposes. As of February 2022, the CCG CDI appeals process has been discontinued. The CCGs have agreed that the Trust Executive RCA Review process

provides sufficient assurance with regards to multi-disciplinary review of CDI cases and identification of any lessons. Hence there will no longer be a requirement for the Trust's clinical teams to present to the CCG, CDI cases in which the Executive RCA Review Panel has identified no lapses in care.

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.
2021/22	54	25	In total, there were 54 positive samples of which 29 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 25.

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.

Lessons identified from RCA's include:

- Have high clinical index of suspicion for CDI in patients with relevant clinical features (e.g. diarrhoea, high white cell count, fever) who have risk factors for CDI, specifically elderly patients who have received recent antibiotics including treatment in the community prior to admission.
- A significant, unexplained rise in white cell count can be a marker of severe/life threatening CDI and may precede the onset of diarrhoea or abdominal symptoms.
- If a patient has type 5 to 7 stool on the Bristol Stool Chart (BSC) which is not explicable by any other reason, stool specimen must be sent for C difficile testing at the earliest opportunity.
- If there is a clear explanation as to why a patient is having diarrhoea (e.g. laxatives, constipation with overflow) there is no indication to send a stool sample for C difficile testing.
- Review antibiotic prescriptions on EPMA as a part of the daily medical review of the patient and document outcome of the review in the medical notes.
- IV antibiotics should be reviewed and changed to oral after 1-2 days if the patient is clinically improving and able to tolerate oral medication.
- Follow the guidance given in the Trust Antibiotic Policy when treating CDI. Metronidazole is no longer first line therapy for CDI.

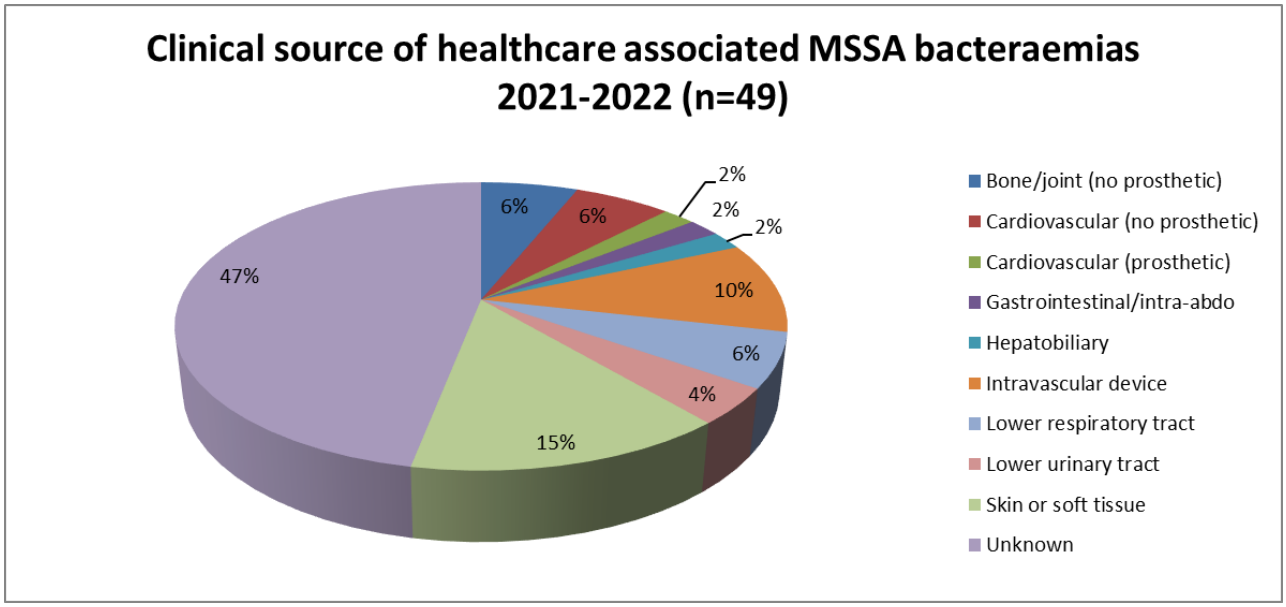
Outbreaks of CDI: There were no CDI outbreaks in 2021/22.

2.13 Meticillin-sensitive Staphylococcus aureus (MSSA)

There were 49 cases of Trust acquired MSSA bacteraemia in 2021/22 (24 HOHA and 25 COHA).

Twenty three HOHA cases MSSA bacteraemia were subject to an Executive led Root Cause Analysis Review Panel of which 12 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 because 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.

2.14. 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.

Trust specific reduction targets for E coli/Klebsiella species and Pseudomonas aeruginosa bacteraemias for 2021-2022 were published by NHSE/I in August 2021 which are as follows:

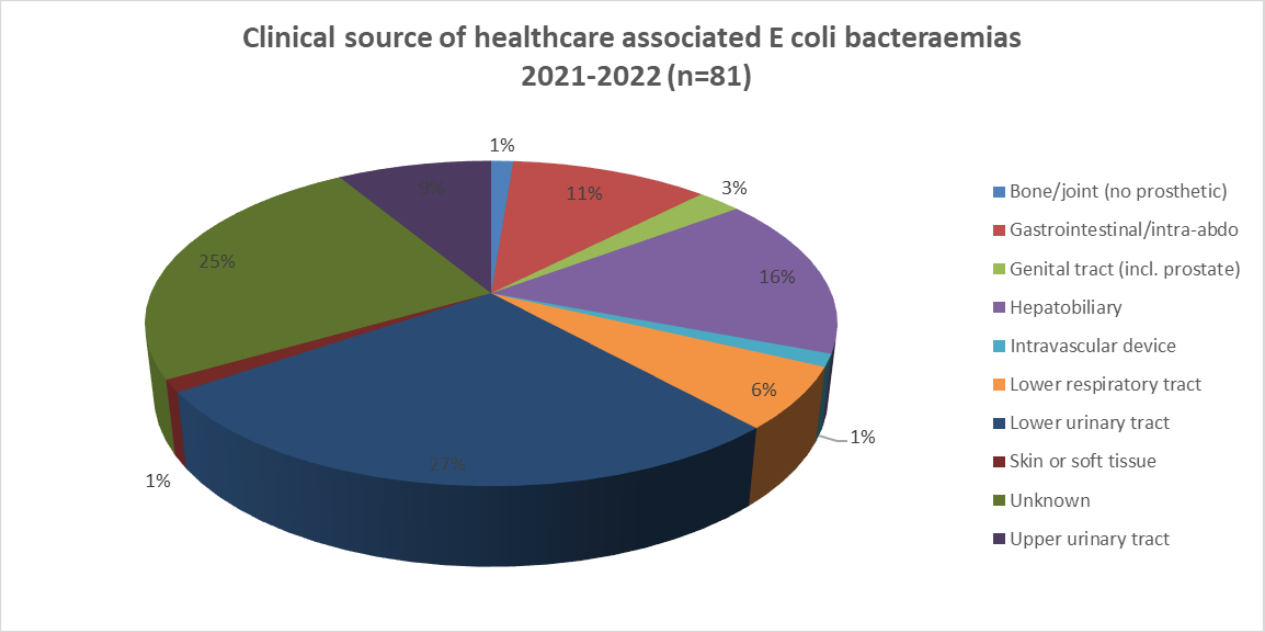
- E coli bacteraemia – no more than 116 healthcare associated cases
- Klebsiella species bacteraemia – no more than 26 healthcare associated cases

- Pseudomonas aeruginosa bacteraemia – no more than 11 healthcare associated cases

2.15 E. coli

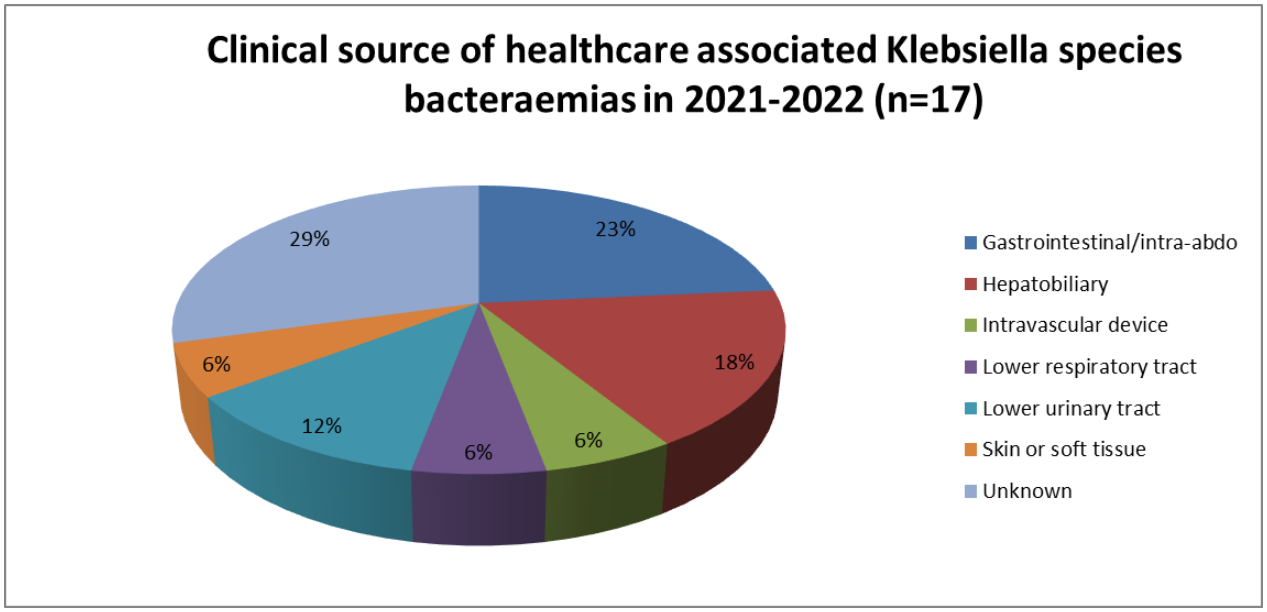
In 2021/22, there were 81 healthcare associated cases (0 HOHA and 41 COHA) Of the hospital onset cases, of the RCA conducted, 1 case was considered to be avoidable.

The clinical sources of Trust acquired E coli bacteraemia in 2021/2022 are as below:



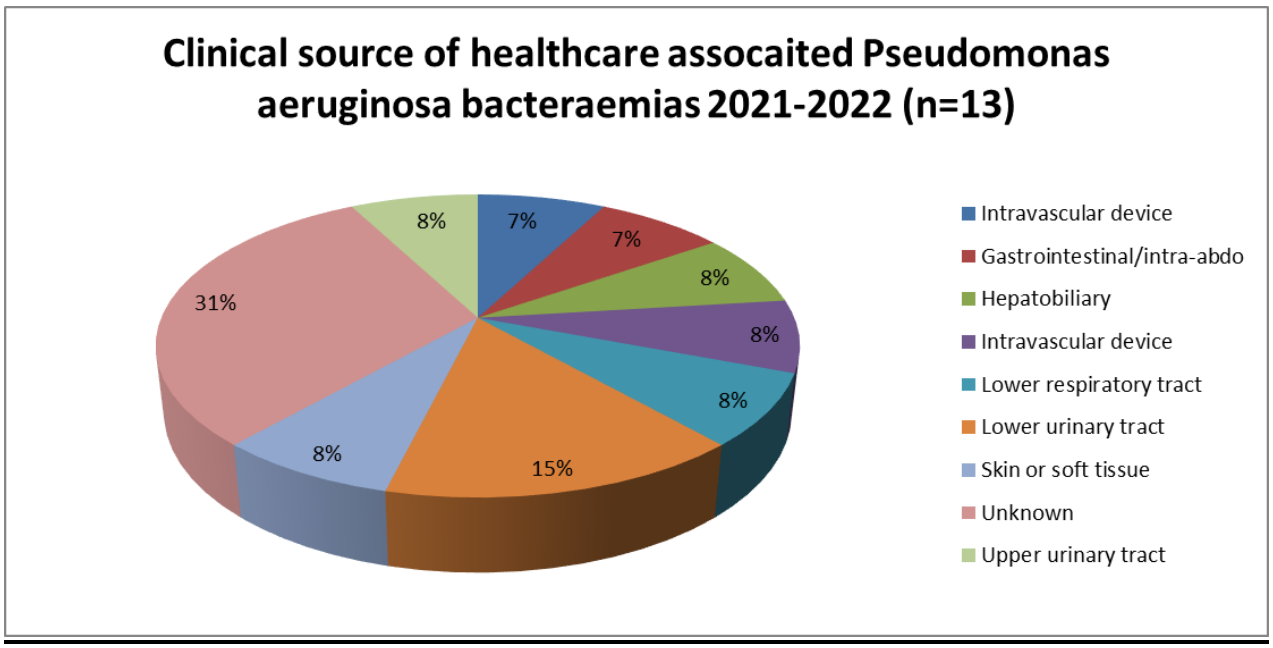
2.16 Klebsiella species bacteraemia.

There were 17 health care associated cases of Klebsiella bacteraemia's in 2021/22. All cases reviewed were deemed unavoidable.



2.17 Pseudomonas aeruginosa

There were 13 cases of healthcare associated Pseudomonas aeruginosa bacteraemia in 2021/22 RCA review of the cases deemed they were unavoidable.



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.

In 2021/2022, there was 1 Trust acquired VRE bacteraemia. 10% of all enterococcal isolates from blood cultures at STHK were resistant to vancomycin (1% in 2019/20 and 11% in 2018/2019).

There were 5 outbreaks of VRE in 2021-22 compared to 6 outbreaks due to VRE colonisation in 2020--2021.

There were 179 hospital onset cases of VRE (non-bacteraemia) compared with 158 in 2020/21 and 285 in 2019/20, The majority of the cases were asymptomatic colonisation detected on routine screening.
VRE rectal screening (on admission and then weekly) was continued on 2A, 3B, 3D, 4C, 4D and 4E. In the absence of national guidance on extending VRE screening further, as agreed by HIPG in 2017 current practice with regards to VRE screening in the areas noted above have 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.

There were no CPE bacteraemias in 2021-2022 (hospital or community acquired).

There were 15 cases CPE detected in 2021/22. All but 2 of these was detected on admission screening. The exceptions being one patient with risk factors for CPE but who was not screened on admission in a timely manner and one patient who did not have any risk factors but was screened after admission due to transfer to 4E/ICU and was found to be positive for CPE. In both cases, bay contacts were traced, the ward environment and practice reviewed and all patients on the relevant wards were screened weekly for 4 weeks as per national guidance (and no further cases were identified).

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

- Document details peripheral cannulae on VIP chart (at insertion, of monitoring at least once per shift and on removal). When the cannula is removed, the site needs to be continued to be monitored at least once per shift for at least another 48 hours, in order to detect in a timely manner, any evidence of infection post-removal.
- Cannula/line sites (current and previous) should be reviewed as a part of medical review in a deteriorating patient.

- Include information about cannulae (and other indwelling devices) in medical and nursing handover especially where there is concern about device related infection.
- Peripheral cannulae must be re-sited at the latest every 72 hours. However, if there is a clinical indication to leave a cannula in for longer (e.g., patient with very difficult IV access), ensure that the rationale is clearly documented in the patient's clinical notes.
- Consider alternative IV access (e.g., PICC line) early in patients with poor peripheral IV access especially if they are likely to require medium or long term IV therapy.
- If a patient fulfils criteria for sepsis, blood cultures must be taken before starting antibiotics (which need to be administered within 1 hour of the diagnosis of sepsis).
- 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.

- Adhere to Trust Antibiotic Policy and review previous positive microbiology results including infection alerts on the patient's medical records (e.g. on Medway/EPMA) when prescribing any antibiotic.

- For inter-hospital transfers, ensure that information regarding patient's previous microbiology results and infection management included in the handover from the transferring trust is reviewed and actioned.

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

3.1 There were 66 confirmed hospital outbreaks in 2021/22 – the majority were nosocomial COVID-19 outbreaks. This equated to a total of 30 lost bed days.

3.1.1 Nosocomial COVID

The trust attributed and reported nosocomial COVID-19 cases according to NHSE definitions/requirements in 2021/22. Summary of numbers of cases below:

Year	Hospital onset DEFINITIVE healthcare associated COVID cases	Hospital onset PROBABLE healthcare associated COVID cases	Hospital onset INDETERMINATE healthcare associated cases	COMMUNITY onset cases
2021	63	56	81	1340
2022	128	67	115	1203
Percentage	6.3%	4.0%	6.4%	83.3%

The trust nosocomial rate was 10.3%. which was the lowest in Cheshire and Merseyside

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 and reported to the Executive Committee weekly.

3.1.2 3D VRE outbreak

This prolonged outbreak has been a challenge to control. Themes identified were in relation to environmental hygiene and clinical practice. Multi-disciplinary outbreak meetings held with representation from Public Health England previously. Ongoing efforts are continuing to maintain both the environmental hygiene and appropriate clinical practice. Actions to date include ward being closed to admission on four occasions and the ward deep cleaned. 3D had hydrogen peroxide fogging undertaken on three occasions following the deep clean. 3D continues to have side rooms deep cleaned and fogged when a patient with VRE is discharged. The number of new VRE acquisitions on the ward during 2021/22 (i.e. 56), was a reduction compared to 2020/21 (59) and 2019/20 (78).

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 have 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, have been introduced since August 2016 to identify who has been assessed as competent in ANTT procedures and when their annual competency assessment is due.

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

- IV Access and Therapy Group are held on a monthly basis and co-chaired by the Lead Nurse IP and Medical Emergency Team Consultant Nurse.

5 Infection Prevention policies/publications

No new IP policies have been required during 2021/22.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. 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 provides 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.

6.4. 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. Infection prevention audit Indicators are now embedded in Tendables

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. Compliance is also monitored by wards and departments daily via Tendables
7.3. Monthly observational audits are conducted of handwashing to determine compliance with the Infection Prevention Manual Hand Decontamination Policy. The overall percentage for hand hygiene compliance is 95%

8. Information Technology

8.1 The ICNet electronic infection prevention surveillance and case management system was implemented in December 2014 which has enabled the IPT to review and manage a much broader range of cases in a timely and time efficient manner. In 2021, the system underwent its annual upgrade
The Trust procured the ICNet Outbreak Manager Module via COVID related funding. The implementation of this module is expected in 2022 after the ICNet upgrade and server upgrade (both of which have been completed).

8.2 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.

8.3 Electronic Bristol Stool Chart (BSC) and CPE assessments previously on Patientrack were transferred to the System C e-Vitals system in April 2021.

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
- Compliance with IP precautions audits throughout 2021/22
- Compliance with IP precautions throughout the SARS CoV2 pandemic
- Audit of CPE risk assessments and screening compliance
- Correct utilisation of pulp products

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

- Commode audit
- Number of deep clean requests that comply with the decontamination policy RAG rating
- 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
- Dirty utilities
- Water coolers
- 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);

2021/22 data indicated that:

- There were 240 Hip operations performed of which 3 infections were reported (1.3% compared to 0.8% national average).
- There were 297 Knee replacements completed of which 3 infections was reported (1.3% compared to 1.1% 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-Together Toolkit standards.

- To ensure a proper senior attendance, regular root cause analysis meetings are conducted quarterly and 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.
- C difficile ward rounds.
- Quarterly audits of antimicrobial use in sepsis carried out for the CQUIN.
- Repeatedly reviewed the Antibiotic Policy at short notice due to many significant drug shortages.
- Reviewed antibiotic renal dose adjustment policy and prepared an app which integrates this information with a CrCl calculator.
- Developed an e-learning package for clinicians to undertake every 3 years focused on prudent antimicrobial prescribing.
- Developed an Outpatient antibiotic therapy (OPAT) database to track patient progress and improve quality/quantity of reporting

10.2. Antibiotic Management Group (AMG) – the AMG meets and reviews all aspects of antimicrobial use throughout the Trust. The antimicrobial management team (AMT) includes antimicrobial pharmacists and clinical microbiologist(s) who are all members of the AMG. The team update and maintain the Trust's antimicrobial formulary, the stewardship strategy/policy and raise agenda items to be discussed at the AMG.

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

10.4. Antibiotic awareness events (European Day and World Antibiotic Awareness Week)

As per 2021, COVID-19 restrictions meant a digital response remained the most appropriate medium to deliver the key messages for the campaign this year. This was again co- ordinated by the Pharmacy and Infection Team. As well as following national messages, it was decided to use this opportunity to re-launch good antimicrobial stewardship practice.

10.5. Key Achievements:

- Provided antimicrobial stewardship ward rounds across multiple specialties at Whiston Hospital
- Published and maintained up to date Antimicrobial Policies for Adults, Paediatrics and Neonates on the MicroGuide platform as well as PDF formats. All guidance is updated based on national guidance and locally reviewed sensitivity 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 312 episodes of outpatient parenteral antibiotic therapy (OPAT) in the absence of a formalised service. During 2021/22 this saved 3464 bed days, which equates to over £1 million in bed day savings.
- The AMT has continued to champion innovative antimicrobial drug therapy delivery systems such as elastomeric infuser devices in the OPAT setting to promote Antimicrobial Stewardship (AMS) and allow patients to be discharged home on optimal therapy. This work was presented at the OPAT and IV Therapy National Networking Forum in May 2022. AMT has also continued to promote the use of a long-acting glycopeptide dalbavancin to help facilitate discharging of patients were clinically appropriate.
- St Helens and Knowsley Teaching Hospitals NHS Trust Antimicrobial Stewardship Strategy was reviewed and updated in 2021 as per National initiatives and guidance.
- Developed patient information leaflets for high-risk antibiotics such as fluoroquinolones, linezolid and gentamicin
- Published and maintained up to date patient group directions relating to the use of antimicrobials.
- Antimicrobial policies available on the Trust intranet have been migrated over to the new Trust extranet
- The AMT participated in the regional gentamicin prescribing audit which due to its findings is being taken forward and audited nationally. The aim is to try and produce standardised guidance on gentamicin prescribing and therapeutic drug monitoring to reduce prescribing errors.

An audit of the appropriateness of antibiotic prophylaxis in elective hip and knee arthroplasty patients at StHK was conducted and presented at the orthopaedic directorate meeting as part of the UKHSA (UK Health Security Agency) national mandatory surgical site surveillance program.

10.5 Key challenges/issues**:**

- OPAT activity continues grow
- Increasing use of broad-spectrum antimicrobials for multi drug resistant infections coupled with increasing winter pressures and the Coronavirus crisis.
- To continue to monitor prescribing, therapeutic drug monitoring and missed doses of antimicrobials through guideline expansion and innovation with the increased use of EPMA, networking and informatics initiatives.

- Expanding the pharmacy aseptic dispensing unit capacity to produce ready-made antimicrobials

10.7. Antimicrobial Forward plan 2022/2023:

- Return of UTI CQUIN for 2022/23. This will require the AMT to audit 100 patients each quarter to achieve the CQUIN data set. Based on the audit results several improvement projects will be implemented.
- To continue to work towards reducing total antibiotics consumption by 1% as set out in the NHS standard contract by employing a range of AMS strategies such as target antimicrobial ward rounds and education**.**
- UTI e-learning package has been updated and launched to help clinicians to diagnose and treat UTI's
- Work with North-West Antibiotic Pharmacist Group to develop and deploy a region-wide gentamicin protocol and calculator.
- Produce Trust Antimicrobial Stewardship e-learning package
- To continue to provide education to other healthcare professionals including junior doctors, pharmacists, and nurses
- Work with Aseptic Dispensing Unit to provide ready-made antibiotics in line with Lord Carter's review of pharmacy aseptic services.

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**

In a very challenging and difficult flu season achieved 72.06 % flu vaccination uptake amongst frontline clinical staff

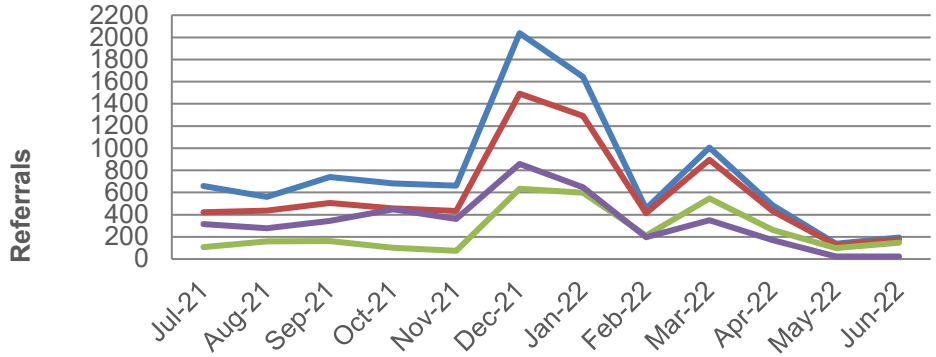
Forward plan:

- 2022/2023 reintroduction of CQUIN
- Re engaged the Flu- MDT team- comms/ pharmacy/ peer vaccinators/ ICP/ Manager and Matron- make the whole trust aware.
- Planning Launch end September- cover all clinical areas first, including the high risk.
- Targeted approach from beginning of campaign.

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

Key Achievements

- Supporting the organisation through the covid wave November – January. There were 3219 staff referrals to the SIT over the three months, of which 1307 were positive and require further intervention from the SIT and HWWB



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Total Referrals	659	560	740	683	663	2038	1644	454	1006	486	138	195
Staff Only Referrals	422	437	505	458	435	1492	1292	413	896	434	127	176
Positive (staff/Isolating)	108	159	161	101	74	634	599	211	545	262	99	147
Negative (Staff)	314	278	344	447	361	858	648	198	351	172	23	23

Key challenges/issues:

- SIT team was small team of redeployed and band staff, worked with the organisation, DON and key managers and matron to ensure staff returned to work safely, and staff who had covid were given correct advice and support.
- Contacting staff who had isolated was often a challenge, some never answered the call.

Actions taken to overcome challenges and issues:

- SIT Team has continued to support the organisation in line with covid guidance. While the swabbing tent has now ceased the SIT nurses do continue to support staff and managers who test positive on LFD

11.6 **Group A Streptococcus (GAS)**

Key Achievements:

- HWWB have supported several GAS outbreaks. The biggest being in the community.
- Worked effective as part of the wider MDT team and ensured everyone was swabbed and given prophylactic antibiotics within the timeframe set by PHE.
- Since gone on to support several smaller outbreaks effectively using lessons learned from the community outbreak

Key challenges/issues:

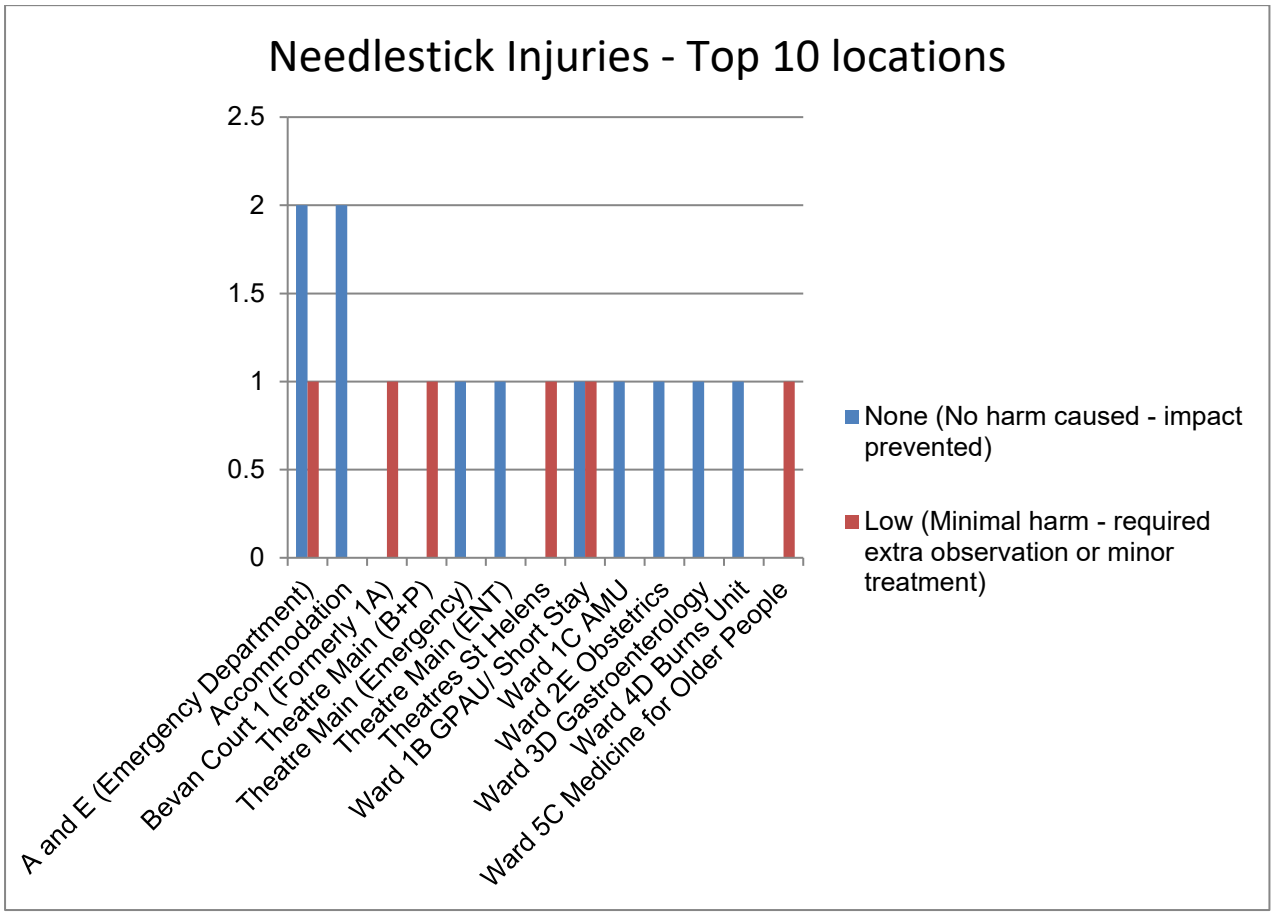
- Acquiring an accurate list of staff who need swabbing in a timely manner
- Staff swabbing- HWWB have been attending on site (where the outbreaks are) as much as reasonably practicable,
- HWWB have devised a spreadsheet template so once they are notified, managers to start populating the staff details so that appointments can be arranged **.**
- HWWB duty nurse links in with the team co ordinating and gives updates as required to ICP/ Microbiology and managers.

11.7 **Needlestick Injuries.**

During the period 1 April 2021 to 31 March 2022, there has bene zero staff-related high risk sharps injuries reported via RIDDOR.

The Health and Safety team and HWWB continue to support those responsible for the completion of RCAs with the aim of understanding how incidents are occurring and implementation of any remedial actions as a result. The findings of the RCA.s continue to be an agenda item at the Trust Hospital infection group meeting (HIPG). These types of injuries have shown a decrease during the pandemic, which is possibly attributed to reduced ED attendances and reduced elective surgeries where these types of injuries would typically be sustained.

No HIV, Hepatitis B or Hepatitis C infections have been reported by those staff sustaining high risk inoculation injuries



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's 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:

- Full implementation of Quality Management System ISO 13485.
- Productivity in the Decontamination Unit is now back to pre-Covid figures.
- Achieving an amber/green rating in the annual IHEEM/JAG Audit carried in September 2021 despite ever ageing decontamination equipment.
- The commencement of quarterly environmental testing, this includes endoscope drying cabinet shelf-life testing and endoscope bioburden micro testing.
- The build phase of the new Decontamination Unit is nearing completion. Build hand- over is scheduled for the end of September 2022
- Plans for a new build Decontamination Unit at Whiston have had Executive approval and have been included in the Trust Strategic Estate Development Plans.
- Two Vinci engineers have been contracted to provide Authorised Person for Decontamination (AP(D)) duties for both St Helens and Whiston Sites. Both engineers have completed all relevant decontamination courses and have been signed off as competent by the Trust Authorised Engineer for Decontamination AE(D).

Key challenges/issues:

- The endoscope washer disinfectors on both sites are now seen as end of life with the manufacturer withdrawing support for the older FC4 endoscope washer.
- Staff shortages due to Covid sickness and isolation has had a massive impact on the unit.
- Providing extra evening and weekend decontamination support for our service users to reduce patient backlogs due to Covid.

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 the 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:

- August 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 all utilise the latest endoscope recognition technology and the unit has been futureproofed to provide the ability to expand alongside the growth in endoscopy procedures.
- A full electronic endoscope track and trace system with the ability to interface with the decontamination equipment will be installed at St Helens, providing a complete time stamped audit trail for all flexible endoscopes use and decontamination processes.
- Autumn 2022 should see the start of the build phase of the new Endoscope Decontamination Unit at Whiston.
- In December Whiston and St Helens units seeking certification for its ISO 13485 quality management system.

13. Estates and Facilities

The Estates, Facilities and Non-Clinical Risk Team in collaboration with our PFI partners have worked closely with the Trusts Infection prevention and control Team over the past twelve months to ensure that a safe environment for our patients, staff and visitors is maintained.

This effective partnership will continue as we work together to constantly maintain the highest standards possible, meet the requirements of the ever-changing legislation, guidance, compliance, and safety standards of the NHS and develop the Trusts Estate

The introduction of new cleaning standards, updated Health Technical Memorandums (HTMs) and IPC standards will be embedded in the teams' work plans for the coming twelve months. Along with close working with the IPC team as the Trust continues to deliver an ambitious capital works programme.

Each section of this report demonstrates our continued commitment to the IPC agenda.

Key Achievements:

The report has been split into categories to demonstrate key achievements from across the services linking with the IPC agenda: -

Premises Assurance Model

NHS constitution right – 'to be cared for in a clean, safe and secure environment'

The NHS Premises Assurance Model is a set of mandatory standards the Estates and Facilities services are required to report upon and complete a return demonstrating compliance annually**.**

A gap analysis against Premises Assurance Model (PAM) whereby all aspects under the management of/linking to Estates and Facilities are benchmarked against national standards, audited by external auditors, in order to achieve high quality clinical care within safe, high quality and efficient estate has been completed, the areas monitored that link to infection control:

- PLACE & other assessments of cleanliness
- Cleaning schedules
- Waste management
- Air pollution
- Water safety
- Health & safety at work
- Emergency planning
- Ventilation systems
- Decontamination

Key Achievements:

The work completed to comply with the requirement of the NHS PAM includes: -

- Submission of evidence from Trust, Contractors and Sub-contractors re Trust-wide and site-wide infection control and related issues
- Identification of areas needing updating or revising
- Comprehensive action plan with named personnel, expected submission dates and monitoring process within Estates & Facilities and Trust Infection Control governance arrangements
-

The NHS Premises assurance self-assessment tool enables comparison to be drawn against the Trusts current estate and services and identifies areas for further developments, some of which are already in plan for 2022/2023. Such as instillation of a second liquid oxygen vessel to improve resilience. Other workstreams include assessment of the organisations ventilation systems in comparison to the latest legislation released.

Estates and Facilities Services

Hospital Ventilation Systems

- Ventilation systems have been under increased scrutiny to cope with evolving guidance because of the COVID-19 pandemic. Vinci facilities have been able to complete all ventilation planned maintenance to ensure standards and compliance were maintained.

- New Laser room at St. Helens - A therapy area at St. Helens Hospital was refurbished to create a fully functioning laser clinic facility. Part of the requirements was the installation of new ductwork, grilles, and an increased ventilation rate to accommodate

the requirements of the room. This work has now been completed and performing to the new design criteria.

- Extensive ventilation work has taken place with the Trusts partners Community Health Partnership at Newton Community Hospital to improve the performance and compliance of the ward ventilation systems capabilities. Systems have been validated and are working to design criteria.

- As a result of the updated HTM 0301 in August 2021 the Trust has established a ventilation safety group to discuss compliance with this guidance and identify gaps in compliance. A Trust ventilation policy is currently in development.

Water Safety Systems

- All Water Safety Risk Assessments and action plans have been completed at both St Helens, Whiston and all community sites. This has provided assurance that all control measures are being adhered to.

- There is a Water Safety Group which receives regular reports that identifies all actions taken and results for any water safety works. This provides assurance that the Trust is compliant with relevant legislation.

- During 2021/22 it was identified that the Trust was using flexible hoses which had potentially been manufactured from ethylene propylene diene monomer (EPDM). A replacement programme was agreed to remove these flexible hoses, the programme is now complete.

- Water Cooler Audits continued throughout 2021/22 with the predominant issues being limescale and incomplete paperwork. The ward housekeeper and domestic teams are informed of all noncompliance issues.

Water Cooler Audits 2021 – 2022

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Water Tray	96%	96%	74%	100%	100%	81%		89%	100%	89%	92%	100%
Spout	92%	89%	93%	96%	100%	100%		100%	100%	100%	100%	100%
Cups	67%	78%	78%	89%	100%	93%		85%	81%	96%	70%	100%
Cups Holder	92%	89%	85%	100%	93%	96%		85%	81%	96%	70%	100%
Paperwork	63%	70%	56%	89%	56%	67%		96%	100%	100%	67%	100%
Floor Area	100%	100 %	96%	100%	93%	100%		100%	100%	100%	89%	96%
Average overall compliance %	85%	87%	80%	95%	90%	90%		93%	94%	97%	81%	99%

- The flushing of underused outlets by the wards is undertaken by ward staff and monitored by the Estates and Facilities Management Team on a monthly basis, with any issues escalated to the ward manager for immediate action.

Waste Management

- The waste service has continued to function as normal with additional waste measures in place throughout the Covid-19 pandemic.
- During the year we have promoted recycling across the trust with successful trails in the Theatre and Radiology departments this year.

Clinical Waste Collection:

- Training materials are available to help staff identify correct disposal of clinical waste (e.g. clinical bins/Sharpsmart containers) to comply with safety guidelines.
- Extra internal collections have been requested during this period as more clinical waste is being produced 24 hours a day in extra areas. Areas are monitored daily, and support is available to ensure all waste is disposed of regularly.
- Whiston Hospitals clinical waste collections faced disruption due to the unprecedented volume of waste being generated nationally. Business continuity plans were put in place to ensure the service continued to function safely.
- Onsite storage facilities for internal offensive (yellow/black stripped) tiger clinical bags have proved successful ensuring that the hospital has enough clinical bins.
- A review took place of the Sharpsmart system. This review raised some areas of concern, e.g., not disposing of sharps at point of use and items placed in the sharpsmart system are appropriate and do not cause operational issues at the waste disposal plant. To this end the following revised practises have been put in place: -
    1. In the majority of areas there will no longer need to use the blue lidded containers – the decision was made to remove them from certain clinical areas. All empty bottles, vials or other pharmaceutically contaminated items are now placed in a mobile sharp smart container, which cannot be opened on site and when full is removed and disposed of through the sharpsmart system.
    2. Small green containers are now used for the disposal of metal knee and hip joints in theatres. Metal knee or hip joints are NOT put in a yellow lidded container as they can cause huge operational delays (and costs) at the waste processing facility. Any other small metal single use instruments can also go into the small green containers.
    3. Large green containers are now in place throughout the theatre departments. These containers are also for single use metal instruments, but due to their size are normally used for laparoscopic instruments and guide wires.

- In the period March 2021 to February 2022, 50.4 tonnes of clinical waste was disposed of using Sharpsmart Reusable Containers at Whiston & St Helens Hospitals. The average monthly useage of containers is circa 1764, these are split by site as follows St Helens Hospital circa 388 and Whiston Hospital – 1376. This has resulted in a cost avoidance of circa £19k through using the recycling bins instead of purchasing plastic sharps bins. Which in turn has contributed to the reduction of annual carbon emmissions by circa 145 tonnes.

FIT Testing Service

- In February 2022 we transitioned from the Qualitative to Quantitive respititory protective equipment (RPE) fit testing method
- The fit testing service was originally undertaken by temporary staff due to the increase in demand as a result of the pandemic, but this has now been incorporated into BAU activities.
- The Trust has reduced the numbers of RPE suppliers and alternatives to 3M mask (Procurement request) to ensure continuity and quality of equipment within the organisation.
- A TSI Porta Count machine purchased in January 2022 – which enables the trainers to assess the effectiveness of the fit
- The Fit testing service now covers students, community practitioners and international nurses
- A booking service has been introduced to make the service more accessible.

COVID-19 Measures

- The team worked with both clinical and non-clinical teams to maintain safe working environments for all by ensuring correct signage and screening was in place.
- Audits were undertaken to ensure that 2 metre social distancing is in operation in office environments.

Estates and Facilities Audits

- The Estates and Facilities audits follow the specification laid out in PLACE and the PFI (Private Finance Initiative) Facilities Management contract. The team look in every room and highlight every patient environment and cleaning issue found.

- A score is awarded using the same format as PLACE and is RAG rated. A report and action plan are submitted to ward managers, Infection Control, and the cleanliness and maintenance team. Any issues identified are escalated to Medirest, Vinci or the Ward Manager as appropriate. The team then follow up the audit within 1 month and work closely with all involved to ensure the issues found are rectified.

- These inspections are carried out twice yearly on every ward, in outpatients and all other patient areas. The scoring system that is used is: -

  Green = 90 – 100%, Amber = 85 – 89%, Red = Under 84%
  Estates and Facilities Audits continued within areas e.g., from the last 3 months the Trust's overall compliance = 93.67%
- It Should be noted that access to all rooms during the pandemic was not always achieved due to the IPC restrictions but maintenance work, the painting programme and cleaning continued where possible with ward refurbishments taking place when decant facilities became available.

Key challenges/issues:

Ventilation

- The changing use of areas during COVID-19 and the changing national guidance made adapting to the demand / requirements of increased air flow or different pressure regimes to help decrease to the spread of COVID 19 was a challenge and required innovative and timely responses as the situation developed/changed. Both Whiton and St Helens hospitals are modern and have good infrastructure which meant these challenges could be met on these sites more easily than in some older hospitals/

- St. Helens ENT have a temporary air change system installed to enable the required air changes in the room. A permanent solution has now been installed.

- The attenuation that lines the Ultra Clean Theatre canopy ducts at both Whiston and St. Helens Hospital has started to deteriorate. Estates and Facilities Management are working with operational colleagues and IPC to agree a replacement programme that will have minimal impact on the elective recovery programme and in the meantime the risk is being mitigated with additional testing.

- Accident and Emergency Department Corridor ventilation does not meet the new standards and work has been undertaken to establish how this could be increased. Options have been developed and the engineering and operational feasibility are being evaluated by the Ventilation Safety Group and the feasibility, value for money and operational managers in the area.

Water Safety

- We had a repeat positive pseudomonas sample on one of the assisted baths on Ward 4E. As per procedure Vinci installed Point of Use Filters and undertook the flushing of this bath however this outlet a continued to test positive. The next course of action was to chemically dose this outlet, which resulted in the level of contamination reducing. After repeated doses the outlet provided 3 negative samples as recommended in the HTM. The ward has continued with the daily flushing regime and this outlet has remained negative.

- As per HTM 04-01 a scalding risk assessment must be undertaken. The risk assessment is to 'review the need for Thermostatic Mixing Valves that mix hot and cold water to a safe water temperature to considering the relative risks of scalding. Vinci are engaging a specialist sub-contractor to undertake this work across all the hot water outlets over the coming 12 months.

Waste

- A total of seventeen waste breaches were reported at Whiston in 2021/2022.

Types of Waste Breaches	2021 / 2022
Sharps bins not closed	1
Sharps Spill	2
Sharpsmart Container out of date	2

Sharps lids off	1
Medicine bins not closed	0
Cytoxic Sharps	0
Contaminated Bins / Bags	11
Total	17

All Matrons and Ward Managers were informed of the breaches and additional training offered to staff.

Follow-up reminder emails sent by the waste management Environmental Officer stating the importance of investigating, reporting, and learning lessons from Waste disposal breaches.

Community Properties

Newton

- Supporting the delivery of further lifecycle flooring work to the site in the coming months.

Estates and Facilities Capital schemes

- External capital funding has been secured to create two new Theatres at Whiston Hospital within the existing footprint of the building to support the reduction of waiting lists for surgery following the pandemic.
- Children's Observation Ward and Paediatric A&E Scheme is in progress and work will continue on site until Q4 of 2022/23.
- St Helens Decontamination Unit - work continues to deliver the new unit this financial year.

All of these schemes are being undertaken in a working hospital which creates the risk of service disruption and IPC hazards, and they need to be closely managed with IPC colleagues to minimise these risks.

15.Risk Register

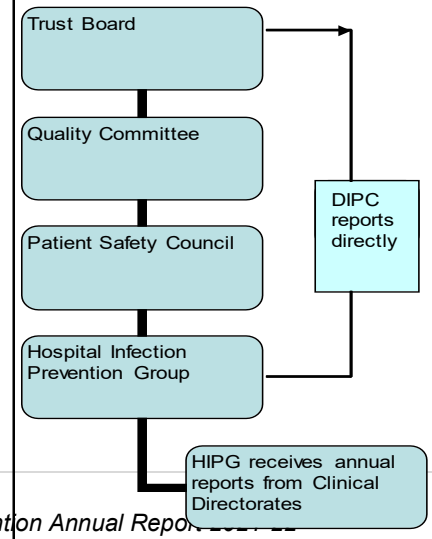
There is a number of low-level risks on the risk register, the most significant infection risks on the Trust's risk register is the identification of patients within the Trust colonised with multidrug resistant bacteria and SARS CoV2 pandemic.

20. 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 & Knowsley Teaching Hospitals NHS Trust Infection Prevention Annual Work Plan 2021/2022	
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.

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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)	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	Rachel Jackson (RJ)					
	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				
							

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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			

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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	Continue to audit compliance with policy	IPT	Report Trust wide				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code:	**5. ANTT/Intravascular Access and Therapy**						
1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	Monitor Trust wide compliance and increase compliance rates.	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.				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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. 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, 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				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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.				

IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	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).				

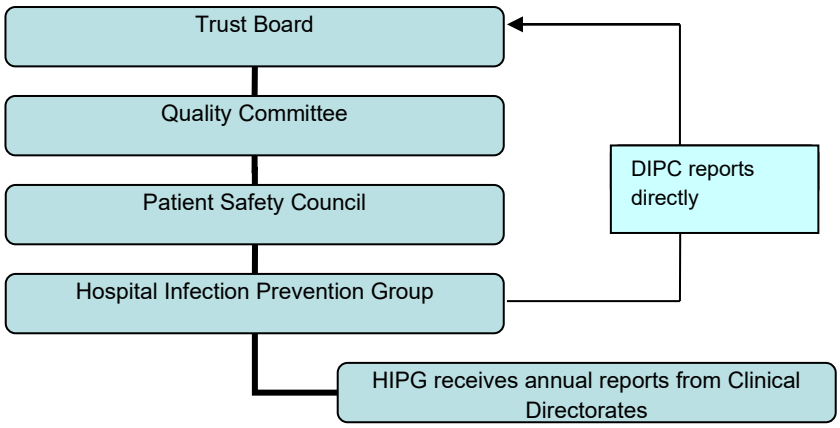
IP Code and Trust Objectives	Plan and Priority Activities 2021/2022	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IP Code: 1, 2, 3, 4, 5, 6,9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**12. Interface with relevant groups** IP to attend and provide expert opinion for topics related 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: 2022/23
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.
Quorum	50% of the core membership (or appropriate deputies) must be present. To include at least one Infection Control specialist.
Accountability & Reporting.	The Hospital Infection Prevention Group was established by and is responsible to the Trust Board via the Patient Safety Council:  .
Meeting Frequency	6 times a year
Agenda Setting and Minute Production and Distribution.	**Agenda** Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Group and any other person required to attend prior to the meeting.

Supporting papers shall be sent to Group members and to other attendees as appropriate, at the same time.

Regular reports received by HIPG.

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